2020 General Practice Workforce Survey

Overview report – Final

16 December 2020

ALLEN+CLARKE

ACKNOWLEDGEMENTS

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REVIEW

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INSIGHTS

The year 2020 has been a particularly difficult year – reflected in high burn-out scores and the importance GPs gave to having a less stressful working environment.

Equity continues to be an issue: we found a disproportionately lower number of Māori and Pacific GPs, female GPs were paid less on average, and many GPs noted that patient access to telehealth services was a problem.

A younger female cohort of GPs is coming through who may need to be supported in different ways to improve wellbeing.

There is an older cohort who were working longer hours and had more after-hours commitments.

Telehealth technology use and confidence in using technology among GPs is high, with respondents also rating the usefulness of telehealth very positively.

Succession planning for rural hospital medical staff is needed: more than one-quarter state they intend to retire in the next five years and a further 18 percent intend to retire in 6-10 years' time.

There is an impending GP workforce shortage: almost one third intend to retire within the next five years and almost half intend to retire within the next 10 years.

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EXECUTIVE SUMMARY

This is the first in a series of reports from The Royal New Zealand College of General Practitioners' (the College's) 2020 Workforce Survey. It provides an overview of the general practice and rural hospital medicine workforce in 2020. It is intended to provide a technical summary of the survey findings.

The survey results have been collated and analysed by *Allen + Clarke* with support from College staff. Over 5,000 Fellows, Members and Associates of the College and the Division of Rural Hospital Medicine were surveyed (almost all doctors working in New Zealand general practice and rural hospital medicine), with a response rate of 60 percent.

General Practice workforce - Demographics

- The median age of participants is 52 years.
- 25 percent are aged between 24 and 39 and 13 percent are 65 or more.
- While 58 percent of respondents are female, a large cohort effect exists: there are more older male GPs in the 65+ age group (72 percent), while there are more female GPs in the 24 to 54 age bracket (67 percent), indicating a changing gender distribution for the GP workforce into the foreseeable future.
- There is a differing age and gender distribution between GPs trained overseas (older and 54 percent female) and those trained in NZ (younger and 60 percent female).
- The ethnic distribution of the GP workforce continues to be dominated by respondents identifying as European (77 percent) – higher than was found in the 2018 GP workforce survey (75 percent) and considerably higher than in the general population.
- Significant and persistent deficits are seen for the number of Māori or Pacific GPs compared to the general population. Four percent of respondents identify as Māori and two percent of respondents identify as Pacific peoples – similar to 2018 survey findings.
- The percentage of survey respondents who identify as Asian has steadily increased from 16 percent in 2017, to 18 percent in 2018, and 19 percent in 2020 – higher than in the general population.
- Half of respondents working in rural-based practices obtained their first medical degree overseas, compared with 34 percent of respondents in urban-based practices.

Training and teaching in general practice

- Almost a quarter (22 percent) of GPs are currently enrolled in a vocational training programme, with 19 percent in the General Practice Education Programme (GPEP).
- Of those enrolled in GPEP, 82 percent are at GPEP2/3 and 18 percent at GPEP1.
- 85 percent of those in GPEP1 and 73 percent of GPEP2 are under the age of 40.
- Two-thirds of those in training are female (64 percent).
- Half (49 percent) report that they currently provide training to medical students or doctors, with 18 percent provide at least 2 types of training to medical students or doctors.
- Over half of those training medical students are female (55 percent) and are more likely to be 35 or older.
- Reflecting the smaller workforce and the push for training in rural hospitals, 64 percent of respondents in rural situations are teaching compared to 45 percent of those in urban practices.

Hours worked and after-hours commitments in general practice

- The average number of hours worked in general practice is 34.8 hours per week.
- Males tend to work longer hours than females (mean 38.5 vs 31.5 hours).
- A little less than half of GPs work 'full-time[1]' (45 percent).
- Those working in rural practices are more likely to be working full-time (54 percent) compared to respondents in urban practices (44 percent).
- Rural practices report having far more after-hours practice related commitments - 28 percent of rural and 9 percent of urban have commitments every week.
- Those working longer hours and male GPs report more frequent after-hours practice related commitments.
- GPS aged 55 or more are the most likely to report having no commitments.

[1] In this report, full-time was defined as any GPs or rural hospital doctors working 36 hours or more per week.

GP incomes

- GPs' average personal annual before-tax income is $157,594, the median income is $140,000, indicating a right-skewed income distribution.
- Among respondents working at least 36 hours per week in general practice, the median incomes for male and female GPs are $200,000 and $160,000 respectively.
- Male GPs working over 36 hours per week (47 percent) are more likely to earn over $200,000 than female respondents (26 percent).
- Respondents who are Fellows of the College and work full-time (45 percent) are more likely to state they earn over $200,000 per annum than those who are not Fellows but work full-time (12 percent).

Factors that might enable part-time GPs to increase working hours

- Among part time GPs, a less stressful working environment is the most commonly identified factor (38 percent) in encouraging increased working hours, followed by higher remuneration (29 percent) and greater workplace flexibility (28 percent).
- A less stressful working environment is considered the most important factor (28 percent) in encouraging increased working hours, followed by higher remuneration (18 percent) and increasing age of children (17 percent).
- A less stressful working environment is the most important factor for both males and females.
- The next most common factor is different across gender, with males rating higher remuneration (23 percent) and females reporting that their children getting older (20 percent) as most important.
- Respondents over 55 state a less stressful working environment is most important (31 percent) and higher remuneration next (21 percent).
- Respondents under 55 years of age also state a less stressful working environment as being the most important (albeit lower at 26 percent) and the increasing age of their children (23 percent) as the second most important factor.
- Higher remuneration is highest rated by long-term employees/contractors (19 percent), with short-term employees/contractors lower at 16 percent, and 15 percent of practice owners/partners.

- A fifth of short-term employees (20 percent) reported that flexibility in working hours was the most important factor in encouraging them to increase their hours compared to long-term (14 percent) and practice owners/partners (9 percent).
- Almost a quarter of GPs earning less than $75,001 reported that their children growing older (23 percent) was the most important factor, while those earning over $75,000 rate a less stressful working environment highest (between 29 and 32 percent).

Employment type and practice ownership

- Respondents who are long-term employees or contractors make up the largest group (52 percent), while more than a third of respondents (34 percent) are either practice owners or partners. Among female respondents, however, only 26 percent are practice owners or partners.
- Practice ownership increases steadily with age, peaking in the 55-59 age cohort.
- Short-term contractors and employees make up 11 percent of respondents; however, among rural respondents this increases to 16 percent.
- Most respondents (69 percent) work in practices owned by GPs. The next most common ownership model in urban areas is corporate ownership (11 percent), and in rural areas it is community, trust or charity ownership (14 percent).

Retirement intentions in general practice

- Nearly one-third (31 percent) of respondents are intending to retire from the GP workforce in the next five years and nearly half (49 percent) in the next 10 years.
- If we exclude registrars, these percentage rise to 36 percent intending to retire in the next five years and 58 percent in the next ten years.
- There is little difference in retirement intentions between rural and urban GPs.

Burn-out and general practice as a career

- Nearly one-third (31 percent) of respondents rate themselves 'high' on the burn-out scale.
- Respondents reporting high burn-out are more likely to be aged between 40 and 64 years, a practice owner or partner, and working full-time.
- More than half of GPs (54 percent) rate themselves as likely to recommend a career in general practice.
- 14 percent rate themselves as unlikely to recommend a career in general practice.

Ways of working in general practice

- Between pre- and post-COVID-19 Level-4 lockdown, we observed an increase in use of all the technologies enquired about, with the largest changes seen in video conferencing (11 percent vs 54 percent). This is followed by the use of phone messaging, which also increased during the period (13 percent vs 22 percent).
- Half (49 percent) of participants report being confident or very confident in using Video conferencing – a dramatic increase from 2016 (12 percent).
- The vast majority (over 95 percent) of respondents feel that the use of telehealth was positive at least sometimes.
- Almost one-fifth respondents (19 percent) report that their patients face barriers to using these technologies often or always.
- Over a quarter (26 percent) of respondents report that their practice was a Health Care Home practice pre-lockdown, increasing to 29 percent post-lockdown.
- Almost a third (32 percent) report having a nurse practitioner at the practice, which did not change over the lockdown period, with 45 percent reporting having a healthcare assistant pre-lockdown rising slightly to 47 percent post-lockdown.

Rural Hospital Medicine workforce – Demographics

- A higher percentage of respondents who are either working in rural hospital medicine or are registrars training towards FDRHMNZ identify as male (56 percent) than female (44 percent).
- Nearly a quarter of these respondents (22 percent) are aged 60 years or older. Meanwhile, one-tenth of the respondents (10 percent) are in the age range of 25 to 29 years old. The median age of the group was 49 years.
- Just under half (46 percent) of respondents in this group report that they gained their first medical degree overseas, compared to the 54 percent who gained their degree in New Zealand. The most common country in which respondents indicated that they had gained their first medical degree overseas was the United Kingdom (42 percent).
- Just one-third of respondents working or training in rural hospital medicine (31 percent) first gained medical registration in New Zealand in the past 10 years.
- More than three-quarters of respondents (76 percent) who work in rural hospital medicine or who are rural hospital medicine registrars state they were registered in a

vocational scope, most frequently in general practice (54 percent) and/or rural hospital medicine (42 percent).

- Just under one-third of respondents working or training in rural hospital medicine (30 percent) state they were enrolled in a vocational training programme. Of these, 95 percent are training towards FDRHMNZ and 64 percent towards FRNZCGP.

Working in rural hospital medicine

- More than two-thirds (68 percent) of respondents who work in rural hospital medicine work in a Level 3 rural hospital. While 16 percent of respondents work in a Level 2 rural hospital and very few in a Level 1 rural hospital (4 percent).
- The average number of hours worked in rural hospital medicine is 28.4 hours per week. More than half of respondents working in rural hospital medicine (55 percent) work up to and including 35 hours per week in rural hospital medicine.
- Between pre- and post-lockdown, we observed a noticeable increase for the use of video call (38 percent to 47 percent) or SMS messaging (43 percent to 52 percent) or phone messaging app (27 percent to 34 percent). Conversely, the use of email went down over the period (56 percent to 54 percent).

Retirement intentions in rural hospital medicine

- Fifteen percent of respondents working in rural hospital medicine or enrolled in the rural hospital medicine vocational training programme intend to retire in the next one to two years.
- More than one-quarter (29 percent) state they intend to retire in the next five years. Looking only at those FDRHMNZ, the percentage decreases to 23 percent intending to retire in the next five years.
- A further 18 percent intend to retire in 6-10 years' time, meaning that in total nearly half (46 percent) intend to retire in the next 10 years.

Burn-out and options about a career in rural hospital medicine

- More than one-fifth of rural hospital doctors (21 percent) working in rural hospital medicine rate themselves as being burnt out to some degree.

- Eighty percent of rural hospital doctors state they were likely to recommend a career in rural hospital medicine. Only 5 percent state they were unlikely to do so.

1. INTRODUCTION

1.1. Context

The Royal New Zealand College of General Practitioners (the College) works to improve the health of all New Zealanders through high quality general practice care. The College is a professional membership organisation that works to strengthen the professionalism and practice of its members. The College provides education, assessment, quality and support services for general practice and rural hospital medicine; and represents its members by providing advice and expertise to government and within the wider health sector.

The College works to achieve its strategic aims of:

- Growing the GP workforce
- Setting quality standards for practices
- Representing its members
- Contributing to equitable health care for all New Zealanders
- Becoming a contemporary and sustainable organisation.

The College is the largest professional medical college in New Zealand and provides ongoing professional development to approximately 5,700 GPs and Rural Hospital Medicine practitioners.

The General Practice Workforce Survey is a cross-sectional survey conducted by the College among its members, first carried out in 2014. Prior to 2018, the survey was undertaken annually. In 2020, the College decided to change its frequency to a biennial survey. The survey aims to provide the College (and the wider health sector) with a strong evidence base that will help inform future decisions about general practice in New Zealand, track trends over time, and respond in a timely manner to emerging issues.

Allen + Clarke was commissioned by the College to co-design and conduct the 2020 General Practice Workforce Survey. In addition to core questions that have been included in previous workforce surveys, it was decided to add content to the 2020 Survey relating to 'new ways of working'. This included timely reporting on changes to service delivery models related to COVID-19 lockdown restrictions. New Zealand went into COVID-19 Alert Level 4 lockdown in March 2020; this may have influenced some of the findings of this report.

1.2. Objective

The aim of this work is to add to the College's evidence base to inform quality standards, and programmes to improve general practice workplace and clinical systems in general practice for the benefit of practices and patients.

1.3. Limitations

Due to the lack of access to the full historical workforce survey datasets, *Allen + Clarke* has adopted a 'Single Source of Truth' approach and extracted the previous surveys' results from the 2014 to 2018 GP Workforce reports.

2. METHODOLOGY

The 2020 Workforce Survey was conducted from 3 August to 6 September 2020. *Allen + Clarke*, an independent research company, was commissioned to co-design and conduct the survey and to analyse and report the results. It worked closely with College staff.

The main questionnaire of the survey has been adapted from the core set of questions in the previous 2018 workforce survey, allowing comparison to past responses and trend analysis, and additional modules of questions have also been added in 2020. For example, this year's theme is "Ways of Working". The college is interested in understanding how work has changed because of the COVID-19 lockdown, including how GPs engage with their patients. The rural hospital medicine module is on its second survey cycle after being introduced in the 2018 workforce survey.

The questionnaire was pre-tested to ensure that the questions were appropriate, effective and easy to understand. After this process, some modifications were made to the questionnaire. Prior to the main phase of the data collection, a pilot study was carried out among 20 GPs. The pilot study confirmed that the questionnaire flowed well, and the estimated duration of survey was approximately 15 minutes.

The survey's **target population** was all doctors currently working (three months prior to the survey) in either general practice or rural hospital medicine in New Zealand. We used a "census" approach (complete enumeration survey method) wherein every registered member of the College is selected for the study. The College's database, which includes most doctors working in New Zealand general practice, was used as the survey's **sampling frame** to identify and contact survey participants.

In New Zealand, doctors are legally able to work in general practice without the additional training required for vocational (specialist) registration, and these non-vocationally registered doctors may not be included in the College's database, i.e., they were not be covered by the participant list (out of coverage), as a result, they were not reached by the survey. In addition, survey recipients also included doctors who are retired, currently out of the workforce, working in other careers, working overseas or have not been involved in clinical work in the previous three months. We have excluded those GPs (out of scope) in our analysis and reporting.

