Over the edge

Findings of the 2022 survey of the future intentions of senior doctors and dentists

ASMS
TOI MATA HAUORA

Contents

Future intentions of the senior medical workforce

Key statistics and comparisons with 2017

ASMS previously published results of a Future Intentions survey in 2017. While the phrasing of questions has differed slightly between the two iterations of the survey, some major themes can be drawn from the findings and compared.

Intentions to leave **2017: 16 %**

Intentions to leave **2022: 18 %**

Across all age groups, the overall rate of intention to leave medicine or dentistry within the next five years to 2027 was 17.7 per cent (n=1594).

36 per cent (n= 562) of doctors and dentists aged over 55 years intend to leave compared to 6 per cent of doctors and dentists under 45 years (n=471).

No significant associations with gender or ethnicity, but those with no dependant children were more likely to indicate an intention to leave (p= <0.001).

Likely to continue in DHB-based employment **2017: 83 %**

Likely to continue in current employment **2022: 62 %**

62% (95% CI 60.6% - 62.9%) were likely or very likely to remain in their current employment over the next 5 years.

This is a significant drop from 2017, where 83% indicated they were likely to remain.

Going overseas to practice — 2017: 4.24 %

Going overseas to practice (temporarily) — 2022: 12.7 %
Going overseas to practice (permanently) — 2022: 10.9 %

In 2017, fewer than 5 per cent of respondents (4.24%, n=79) indicated an intention to leave Aotearoa and practise medicine abroad, though there was no option to distinguish between permanent or temporary relocation.

In 2022, respondents could signal a temporary or permanent relocation. 12.7 per cent (n=202) said they would leave on a short-term basis, and 10.9 per cent said they would leave permanently. As affirmative responses could be given to either question, the overall rate of intention to practise abroad should not be combined.

There were significant negative associations by age for both variables (p-value <0.001 and 0.002 respectively) with respondents aged under 50 more likely to consider moving abroad.

Ethnicity and intentions to practise overseas were associated for respondents of Asian ethnicity, and for members of Pasifika ethnicity, but a small sample size of the latter group means this should be treated with caution.

Decrease DHB FTE — 2017: 40 %

Reduce hours in the public system and increase private practice — 2022: 42 %

For the first time, ASMS asked members about their intentions for private practice, and whether they intended to start or increase their private full time equivalent (FTE) hours.

While 42% likely to drop public hours, not all were doing this to start or increase private practice: it was a means of work recovery and self-care.

A nearly equal proportion (41.07%) were unlikely to start or increase private practice, which may also reflect members in specialities that do not have provision for such arrangements, such as emergency medicine and public health medicine.

Research design and methodology

The 2022 Future Intentions and International Medical Graduate (IMG) Experiences survey was designed with a dual-purpose aim, founded on two research questions:

1. What are the future intentions of the Aotearoa New Zealand senior medical workforce for the 2022-2027 period?
2. What factors have influenced IMGs in choosing to live and practice in Aotearoa New Zealand, and what has impacted their experience?

This report will focus on findings and results related to question one (Future Intentions) above.

ASMS first undertook a future intentions survey in 2016, where SMOs working in the then-District Health Boards (DHBs) were asked to consider separate scenarios regarding their employment in the coming five years: those seeking to leave medicine entirely (retirement or career change); those intending to leave DHB-based practice; and those who were considering practising overseas. This was the first study (published 2017) to explore associations between age, gender, and intentions to leave in the Aotearoa New Zealand context[1].

The 2022 Future Intentions survey sought to expand its scope by inviting all ASMS members to participate (in 2016, participants were limited to those employed by DHBs) thus widening the cohort to members employed in national services, non-DHB rural hospitals, and salaried general practitioners (GPs).

In addition to a more fulsome survey cohort covering the breadth of SMO employment, the survey sought to explore the motivations and experiences of IMGs living and working in Aotearoa New Zealand. All ASMS members (n= 5,560) were invited to participate in the survey, but only IMGs were asked to complete the second half. This was self-selecting. IMGs were defined for the purposes of the survey as doctors working in the Aotearoa New Zealand health system with a primary medical qualification from a country other than New Zealand.

IMGs make a significant contribution to the health workforce, comprising 42 per cent of SMOs. Over 1000 IMGs registered from overseas with the Medical Council of New Zealand (MCNZ) in the year to June 2022. Some districts have higher numbers of IMGs, particularly those outside the main centres: the Districts with the greatest proportions of IMGs were Whanganui (66.1 per cent), West Coast (65.6 per cent) and Wairarapa (65 per cent). Conversely, the centres with the lowest proportions of IMGs were Te Toka Tumai Auckland (30.9 per cent) Capital and Coast (33.3 per cent) and Waitaha Canterbury (36.1 per cent).

As the second half of the survey had a specific research interest in IMGs, it could be hypothesised that IMGs would be overrepresented in the survey cohort; rather a slight majority of respondents received their primary medical qualification in Aotearoa New Zealand (50.9 per cent). The United Kingdom and Northern Ireland (22.5 per cent), South Africa (6.7 per cent) and the United States (4.7 per cent) were the three most frequently cited countries where respondents had received their primary qualification.

[1] ASMS. Future Intentions of the New Zealand DHB-based senior medical workforce. Wellington: ASMS; 2017. https://asms.org.nz/wp-content/uploads/2022/05/Future-intentions-of-the-NZ-DHB-based-senior-medical-workforce.pdf.

The survey was hosted on Survey Monkey and open for 4 weeks during August and September of 2022. All current members of ASMS (5,560) were invited to participate, with two follow-up reminder emails circulated. Participation was voluntary, and no incentives were provided in exchange.

The future intentions section applied the Warr-Cook-Wall job satisfaction scale, a nine-point tool to measure employment satisfaction with extensive application in healthcare worker research[2] [3] [4]. To ensure consistency with the previous Future Intentions survey, the questionnaire was modified from a 10-item to a 9-item job satisfaction scale, using a five-point Likert scale in place of the 7-point scale used in the original[1]. Answers on the 5-point scale went from 1 (extremely dissatisfied) to 5 (extremely satisfied). Scores were calculated using scores over the mid-point of 3 (neither dissatisfied or satisfied) to mean satisfaction, while scores equal to 3 or lower signalled dissatisfaction.

The Future Intentions questions were structured differently in 2022, compared to the previous survey. While the question content was broadly similar (remaining in current employment; practising overseas; leaving medicine altogether), the format was altered. Given the increased length of the 2022 survey (wider scope and its dual focus) this was done to prevent incomplete surveys and maintain participation. Respondents were to consider each question as an item on a 5-point scale from extremely unlikely to extremely likely. As with the job satisfaction scale, scores greater than 3 were analysed as likely/extremely likely, with less than 3 being unlikely/extremely unlikely.

Where possible, results in 2022 are compared to previous surveys and other available data, such as workforce data of the MCNZ. Limitations have been included following the Discussion section below.

[2] Warr P, Cook J, Wall T. Scales for the measurement of some work attitudes and aspects of psychological wellbeing. J Occupational Psychol. 1979; 52(2):129-48.
[3] Szecsenyi J, Goetz K, Campbell S et al. Is the job satisfaction of primary care team members associated with patient satisfaction? BMJ Quality & Safety 2011; 20:508-14. https://pubmed.ncbi.nlm.nih.gov/21262790/.
[4] Seston E, Hassell K, Fergusson J, Hahn M. Exploring the relationship between pharmacists' job satisfaction, intentions to quit the profession, and actually quitting. Res Social Adm Pharm. 2009; 5(2):121-32. https://doi.org/10.1016/j.sapharm.2008.08.002

Demographics

All ASMS members (n=5,560) were invited to participate, and unlike the previous survey invitation, responses were not restricted to those employed by the then-District Health Boards (since 1 July 2022, Te Whatu Ora Health New Zealand). This enabled all ASMS members to participate if they chose.

Of the 1639 responses, 1594 provided demographic data as well as completed intentions-to-leave responses, and analysis was undertaken on the most data available. As a result, precise numbers vary according to the completeness, and are indicated throughout.

The 2022 survey also included options for members to state gender identity and their ethnicity/ies – options that were not available in 2017.

Gender, age, and ethnicity across recent workforce surveys

Table 1: Gender responses across recent workforce surveys

	ASMS Intentions to leave (2017) (%)	ASMS Burnout 5 years on (2021) (%)	2022 MCNZ Workforce survey (%)	ASMS Intentions to leave (2022) (%)
Male	62	54	52.6	53.8
Female	38	43	47.4	44.7
Gender diverse, Trans and Non-binary	-	0.3	-	0.18
Prefer not to answer	-	3	-	11.2

The gender balance of the medical workforce has been shifting for some time, with women entering the profession in higher numbers than men. ASMS surveys have shown steady increases in the number of women practising as senior doctors and dentists, reflecting trends captured globally and locally[5] [6] [7]. In November 2022, the MCNZ announced that it predicts 2025 will see gender equality in the registered medical workforce, although it may be several years beyond that date for parity in the senior medical cohort.

Age composition was fairly distributed across the age range, with most respondents (n=835, 52 per cent) between the ages of 40 and 54 years. No respondents were under 30 years of age, and under 1 per cent declined to state their age.

[5] General Medical Council. The state of medical education and practice in the UK. London: General Medical Council; 2022. https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf?la=en&hash=9267A7B904842B44133BC982EEB3F5E8ED1A85F4.

[6] Australian Institute of Health and Welfare. Health workforce: Medical practitioner FTE by sex. July 2022. https://www.aihw.gov.au/reports/workforce/health-workforce.

[7] Te Kaunihera Rata o Aotearoa Medical Council of New Zealand. Workforce survey 2022. Wellington: Medical Council of New Zealand; 2022. https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/64f90670c8/Workforce-Survey-Report-2022.pdf.

