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New Zealand Productivity Commission
Te Komihana Whai Hua o Aotearoa
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Via email: info@productivity.govt.nz

Tēnā koe

Submission to The New Zealand Productivity Commission Te Komihana Whai Hua o Aotearoa (The Commission) – Immigration Settings

The Royal New Zealand College of General Practitioners (the College) is pleased to provide comment on the Commission's Immigration, productivity and wellbeing: Issues paper. The Royal New Zealand College of General Practitioners is the largest medical college in New Zealand. Our membership of 5,675 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. The Rural Division of Hospital Medicine also sits within the College's academic remit of vocational training of doctors working in rural hospitals. Our members cover both urban and rural settings, funded through capitation and co-payment, and work either as business owners or community corporate trusts. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

Key issues that we would like to highlight at this time for the Productivity Commission inquiry:

1. There is a shortage of GPs in New Zealand

New Zealand is facing a shortage of suitably qualified General Practitioners, with the number of full-time equivalent GPs per 100,000 people dropping, retirement intentions increasing as the workforce gets older, and burnout amongst GPs becoming a significant issue. The current GP workforce is dominated by the large numbers of medical graduates from the late 1970s to mid-1980s, who are now in their late 50s or 60s and are moving toward retirement. General practices across the country are also having increasing difficulty in sourcing and retaining Specialist GP's.

As a result, New Zealand's medical workforce relies on international graduates to sustain health care in our communities, particularly so in rural areas, with about a third of rural practices having long term vacancies. West Coast has the highest percentage of IMGs – almost 69 percent, followed by Whanganui (62 percent), Wairarapa (52 percent), and Taranaki (52 percent). The Medical Council of New Zealand (MCNZ) has policy and regulatory processes in place to manage the multifactorial issues around International Medical Graduates (IMGs)[1] who form a vital part of the NZ medical workforce, at about 40% of that workforce. They bring critical expertise into the New Zealand health system, contribute clinical and cultural skills and perspectives that are highly valued and respected, and contribute to our multicultural society. The MCNZ reports on numbers of doctors working in New Zealand annually[i], and reports on IMGs and provides best practice guidance on Orientation, Induction, and Supervision for IMGs. Immigration statistics show that the number of GPs applying and being approved to come to New Zealand is falling.

1 No matter how long they are resident here or how they see themselves (e.g., may adopt New Zealand citizenship or be Māori), or how many post-graduate qualifications they may obtain in New Zealand, the individual doctor remains classified as an IMG under the MCNZ's workforce definition.

2. Current immigration settings

General practitioners and resident medical officers (who work under the supervision of medical specialists or senior general practitioners) are currently ANZSCO skill level 1. General practitioner is on the long-term shortage list but not the regional skill shortage list. Resident Medical officer is on the regional skill shortage list, but not the long-term skill shortage list.

Recommendation

That both general practitioners and resident medical officers be on both the long-term shortage list and the regional skill shortage list, due to known sustained workforce shortages, and considered for addition to the critical skills list.

3. RNZGP workforce survey

The College's Workforce Survey[ii] is a biennial event that provides data and trend information on retirement, income, employment status, working hours, and demographics.

Key statistics from the 2020 workforce survey include:

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- Nearly one-third (31 percent) of respondents rate themselves 'high' on the burn-out scale.
- The GP workforce continues to face an issue of aging, especially in the 60-74 age range.
- Almost one third of GPs intend to retire within the next five years and almost half intend to retire within the next 10 years.
- For the first time, in 2020, the number of part time GPs exceeded full time GPs.
- More than one-quarter of rural hospital medical staff stated they intend to retire in the next five years and a further 18 percent intend to retire in 6-10 years' time - succession planning for rural hospital medical staff is needed.
- IMGs were asked from which country they had received their first medical qualification. This was predominantly the United Kingdom, followed by South Africa, India and Australia over the period from 2014 to 2020. The UK is also facing GP and doctor shortages.

Allen and Clarke are currently undertaking research for the College on GP Future Workforce Requirements which we expect to be published in October 2021.