In total, 5193 Fellows, Members and Associates of the College and the Division of Rural Hospital Medicine received the email invitation with a link to a personal copy of the online survey. A reminder email was sent to those who had not responded approximately one week later. To

further boost the final participation rate, two more follow-up emails were sent in subsequent weeks.

We received 3139 responses of which 22 were not valid (i.e., did not complete section one of the survey), leaving 3117 valid and useable responses and giving a response rate of 60.0 percent. This included 98 incomplete responses. These were included in the analysis as the majority were missing only the responses to some questions in the survey. The response rate is very close to the rate in the 2018 survey, which was 60.9 percent.

According to the 2020 survey, 242 respondents were GPs who are not part of the current workforce (e.g. they are retired or are working overseas), 46 respondents had not been involved in clinical work in the previous three months, 41 respondents stated they had only worked in rural hospital medicine, three respondents had worked in rural hospital medicine and some 'other' non-general practice setting, and one respondents were enrolled in rural hospital medicine but had not worked in rural hospital medicine or general practice in the previous three months.

As a result, unless otherwise specified, the data and analysis in the GP section of this report is based on the response to the survey questions for 2,784 respondents who stated they had done clinical work in general practice in New Zealand in the three months prior to the survey.

Where appropriate, the responses from the 46 who stated that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison) are also taken into account. For example, this is the case for the demographics section of the report.

The number of respondents who stated they had worked in rural hospital medicine in the three months prior to the survey was 114. With 193 rural hospital doctors recorded in the College's membership records, 114 responses represent a response rate of 59.1 percent. As such, the results can be regarded as being representative, despite the number responding being relatively small in an absolute sense.

Another 21 respondents identified themselves as registrars training towards Fellowship of the Division of Rural Hospital Medicine (FDRHMNZ). While these respondents had not worked in rural hospital medicine in the preceding three months, they were asked relevant questions and were therefore included in the RHM section of this report. This increased the total possible number of responses to relevant questions to 135.

In preparation for the analysis, a comparison of the age and gender profile of the survey respondents with the age and gender profile of those on the College database was undertaken. As this showed a close match between the two profiles, the survey data has not been 'weighted' to

correct for any variations. That is, all the data for 2020 in this report are presented in an unweighted basis.

As not all questions were compulsory, the survey included conditional logic, so only relevant questions were presented to participants according to their earlier responses. Therefore, the total number of respondents on which tabulations and figures are based differs according to the number of GPs or rural hospital doctors who were eligible to answer each question in the survey.

3. GENERAL PRACTICE WORKFORCE - DEMOGRAPHICS

This section of the report is based on survey respondents who indicated they are working or had worked in general practice in the three months prior to the survey. There are 2830 of these respondents, which includes 46 who state that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison). Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

3.1. Age and gender

Based on the results of this year's survey, the median age of GPs is 52 years, as in previous years. Figure 1 shows that half of survey respondents are aged 52 years and over, with 13% aged 65 or over. A quarter of the GP population are aged between 24 and 39 years of age and a further quarter are aged between 40 and 52.

The current GP workforce is dominated by the large numbers of medical graduates from the late 1970s to mid-1980s, many of whom pursued a career in general practice. These GPs are now in their late 50s or 60s and many are moving toward retirement. The relatively low numbers of GPs in their 40s, coupled with the impending retirement of many older GPs has implications for the sustainability of the GP workforce. It highlights the need to encourage a new generation of medical graduates to pursue a career in general practice with a well-supported programme of training.

Figure 1. Age profile of GPs (n=2830)

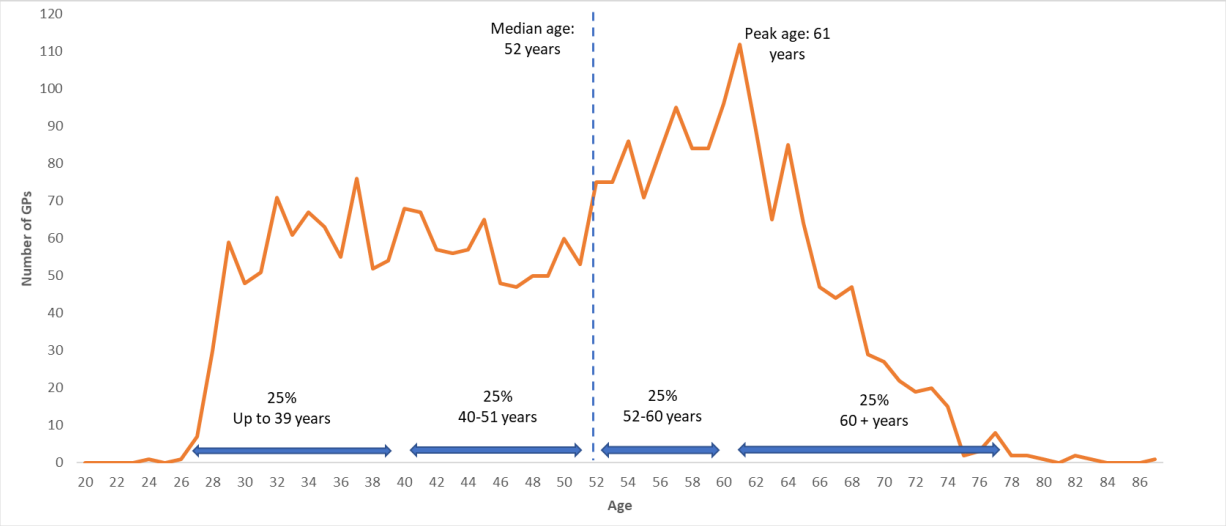


Table 1 shows that, overall, 58 percent of survey respondents are female and 42 percent are male. Reflecting a cohort shift, it is only in the 65+ age group that the proportion of male GPs is higher than female GPs, whereas in 2018 there were more male than female GPs in the 55 to 64 as well as in the 65+ age groups. There is a close to even split between genders in the 55 to 64 age group in 2020 (52 percent were female), with female GPs more common in the 24 to 54 age band indicating a changing gender distribution for the GP workforce into the foreseeable future.

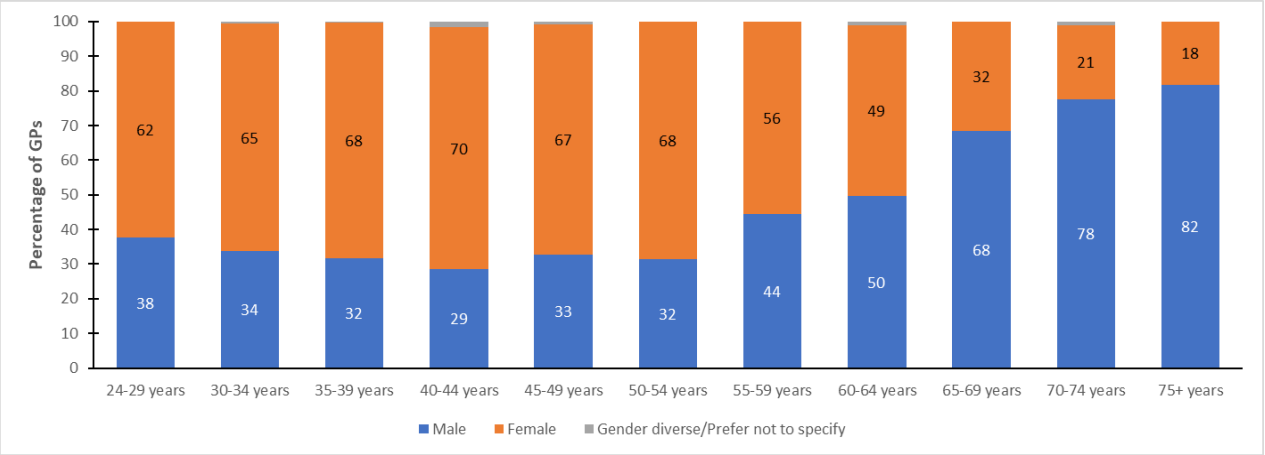
Table 1. Gender by age of GPs (n=2830)

	Total GPs	24-39 years	40-54 years	55-64 years	65+ years
Unweighted base	**2830**	**696**	**914**	**864**	**356**
	%	%	%	%	%
Male	42	33	31	47	72
Female	58	66	68	52	28
Gender diverse/I prefer not to specify my gender	1	0	1	1	0
Total	100	100	100	100	100

Total may not sum to 100% due to rounding.

Figure 2 shows this pattern in greater detail with an older male dominated cohort moving into retirement and a younger mostly female cohort comprising the GP workforce.

Figure 2. Gender by age of GPs (n=2830)

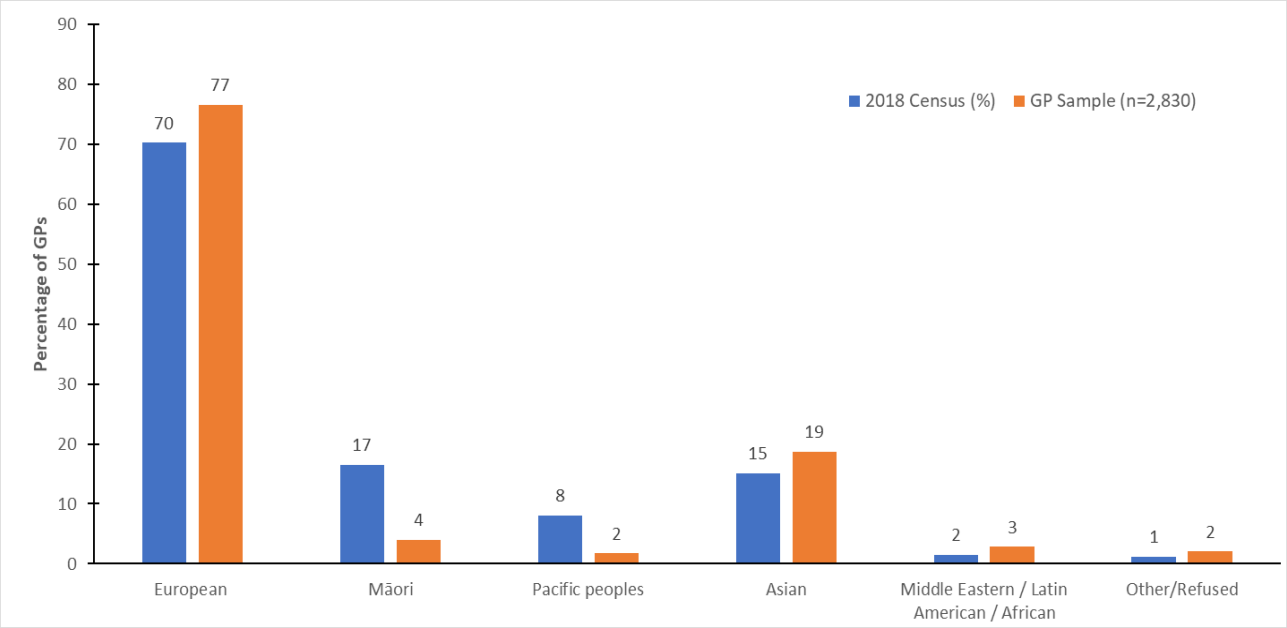


3.2. Ethnicity

Figure 3 shows the profile of the New Zealand GP workforce by total-response ethnicity[2] and compares it with the total ethnic distribution of the New Zealand population as at the 2018 census.

The largest ethnic group is those identifying themselves as European (77 percent of respondents) which is higher than the 2018 census population (70 percent of the New Zealand population). Significant and persistent deficits were seen for Māori or Pacific. Four percent of respondents identified as Māori compared to 17 percent of the 2018 census population. Two percent of respondents identified as Pacific peoples compared to 8 percent of the population. The percentage of survey respondents who identified as Asian has steadily increased from 16 percent in 2017, to 18 percent in 2018, and 19 percent in 2020 – compared to 15 percent of the population.

Figure 3. Comparison between the ethnicity of GPs and that of the New Zealand population in general (n=2830)



Total may be greater than 100% as respondents could identify with more than one ethnicity.

Table 2 shows that there are 55 respondents aged 40 years and over who identify as Māori making 2.6 percent of all respondents aged 40 and over. The 58 respondents aged under 40 years who

[2] Total-response ethnicity involves each respondent being allocated to all ethnic groups that they have identified with. A respondent may fit into more than one ethnicity group. For example, a person who identifies as both Chinese and Māori will appear in both the Māori group and the Asian group. Consequently, the Māori and Asian groups should not be directly compared; Māori can only be compared with the non-Māori group and Asian can only be compared with non-Asian.

identify as Māori make up 8.3 percent of all respondents under 40 years. Māori GP representation (4 percent) is still well below that of the entire NZ population (17 percent in the 2018 census).

Table 2. Age profile of Māori GPs (n=113)

	Total GPs		Māori respondents	
Unweighted base	**2830**		**113***	
	n	%	n	% of all respondents
Respondents under 40 years	696	25	58	8.3
Respondent 40 years and over	2134	75	55	2.6
All respondents	2830	100	113	4.0

Total may not sum to 100% due to rounding.

*Subsample based on those GPs who identified as Māori.

3.3. International medical graduates (IMGs)

Table 3 shows 63 percent of survey respondents state they had obtained their first medical degree in New Zealand compared to 37 percent who state they obtained their first medical degree overseas. The percentage who obtained their first medical degree overseas may be dropping with 42 percent in 2014 and 40 percent in 2015 reporting this.

International medical graduates (IMGs) were asked from which country they had received their first medical qualification. Table 3 shows that this was predominantly the United Kingdom (42 percent), followed by South Africa (12 percent). This is like the result recorded in 2018.

Table 3. Country of origin of first medical degree for IMGs (n=1058)

	Total GPs	IMGs
Unweighted base	**2830**	**1058***
	%	%
New Zealand	63	N/A
United Kingdom	16	42
South Africa	5	12
India	3	8
Australia	2	7
Ireland	1	3
Sri Lanka	1	3
Germany	1	2
Iraq	1	2
Canada	0	1
Pakistan	0	1
Other European country	3	7
Other Asian country	2	6
Other	2	6
Total	100	100

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who gained their first medical degree overseas.

Figure 4 shows that IMGs tend to be older, only 4 percent of respondents who identified as IMGs are aged 34 years or younger compared with 20 percent of New Zealand medical graduates (NZMGs). Table 4 shows female IMGs tend to be slightly less, 54 percent of IMGs were female compared with 60 percent of New Zealand medical graduates.