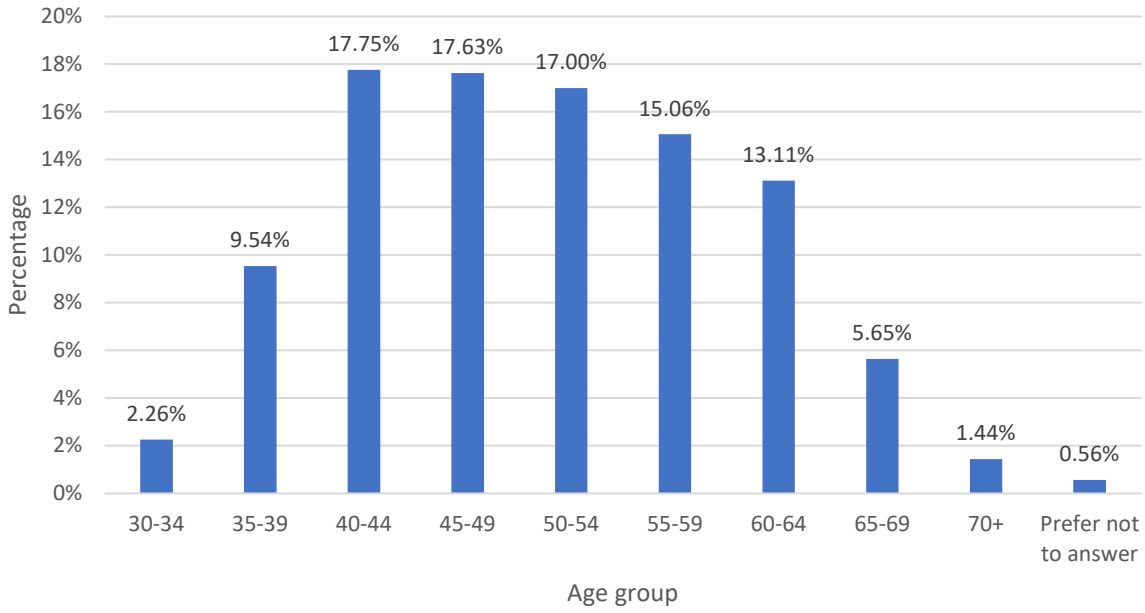

Figure 1: Respondents by age group

Ethnicity data was provided by 1616 respondents. Ethnicity is self-identified, and respondents wishing to identify with multiple ethnicities could do so via the free text field.

Table 2: Ethnicity responses in recent ASMS and MCNZ surveys

Ethnic group	MCNZ Workforce Survey (2022) (%)	ASMS Intentions to leave (2022) (%)
NZ European/Pākehā	45.7	42.8
Other European	19.2	36
Māori	4.6	1.6
Pasifika	2.2	0.33
Chinese	6.6	4.14
Indian	6.2	4.33
Other Asian	-	4.89
Other ethnicity	11.8	4.0

The majority of respondents identified as NZ European/Pakeha (n=706, 42.8 per cent) or Other European (n=576, 36 per cent). Respondents of Chinese, Indian or other Asian ethnicities were each around 4 per cent.

Numbers of Māori and Pasifika doctors and dentists have increased through equity pathways established by both the University of Otago and the University of Auckland, which the MCNZ note are now beginning to enter the early-career doctor workforce[7]. Gaps remain at SMO level, with 1.6 per cent identifying as Māori and 0.33 as Pasifika.

Place of work

For members employed by the former DHBs, the survey asked respondents to state their main place of work. Due to small numbers of repondents employed outside Te Whatu Ora Districts, including national services, non-District rural hospitals and hospice, these have been grouped together for reporting purposes.

As might be anticipated, the majority of respondents (n= 593, 36 per cent) were from the Northern Region (Te Toka Tumai Auckland, Waitematā, Counties Manukau and Te Tai Tokerau). Te Wai Pounamu, the region comprising of the five former South Island DHBs, accounts for 24 per cent (n= 394), with Te Manawa Taki 17 percent (n=273) and Central 19 per cent (n= 318) respectively. The remaining 4 per cent include national services and other work sites.

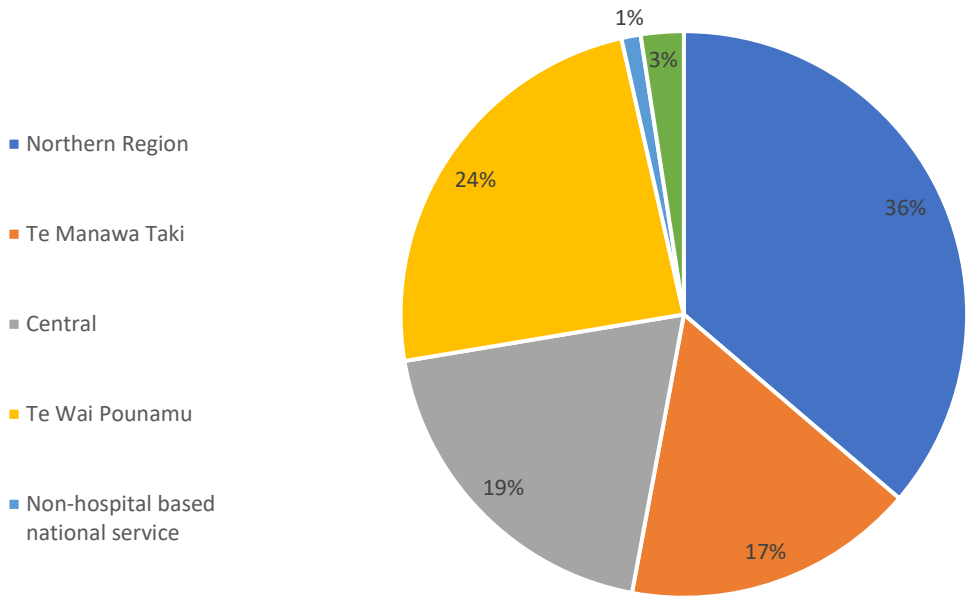

Figure 2: Respondents' place of work by Te Whatu Ora Region

Place of work by primary medical qualification

International Medical Graduates (IMGs) are essential to Aotearoa New Zealand's senior medical workforce, allowing for critical vacancies across all medical specialties to be filled, patients and whānau to gain from their experience and expertise, and for IMGs to gain skills and experience while practising in Aotearoa.

Aotearoa New Zealand has a high number of IMGs working in the health sector, with the 2022 MCNZ workforce survey finding 42.2 per cent of doctors on the register had an overseas primary

(undergraduate) medical qualification. Aotearoa is second only to Israel in the numbers of overseas-trained practising doctors[8].

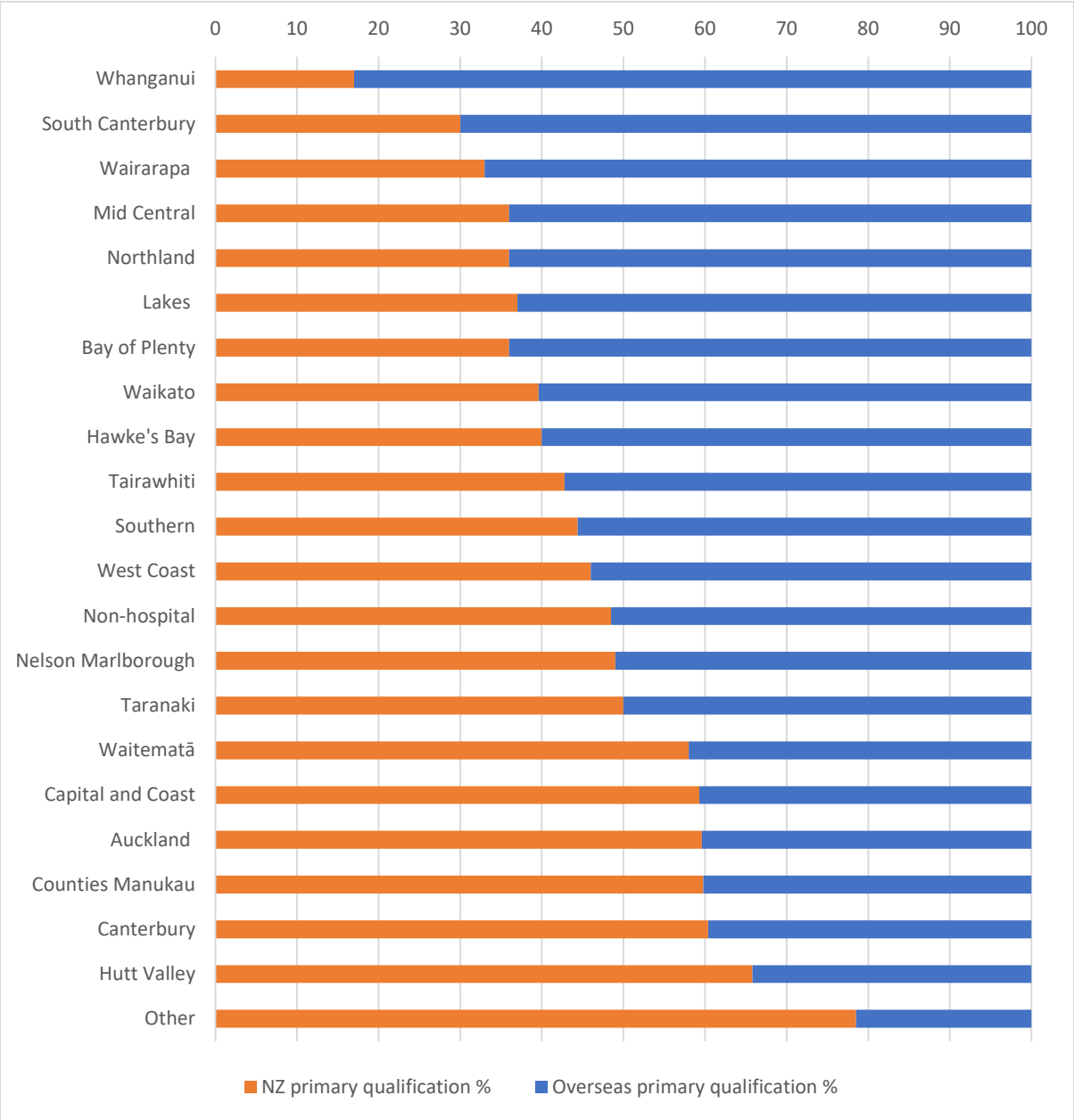

Figure 3: Place of work by primary qualification

Similarly to the 2017 findings, Whanganui and Wairarapa have the highest proportion of IMGs at 83.3 per cent and 66.6 per cent respectively. Districts with growing provincial centres, such as Bay of Plenty (Tauranga Moana), MidCentral (Papaoiea Palmerston North) and Waikato (Kirikiriroa Hamilton) also have SMO cohorts where more than 60 per cent of doctors are overseas graduates.