4. Are there barriers to migrants fully contributing to New Zealand's productivity growth?

We have heard from some of our members seeking help, and there have been several reports in the media about difficulties relating to the delay in residential visa applications and immigration process over the last year and a half during the freeze on immigration decisions during the Covid-19 response. Some recent GP stories include:

- June 2021 - Skilled migrants awaiting residency: 'We feel like we're being left to sink or swim'
- July 2021 - Young regional GP with 1300 patients leaves New Zealand following residency limbo
- July 2021 - Frozen residency queue strikes again: Whangārei loses UK GP today
- July 2021 - Ōtaki GP returns to UK as freeze on residency applications hits home

Delays in long-term and residential visa applications have lengthened to more than two year wait times, managed isolation and quarantine procedures are causing delays to recruitment and settings for skilled worker visas have changed giving employers, workers and their families no certainty about future rights to work, or to study or buy a home in New Zealand. RNZCGP understands that the Medical Council of NZ has also removed conditions on practitioners' scope of practice as a result of immigration delays and the age waiver of 55 for residency has also caused issues for some of our members seeking residency in NZ.

It can take a significant length of time to move to New Zealand (quite often up to a year), especially from countries already under workforce pressure. RNZCGP praised the decision of the government to remove the deadline that was causing difficulties for healthcare workers to enter New Zealand in March this year[iii] and would recommend this is a feature that is kept in the new framework.

We recently submitted 29 applications for GP training to the Ministry of Health. Only seven of these so far have been approved. Candidates need to show that they are committed to being in New Zealand, and hold residency, but that has proven harder over the last year for many applicants.

Recommendations

- *That the Productivity Commission consider how an applicant could show commitment to New Zealand at a time when residency applications are paused, and they are unable to obtain a training place due to not being able to obtain residency, and how the recruitment of overseas applicants can be considered.*
- *The Productivity Commission may also wish to consider visa lengths that align with training programmes (general practice is 3 to 4 years) to avoid difficulties with visas running out of time part way through training.*
- *The government should consider whether residency is a requirement for any medical training programmes or funding in its consideration of regulating residency, to ensure that the workforce is not further constrained. This should be underpinned by need in various sectors*.

5. Is the Commission's proposed framework a useful way of thinking about the immigration system for this inquiry? What changes would you make?

New Zealand has been through a major health crisis this year and people have a right to the best care, which means having enough specialists in general practice and rural hospital medicine to meet patient's ongoing demand. Covid-19 has significantly impacted the international medical workforce. The loss of international tourism and education market for overseas students, extended border closures, associated costs of travel/MIQ, and the shortage of critical high value skills – for which New Zealand is competing in a global market, have all impacted the labour, housing and regional markets, especially rural farming and rural health services.[iv] The world is now very different with temporary and permanent migration patterns changed for the foreseeable future.[v]

There needs to be flexibility and fluidity in the approach. Doctors are not unique in being highly sought-after post qualification, but they are enabled to migrate off-shore as both part of post-graduate training (to the UK and Canada), and due to Trans-Tasman Mutual Recognition Arrangements with Australia; to work on both sides of the Tasman. This flexibility and fluidity is both an advantage and disadvantage in terms of retaining skilled migrant labour that both countries need to draw on. The College upholds the principle of active protection to protect the rights of Māori as tangata whenua under Te Tiriti.

There is also a strong ethical argument for managing the volume of recruitment of overseas trained doctors and supply of doctors to first world countries. The depletion of trained doctors from developing countries has a significant negative impact on their own health systems and the appetite for increasing doctor patient ratios in the OECD/western world is inexhaustible by comparison. The WMA 2017 and WHO 2010 both issued voluntary codes of practice on the recruitment of overseas doctors by first world countries that often rely on 25 percent of their workforce being sourced from other countries. New Zealand at 40 percent, stands out for its poor performance in training sufficient doctors.[vi] New Zealand should be investing in growing the domestic workforce of general practitioners and rural medicine specialists. The College upholds the principle of active protection to protect the rights of Māori as tangata whenua under Te Tiriti in doing this.