Figure 4. Age profile of NZ medical graduates and International medical graduates

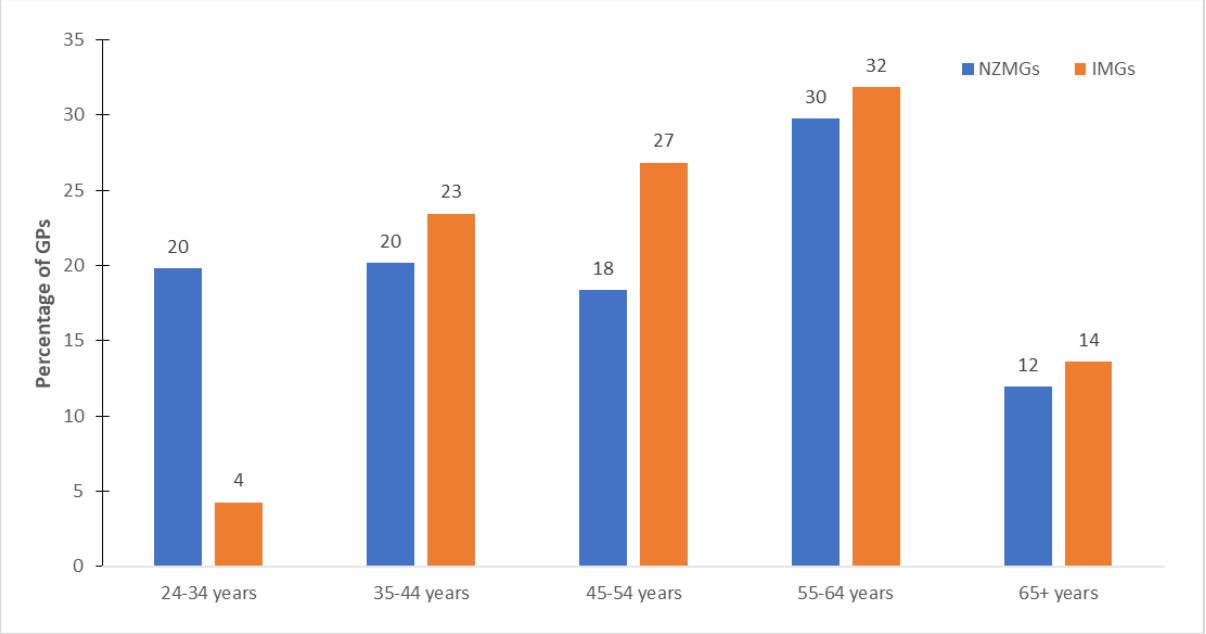


Table 4. Gender profile of NZ medical graduates and international medical graduates

	NZMGs	IMGs
Unweighted base	**1772**	**1058**
	%	%
Male	40	45
Female	60	54
Gender diverse/Prefer not to specify	1	1
Total	100	100

Total may not sum to 100% due to rounding.

3.4. Rural or urban practice location

Practice location was self-defined, meaning that survey respondents were presented with three location categories ('urban', 'rural', and 'not clearly urban or rural') and asked, "Is the practice you are currently working in urban or rural based? The way you answer this question doesn't need to be based on your eligibility for rural funding support."

In response to this question, three-quarters of respondents (74 percent) consider the practice they work in to be urban based, compared with 15 percent who consider they work in a rural-

based practice. The remainder (9 percent) consider themselves to be working in a practice that is not clearly urban or rural.

Table 5 shows that there are small differences in practice location by age. For example, respondents currently working in rural-based practices are more likely to be aged under 40, compared with those in urban-based practices, and respondents in urban practices are slighter older. Respondents in practices that are not clearly urban or rural tend to fall between urban and rural practices in terms of their age distribution.

Table 5. Age profile of GPs working in general practices that are located in urban and rural areas (n=2724)

	Total	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724***	**2048**	**419**	**257**
	%	%	%	%
25-39 years	25	24	27	26
40-54 years	32	33	31	31
55-64 years	31	31	29	30
65+ years	12	12	13	12
Total	100	100	100	100

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who answered the relevant question

Reflecting the general shift towards more female GPs overall, Table 6 shows more female respondents report being in urban, rural or the unclear category, with the greatest difference being in urban practices where 59 percent are female compared to 40 percent male. The other practice types have 54 percent women compared to 45 percent male. Again, this reflects a large younger female cohort following behind an older male-dominated cohort now moving into retirement age.

Table 6. Gender profile of GPs working in general practices that are located in urban, rural, and 'not clearly urban or rural' areas (n=2724)

	Total	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
	%	%	%	%
Male	41	40	45	45
Female	58	59	54	54
Gender diverse/Prefer not to specify	1	0	1	1
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Examining how ethnicity varies across rurality (Table 7), there are clear differences for urban practices, where fewer European/other (72 percent) and more Asian (22 percent) work than was found for rural or unclear practice types. No significant difference is found for Māori across

rurality and those reporting a Pacific ethnicity are exclusively in urban practices. Respondents reporting a European/other ethnicity are the majority in rural and (85 percent) unclear practices (82 percent) with those reporting an Asian ethnicity the next most common (9 percent and 11 percent respectively).

Table 7. Ethnicity profile of GPs working in general practices that are located in urban, rural, and 'not clearly urban or rural' areas (n=2724)

	Total	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
Prioritised Ethnicity[3]	%	%	%	%
Māori	4	4	4	5
Pacific People	2	2	0	0
Asian	19	22	9	11
European/Other	75	72	85	82
Refused/Not Stated	1	1	2	2
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 8 shows that there are differences by whether respondents obtained their first medical degree in New Zealand or overseas. Half of respondents working in rural-based practices report obtaining their first medical degree overseas, compared with respondents in urban-based practices (34 percent), or in practices not clearly urban or rural (45 percent).

Table 8. Origin of first medical degree (n=2724)

	Total	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
	%	%	%	%
New Zealand	62	66	50	55
Overseas	38	34	50	45
Total	100	100	100	100

Total may not sum to 100% due to rounding.

[3] Prioritised ethnicity refers to where each respondent is allocated to a single ethnic group, in the prioritised order of Māori, Pacific, Asian, European/Other. For example, if someone identified as being both Chinese and Māori, their prioritised ethnicity is Māori for the purpose of analysis. The prioritised ethnicity group European/Other effectively refers to non-Māori, non-Pacific, and non-Asian people.

4. TRAINING AND TEACHING IN GENERAL PRACTICE

This section of the report is based on survey respondents who indicated they are working or had worked in general practice in the three months prior to the survey. There are 2830 of these respondents, which includes 46 who state that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison). Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

These questions are key in understanding what training respondents are undertaking and who is doing the training. Such a stocktake will show us where the demand is and how the additional burden of training is distributed amongst practising GPs in New Zealand.

4.1. Respondents currently training

Twenty-two percent of survey respondents state they are currently enrolled in a vocational training programme (Table 9), with 19 percent enrolled in training towards Fellowship of the College, i.e. the General Practice Education Programme (GPEP). The majority of the respondents report that they are not in training (79 percent). This reflects the high proportion of respondents who were already a College fellow.

Table 9. Vocational training programme in which enrolled as a registrar (n=2830)

	Total GPs	Respondents in vocational training	
Unweighted base	2830	596*	
	%	Frequency	%
General practice training (RNZCGP)	19	544	91
Rural hospital medicine training (DRHMNZ)	1	29†	5
Urgent care training (FRNZCUC)	1	30	5
Other	1	33	6
Not enrolled in any vocational training programme	79	N/A	N/A

Total may not sum to 100% due to multiple responses.

* Sample based on respondents who reported they were enrolled in a training programme.

† This does not include the 8 rural hospital medicine registrars who had not worked in general practice in the past three months. A total of 37 rural hospital medicine registrars responded to the survey.

Table 10 shows that most respondents enrolled in the training programme towards gaining Fellowship of the College (GPEP) are at GPEP2/3 (82 percent) and less than a fifth (18 percent) at GPEP1. Overall, most are under the age of 40 years (75 percent) with more of those enrolled in GPEP1 being under the age of 40 than those in GPEP2/3 (85 percent and 73 percent respectively).

Again, reflecting the gender distribution of the younger GP cohort, the majority of those in training are female (64 percent) with a small difference between GPEP1 and GPEP2/3 where 61 percent of those reporting GPEP1 study are female compared to 65 percent at GPEP2/3 (Table 11).

Table 10. GPEP study stage by age (n=544)

	Total GPs training	GPEP1	GPEP2/3
Unweighted base	**544***	**100**	**444**
	%	%	%
25–39 years	75	85	73
40–54 years	22	14	23
55–64 years	3	1	3
65+ years	1	0	1
Total	100	100	100

Total may not sum to 100% due to multiple responses.

*Sample based on those GPs who stated they were enrolled in GPEP.

Table 11. GPEP study stage by gender (n=544)

	Total GPs training	GPEP1	GPEP2/3
Unweighted base	544*	100	444
	%	%	%
Male	35	38	34
Female	64	61	65
Gender diverse/Prefer not to specify	1	1	1
Total	100	100	100

Total may not sum to 100% due to multiple responses.

*Sample based on those GPs who stated they were enrolled in GPEP.

Overall, there is no difference between those training and those not in training across rural and urban practices (Table 12). There is a larger proportion of GPEP1 in rural practices (20 percent) compared to respondents in GPEP2/3 training in rural practices (14%).

Table 12. GPEP study stage by rurality (n=528)

	Total GPs	Total GPs in training	GPEP1	GPEP2/3	Not training
Unweighted base	2724	528*	97	431	2196
	%	%	%	%	%
Urban	75	75	74	75	75
Rural	15	15	20	14	16
Not clearly urban or rural	9	10	6	11	9
Total	100	100	100	100	100

Total may not sum to 100% due to multiple responses.

*Sample based on those GPs who are currently enrolled in GPEP and answered the relevant question.

4.2. Respondents providing training

Half (49 percent) of survey respondents report that they currently provide training to medical students or doctors, 18 percent provide at least 2 types of training, which is notably up from 2018 (39 percent), with over half of these female (55 percent) and more likely to be 35 or older (Figure 5). Probably reflecting the smaller workforce and the push for training in rural-based practices, 64 percent of respondents in rural situations are teaching compared to 45 percent of those in urban practices.

Figure 5. Age profile of GPs who provided training

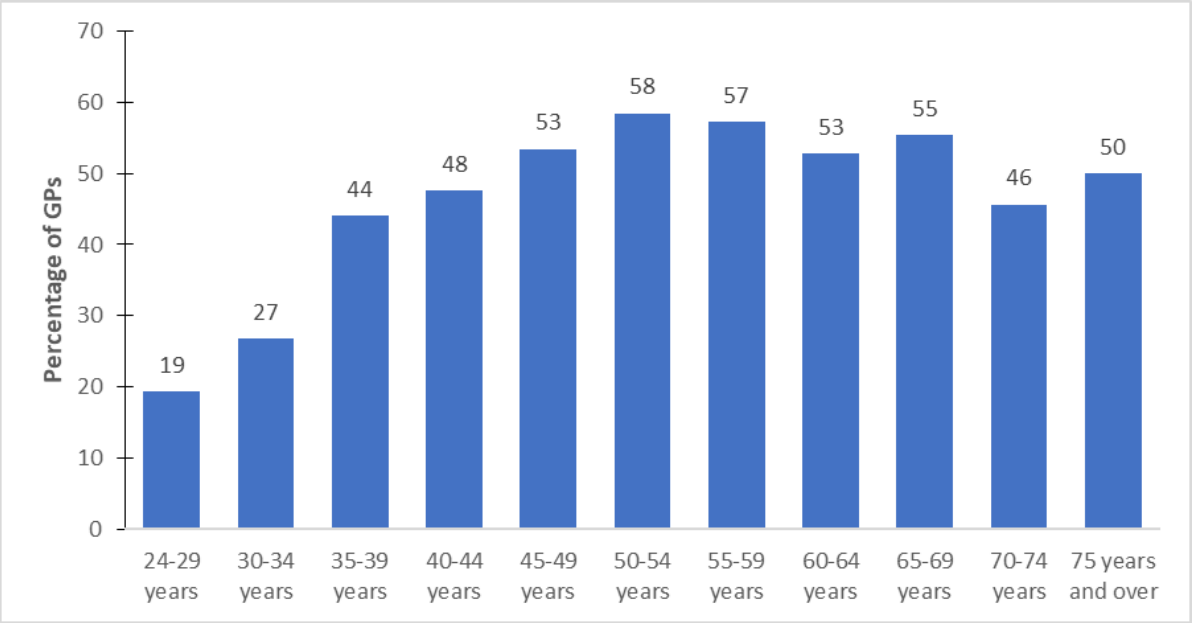


Table 13 shows that almost two-thirds (58 percent) of trainers are teaching undergraduate medical students. Almost a quarter (23 percent) teach GPEP1 and/or are mentors for GPEP2/3 registrars (22 percent). The table also shows that many respondents are providing training at more than one level with 38 percent teaching at least two training types.

Table 13. Type of vocational training (n=1380)

Which, if any, of the following training do you provide?	Frequency	%
Teacher of undergraduate medical students	796	58
GPEP1 teacher	317	23
Mentor of a registrar in GPEP 2/3	298	22
Nurse practitioner training	202	15
Supervisor of house officers doing postgraduate community-based runs	111	8
GPEP medical educator	103	7
Teacher or educational facilitator on the DRHM programme	21	2
Pharmacist training	18	1
Other health professional training (please specify)	359	26

Total may not sum to 100% due to multiple responses.

5. HOURS WORKED AND AFTER-HOURS COMMITMENTS IN GENERAL PRACTICE

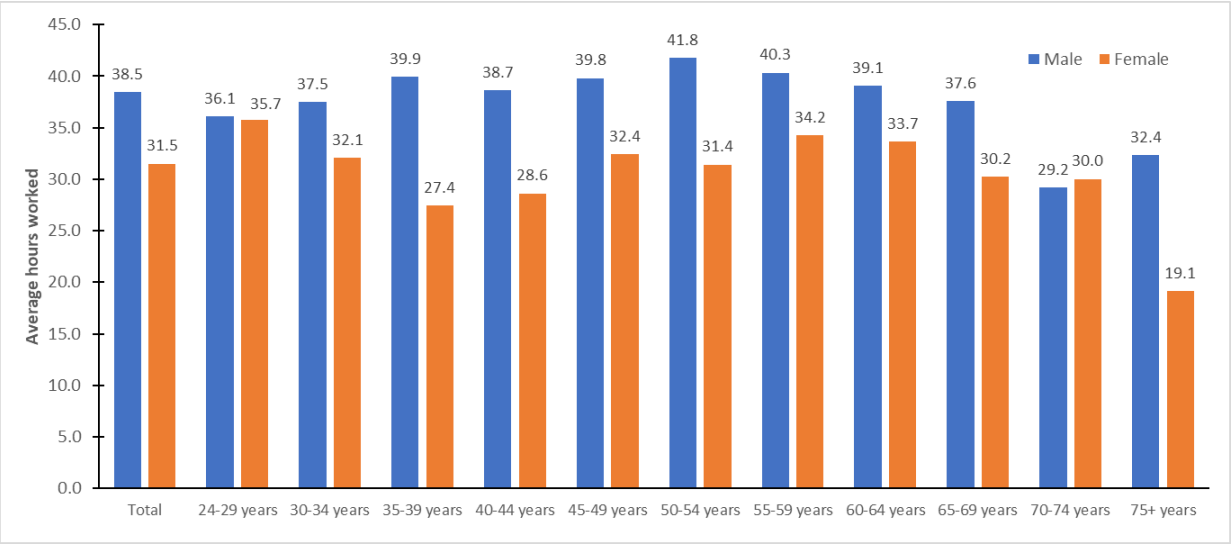
This section of the report is based on survey respondents who indicated they are working or had worked in general practice in the three months prior to the survey. There are 2784 of these respondents. Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

NOTE: This section excludes the 46 who stated that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison).