Districts encompassing the metropolitan centres of Tāmaki Makaurau Auckland, Te Whanganui-a-Tara Wellington and Otautahi Christchurch were more likely to have greater proportions of New

[8] ASMS. Workforce: The Make or Break of the Health Reform. Wellington: ASMS; 2022. https://asms.org.nz/workforce-the-make-or-break-of-the-health-reform/.

Zealand medical school graduates among the SMO workforce, which is consistent with the results of the previous survey and MCNZ findings.

The group with the highest proportion of New Zealand graduates was the 'Other' category. For these respondents (n= 11, 78.5 per cent), they were more likely to state a government department or public health unit as their main place of work.

Dependants by age group

Respondents between the ages of 35 and 54 were more likely to report responsibility for children compared to other age groups, with an average rate of 66 per cent (range 6.2.6 per cent to 70.8 per cent). High rates of responsibility for dependant children (70 per cent) was also seen for those who preferred not to state an age group, but it is obviously difficult to know if this reflects participants aged 54 and under or not.

The 2017 survey asked participants to consider dependant children and 'others' – that is, other dependant people who may live in the same household. In 2022, the question was clarified, specifiying 'older people' but removing the requirement for respondents and dependents to co-habitate. This allowed survey participants to declare wider familial responsibilities, including for parents, grandparents and partners/spouses.

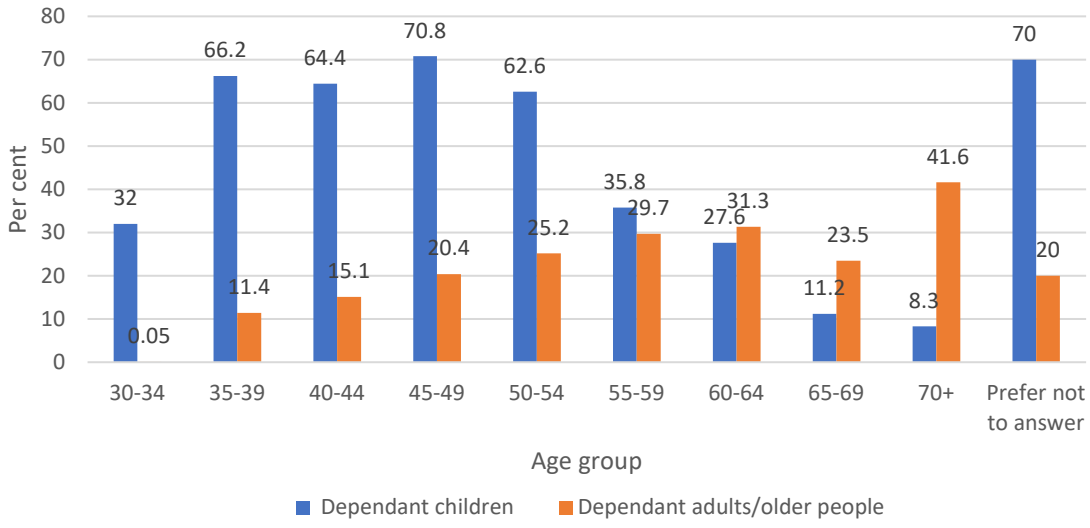

Figure 4: Dependants by age group

The proportion of respondents reporting dependants has dropped compared to 2017. In the previous survey, 84 per cent of those aged 40-44 stated they had dependant children, which has dropped in 2022 to 64.4 per cent for the same age group. The cohort with the highest proportion of dependant children (70.8 per cent) in 2022 was the 45-49 age group.

An increase in the proportion of respondents declaring responsibility for older adults could be anticipated given the broadening of the question in 2022, meaning that older adults not living with survey respondents could be included as dependants. However, rates were overall higher compared to 2017, when 30 per cent of those aged over 70 years said they were responsible for older people. In 2022, this same proportion had increased to 40 per cent.

Specialties and subspecialties

The table below shows survey respondents by speciality and subspecialty. Given the workforce pressures across many medical and surgical subspecialties, this table shows the specialty of all respondents, rather than those meeting a certain threshhold.

Table 3: Survey respondents by main speciality or subspecialty

Specialty/Sub-specialty	n	Specialty/Sub-specialty	n
Additction Medicine	8	Neurosurgery	6
Anaesthesia	264	Obstetrics and gynaecology	65
Cardiology	26	Occupational medicine	6
Cardiothoracic surgery	4	Ophthalmology	28
Clinical genetics	4	Orthopaedic surgery	48
Clinical pharmacology	1	Otolaryngology	24
Dentistry	23	Paediatric cardiology	3
Dermatology	7	Paediatric haematology	2
Developmental paediatics	5	Paediatric oncology	4
Diagnostic & interventional radiology	94	Paediatric palliative care	2
Emergency medicine	131	Paeditaric rheumatology	1
Endocrinology	12	Paediatrics	80
Family planning & reproductive health	4	Paediatric surgery	5
Forensic pathology	2	Pain medicine	6
Gastroenterology	18	Palliative medicine	20
General medicine	70	Pathology	41
General practice	19	Plastics and reconstructive surgery	22
Geriatric medicine	44	Psychiatry	177
Haematology	23	Public health medicine	38
Immunology	2	Radiation oncology	19
Infectious diseases medicine	6	Rehabilitation medicine	5
Intensive care medicine	41	Respiratory medicine	19
Medical administration	5	Rheumatology	14
Medical oncology	21	Rural hospital medicine	25
Medicine	6	Urgent care	2
Neonatology	9	Urology	12
Nephrology	17	Vascular surgery	5
Neurology	14	Other (please specify)	21
	TOTAL		**1635**

Data was compared to the most recent MCNZ report detailing numbers of doctors in each vocational scope for representativeness using the Chi-square goodness of fit test (163.99, p= <0.001). Survey

data was close to, but slightly under-representative of expected distribution when compared to the MCNZ data. Specialities with low numbers of ASMS members, such as General Practice and Urgent Care were excluded from the analysis, given the different employment structures for doctors in these specialities.

Length of service

Respondents were asked to state their years of employment in Aotearoa New Zealand, and their tenure with their current employer (Employer categories included all DHBs, non-DHB national services, hospice, general practice and other). Most had been employed in Aotearoa for at least 10 years (n= 1248, 78 per cent), and of this cohort, 68 per cent (n= 857) had been with the same employer for more than 10 years.

Several added comments stating specific tenure, including many stating more than 20 years with the same employer; two stated they had been with the same employer more than 40 years.

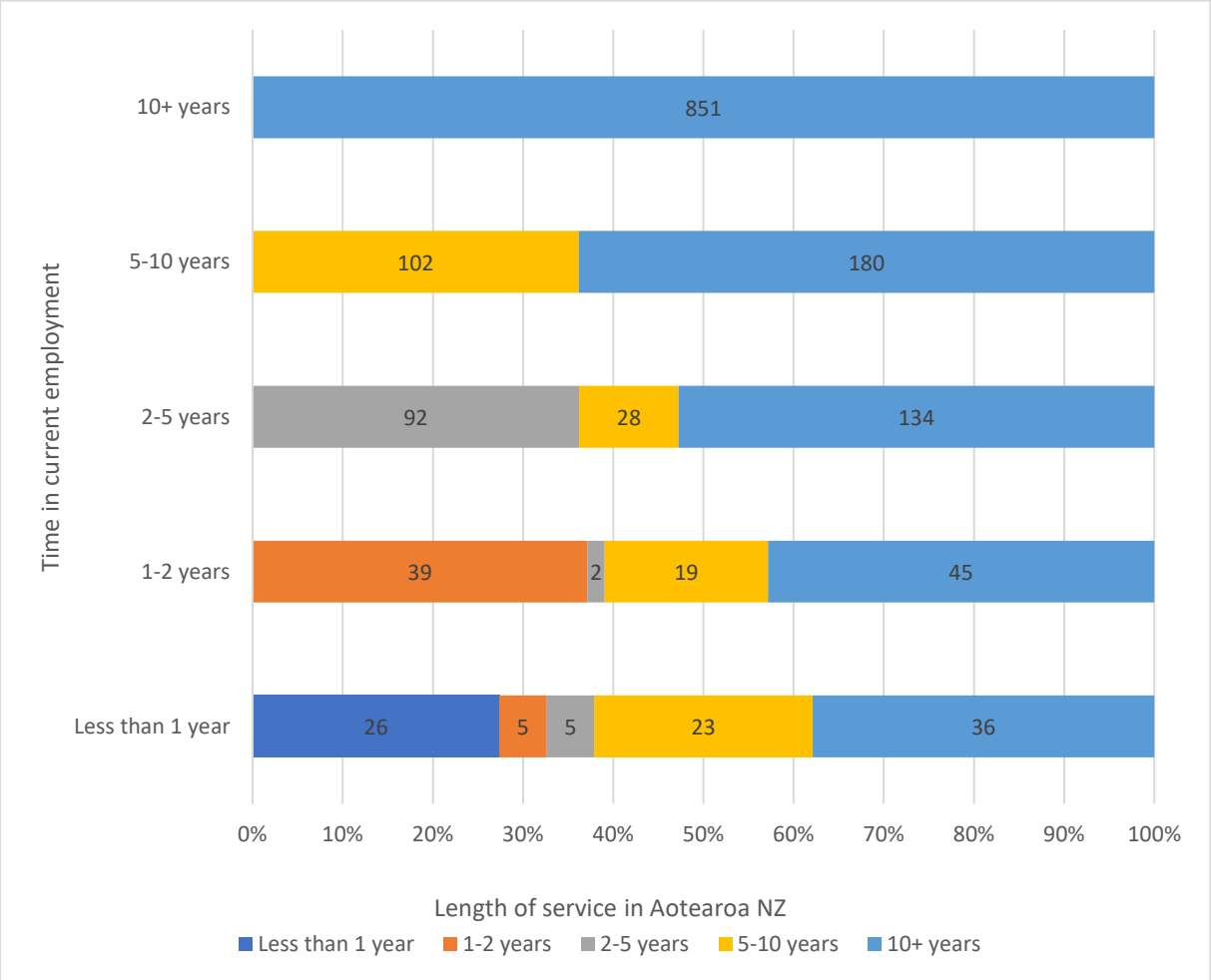

Figure 5: Time at current employer by length of service in Aotearoa NZ

Results: Job satisfaction

57 per cent of participants scored as being satisfied overall in their work, compared to 43 per cent of respondents who were dissatisfied. This is a significant drop from 2017, where job satisfaction overall was 81 per cent and dissatifaction 19 per cent.