Recommendation
We consider that Immigration NZ and the Productivity Commission should work with Health Workforce NZ and professional bodies, and there should be ongoing collaboration to ensure that immigration settings reflect GP workforce shortages and skill shortages.

There is a large focus on productivity in the document. The value and contribution of general practitioners and other medical practitioners contributes heavily regarding aspects that may contribute to productivity, keeping people healthy and helping people to return to work after illness, contributing to the wellbeing of people in New Zealand.[vii] They can also raise productivity by investing in practices. However, the policy of importing high-net worth individuals and the use of bringing in large sums of capital or net salary income as high immigration points criteria increases the levels of inequity experienced by others in the country. The issues paper sems to distinguish people primarily in monetary value terms, with less reliance on the holistic view of people's potential contribution to society, cultural competence compatibility within New Zealand aims and values, and importantly willingness to stay and invest/commit to the country.

We consider sustainability of the general practice workforce poses a major risk to the health of New Zealanders and that the issues paper could also assess the impact and contribution of immigration settings on different parts of the labour market, including existing arrangements in place.

6. Vocational Registration

General practice has been recognised as a medical specialty under New Zealand law since 1995, however there are doctors working in a general practice setting that have not undertaken vocational training, that are regulated by the Medical Council of NZ. Other OECD countries like Australia, the United Kingdom and Canada require vocational training. The Medical Council of New Zealand (MCNZ) registration data reveals that as of 16 September 2021 there were 730 medical practitioners working in general practice who were neither vocationally registered GPs nor participating in vocational training.

The RNZCGP position on vocational registration since 2010 remains consistent. Doctors working in general practice should be trained and vocationally registered to practice as a GP as this has been shown to improve quality of medical practice and patients have a right to be informed that quality of care is impacted by specialist training and registration requirements. on-vocationally registered doctors are more likely to be subject to complaints and competence concerns, particularly in general practice. [viii]

Recommendation
The immigration system should set higher skill levels for the doctors that undertake vocational training in comparison to those that are not vocationally registered.

7. Partners, parents and families of migrants

It can take nearly two years for an overseas GP to settle into life in New Zealand[ix]. As mentioned above, factors relating to family can be an important part in the GP remaining in New Zealand. It is important that there are policies in place to help partners of skilled migrants find work to retain skilled workers. The recruitment and retention of a sufficient GP workforce in rural and remote locations is an ongoing problem internationally. Lack of meaningful job opportunities for a partner/spouse and reduced opportunities for children's schooling are identified internationally as key barriers to general practitioners (GPs) working rurally[x].

Recommendation

The new immigration system should not take a blanket approach to partners and families of migrants, and the process should be informed by evidence in relation to how this may affect the retention of skilled workers in New Zealand.

Conclusion

Achieving a fine balance in immigration settings takes time. We ask the commission to specifically consider the impacts of immigration settings on the recruitment and retention of GPs and rural hospital medicine, as well as other critical healthcare workers. Recognising Crown obligations under Te Tiriti o Waitangi in how we set immigration policy is a critical first step.

The College would appreciate the opportunity to meet with you to discuss our submission and issues arising from it. We are seeking the views of our members on this issue and will share these in a further submission. We consider there should be an open dialogue about health workforce issues and look forward to discussing with you.

If you have any questions, or require additional information, please email us at policy@rnzcgp.org.nz.
We look forward to hearing from you.

Nāku noa, nā

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i https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/6be731ea72/Workforce-Survey-Report-2019.pdf
ii The GP workforce
iii Glimmer of hope for GP practices struggling with severe doctor shortages and Immigration changes just what the doctor ordered
iv https://www.beehive.govt.nz/release/border-class-exceptions-approved-more-farm-workers-and-vets
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vii https://www.who.int/workforcealliance/media/news/2016/health-workers-economic-growth/en/
viii St George I. Should all general practitioners be vocationally registered? N Z Fam Physician. 2004;31(1):17–19.
ix https://www.newzealandnow.govt.nz/live-in-new-zealand/tips-for-settling-in/stages-of-settling-in
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