5.1. Hours in general practice per week

Survey respondents were asked about the hours they work in general practice per week. They were asked to include the time spent on paperwork, teaching, practice management and time worked when on-call, but not the time spent on other medical work outside of general practice. Based on respondents' answers to this question, the average number of hours worked in general practice is 34.8 hours per week. Figure 6 shows that there is a strong trend for males to be working longer hours than females (mean 38.5 vs 31.5 hours, respectively).

Figure 6. Hours worked in general practice per week by age and gender (n=2784*)



* Note this graph excludes respondents who did not specify their gender.

Table 14 shows that a little less than half of all respondents have been classified as working 'full-time' (45 percent), which for the purposes of this survey is defined as 'working 36 hours per week

or more in general practice'. This means that a large percentage work 'part-time' (54 percent). Female GPs are more likely to work in part-time (66 percent) in comparison to male GPs (36%).

Table 14. Total hours worked in general practice per week by gender (n=2784)

	Total GPs	Male	Female	Gender diverse/I prefer not to specify my gender
Unweighted base	**2784**	**1157**	**1611**	**16**
	%	%	%	%
Fewer than 36 hours	54	36	66	50
36 hours or more	45	62	33	50
Don't know	1	1	1	0
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 15 shows that those working in rural practices are more likely to be working full-time (54 percent) compared to respondents in urban practices (44 percent).

Table 15. Total hours worked in general practice per week by location of general practice (n=2724)

	Total GPs	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**257**	**419**
	%	**%**	**%**	**%**
Fewer than 36 hours	54	56	45	52
36 hours or more	45	44	54	44
Don't know	1	1	1	4
Total	100	100	100	100

Total may not sum to 100% due to rounding.

5.2. After-hours practice commitments

Table 16 shows that those in rural practices report having far more after-hours practice related commitments than any other practices. For those in rural practices, 28 percent have commitments every week and 12 percent every second week compared to urban (9 percent and 8 percent respectively). Looking at the entire sample, over half (58 percent) report some level of after-hours practice related commitments.

Table 16. After-hours general practice commitments by general practice location, and frequency (n=2724)

	Total GPs	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**257**	**419**
	%	%	%	%
No commitments	42	46	26	33
Frequency of commitments:				
Yes – every week	12	9	28	12
Yes – approximately every second week	9	8	12	9
Yes – approximately every three weeks	6	6	6	7
Yes – approximately every month	19	19	16	19
Yes – but less frequently than monthly	13	12	11	20
Sub-total with commitments	58	54	74	67
Total	100	100	100	100

Total may not sum to 100% due to rounding.

There was a strong pattern for those working longer hours to also report more frequent after-hours practice related commitments (Table 17) with 31 percent of full-time GPs reporting having these commitments at least every second week compared to those working part-time (12 percent).

Table 17. After-hours general practice commitments by hours worked in general practice per week, and frequency (n=2750)

	Total GPs	Part-time (fewer than 36 hours per week)	Full-time (36 hours or more)	Don't know
Unweighted base	**2750**	**1476**	**1243**	**31**
	%	%	%	%
No commitments	42	49	32	84
Frequency of commitments:				
Yes – every week	12	7	18	13
Yes – approximately every second week	9	5	13	0
Yes – approximately every three weeks	6	5	8	0
Yes – approximately every month	19	19	19	3
Yes – but less frequently than monthly	13	15	10	0
Sub-total with commitments	58	51	68	16
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 18 shows that there was an additional trend for male GPs to report more frequent commitments on a weekly or fortnightly basis (26 percent) than female GPs (16 percent).

Table 18. After-hours practice commitments by gender in general practice per week (n=2750)

	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base =	**2750**	**1476**	**1243**	**31**
	%	**%**	**%**	**%**
No commitments	42	39	44	31
Frequency of commitments:				
Yes – every week	12	16	9	19
Yes – approximately every second week	9	10	7	13
Yes – approximately every three weeks	6	7	6	19
Yes – approximately every month	19	18	19	0
Yes – but less frequently than monthly	13	9	15	19
Sub-total with commitments	58	61	56	69
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 19 shows that GPs over 40 years report more frequent commitments on a weekly basis compared to younger GPs. However, GPs over 40 years tended to report fewer after-hours commitments fortnightly or less frequently; the older the respondent was, the fewer after-hours practice related commitments were reported. GPS aged 55 or more were also the most likely to report having no commitments.

Table 19. After-hours practice commitments by age in general practice per week (n=2750)

	Total GPs	24-39 years	40-54 years	55-64 years	65 years and over
Unweighted base =	**2750**	**679**	**893**	**844**	**334**
	%	**%**	**%**	**%**	**%**
No commitments	42	38	36	45	57
Frequency of commitments:					
Yes – every week	12	10	13	13	12
Yes – approximately every second week	9	10	9	8	5
Yes – approximately every three weeks	6	7	7	6	5
Yes – approximately every month	19	21	21	17	13
Yes – but less frequently than monthly	13	14	15	10	8
Sub-total with commitments	58	62	64	55	43
Total	100	100	100	100	100

Total may not sum to 100% due to rounding.

6. GP INCOMES

This section of the report is based on survey respondents who indicated they are working or had worked in general practice in the three months prior to the survey. There were 2784 of these respondents. Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

NOTE: This section excludes the 46 who stated that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison).

6.1. Personal income

Table 20 shows that 31 percent of respondents stated they had a personal annual before-tax income of $100,000 or less, over one-third (36 percent) stated they had a personal income of between $100,001 and $175,000, and the remainder had an income of $175,001 or more (34 percent). The average personal income was $157,594 and the median income was $140,000.

Table 20. Annual personal income (n=2701)

	Total GPs
Unweighted base	**2701**
	%
$25,000 or less	3
$25,001 to $50,000	4
$50,001 to $75,000	8
$75,001 to $100,000	16
$100,001 to $125,000	12
$125,001 to $150,000	15
$150,001 to $175,000	9
$175,001 to $200,000	12
$200,001 to $225,000	5
$225,001 to $250,000	6
$250,001 to $275,000	2
$275,001 to $300,000	3
$300,001 to $400,000	4
$400,001 to $500,000	1
$500,001 or higher	1
Total	100
Median	**$140,000**
Average	**$157,594**

Total may not sum to 100% due to rounding

Table 21 shows that annual personal incomes differ by gender. This table shows that male respondents are considerably more likely to state they earn more than $200,000 per annum compared with female respondents (35 percent and 12 percent respectively). On the other hand, female respondents were more likely than male respondents to state their income was $75,000 or less per annum (20 percent and 10 percent respectively). The median income for male respondents was $180,000, while the median income for female was $120,000.

Table 21. Annual personal income by gender (n=2701)

	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base	**2701**	**1118**	**1567**	**16**
	%	**%**	**%**	**%**
$75,000 or less	16	10	20	38
$75,001 to $125,000	27	15	36	25
$125,001 to $200,000	36	40	33	19
More than $200,000	22	35	12	19
Total	100	100	100	100
Median	**$140,000**	**$180,000**	**$120,000**	**$94,750**
Average	**$157,594**	**$192,647**	**$133,080**	**$109,095**

Total may not sum to 100% due to rounding.

These results may be heavily influenced by the weekly hours worked in general practice. Table 22 is based on respondents who work full-time (i.e., 36 hours or more in general practice per week). This shows that with the part-time GPs excluded, the median income for female (full-time) respondents increased by 33 percent, compared to an 11 percent increase for male (full-time) respondents. However, the table also shows that, on average, full-time male respondents have a higher annual income (More than $200,000) than do full-time female respondents. Note that the average hours worked by full-time male GPs exceeds that worked by full-time female GPs; therefore, this analysis does not fully control for the effect of hours worked.

Table 22. Annual personal income by gender, full-time GPs only (n=1223)

	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base	**1223***	**700**	**515**	**8**
	%	**%**	**%**	**%**
$75,000 or less	3	3	4	13
$75,001 to $125,000	16	9	24	25
$125,001 to $200,000	43	41	46	25
More than $200,000	38	47	26	38
Total	100	100	100	100
Median	**$187,501**	**$200,000**	**$160,000**	**$158,000**
Average	**$203,859**	**$223,958**	**$177,382**	**$149,751**

Total may not sum to 100% due to rounding.

* Sample excludes part-time GPs.

Annual personal incomes also differ by age (Table 23). This table shows that respondents in the 24–39-year age band reported having generally lower incomes (up to $125,000) than did all other age bands, with 53 percent earning up to $125,000 per annum. In comparison, respondents in the 55–64-year age band were significantly more likely to state they earned higher incomes ($125,00 and above). Sixty-six percent earned over $125,001 per annum and 29 percent earned more than $200,000 per annum.

Table 23. Annual personal income by 15-years age group (n=2701)

	Total GPs	24–39 years	40–54 years	55–64 years	65 years and over
Unweighted base	**2701**	**668**	**880**	**828**	**325**
	%	**%**	**%**	**%**	**%**
$75,000 or less	16	14	16	14	24
$75,001 to $125,000	27	39	28	20	19
$125,001 to $200,000	36	39	34	37	31
More than $200,000	22	8	22	29	26
Total	100	100	100	100	100
Median	**$140,000**	**$120,000**	**$140,000**	**$160,000**	**$140,000**
Average	**$157,594**	**$130,873**	**$155,068**	**$181,457**	**$158,562**

Total may not sum to 100% due to rounding.

With part-time GPs excluded, Table 24, based on full-time respondents, shows a similar income pattern by age. That is, full-time survey respondents in the 24–39- year age band are more likely to report they earn up to $125,000 in comparison to all other age bands. 87 percent of respondents working full-time in the 55–64-year age band stated they earn $125,001 or more, and almost one-half stated they earn more than $200,000 per annum (46 percent). The median income for the full-time GPs in 24–39- year age band is $150,000, which is lower than all other age bands.

Table 24. Annual personal income by age, full-time GPs only (n=1223)

	Total GPs	25–39 years	40–54 years	55–64 years	65 years and over
Unweighted base	**1223***	**279**	**365**	**436**	**143**
	%	**%**	**%**	**%**	**%**
$75,000 or less	3	4	2	3	8
$75,001 to $125,000	16	30	13	10	10
$125,001 to $200,000	43	50	41	41	37
More than $200,000	38	16	44	46	45
Total	100	100	100	100	100
Median	**$187,501**	**$150,000**	**$200,000**	**$200,000**	**$200,000**
Average	**$203,859**	**$161,683**	**$208,599**	**$223,931**	**$212,854**

Total may not sum to 100% due to rounding.

* Sample excludes part-time GPs.

Table 25 shows that survey respondents who are Fellows of the College were significantly more likely to state they earn higher incomes than those who are not Fellows. For example, 26 percent stated they earn more than $200,000 per annum compared with 6 percent who are not Fellows.

Table 25. Annual personal income by Fellow status (n=2701)

	Total GPs	Not a Fellow	Fellow of College	Fellow status unclear
Unweighted base	**2701**	**585**	**2108**	**8***
	%	**%**	**%**	%
$75,000 or less	5	15	16	0
$75,001 to $125,000	15	40	24	25
$125,001 to $200,000	40	39	35	38
More than $200,000	40	6	26	38
Total	100	100	100	100
Median	**$187,501**	**$120,000**	**$150,000**	**$140,000**
Average	**$157,594**	**$126,136**	**$166,154**	**$202,500**

Total may not sum to 100% due to rounding.

* Caution: low base number of respondents – results are indicative only.

When registrars are excluded from the analysis, Table 26 shows that respondents who are Fellows of the College were more likely to state they earn more than $125,000 per annum (61 percent) in comparison to those who are not Fellows (47 percent).

Table 26. Annual personal income by Fellow status, excluding registrars (n=2169)

	Total GPs	Not a Fellow	Fellow of College	Fellow status unclear
Unweighted base =	**2169***	**65**	**2096**	**8†**
	%	**%**	**%**	%
Up to $75,000	3	25	16	0
$75,001 to $125,000	16	28	24	25
$125,001 to $200,000	43	32	35	38
More than $200,000	38	15	26	38
Total	100	100	100	100
Median	**$187,501**	**$149,000**	**$200,000**	**$225,000**
Average	**$203,859**	**$155,481**	**$216,520**	**$230,000**

Total may not sum to 100% due to rounding.

* Sample excludes registrars.

† Caution: low base number of respondents – results are indicative only.

The same income pattern is evident when part-time GPs are excluded. Table 27 shows that respondents who are Fellows of the College and work full-time were significantly more likely to state they earn more than $200,000 per annum than those who are not Fellows but worked full-time (45 percent and 12 percent).

Table 27. Annual personal income by Fellow status, full-time GPs only (n=1223)

	Total GPs	Not a Fellow	Fellow of College	Fellow status unclear
Unweighted base	**1223***	**255**	**962**	**6†**
	%	**%**	**%**	**%**
$75,000 or less	3	4	3	0
$75,001 to $125,000	16	33	11	17
$125,001 to $200,000	43	51	41	33
More than $200,000	38	12	45	50
Total	100	100	100	100
Median	**$187,501**	**$149,000**	**$200,000**	**$225,000**
Average	**$203,859**	**$155,481**	**$216,520**	**$230,000**

Total may not sum to 100% due to rounding.

* Sample excludes part-time GPs.

† Caution: low base number of respondents – results are indicative only.

7. FACTORS THAT MIGHT ENABLE PART-TIME GPS TO INCREASE WORKING HOURS

This section reports on the 54 percent respondents (n=1494) who work part-time (defined for the purposes of this survey as less than 36 hours per week). All tables are based on the respondents in this subsample who answered the relevant questions, unless otherwise stated.