The job satisfaction question applies nine different aspects of work against a five-point Likert scale as per the Warr-Cook-Wall questionnaire (Warr, Cook et al., 1979), which was also used in the 2017 Future Intentions survey. Of the total respondents to the 2022 survey, 1547 submitted completed job satisfaction responses. Participants scored their responses against a five-point Likert scale, with 1= extremely dissatisfied and 5= extremely satisfied. Scores equal to or less than the mid-point of three were reflective of dissatisfaction, while scores above the midpoint of three indicated satisfaction.

Table 4: Job satisfaction indicators, 2017 and 2022

Job satisfaction variable	Satisfaction 2017 (%)	Satisfaction 2022 (%)	Difference
Variety in work	77	73	-4
Hours of work	68	54	-14
Opportunity to use skills	68	61	-7
Remuneration	57	40	-17
Level of responsibility	72	66	-6
Recognition for good work	47	41	-6
Interactions with colleagues	84	81	-3
Ability to choose way of working	57	54	-3
Physical working conditions	60	46	-14

There have been decreases in satisfaction against every measure on the Warr-Cook-Wall questionnaire, with an average difference of -8 per cent (range -3 to -17).

Remuneration scores between 2017 and 2022 signal one of the most significant shifts in satisfaction rates. In 2017, 57 per cent of respondents were satisfied with their salary, which in 2022 decreased 17 percentage points to 40 per cent. Remuneration was followed closely by level of recognition for good work (41 per cent) and physical working conditions (46 per cent) for the lowest levels of satisfaction among respondents. Remuneration and physical conditions, along with hours of work showed the greatest percentage descrease, at 17, 14 and 14 per cent respectively.

Table 5: Lowest job satisfaction indicator

Lowest satisfaction rates by indicator	Rank in 2017 (% satisfied)	Rank in 2022 (% satisfied)
Recognition for good work	1st (47)	2nd (41)
Remuneration	2nd = (57)	1st (40)
Physical working conditions	4th (60)	3rd (46)

Looking at the variables with the lowest satisfaction rates, there has been little change in the top three between 2017 and 2022, although significant drops in satisfaction have been recorded. Remuneration had both the lowest satisfaction rate (40 per cent satisfied) and largest drop between the two iterations of the survey (17 percentage points). This may reflect frustration with the government's public service pay restraint policy, and ongoing cost of living increases driven by inflation, rising interest rates and supply chain issues.

The challenges of run-down hospital infrastructure, including leaking, unsafe and not fit-for-purpose buildings, unable to cope with increased public demand was captured in an audit published in 2020. It noted that $14 billion of investment in buildings and infrastructure would be required over 10 years, as well as a further $2.3 billion in information technology investments[9]. Examples of SMOs' frustration at their physical working conditions are captured in the thematic summary of qualitative comments further in this report.

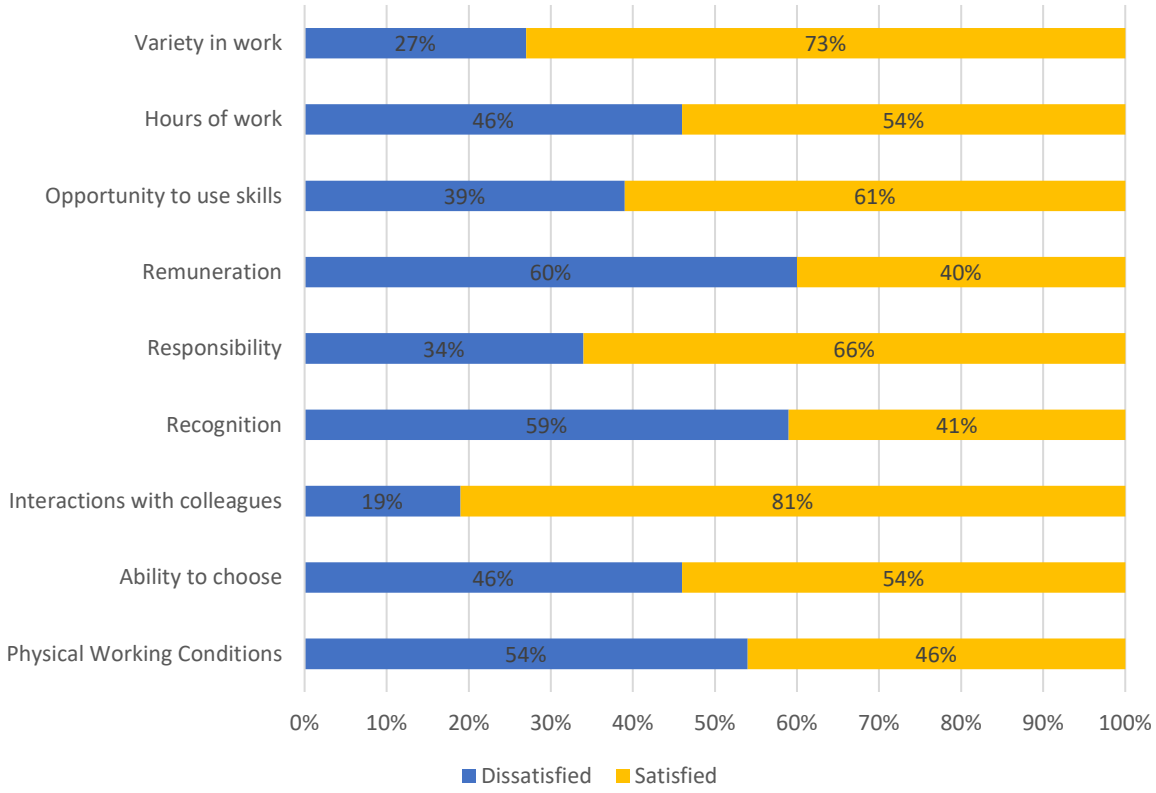

Figure 6: Job satisfaction 2022

[9] Manatū Hauora Ministry of Health. The National Asset Management Programme for district health boards. Report 1: the current state assessment. Wellington: Manatū Hauora Ministry of Health; 2020. https://www.health.govt.nz/publication/national-asset-management-programme-district-health-boards-report-1-current-state-assessment.

Results: Intentions to leave medicine or dentistry entirely

Across all age groups, the overall rate of intention to leave medicine or dentistry within the five years to 2027 was 18 per cent (n=1594). The mean age of those intending to leave was 58.5 years (95% CI 57.4 to 59.6 years).

This section will explore associations between intentions to leave and independent variables. Where possible, findings will be compared to 2017 results.

Intentions to leave by age and gender

There was a strong positive association between increasing age and likelihood to leave medicine or dentistry by 2027 (p= <0.001). These findings are consistent with the 2017 study, which also found a clustering of respondents aged 60 and over being more likely to exit clinical practice.

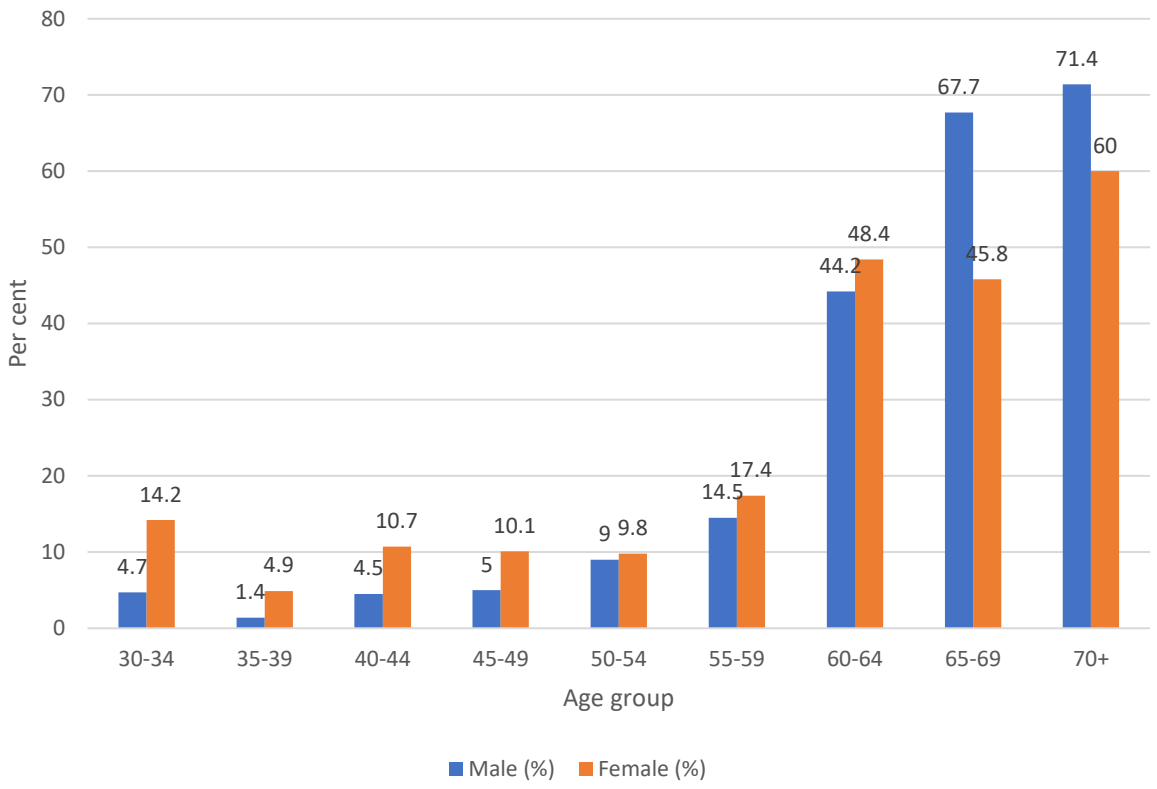

Figure 7: Likely or very likely to leave medicine or dentistry entirely by gender and age group 2022

Doctors under 50 and intentions to leave medical or dental practice entirely

Responses to the question "how likely are you to leave medicine or dentistry altogether?" by age and gender from the two iterations of the Future Intentions survey were compared and contrasted, with the 2015 and 2021 burnout survey results offering important contextural information.

While there were no significant associations with gender overall (p= 0.14) in the 2022 survey, the 2017 results had shown that more women aged 35-39 intended to leave (14.5 per cent – note that this is across all scenarios not just "leave medicine/dentistry entirely) which was not only above average for this age group, it was also the age band more likely to experience burnout in the 2015 ASMS burnout study[1] [10].

Analysis of the 2022 results was limited to respondents <50 years, given the steady upswing in SMOs leaving for retirement and lifestyle reasons from that age. Results from 2017 show very small numbers intending to leave medicine or dentistry entirely in the 30-49 years age groupings for all genders; although there was an increase when "unsure" was included as a variable. 1.6 per cent of females aged 35-39 years were likely or extremely likely to leave the profession entirely in 2017, though when this included those still considering their options this increased to 10.8 per cent.

In 2022, greater numbers across all cohorts signalled an intention to leave medicine or dentistry. Increases were seen for men (range 0.7 – 4.7 per cent) and women (range 3.3 – 14.2 per cent). The survey did not seek specific reasons as to why SMOs were looking to leave, but comments left in the free-text section provide context to these numbers:

> *"Looking to exit medicine in a timely manner. Have been working 50+ hours per week during med school and throughout medical career – so nearly 3 decades now. It is increasingly complex and under-resourced in the public health sector"*

Table 6: Intentions to leave medicine or dentistry entirely by gender and age, 2017 and 2022

	Leave medicine/dentistry entirely 2017 (%)		Leave medicine/dentistry entirely 2022 (%)		Change (%)	
Age group	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
30-34 years	0	0	4.7	14.2	+4.7	+14.2
35-39 years	0	1.6	1.4	4.9	+1.4	+3.3
40-44 years	3.8	1.6	4.5	10.7	+0.7	+9.1
45-49 years	4.2	5.4	5.0	10.1	+0.8	+4.7

The increases observed in burnout among SMOs give further context to these results. ASMS' surveys on burnout in 2015 and 2020 showed increases for women aged 30-39 and 40-49 years – age groups that recorded the highest mean scores overall[10] [11]. Conversely, this was not seen for male

[10] ASMS. "Tired, worn out and uncertain" Burnout in the New Zealand public hospital senior medical workforce. Wellington: ASMS; 2016. https://asms.org.nz/issue-12-tired-worm-out-and-uncertain/.
[11] ASMS. "My employer is exhausting" Burnout in the senior medical workforce five years on. Wellington: ASMS; 2021. https://asms.org.nz/wp-content/uploads/2022/07/Health-Dialogue-Burnout.pdf.

respondents, with a drop in mean personal burnout scores for those aged 30-39, and a marginal increase for those aged 40-49.

Table 7: Mean personal burnout scores by gender, age 30-49 years, 2015 and 2020

	Mean personal burnout scores 2015 (%)		Mean personal burnout scores 2020 (%)	
Age group	**Male**	**Female**	**Male**	**Female**
30 – 39 years	49	53	43.6	56.5
40 – 49 years	47	50	47.1	62.1

Although the 2022 survey did not pose specific questions regarding the impact of the Covid-19 pandemic on career intentions, the results may offer some potential insights to support the prioritisation of healthcare worker retention by policymakers. International research has shown that the pandemic has impacted rentention and career planning for healthcare workers[12] [13].

Job satisfaction and Intentions to Leave medicine/dentistry entirely

Job satisfaction measures have been utilised as predictors of employee experience and exit intentions. Results show that both satisfied and dissatisfied respondents signalled an intention to leave medicine or dentistry, though those expressing dissatisfaction were more likely overall to consider leaving.

Table 8: Intentions to leave: per cent dissatisfied and satisfied

Job satisfaction variable	Intending to leave			
	Dissatisfied cohort (%)	**P-value**	**Satisfied cohort (%)**	**P-value**
Ability to choose	22.9	**0.005**	15.6	**0.018**
Level of responsibility	23.9	**0.008**	15	**<0.001**
Recognition of good work	21.2	**0.016**	15.5	0.061
Physical conditions	20.7	**0.025**	15	**0.009**
Variety in work	22.6	0.08	15.1	**<0.001**
Hours of work	21.5	**0.031**	17.1	0.46
Remuneration	19.2	0.203	18	0.72
Opportunities to use skills	21.2	0.58	15.6	**0.007**
Interactions with colleagues	18.3	0.86	16.8	0.067

Significant p-values are shown in bold.

[12] Poon YSR, Lin YP, Griffiths P, Yong KK, Seah B. A global overview of healthcare workers' turnover intention amid Covid-19 pandemic. Human Resources for Health 2022; 20:70. DOI: https://doi.org/10.1186/s12960-022-00764-7.

[13] OECD. Ready for the next crisis? Investing in health system resilience. OECD Health Policy Studies. Paris: OECD Publishing; 2023. https://doi.org/10.1787/1e53cf80-en.

Several job satisfaction measures across both analyses were predictors of intentions to leave regardless of being satisfied or dissatisfied – Level of responsibility, ability to choose method and way of working, and physical conditions. For members who were satisfied but still intended to leave, this is likely an indication of retirement intentions, particularly as these SMOs would have a relatively greater degree of autonomy and level of responsibility.

Qualitative comments on job satisfaction

275 comments regarding

Core theme	Illustrative comments
Workload (n= 105)	"To maintain our service, I contribute at least 15 hrs of unrecognised overtime every week" "My ideal job would be a mix of clinical, with opportunities for teaching / research / clinical governance / innovation, but I work quite a lot of unpaid hours simply keeping on top of the admin. I do the other stuff, but in my own time mainly." "Feeling a little overwhelmed at times with workload. Still thoroughly enjoying the work."
Facilities (n=25)	"Main complaint with physical conditions is cramped, overcrowded theatre environment that is not big enough for the amount of work that needs doing"
Staffing shortages (n= 43)	"I don't believe someone in their 60's should be doing 24-hour periods of call with all the demands and stress of a Provincial hospital" "Due to chronic staffing issues, I am rarely rostered to my area of expertise. It means I don't progress and have little job satisfaction"
Flexibility (n= 10)	"Pressure to work extra, lack of lunch break often, unpredictable finish times, often late finishes, definitely get no thanks for working late. Roster not very flexible and leave not always easy to get"
Remuneration (n= 60)	"Hours of ACTUAL work and hours of PAID or ROSTERED work are two entirely different things" "We feel undervalued, and rapidly the trainee pay is approaching what we are paid despite our years of training, responsibilities & ability to adapt and perform during the pandemic"
Health system factors (n= 16)	"Current pandemic and it's duration has changed the status quo. Current professional life is not good, the pandemic has exposed acutely our previously known significant weaknesses. There is a sense there is no commitment to address those challenges hence the gloom." "Facing increased risk due to access block is dangerous and awful"
Job autonomy (n= 16)	"The inability to have any control over the content and structure of work (or course within the requirements of the service) leaves one feeling disenfranchised and

	undervalued - this simple accommodation of trusting us- the experts in treating our patients, to design and implement our service delivery would reap huge benefits”
Wellbeing (n= 30)	“Grossly overstretched at moment, work in 9 hospitals across half the country because of ongoing SMO shortages. Compromising my family life, and at my age I should not have to do as many nights on call and long hours - not good for my health”
Managerialism (n= 20)	“No control over our workload and outcome. First & Second line managers are in charge and often override some of our clinical decisions and recommendations.”
Private practice (n= 8)	“I see my future being more in the private sector - not because of financial reward - but the benefits that come with working in smaller organisations.”
Recognition (n= 54)	“The stress of the pandemic has caused most peoples behaviour to understandably deteriorate. There is no acknowledgment of this currently. We got some food boxes some months back during delta which although I was cynical at the time actually made me realise somebody thought the team was worth the effort.”
Relationships (n= 30)	“I have wonderful colleagues and an amazing clinical director. Under-staffing is an issue as it is everywhere, but I still consider myself very fortunate to do the work that I do.”
Resources (n= 15)	“Lack of access to theatre is a real issue currently - hard to train the next generation”
	“Under resourced bed blocked department unable to deliver care to patients in timely manner”

Results: Practising medicine or dentistry overseas

Both iterations of the future intentions survey have asked about overseas relocation, but the 2022 survey distinguished between temporary and permanent relocations. The rate signalling a temporary shift abroad to practise medicine was 12.7 per cent, while 10.9 per cent indicated they would relocate permanently. As respondents could indicate affirmative responses to each question, these results are not mutually exclusive and should be interpreted as such.

Younger doctors are more likely to plan to leave Aotearoa NZ

Age was significant for doctors considering a temporary or permanent move overseas (p= <0.001 and p= 0.002 respectively), with doctors in the 30-39 age groups more likely to signal this intention than their colleagues >40 years. However, permanent relocation was most readily considered by SMOs in the 40-49 age group which may reflect a desire to gain further professional knowledge and experience beyond what they have acquired in Aotearoa.

While gender was not significantly associated with temporary move, (p= 0.93) it was for a permanent relocations (p= 0.03), with more male respondents intending to practise medicine abroad permanently. Ethnicity was also associated with both temporary and permanent moves (p= <0.001 for each variable) with respondents of Asian and Other ethnicities more likely to report intentions for overseas medical or dental practice.