In this regard, it should be noted that many of the tables are based on a subsample of respondents (n=987) who had given at least one factor that might influence or enable them to work longer hours in general practice.

The supply of general practice services to the New Zealand population is primarily driven by the number of GPs working, but also the hours those same GPs are willing to work. To understand what factors might encourage those working part-time (less than 36 hours) to work longer hours, a list of nine possible factors was presented as two questions and respondents asked to select all that apply as well as a separate question asking which single factor would be the most important to them.

There were significant changes from 2018 in the respondents' ratings of what would be a factor in increasing working hours with both the most common (38 percent) and the most important factor (28 percent) being a less stressful working environment - significantly up from 2018 (32 percent and 16 percent respectively). The next most common important factor given was higher remuneration (18 percent said it was the most important), up from 2018 (16 percent) and their children getting older (17 percent said it was the most important), down from 2018 (20 percent). Also down from 2018 was having less emphasis on targets and other bureaucratic requirements from 8 percent saying it was the most important factor in 2018 to 5 percent in 2020. Having flexible working circumstances was unchanged as a factor from 2018 (14 percent said it was the most important factor). As noted previously, several of the factors were related to the working environment, in particular having a less stressful working environment, having more flexibility to adjust working hours including around family responsibilities, and less emphasis on targets and other bureaucratic requirements, together contributing almost half (47 percent) of the most important factors.

Table 28. All factors and the single most important factor likely to encourage or enable part-time GPs to increase their current hours worked in general practice (n=1494)

	A factor	Most important factor
Unweighted base	**1494**	**987***
	%	%
Less stressful working environment	38	28
Higher remuneration	29	18
Increasing age of children (children growing older)	27	17
Having more flexibility to adjust my working hours including around family responsibilities	28	14
Less emphasis on targets and other bureaucratic requirements	19	5
Purchasing an ownership stake in a practice	8	2
Being able to get quality locum cover at short notice	9	1
Better childcare	8	2
Nothing would encourage me to increase my current hours/days worked	32	N/A
Other	15	13
Total	**	100***

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

** Total may exceed 100% because of multiple responses.

*** Total may not sum to 100% due to rounding.

The 'other' category was also highly rated and largely fell into similar categories as 2018, notably reducing paperwork and administration/compliance burden. Financial hardship, difficulties with 'easing into retirement', and a desire for more work/study balance.

Examining the split between male and female responses for the factor most likely to encourage increased hours (Table 29), while the most common factor was a less stressful working environment for both males and females (29 percent and 28 percent respectively), there were substantial differences in the next most common factor, with males rating higher remuneration (23 percent) and females reporting that their children getting older (20 percent) as the second most important factor. For female GPs, remuneration (17 percent) and flexible working hours (15 percent) are next, while for male GPs, flexible working hours (11 percent) and 'other' (21 percent) factors are next most important. As a total, the working environment (stress, flexibility, and bureaucracy) shows no difference between males and females (47 percent for both). The other category for males largely reflects the older demographic with many commenting about the

difficulty in increasing their working hours due to increasing age, desire to retire, and more doctors/support for their practice.

Table 29. Factors rated most likely to encourage or enable part-time GPs to increase their current hours/days worked in general practice, by gender (n=987)

	Total	Male	Female	Gender diverse/ Prefer not to specify
Unweighted base	**987***	**214**	**767**	**6**
	%	**%**	**%**	**%**
Less stressful working environment	28	29	28	0
Higher remuneration	18	23	17	33
Increasing age of children (children growing older)	17	5	20	17
Having more flexibility to adjust my working hours including around family responsibilities	14	11	15	0
Less emphasis on targets and other bureaucratic requirements	5	7	4	0
Purchasing an ownership stake in a practice	2	2	2	0
Being able to get quality locum cover at short notice	1	1	1	0
Better childcare	2	0	3	0
Other	13	21	10	50
Total	100	100	100	100

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

Total may not sum to 100% due to rounding.

There were clear differences between the two age-groups reflecting the gender difference between the older and younger cohorts (younger had far more female GPs), with respondents over 55 stating a less stressful working environment is most important (31 percent) and higher remuneration next (21 percent). In comparison, those under 55 years of age also state a less stressful working environment as being the most important (albeit lower at 26 percent) and the increasing age of their children (23 percent) as the second most important factor. 44 percent of those aged under 55 rate the working environment (stress, flexibility, and bureaucracy) as most important compared to 52 percent of respondents aged 55 or over.

Table 30. Factors rated most likely to encourage or enable part-time GPs to increase their current hours/days worked in general practice, by age (n=987)

	Total	Under 55 years	55 years and over
Unweighted base	**987***	**713**	**274**
	%	**%**	**%**
Less stressful working environment	28	26	31
Higher remuneration	18	17	21
Increasing age of children (children growing older)	17	23	1
Having more flexibility to adjust my working hours including around family responsibilities	14	16	9
Less emphasis on targets and other bureaucratic requirements	5	2	12
Purchasing an ownership stake in a practice	2	3	0
Being able to get quality locum cover at short notice	1	1	3
Better childcare	2	3	0
Other	13	9	22
Total	100	100	100

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

Total may not sum to 100% due to rounding.

Table 31 show that there was little difference in the responses across rurality for the most important factor in increasing working hours; both reported a less stressful working environment highest (28 percent urban and 26 percent rural), urban respondents stating that a higher remuneration was next (19 percent) and rural respondents reporting the increasing age of children second highest (19 percent). 46 percent of both urban and rural respondents reported working environment (stress, flexibility, and bureaucracy) as factors most likely to encourage them to increase their working hours.

Table 31. Factors rated most likely to encourage or enable part-time GPs to increase their current hours/days worked in general practice, by practice location (n=982)

	Total	Urban	Rural	Not clearly urban or rural
Unweighted base	**982***	**768**	**132**	**82**
	%	**%**	**%**	**%**
Less stressful working environment	28	28	26	24
Higher remuneration	18	19	16	12
Increasing age of children (children growing older)	17	17	19	17
Having more flexibility to adjust my working hours including around family responsibilities	14	14	12	12
Less emphasis on targets and other bureaucratic requirements	5	4	8	6
Purchasing an ownership stake in a practice	2	3	1	2
Being able to get quality locum cover at short notice	1	1	2	1
Better childcare	2	2	3	2
Other	13	11	14	22
Total	100	100	100	100

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

Total may not sum to 100% due to rounding.

While a less stressful working environment is the highest rated factor for all groups (Table 32), there is a large difference across the employment profiles, with practice owners and partners less likely to rate it as the most important (26 percent), compared to long term employees (28 percent), and a third (33 percent) of short-term employees and contractors. This was significantly up from 2018 by over 10 percent for all employment categories.

Higher remuneration is highest rated by long-term employees/contractors (19 percent), with short-term employees/contractors lower at 16 percent, and 15 percent of practice owners/partners.

Reflecting their age, more owners/partners and long-term employees reported the increasing age of children as being most important (18 percent and 19 percent respectively) compared to short-term employees (8 percent).

Of particular interest is the large rating given by short-term employees (20 percent) for the importance of working hours flexibility when compared to long-term (14 percent) and practice owners/partners (9 percent). Working environment (stress, flexibility, bureaucracy) is similar for practice owners (46 percent) and long-term employees (45 percent), but significantly higher for short-term employees/contractors (60 percent).

Table 32. Factors rated most likely to encourage or enable part-time GPs to increase their current hours/days worked in general practice, by employment status (n=987)

	Total	Practice owner/ partner	Long-term employee/ contractor	Short-term employee/ contractor	Other
Unweighted base	**987***	**151**	**685**	**129**	**22**
	%	**%**	**%**	**%**	**%**
Less stressful working environment	28	26	28	33	9
Higher remuneration	18	15	19	16	23
Increasing age of children (children growing older)	17	18	19	8	5
Having more flexibility to adjust my working hours including around family responsibilities	14	9	14	20	14
Less emphasis on targets and other bureaucratic requirements	5	11	3	7	5
Purchasing an ownership stake in a practice	2	0	3	2	0
Being able to get quality locum cover at short notice	1	5	1	2	0
Better childcare	2	1	3	1	0
Other	13	16	11	13	45
Total	100	100	100	100	100

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

Total may not sum to 100% due to rounding.

There are some interesting relationships between income and how GPs rated these factors (Table 33), with GPs earning less than $75,001 rating their children growing older highest (23 percent) similar to 2018 (26 percent), higher remuneration (16 percent), and a less stressful environment (22 percent) lower than other income groups in 2020.

For those earning over $75,000, a less stressful working environment is rated highest by 29 percent of those earning between $75,001 and $125,000, 32 percent of those earning $125,001 to $200,000, and 29 percent of GPs earning over $200,000.

Higher remuneration is rated highly by GPs earning between $125,001 and $200,000 (23 percent), with GPs earning less than $125,000 rating this factor between 16 and 17 percent. Flexibility is relatively important for those earning less than $125,000 (15 to 16 percent) compared to GPs earning $125,001 to $200,000 (11 percent) or more than $200,000 (8 percent).

Table 33. Factors rated most likely to encourage or enable part-time GPs to increase their current hours/days worked in general practice, by income (n=980)

	Total	Up to $75,000	$75,001 to $125,000	$125,001 to $200,000	More than $200,000
Unweighted base	**980***	**266**	**393**	**272**	**49**
	%	**%**	**%**	**%**	**%**
Less stressful working environment	28	22	29	32	29
Higher remuneration	18	16	17	23	16
Increasing age of children (children growing older)	17	23	17	12	14
Having more flexibility to adjust my working hours including around family responsibilities	14	15	16	11	8
Less emphasis on targets and other bureaucratic requirements	5	4	5	6	4
Purchasing an ownership stake in a practice	2	0	3	4	4
Being able to get quality locum cover at short notice	1	1	1	2	0
Better childcare	2	2	2	2	2
Other	13	16	11	8	22
Total	100	100	100	100	100

* The responses for the question asking respondents to choose the single most important that would encourage them to increase their current hours/days worked in general practice, excluding those who stated 'nothing'.

Total may not sum to 100% due to rounding.

8. EMPLOYMENT TYPE AND PRACTICE OWNERSHIP

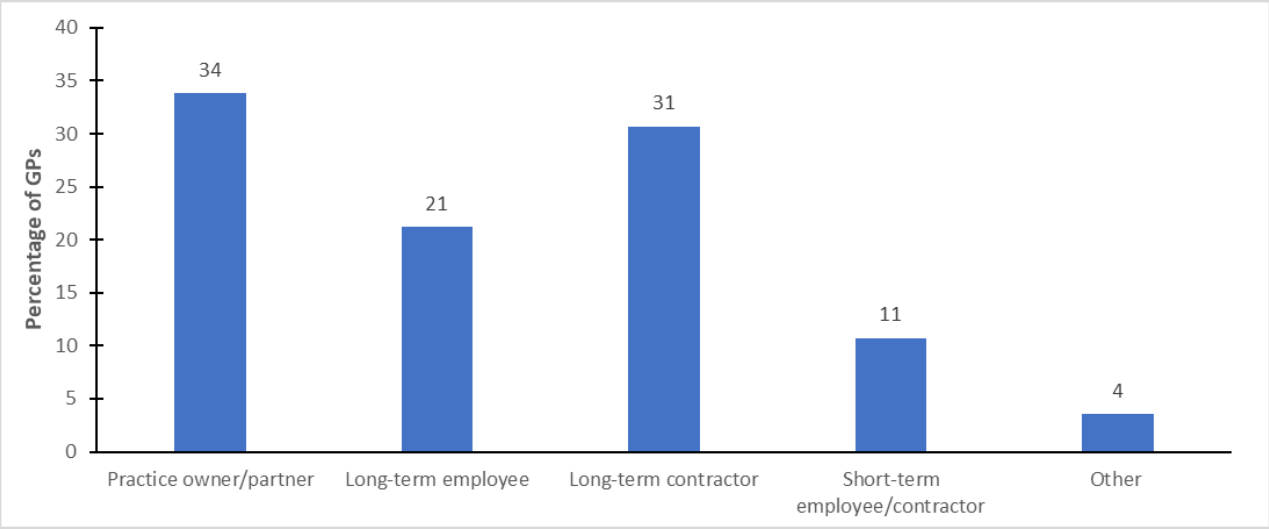
This section of the report is based on survey respondents who indicated they are working or had worked in general practice in the three months prior to the survey. There are 2784 of these respondents. Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

NOTE: This section excludes the 46 who state that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison).

8.1. GP employment status

Figure 7 shows over one-half of respondents (52 percent) state they are either a long-term employee or a long-term contractor regarding the general practice they work in or mostly work in. Over one-third (34 percent) identify themselves as a practice owner or partner. 11 percent of respondents are short-term employee/contractor (note this category includes GP registrars).

Figure 7. Employment status (n=2746*)



* Excludes 38 respondents who did not provide a valid response due to partial completion of the survey.

Table 34 shows that male GPs are significantly more likely than female respondents to identify themselves as a practice owner or partner (44 percent and 26 percent respectively). On the other hand, female GPs are more likely to be long-term employee or contractor (59 percent) compared to male GPs (42 percent).