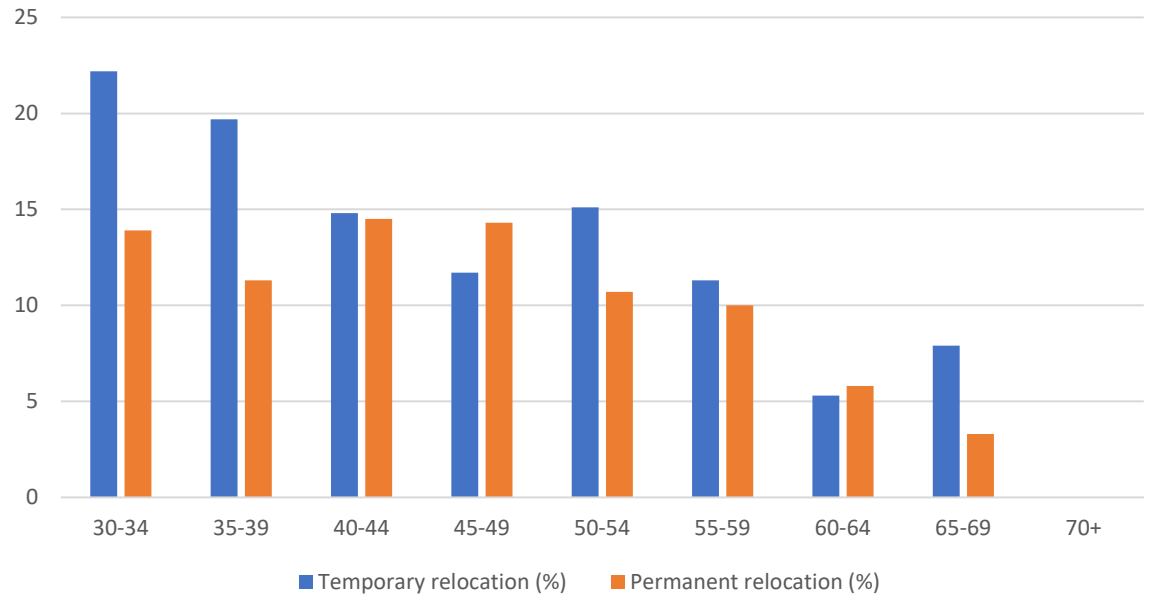

Figure 8: Temporary and permanent relocation overseas by age

Associations with dependants

Similar to 2017 findings, SMOs with dependants (both children and older people) were less likely consider either a temporary or permanent international shift. The qualitative comments reflect some of these whānau considerations, particularly regarding chidlren's education, or caring for parents:

> *"I've had two job offers from Australia and it's tempting. Elderly parents stop me. Once major debt is cleared I am considering taking an income cut and entering a lower stress career"*

> *"I have considered all these options but it is difficult to consider moving overseas or elsewhere when you have teenage children settled in their current schools"*

The attraction of Australia as a location for doctors from Aotearoa NZ was acknowledged:

> *"Very unhappy and do not want to continue in the public health system in NZ. Moving to Australia for better conditions and pay. Unsure if will return to NZ"*

> *"My husband and I are already scoping out work in Australia for just over 5 years' time. We plan to work the last 15-20 years of our working life in Australia"*

Intended destination

Of all respondents who declared a destination (n=380), Australia was the intended destination for the majority of respondents (n= 240, 63.2 per cent), followed by the United Kingdom (n= 68, 17.9 per cent) and North America (n=34, 8.9 per cent). Respondents were not asked to distinguish between temporary and permanent relocation when considering destinations. The preference for

Australia is logical, given its proximity to Aotearoa and similar health care system, as well as the binational college system for many vocational specialties.

The British Medical Association's New Year Message noted that of the 33 per cent of junior doctors looking to practise abroad in 2023, 42 per cent were considering Australia – more than double those considering Aotearoa NZ[14]. The 2022 MCNZ Workforce Report notes 2,187 New Zealand-trained doctors were practising in Australia in 2019[7].

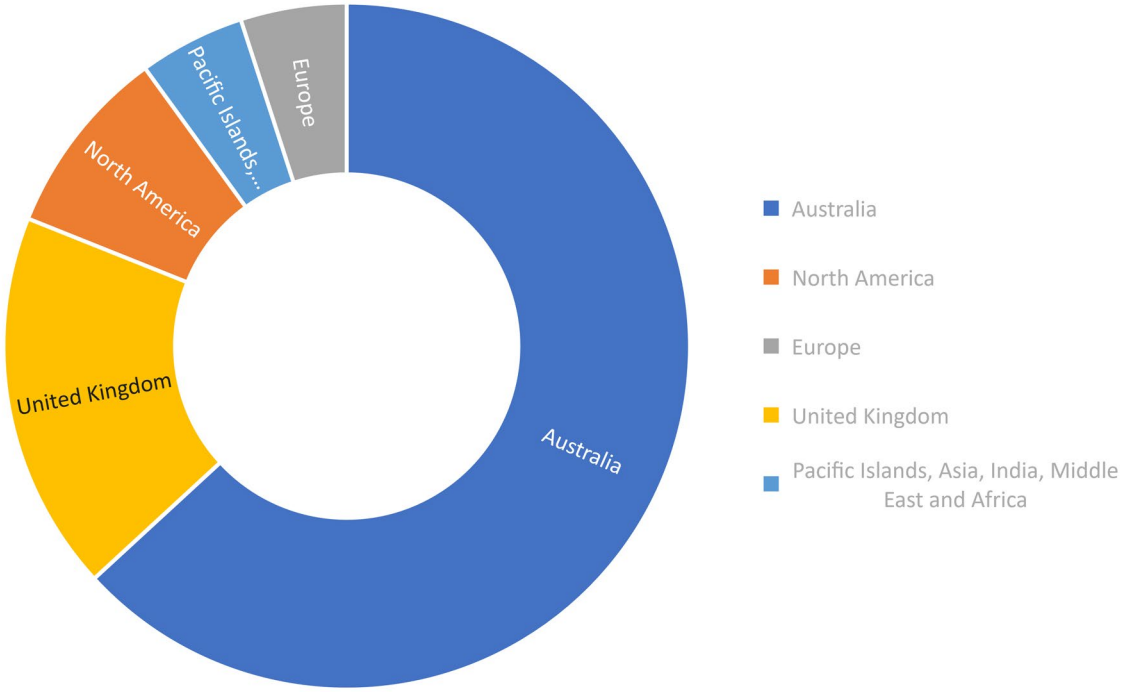

Figure 9: Intended destination

Relocation overseas by specialty

The survey design allowed respondents to indicate intentions to relocate on permanent and temporary basis. For SMOs looking to practise outside of Aotearoa NZ, there were some differences between specialties, depending if the relocation was permanent or temporary. However, the ten specialties with the greatest rates of intention to practice overseas (on a temporary and/or permanent basis)[15]:

1 Psychiatry

5 Rural Hospital Medicine

[14] British Medical Association. Four in ten junior doctors plan to leave the NHS as soon as they can find another job, BMA council chair reveals in New Year's message. 29 December 2022. Available from https://www.bma.org.uk/bma-media-centre/four-in-ten-junior-doctors-plan-to-leave-the-nhs-as-soon-as-they-can-find-another-job-bma-council-chair-reveals-in-new-years-message-to-the-country.

[15] Specialties with more than 20 respondents were included in the analysis: while some specialties with fewer than 20 respondents did have higher rates of intention to relocate, the smaller numbers mean this data should be interpreted with caution.

2	Ophthalmology	6	General Medicine
3	Cardiology	7	Palliative Medicine
4	Emergency Medicine	8	Obstetrics and Gynaecology

Several of these specialties are fundamental to the operation of our health system: emergency medicine, psychiatry, obstetrics and gynaecology and general medicine. Each specialty had rates of intention to temporarily relocate over 20 per cent, and permanent rates of over 14 per cent: both greater than the overall intentions at 12.7 (temporary) and 10.9 (permanent).

Job satisfaction and intentions to practice overseas

As with intentions to leave overall, respondents who were either satisfied and dissatisfied overall with their current employment signalled an intention to move abroad. However, the job satisfaction indicators which had shown the greatest decrease between 2017 and 2022 (hours of work, remuneration and physical conditions) did not predict intentions to practise medicine abroad either temporarily or long-term.

Table 9: Respondents intending the practice overseas (temporary)

Job satisfaction variable	Intending to practise medicine/dentistry overseas (temporary)			
	Dissatisfied Cohort (%)	P-value	Satisfied cohort (%)	P-value
Ability to choose	19.1	**<0.001**	11.0	**0.028**
Level of responsibility	21.8	**<0.001**	10.9	**0.002**
Recognition of good work	17.6	**<0.001**	10.7	0.05
Physical conditions	17.2	**<0.001**	11.1	0.08
Variety in work	20.9	**0.001**	11.5	**0.021**
Hours of work	17.2	**0.003**	10.7	0.014
Remuneration	17.3	**<0.001**	8.6	**<0.001**
Opportunities to use skills	18.8	**<0.001**	10.2	**<0.001**
Interactions with colleagues	15.2	0.38	12.1	0.1

For respondents looking to leave on a short term basis, the most frequent indicators could be reflective of a desire to gain more experience and skills within their specialty, as well as greater autonomy and control in their day-to-day practice and work experience. The dominance of these indicators may also reflect the proportion of younger SMOs intending to practise medicine abroad.

Table 10: Respondents intending to practise overseas (permanently)

Job satisfaction variable	Intending to practise overseas (permanently)			
	Dissatisfied cohort (%)	P-value	Satisfied cohort (%)	P-value
Ability to choose	21.5	**<0.001**	7.4	**<0.001**
Level of responsibility	24	**<0.001**	7.2	**<0.001**
Recognition of good work	18.4	**<0.001**	7.0	**<0.001**
Physical conditions	16	**<0.001**	7.8	**<0.001**
Variety in work	23.9	**<0.001**	8.3	**<0.001**
Hours of work	15.2	**0.003**	8.8	**0.003**
Remuneration	18.5	**<0.001**	4.2	**<0.001**
Opportunities to use skills	20.9	**<0.001**	6.5	**<0.001**
Interactions with colleagues	21.4	**<0.001**	8.9	**<0.001**

When compared to overall job satisfaction results, the most influential factors in those looking to relocate overseas permanently were quite different, with differences between satisfied and dissatisfied SMOs. Responsibility, variety, ability to choose, and interactions with colleagues (p= <0.001 for all variables) were the most prevalent for dissatisfied SMOs.

Proportionally, the numbers of satisfied doctors looking to relocate overseas was smaller than those dissatisfied, suggesting that job satisfaction may have a protective function for retention. Interactions with colleagues, hours of work and variety in work (p= <0.001 for all variables) were the most frequent.

The indicator scoring the higest rates of satisfaction overall (interactions with colleagues at 81 per cent satisfied) could be seen as a protective factor for retention; however those relocating temporarily it was less of a driver at 15.2 per cent compared with permanent relocations at 21.4 per cent.

Results: SMOs reducing public system FTE

ASMS included a question regarding intentions to reduce public health system work and start/increase private practise for the first time in 2022. While not all subspecialities have the ability to operate in a private model (public health medicine and emergency medicine are two examples), some subspecialties such as dermatology are largely based in private practice, as is the majority of dental and oral health care in Aotearoa NZ.

The release of the 2021/22 New Zealand Health Survey results included data on New Zealanders' health insurance status, finding that around 37.8 per cent of adults and 36.4 per cent of children (aged 0-14 years) have private health insurance, reflecting modest but steady increases since 2011/2012[16].

The survey question assumed that an SMO seeking a reduction in public FTE would choose to make up those hours in private practice, due to the conditions and current climate in the public health sector:

> *"Due to constant lack of support, work overload and burnout and lack of flexibility in working hours, I will seek private work"*

Although some SMOs were interested in maintaining both public and private work, it was clear from the qualitative comments left in the free-text field that many SMOs were reducing public hours simply to gain a greater work-life balance, spend time with whānau and prioritise their wellbeing.

Intentions to start or increase private practice by specialty

Data informing this chart (figure 10) was limited to specialties with more than 10 respondents. Of these 18 specialities, eight had rates of greater than 50 per cent intention (likely or extremely likely) to reduce public FTE: Anaestheia, dermatology, diagnostic radiology, general surgery, obstetrics and gynaecology, orthopaedic surgery, psychiatry and urology. Data from the Ministry of Health shows that significant propotions of specialist FTE in these specialties is already being delivered outside of the public health system. Further, around 66 per cent of all elective surgery in Aotearoa each year is delivered by private surgical hospitals[17].

Although 'outside the public health system' encompasses private hospitals, clinics, government departments and university teaching, the estimates reveal significant service delivery in the 'private' system. More than 40 per cent of diagnostic radiology and more than 50 per cent of general obstetric and psychiatry services being accessed this way[18].

The psychiatry workforce is under significant pressure, with high levels of burnout, low job satisfaction and poor resourcing for the sector[19]. Psychiatrists' intentions to start or increase private

[16] Ministry of Health. Private health insurance. New Zealand Health Survey 2021/22: Annual update of key results. Available from https://www.health.govt.nz/publication/annual-update-key-results-2021-22-new-zealand-health-survey.
[17] New Zealand Private Surgical Hospitals Association. https://www.nzpsha.org.nz/.
[18] Ministry of Health. Full-time equivalents in public and private sector by District Health Board. Obtained under the Official Information Act, 2023.
[19] ASMS. Inside the front line of the mental health crisis. Health Dialogue. Wellington: ASMS; 2021. https://asms.org.nz/inside-the-frontline-of-the-mental-health-crisis-2/.

practice in this survey are reinforced by results from the 2022 ASMS Employment Exit survey, which found that 20 per cent of psychiatrists leaving a role in the public health system would be starting or increasing private FTE[20].

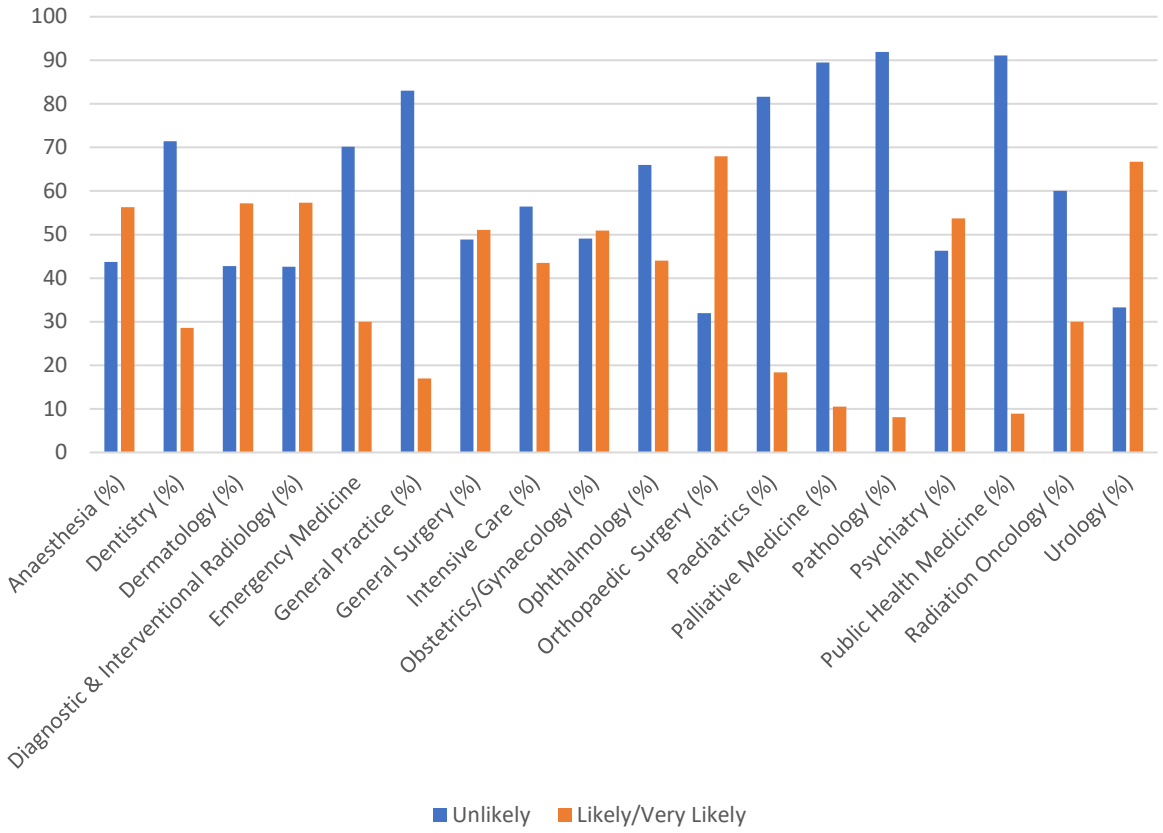

Figure 10: Intentions to reduce FTE and start/increase private practice by specialty

The survey question regarding private practice assumes SMOs making a reduction in public sector FTE would then compensate for this reduction through other employment such as private practice. However, findings from the qualitative comments show the extent to which senior doctors were reducing their public sector FTE to gain greater work-life balance, and to prioritise their wellbeing.

> *"I feel like we have gone beyond the tipping point of coping in our public health system … my plan over the next 10 years is to transition to work that is 50% non-medical in order to maintain my own wellbeing"*
>
> *"If I reduce hours, it will not be to do private work but rather to follow leisure activities and recovery from work."*

Reductions in public FTE may be one way senior doctors are able to protect their rest and recovery time and mitigate some of the adverse impacts of fatigue and burnout. The risks associated with

[20] ASMS. Employment Exit survey 2022.

fatigue and burnout are well established, including clinical errors, compromises in patient safety, compassion and decision fatigue and increased risk of traffic accidents when driving[21] [22]. Although increased private practice hours may not be the intention of many senior doctors, it is clear that a reduction in public FTE is seen as necessary to protect their wellbeing and recovery.

Much more needs to be done to enact safe staffing levels, as well as taking a preventative approach to fatigue in order to retain critical skills and expertise in the public health system.

[21] British Medical Association. Fatigue and sleep deprivation – the impact of different working patterns on doctors. London: British Medical Association; 2018. https://www.bma.org.uk/media/1074/bma_fatigue-sleep-deprivation-briefing-jan2017.pdf.

[22] Machi MS, Staum M, Callaway CW, Moore C, Jeong K et al. The relationship between shift work, sleep, and cognition in career emergency physicians. Acad Emerg Med 2012; 19(1):85-91. DOI: 10.1111/j.1553-2712.2011.01254.x.

Discussion

The results from the 2022 Future Intentions survey underscore the sense of low morale, burnout and job dissatisfaction that has been reported in the Aotearoa NZ health workforce[23] [24]. Although these trends were observed in previous studies, including those undertaken by ASMS, Covid-19 and its impact on the health workers, increased patient acuity and complexity, and chronic staffing shortages have ratcheted these factors up to a new intensity.

"Burnt out. Still enjoy seeing patients but rest of work now just survival"

Economists had pointed to 2021 and 2022 as 'the great resignation' – a period where workers would evaluate their career choices and current employment following the immediate response to Covid-19. As the British Medical Association has pointed out, without comprehensive retention and wellbeing frameworks in place, the senior medical workforce is increasingly likely to seek an extended break or early retirement: a 2022 survey of senior doctors working in the National Health Service found 44 per cent planned to take a break or leave entirely in the next 12 months[25].

Burnout is increasingly acknowledged as a key determinant in intentions to leave; some have found it to have the strongest association with plans to withdraw from clinical practice[26] [27]. Burnout among senior doctors in Aotearoa NZ is widespread, with all age groups and genders reporting some level of personal, work-related and patient-related burnout. The strongest associations in both 2016 and 2021 show that burnout correlates to being younger, having worse self-reported health and wellbeing, and being female[11].