Table 34. Employment status by gender (n=2746)

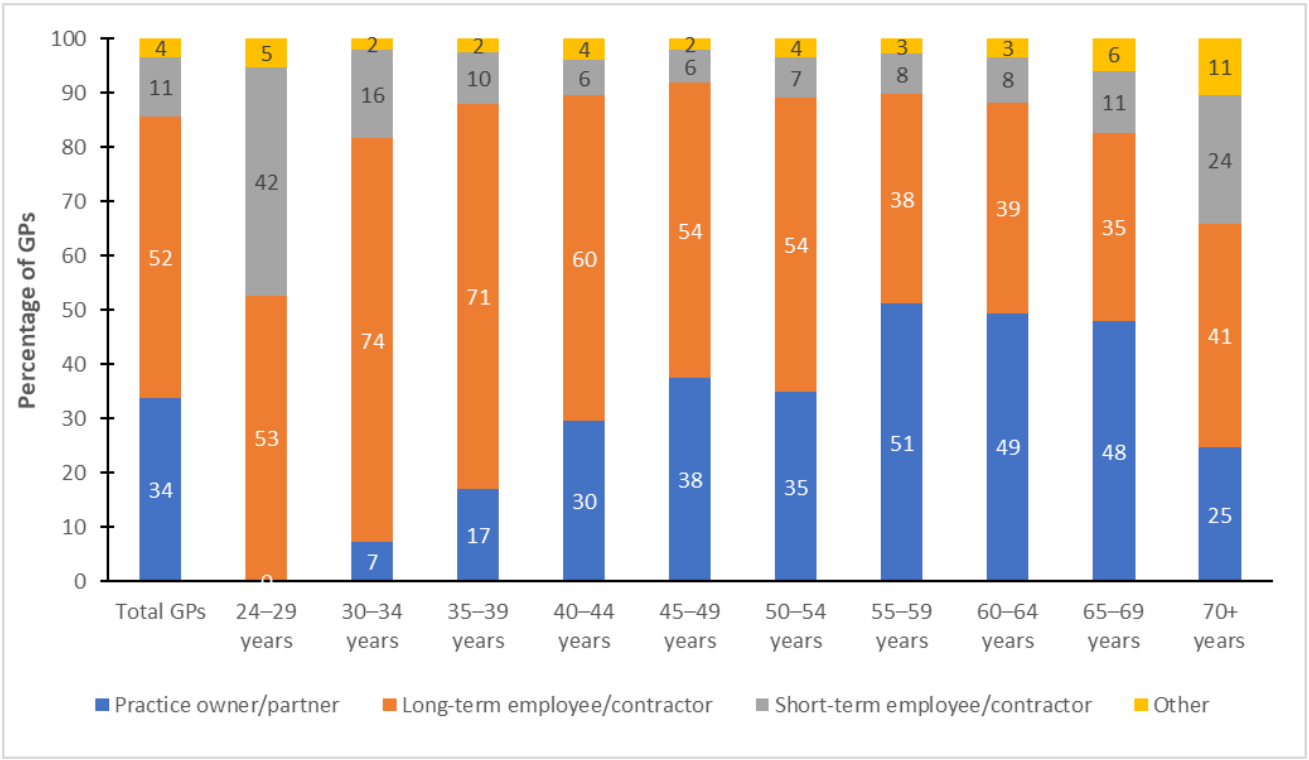
	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base	**2746**	**1138**	**1592**	**16***
	%	**%**	**%**	**%**
Practice owner/partner	34	44	26	31
Long-term employee/contractor	52	42	59	19
Short-term employee/contractor	11	10	11	31
Other	4	4	3	19
Total	100	100	100	100

Total may not sum to 100% due to rounding

*Caution: low base number of respondents – results are indicative only.

Figure 8 shows that practice ownership almost increases with each age band to reach a peak of 51 percent of the cohort aged 55-59 years. In comparison, the proportion who are long-term employees or contractors peaks in the 30-34-year band at 74 percent, while the proportion who are short-term contractors or employees is highest among 24 -29-year band (42 percent). This is a result of the inclusion of GP registrars in this employment category.

Figure 8. Percentage of employment status by 5-years age group (n=2746)



In addition to these differences by gender and age, Table 35 shows that GPs working in general practices that are in rural areas are more likely to be short-term employees or contractors compared to those working in general practices located in urban areas (16 percent and 10 percent respectively). This will reflect registrar placements in rural practices, but it may also reflect rural workforce shortages.

Table 35. Employment status by general practice location (n=2724)

	Total GPs	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
	%	**%**	**%**	**%**
Practice owner/partner	34	34	32	32
Long-term employee/ contractor	52	53	49	50
Short-term employee/ contractor	11	10	16	9
Other	4	3	3	10
Total	100	100	100	100

Total may not sum to 100% due to rounding.

8.2. Practice ownership models

Table 36 shows most respondents report working in general practices that are owned by GPs who are also working in the actual practice (69 percent). The next most common ownership model is full or partial corporate ownership at 10 percent. There is a more diverse range of ownership models among rural practices than urban practices.

Table 36. Practice ownership by general practice location (n=2724)

	Total GPs	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
	%	**%**	**%**	**%**
Owned by one or more GPs who work in the practice	69	72	63	57
Community owned or owned by a trust or charity	7	6	14	5
Fully or partially corporate owned	10	11	6	12
Fully or partially owned by a PHO or a GP organisation	3	3	4	5
Fully or partially owned by a DHB	1	1	4	1
Fully or partially owned by an iwi	2	1	2	4
Owned by a university (student health)	2	2	0	0
Other	6	4	7	14
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 37 examines the relationship between practice ownership models and the number of enrolled patients. This shows that survey respondents working in practices that are owned by a trust or charity are more likely to have relatively smaller enrolled patient number. Twenty-eight percent of respondents from these practices state that there were fewer than 3000 patients enrolled in the practice where they work compared with 13 percent of respondents in all practices.

Table 37. Practice ownership by enrolled patient numbers (n=2614)

	Unweighted base	Up to and including 3000	3001–7000	7001–11,000	More than 11,000	Don't know	Total
		%	%	%	%	%	%
Total GPs	**2614***	13	33	21	22	11	100
Owned by one or more GPs	**1853**	12	33	21	24	9	100
Owned by a trust or charity	**177**	28	45	20	3	4	100
Corporate owned	**275**	7	32	20	28	13	100
PHO owned	**85**	11	36	24	14	15	100
DHB owned	**23****	4	26	30	22	17	100
Iwi owned	**45**	29	53	11	0	7	100
University owned	**43**	19	12	23	21	26	100
Other	**113**	19	22	17	14	28	100

Total may not sum to 100% due to rounding.

*Base excludes those respondents who don't work in a practice that enrols patients

**Caution: low base number of respondents – results are indicative only.

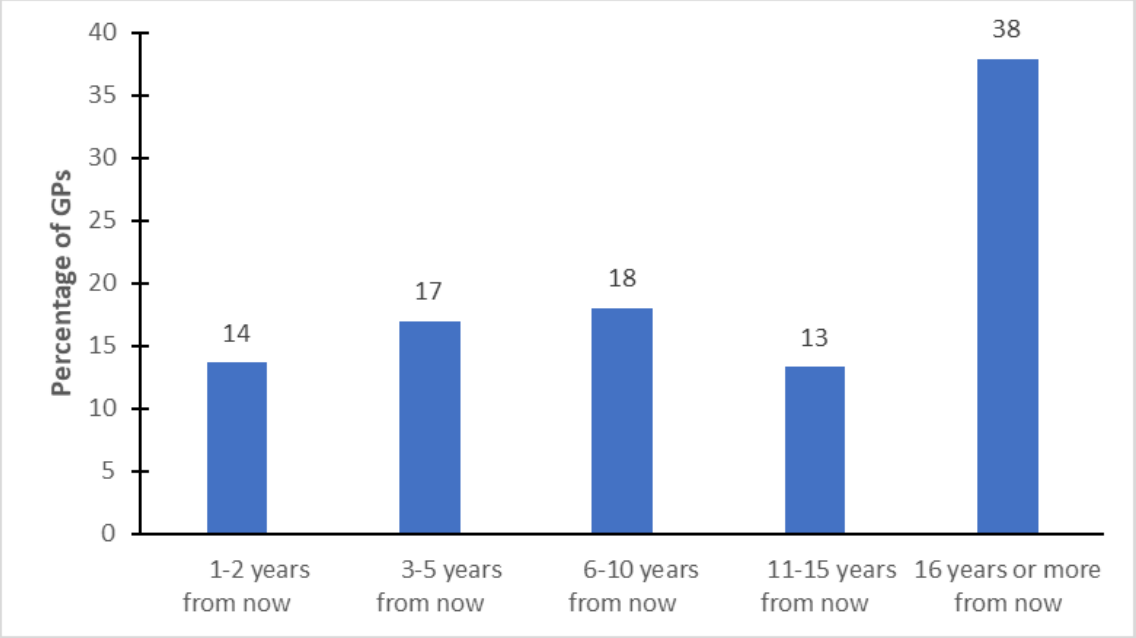
9. RETIREMENT INTENTIONS IN GENERAL PRACTICE

This section of the report is based on survey respondents who indicate they are or had worked in general practice in the three months prior to the survey. There were 2830 of these respondents, which includes 46 who state that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison). Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

9.1. Retirement intentions

Fourteen percent of survey respondents state they intend to retire in the next two years and a further 17 percent in three to five years' time (Figure 9). This means that over the next five years, almost one-third of GPs (31 percent) intend to retire. An additional 18 percent of respondents state they intend to retire in six to ten years' time, so in the next 10 years, almost half of respondents (49%) are intending to retire.

Figure 9. Retirement intentions (n=2772*)



* Base excludes 58 respondents who did not provide a valid response due to partial completion of the survey

Trainees are not usually included when the percentage of the workforce intending to leave or retire is reported; hence, when comparisons are made with the GP workforce, this should be based

on an analysis that excludes GPEP registrars. The inclusion of registrars in the analysis masks the looming retirement crisis among experienced and fully trained GPs.

Table 38 compares the retirement intentions of the 2020 respondents including and excluding registrars[4]. The percentage intending to retire in the next five years increases from 31 percent to 37 percent when registrars are excluded from the analysis, while the 10-year rate increases from 49 percent to 58 percent.

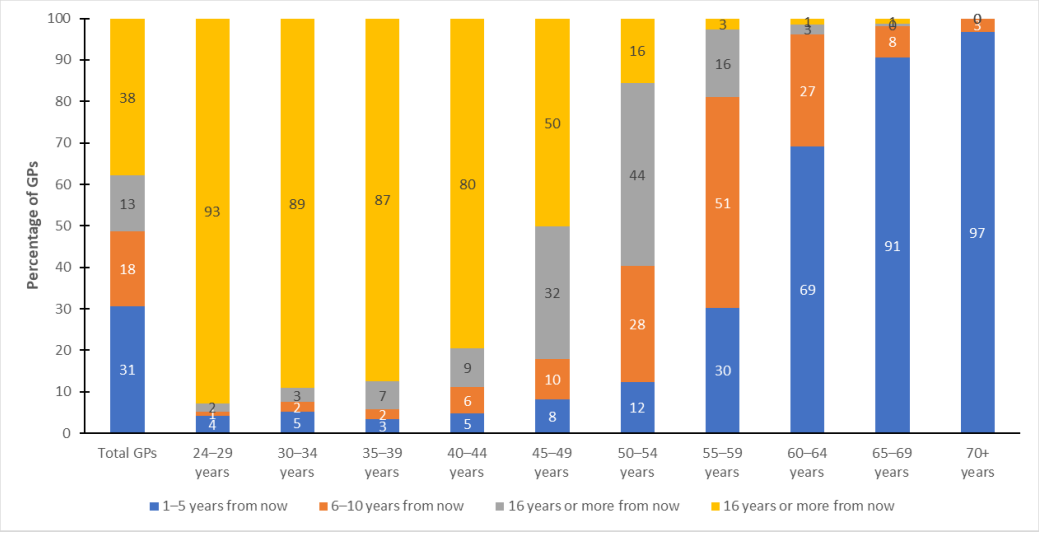
Table 38. Comparison of retirement intentions, including and excluding registrars (n=2772)

	Total GPs	Non-Registrars	Registrars
Unweighted base	**2772**	**2278**	**552**
	%	**%**	**%**
1–2 years from now	14	16	2
3–5 years from now	17	20	4
6–10 years from now	18	21	6
11–15 years from now	13	15	8
16 years or more from now	38	28	81
Total	100	100	100

Total may not sum to 100% due to rounding.

As we would expect, the older a GP the more likely they are to indicate they are intending to retire in the short term. This is reflected in Figure 10, with the percentage of respondents intending to retire in the next five years significantly higher than the average of 31 percent in the 60–64 years age band (69 percent) and beyond.

Figure 10. Percentage of retirement intentions by 5-years age groups (n=2772)



[4] GPEP registrars make up 19 percent of survey respondents and 75 percent of GPEP registrars are aged under 40 (refer to Table 9 and Table 10).

Table 39 examines the relationship between the retirement intentions of respondents and their gender. Reflecting the age-based results presented earlier in this report, this table shows a significantly greater percentage of male respondents state they intend to retire in the next five years compared with female respondents (41 percent and 23 percent respectively). This is a function of the older age profile of male GPs compared with the younger age profile of female GPs.

Table 39. Retirement intentions by gender (n=2772)

	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base	**2772**	**1152**	**1604**	**16**
	%	**%**	**%**	**%**
1–5 years from now	31	41	23	44
6–10 years from now	18	18	18	13
11–15 years from now	13	11	15	6
16 years or more from now	38	31	43	38
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 40 examines the relationship between the retirement intentions of survey respondents and the location of the practice they are currently working in. This shows that a similar percentage of rural and urban respondents intend to retire in the next five and ten years.