Although burnout was not questioned specifically in this survey, the qualitative comments left by respondents offered some insight into the experiences of senior doctors and their career planning intentions. For doctors under 50 years, there were increases across gender and all age groups in those intending to leave medical practice, with the most pronounced increases in women aged 30-34 (14.2 per cent) and 40-44 (9.1 per cent).

Respondents also noted unsustainable work practices are increasingly taken as business as usual. Excessive workloads, significant on-call duties, and long hours often well above contracted and rostered rates simply to keep things running featured heavily among the comments:

---

[23] Russell E. Middlemore hospital: leaked letters reveal doctors warning need to stop teaching junior doctors. NZ Herald 19 Oct 2022. https://www.nzherald.co.nz/nz/middlemore-hospital-leaked-letters-reveal-doctors-warning-need-to-stop-teaching-junior-doctors/M62WRIV7JQHVSIZGCJO3IHF3PM/.

[24] Sutherland D. Moral injury: what happens when exhausted health workers can no longer provide the care they want for their patients. The Conversation. 28 June 2022. https://theconversation.com/moral-injury-what-happens-when-exhausted-health-workers-can-no-longer-provide-the-care-they-want-for-their-patients-185485.

[25] British Medical Association. Catastrophic crisis facing NHS as half of hospital consultants plan to leave in next year, warns BMA. British Medical Association; 11 October 2022. Available from https://www.bma.org.uk/bma-media-centre/catastrophic-crisis-facing-nhs-as-nearly-half-of-hospital-consultants-plan-to-leave-in-next-year-warns-bma.

[26] Sinksy CA, Dyrbye LN, West CP, Satele D, Tutty M, Shanafelt T. Professional satisfaction, and career plans of US physicians. Mayo Clin Proc 2017; 92:1625-35.

[27] Zhang Y, Feng X. The relationship between job satisfaction, burnout and turnover intention among physicians from urban state-owned medical institutions in Hubei, China: a cross-sectional study. BMC Health Serv Res 2011 11:235. https://pubmed.ncbi.nlm.nih.gov/21943042/.

"We are currently working double our contracted hours, doing 2-3 doctors' duties at once due to critical staff shortages and are all overworked and suffering from burnout"

"To maintain our service, I contribute at least 15 hours of unrecognised overtime every week"

"We are working very long hours and at risk of being unsafe for patients"

"Recent staff shortages have put significant pressure on existing permanent staff and redistribution of clinical workload"

Intentions to reduce public sector FTE may not reflect a corresponding intention to increase private practice but to improve wellbeing, and create a greater buffer between work demands and life. The impact of long hours was clear from the signficant reduction in job satisfaction: hours worked fell from 68 per cent satisfied in 2017 to 54 per cent in 2022. The impact of call duties and its determental effect on recovery was well-evidenced through the comments:

"Weekend call at 1:3 becoming arduous after 25 years of it."

"I would prefer not to take overnight call, as in psychiatry we are required to come in to the hospital several times per night, while still working the day of call, and the day post-call as usual (or wasting our "non-clinical" time for post-call recovery)."

"Normal working hours are fine however there is increasing pressure in on call Provision due to lack of registrars and SMO. This is stressful, adding to burnout and extremely frustrating."

The wellbeing of health care workers had been highlighted in Aotearoa and internationally prior to the Covid-19 pandemic. In 2017, the World Medical Association amended the Declaration of Geneva to incorporate a clause recognising the need for doctors to prioritise their own wellbeing, as well as that of their patients[28]. While the amendment has bought renewed attention to the long-standing issue of burnout, interventions leading to improvements at the organisational and systems levels – beyond the individual – remain scarce in the literature[29].

Locally, research into workplace wellbeing in hospital emergency departments may offer some insights that can be scaled to meaningful, collective interventions impacting all staff groups[30]. The health reforms and establishment of Te Whatu Ora Health New Zealand and Te Aka Whai Ora the Māori Health Authority present the necessary conditions for change described by the Clinican Burnout Committee:

"Taking action to mitigate burnout requires a bold vision for redesigning clinical systems – one that focuses on the activities that patients find important to their care and which enables and empowers clinicians to provide high quality care."[29]

The results from the Future Intentions survey show that SMOs are struggling in a system under sustained pressure. Significant decreases in job satisfaction measures, as well as strong indications of

[28] Taylor C. Words matter, says Queenstown doctor after making history to change oath. NZ Doctor 16 October 2017. https://www.nzdoctor.co.nz/article/news/words-matter-says-qtown-doctor-after-making-history-change-oath.

[29] National Academies of Science, Engineering and Medicine. Taking action against clinician burnout: a systems approach to professional wellbeing. Washington DC: National Academies Press; 2019. Available from https://doi.org/10.17226/25521.

[30] Nicholls M, Hamilton S, Jones P, Frampton C, Anderson N et al. Workplace wellbeing in emergency departments in Aotearoa New Zealand 2020. N Z Med J 2021; 134(1541):96-110. Available from https://pubmed.ncbi.nlm.nih.gov/34531600/.

mobility suggest there is little left in the tank to continue. Senior doctors are hungry for tangible and meaningful change that will positively impact their work experience and job satisfaction, their sense of value and wellbeing, and ultimately improve health outcomes for people and whānau.

The "bold vision for redesigned clinical systems" cited by the Clinician Burnout Committee must be a goal for Te Whatu Ora and Te Aka Whai Ora. That vision can come from within the health workforce, and from the communities the workforce serves. Together, health service design and delivery must be approached collectively through sharing power and recognising the diversity of skills and expertise within the health workforce and the knowledge and lived experience of communities[8].

Limitations

There are some limitations to this survey. The dual-purpose aim, with the combination of intentions to leave and IMG experience questions, meant that for some respondents there would be a longer time commitment. In order to gather as many complete responses as possible, the number of questions, the length, and the time commitment were key consideration during design and devlopment phase.

The opt-in nature of the survey could introduce selection bias, resulting in data that favoured a particular response. The phrasing of some questions, such as "*How likely are you to reduce the amount of public work you do, and start or increase private work?*" assumes that a reduction in public FTE would be compensated by increased private practice, yet many respondents were reducing public FTE to gain improved work-life balance.

While this was proposed as an opportuntistic means to obtain updated future intentions data, it did impact the design and organisation of the questions. This meant that where career intentions questions had been discrete in the past, they were combined into a matrix making it more difficult to determine the exclusivity of each variable, particularly for intentions to practice overseas.

In 2022 the survey cohort was expanded beyond members who worked for the former DHBs to members working in any context in Aotearoa New Zealand. Combined with the variation in questions, the comparison with 2017 data was unable to be in exact alignment. Further, respondents were not asked to provide written responses on their motivations, or identify any factors that may cause them to reconsider their choice.

Conclusions and recommendations

"This year has pushed many of us over the edge"

The 2022 Future Intentions survey holds a mirror to a health system that is held together by an overstretched, underresourced and short-staffed health workforce. At the time the survey was open, senior doctors and their nurse, midwife and doctors-in-training colleagues had come through a relentless winter of chronic staff shortages and surging Covid-19 and influenza infections.

The job satisfaction results showed a significant shift in SMO perceptions of value and worth, and how their contributions to the system are recognised. The highest levels of dissatisfaction (remuneration, 60 per cent dissatisfied; and recognition of good work, 59% dissatisfied) underscore that not only do SMOs feel undervalued in terms of their salaries, acknowledgement of their work, expertise and contributions is lacking across the board. Together with other factors, particularly hours of work – another area that has seen a sharp drop in job satisfaction since 2017 – it is clear that the monetary and non-monetary aspects of work have strong influences on job satisfaction overall.

Decades-long underinvestment in health infrastructure and the impact of inflation means that many large-scale projects may not be delivered to meet the level of need – complexity, acuity, and demand – within our communities. Thousands of planned care procedures, delayed by the pandemic, required rescheduling while people continued to deteriorate on waitlists, meaning treating their condition became more acute.

The work of systems change is complex; yet there are immediate and short term actions Te Whatu Ora and Te Aka Whai Ora can take to value, acknowledge and support the health workforce.

Value and invest in the health workforce

Immediate and short-term

a) There need to be increases in remuneration in order to recruite and retain members of the medical workforce.
b) Reaffirm relativities between different professional groups
c) Address demands on SMOs on call, and build in adequate recovery time that doesn't detract from non-clinical time
d) Design and implement a retention strategy for IMGs and later-career SMOs, in collaboration with unions and other stakeholders
e) Initiate a regular Health Workforce Census to support strategic planning across all health professional groups
f) Ensure that the development (underway in 2023) of the 10-15 year National Asset Management Plan involves and engages with clinicians

Medium term

a) Increase the number of doctors graduating from New Zeland medical schools to 600 by 2027
b) Strengthen postgraduate medical training pathways by engaging with specialist colleges, associations, responsible authorities, and unions to improve coordination, increase flexibility and provide certainty for employment prospects for early-career doctors
c) Ensure that the 2024 iteration of Te Pae Tata, the New Zealand Health Plan, establishes priorities and timeframes to deliver infrastructure improvements

Systems improvements to facilitate workplace wellbeing and culture change

Immediate and short-term

a) Establish a framework informed by continuous quality improvement principles for service-level audits covering:
    - service sizing
    - recovery time
    - non-clinical time
b) Agree to regular and routine resourcing assessments through service sizing on a 3–5-year cycle, ensuring that FTE is matched to need

Action on shift work

Immediate and short-term

a) Stop triple shifts
b) Start providing meals, corporate rideshare services and shuttle services and sleeping accomodation for night workers in every hospital to improve wellbeing, recovery and minimise the risks from fatigue

Medium term

a) Establish regionally and nationally-consistent additional duties rates for Emergency Departments

Reduce duplication and system inefficiencies

Immediate and short term

a) Te Whatu Ora implements one app to improve clinical workflow
b) Prioritisation of work guidelines are developed for all roles and levels, recognising the context of resource limitation

Acknowledgements

Prepared by Harriet Wild, Director of Policy and Research, ASMS. Statistical analysis completed by Professor Chris Frampton, University of Otago. Survey concept and design draft by Dr Charlotte Chambers.