Table 40. Retirement intentions by practice location (n=2772)

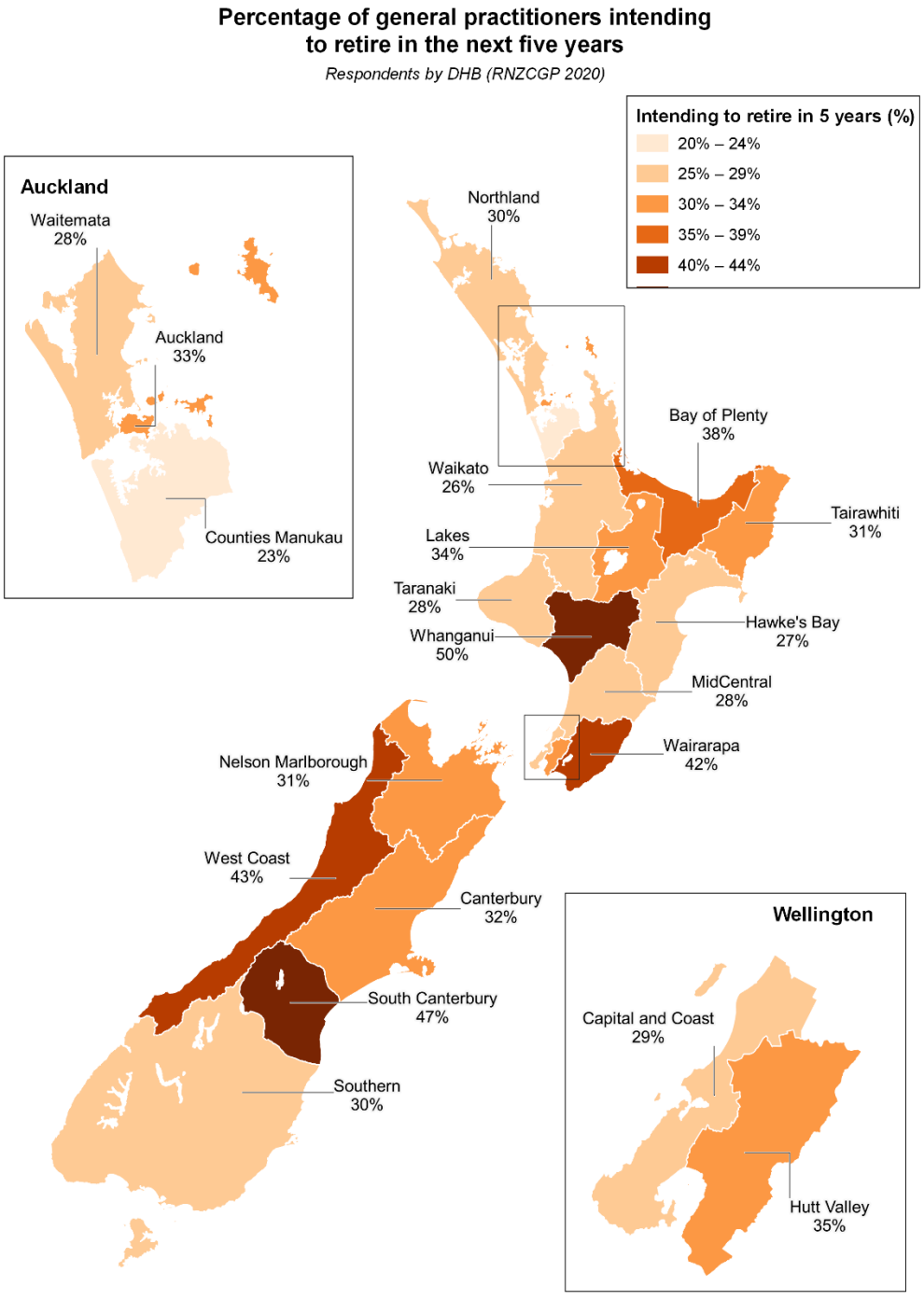
	Total GPs	Urban	Rural	Not clearly urban or rural
Unweighted base	**2724**	**2048**	**419**	**257**
	%	**%**	**%**	**%**
1–5 years from now	31	30	31	32
6–10 years from now	18	18	18	17
11–15 years from now	13	14	11	12
16 years or more from now	38	37	40	39
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Figure 11 shows that the percentage of GPs intending to retire in the next five years break-down by the 20 DHBs. It suggests that the GP workforce in some DHBs will be particularly severely affected by retirement. The results from Wairarapa, West Coast, South Canterbury and Whanganui

DHBs should be interpreted with caution due to the small numbers of respondents (n<30). The DHBs with the lowest rate of respondents intending to retire in the next five years are Counties Manukau (23 percent), Waikato (26 percent), Hawke's Bay (27 percent), Waitemata (28 percent), Taranaki (28 percent).

Figure 11. Percentage of GPs intending to retire in the next five years by DHB



10. BURN-OUT AND GENERAL PRACTICE AS A CAREER

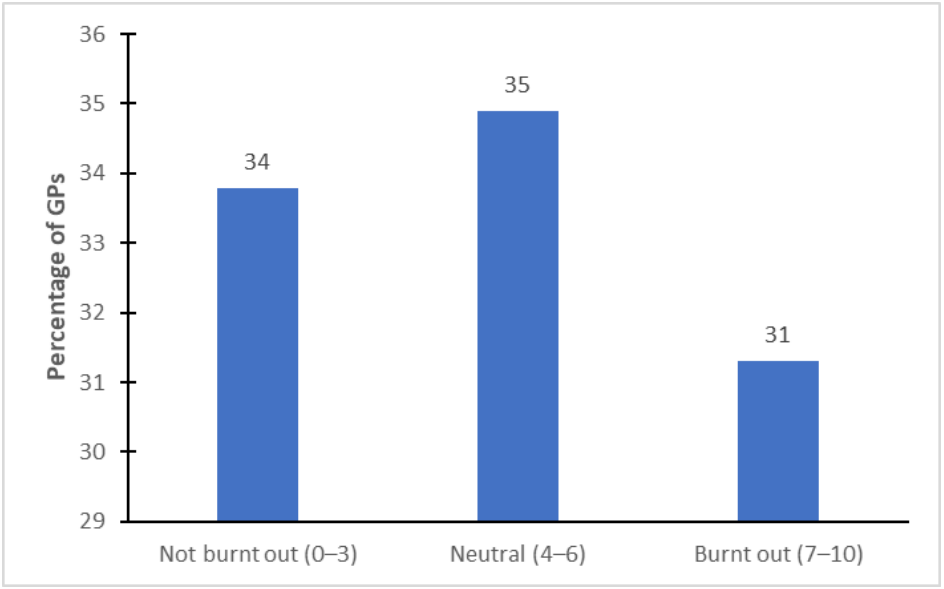
This section of the report is based on survey respondents who indicate they are or had worked in general practice in the three months prior to the survey. There are 2830 of these respondents, which includes 46 who state that all their work in the three months prior to the survey had been entirely non-clinical (e.g., management, administration, liaison). Unless otherwise stated, all tables and figures are based on those within this sample of respondents who answered the relevant questions.

10.1. Burn-out

Using an 11-point scale, which ran from 'not at all burnt out' (0) through to 'extremely burnt out' (10), survey respondents were asked to rate the extent to which they felt burnt out with the following question: "How would you currently rate yourself on a 0 to 10 scale, where 0 = 'not at all burnt out' and 10 = 'extremely burnt out'?"

Figure 12 shows that 31 percent of respondents rate themselves as being burnt out to some degree, based on those who rate themselves from 7 to 10 inclusive on the scale. In contrast, 34 percent rate themselves as not being burnt out, based on those who rate themselves 0 to 3 inclusive on the scale. The remainder (35 percent), those who rate themselves 4 to 6 inclusive on the scale, are described as providing a 'neutral' response.

Figure 12. Burn-out (n=2791*)



* Base excludes 39 respondents who did not provide a valid response due to partial completion of the survey.

Figure 13 shows the percentage of respondents who consider themselves to be burnt out by age groups. Respondents aged 40 to 64 (36 percent) are more likely to state that they are burnt out than those aged up to 39 years (25 percent) and 65 years and above (21 percent).

Figure 13. Burn-out by 5-years age groups (n=2791)

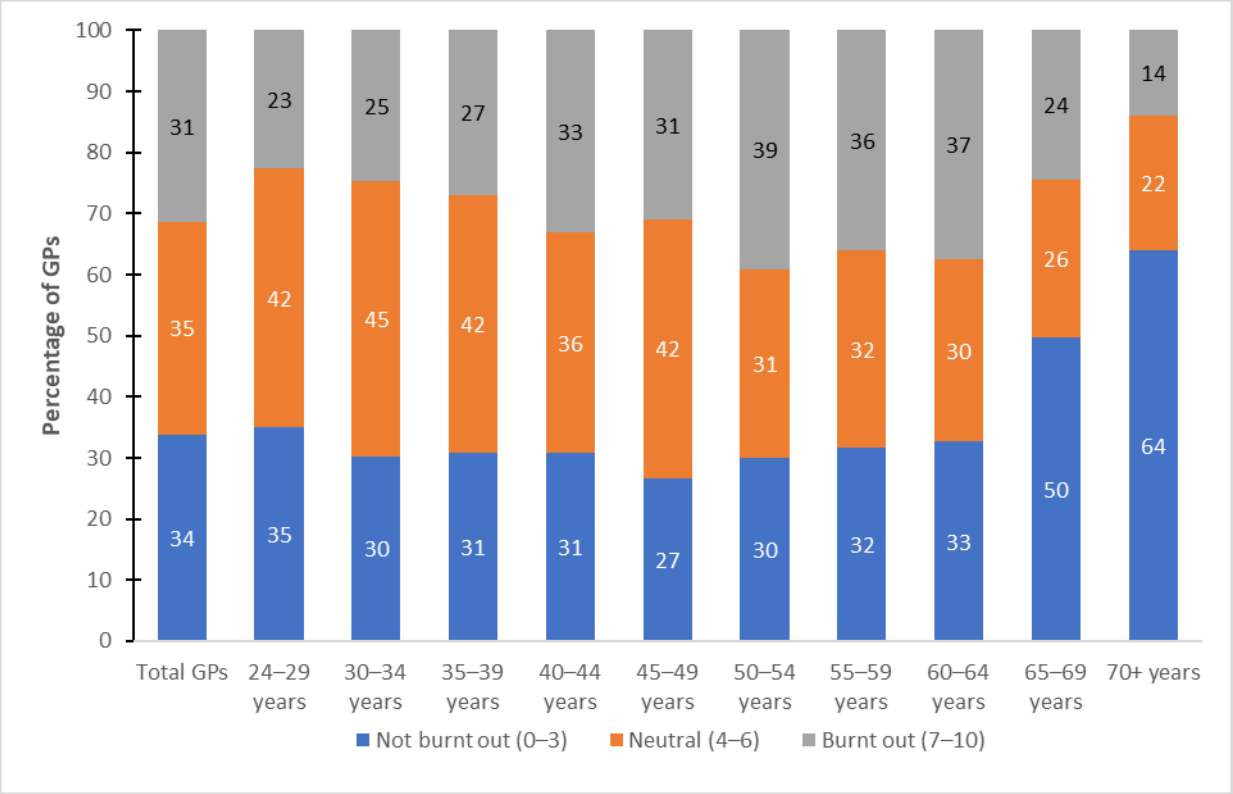


Table 41 shows that nearly one-third (31 percentage) of male and female GPs rate themselves at the high end of the burn-out scale. Note that male GPs are more likely to be older, to work full-time, and to be practice owners/partners, all of which are also associated with burn-out.

Table 41. Burn-out by gender (n=2791)

	Total GPs	Male	Female	Gender diverse/Prefer not to specify
Unweighted base	**2791**	**1158**	**1617**	**16***
	%	**%**	**%**	**%**
Not burnt out (0–3)	34	37	32	25
Neutral (4–6)	35	32	37	25
Burnt out (7–10)	31	31	31	50
Total	100	100	100	100

Total may not sum to 100% due to rounding.

*Caution: low base number of respondents – results are indicative only.

Table 42 shows that respondents who work full-time (i.e., 36 hours or more in general practice each week) are significantly more likely to state they are burnt out compared with those working part-time (37 percent and 27 percent respectively).

Table 42. Burn-out by hours worked in general practice (n=2773)

	Total GPs	Fewer than 36 hours (Pat-time)	36 hours or more (Full-time)	Don't know
Unweighted base	**2746**	**1473**	**1242**	**31**
	%	**%**	**%**	**%**
Not burnt out (0–3)	34	37	29	39
Neutral (4–6)	35	35	35	39
Burnt out (7–10)	31	27	37	23
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 43 shows that practice owners and partners are significantly more likely to state they are burnt out compared with long-term employees and contractors for example (39 percent and 29 percent respectively).

Table 43. Burn-out by employment status (n=2746)

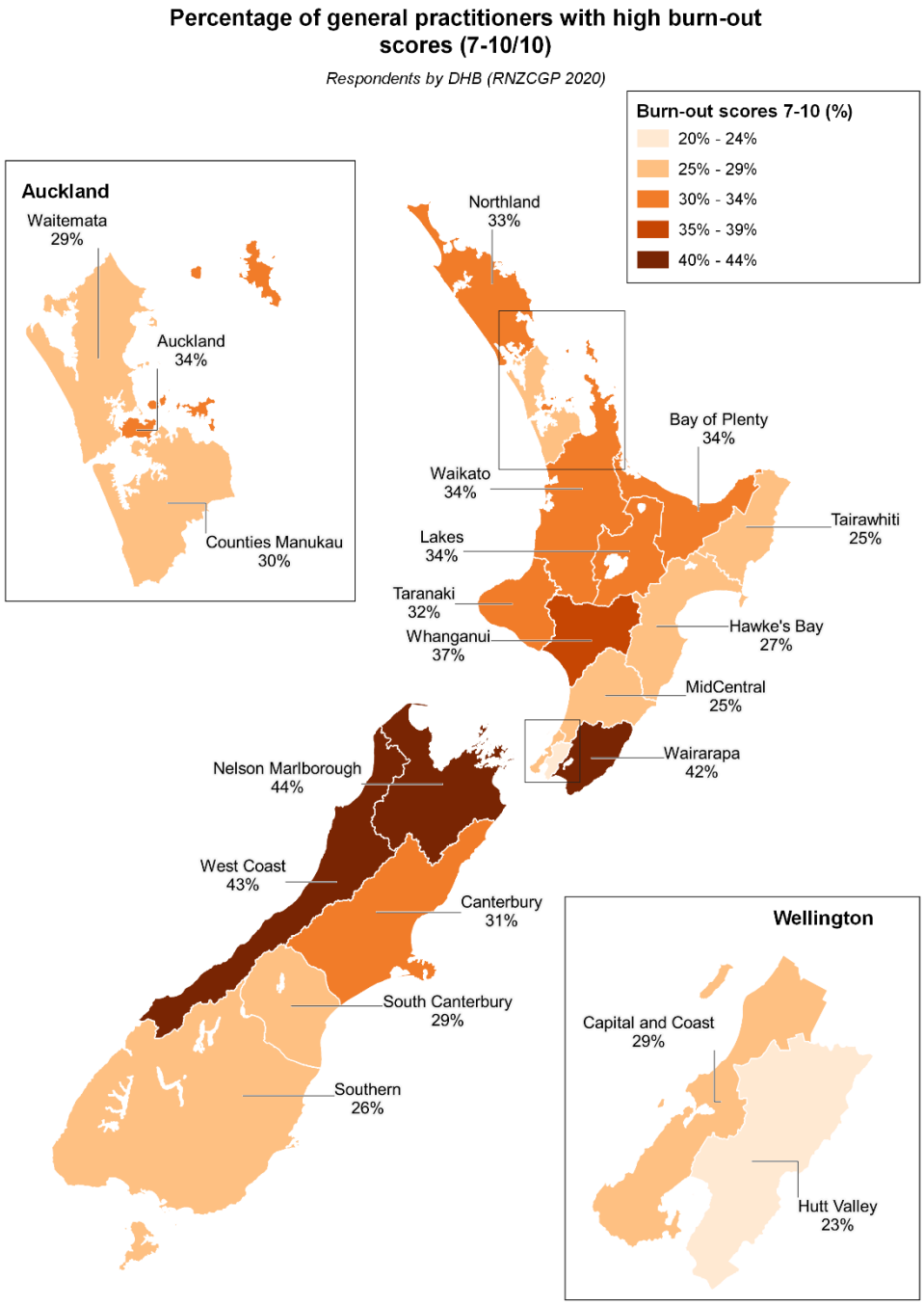
	Total GPs	Practice owner/ partner	Long-term employee/ contractor	Short-term employee/ contractor	Other
Unweighted base	**2746**	**928**	**1425**	**295**	**98**
	%	**%**	**%**	**%**	**%**
Not burnt out (0–3)	34	29	33	45	48
Neutral (4–6)	35	32	38	30	32
Burnt out (7–10)	31	39	29	25	20
Total	100	100	100	100	100

Total may not sum to 100% due to rounding.

10.2. Burn-out by district health board

Figure 14 illustrates the percentage of respondents in each DHB who score themselves at 7–10 on the burn-out scale. The highest rates of burn-out are seen in Nelson Marlborough (44 percent) and West Coast DHBs (43 percent). At the other end of the scale, Tairawhiti and Hutt Valley DHBs have relatively low burn-out rates of 25 percent and 23 percent respectively. However, results from Wairarapa, West Coast, South Canterbury and Whanganui DHBs should be interpreted with caution due to the small numbers of respondents (n<30).

Figure 14. Percentage of GPs with high burn-out scores by DHB

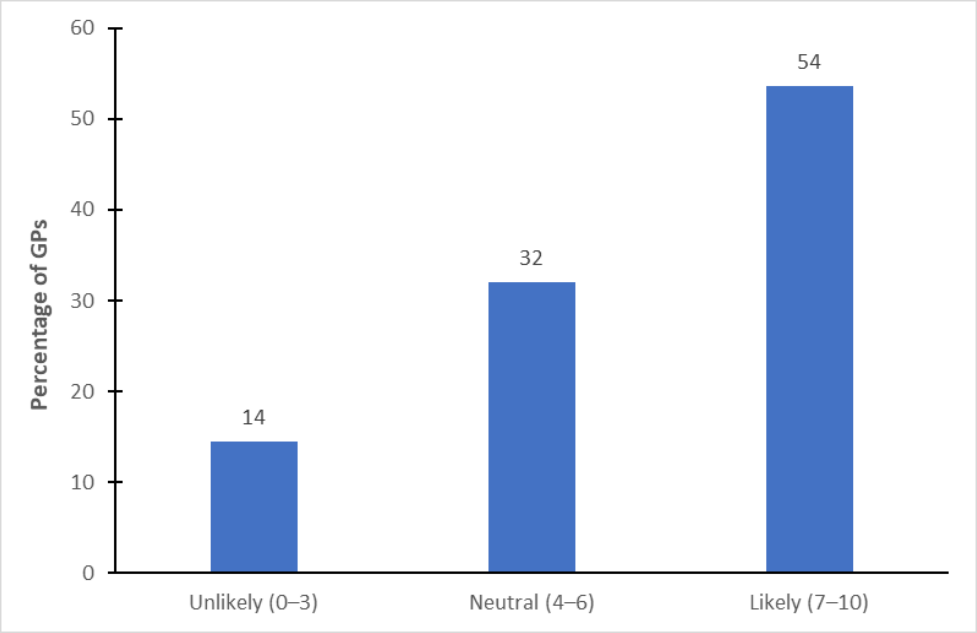


10.3. Likelihood of recommending general practice as a career

Using an 11-point scale, which ran from 'not at all likely' (0) through to 'extremely likely' (10), respondents were asked to rate their likelihood of recommending a career in general practice.

Figure 15 shows that 54 percent of respondents state they were likely to recommend a career in general practice, based on a grouping of those who rate themselves a 7 to 10 inclusive on the scale. At the other extreme, 14 percent rate themselves as unlikely to do so, based on a grouping of those who rate themselves 0 to 3 inclusive on the scale. The remainder (32 percent), those who rate themselves 4 to 6 inclusive on the scale, are described as providing a 'neutral' response.

Figure 15. Career recommendation (n=2791*)



* Base excludes 39 respondents who did not provide a valid response due to partial completion of the survey.

Figure 16 examines the results by age to the question recording the likelihood of recommending general practice as a career. This shows a very high recommendation rate for younger and older respondents. For example, respondents aged up to 34 years (59 percent) and those aged 65 years (66 percent) and over are more likely to recommend a career in general practice then are those aged between 35 and 64 years (50 percent).

Figure 16. Career recommendation by 5-years age group (n=2791)

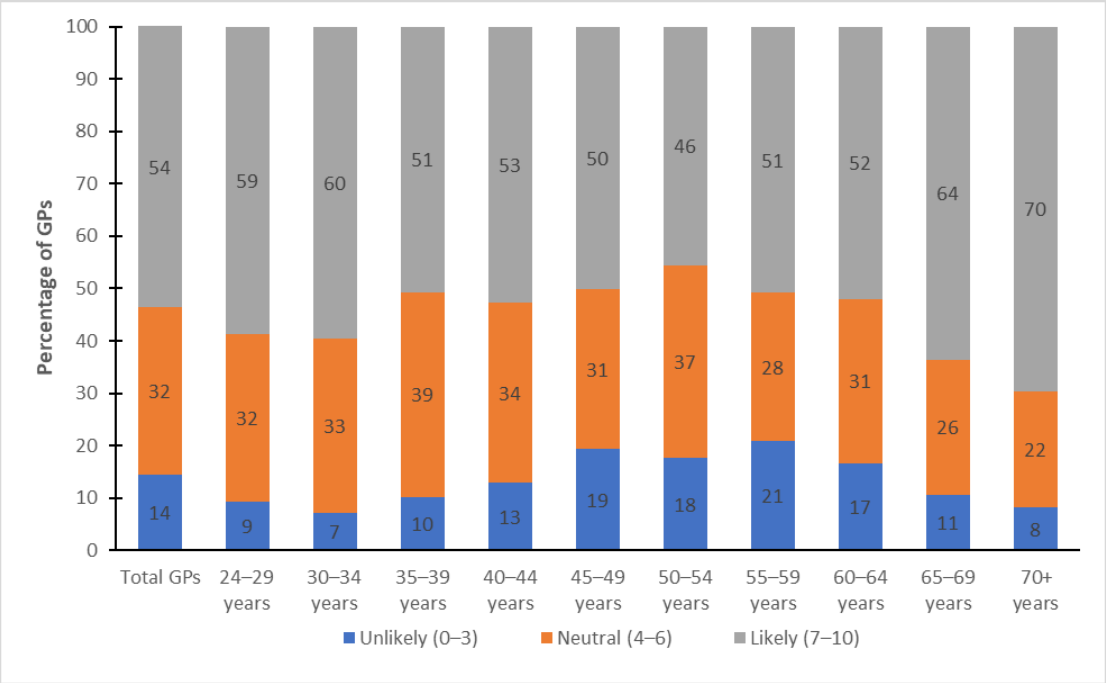


Table 44 shows that respondents who were practice owner/partner (48 percent) are less likely to recommend a career in general practice in comparison to employees or contractors (55 percent).

Table 44. Career recommendation by employment status (n=2746)

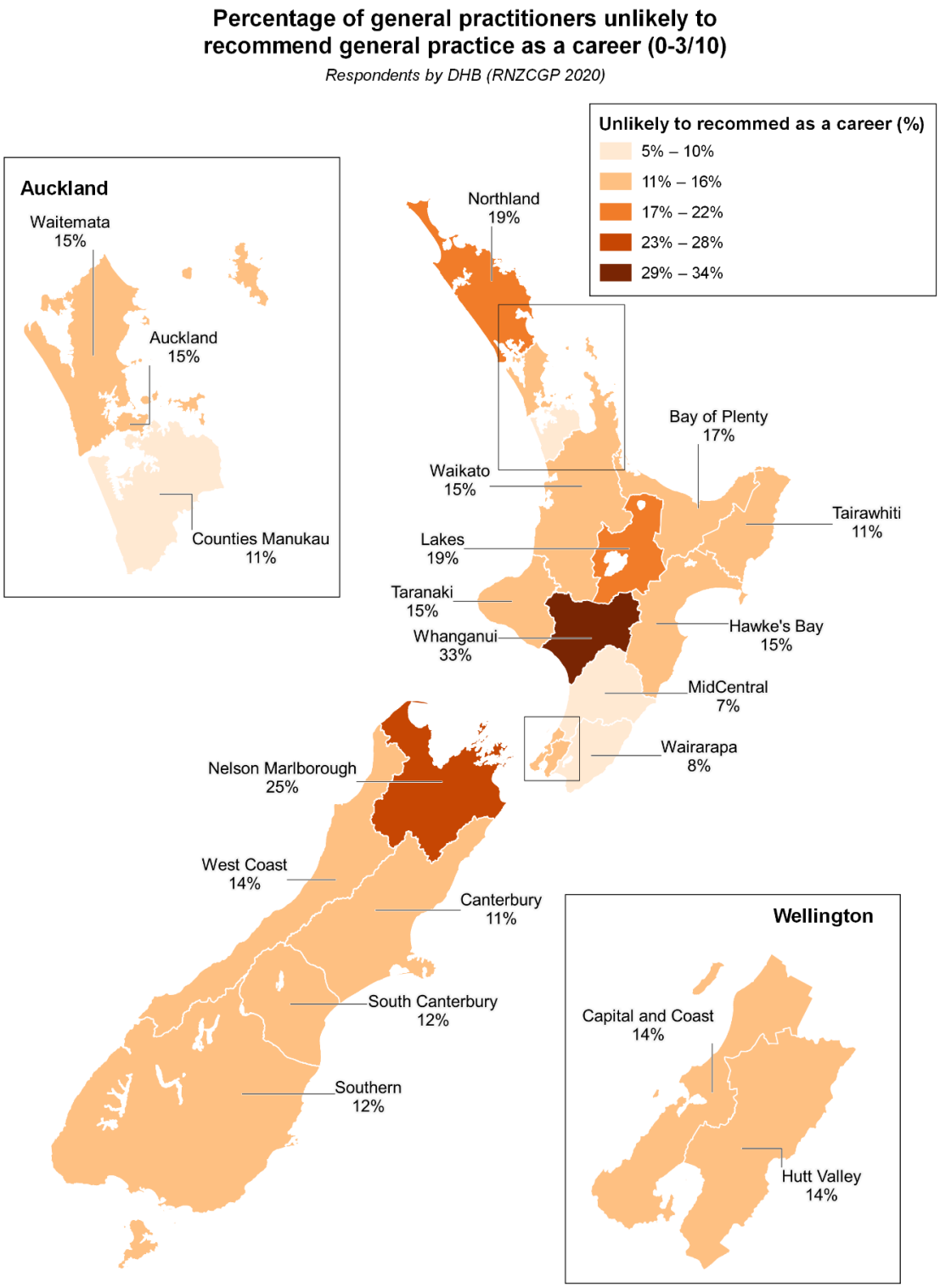
	Total GPs	Practice owner/partner	Employee/contractor (long- and short-term)	Other
Unweighted base	**2746**	**928**	**1720**	**98**
	%	**%**	**%**	**%**
Unlikely (0–3)	14	19	16	13
Neutral (4–6)	32	33	29	33
Likely (7–10)	54	48	55	53
Total	100	100	100	100

Total may not sum to 100% due to rounding.

10.4. Career recommendation by district health board

The DHBs with the top 5 highest percentage of respondents unlikely to recommend a career in general practice are Whanganui (33 percent), Nelson Marlborough (25 percent), Lakes (19 percent), Northland (19 percent) and Bay of plenty (17 percent). The results from Wairarapa, West Coast, South Canterbury and Whanganui DHBs should be interpreted with caution due to the small numbers of respondents.

Figure 17. Percentage of GPs unlikely to recommend general practice as a career by DHB



10.5. Association between burn-out, retirement intentions, career recommendations and training role

Earlier in this report we noted that 31 percent of survey respondents intend to retire in the next five years, 31 percent feel they are burnt out, and 14 percent of respondents are unlikely to recommend a career in general practice.

Table 45 shows that there is a strong negative correlation between the likelihood of recommending a career in general practice and the extent to which survey respondents state they are burnt out. While 34 percent of respondents who state they are burnt out also state they would be willing to recommend a career in general practice, more than twice the percentage of those who state they were not burnt out were likely to recommend general practice as a career (70 percent).

A significantly higher percentage of respondents who feel burnt out state they are unlikely to recommend a career in general practice (27 percent), compared with only 8 percent of those who are not burnt out.

Table 45. Career recommendation by burn-out (n=2791)

	Total GPs	Not Burnt out (0–3)	Neutral (4–6)	Burnt out (7–10)
Unweighted base	**2791**	**943**	**974**	**874**
	%	**%**	**%**	**%**
Unlikely to recommend (0–3)	14	8	9	27
Neutral (4–6)	32	22	36	39
Likely to recommend (7–10)	54	70	55	34
Total	100	100	100	100

Total may not sum to 100% due to rounding.

Table 46 shows that respondents involved in training in some capacity are more positive about a career in general practice (58 percent) compared with those not involved in training (49 percent).

Table 46. Career recommendation by training role (n=2791)

	Total GPs	Not providing training	Provide training
Unweighted base	**2791**	**1425**	**1366**
	%	**%**	**%**
Unlikely (0–3)	14	16	13
Neutral (4–6)	32	35	29
Likely (7–10)	54	49	58
Total	100	100	100

Total may not sum to 100% due to rounding.

Table 47 examines the relationship between retirement intentions, burn-out and career recommendation. It shows that 35 percent of respondents who feel burnt out intend to retire in the next five years, and this is higher than the percentage of GPs in general who intend to retire within the same timeframe (31 percent). Similarly, 43 percent of respondents who would not recommend a career in general practice intend to retire in the next five years, which is higher than the percentage of GPs in general who intend to retire within the same time-frame (31 percent).

Table 47. Relationship between intentions to retire, burn-out and a willingness to recommend a career in general practice (n=2772)

	Total GPs	GPs who are burnt out (7-10)	GPs who would not recommend a career in general practice (0-3)
Unweighted base	**2772**	**869***	**401****
	%	**%**	**%**
1–2 years from now	14	15	19
3–5 years from now	17	20	23
6–10 years from now	18	20	24
11–15 years from now	13	15	14
16 years or more from now	38	29	19
Total	100	100	100

Total may not sum to 100% due to rounding.

* Subsample based on GPs who rated themselves 7–10 on an 11-point scale, indicating they felt burnt out.

** Subsample based on GPs who rated themselves 0–3 on an 11-point scale, indicating they would not recommend a career in general practice.

11. WAYS OF WORKING IN GENERAL PRACTICE

For the 2020 survey, in response to the impact of COVID-19 on GPs work, we added questions looking at the use of remote technologies and patient engagement. These questions were drawn from a previous RNZCGP survey in 2016[5], telehealth evaluation questions[6], and a new set of questions based on College insights into the challenges faced by GPs in 2020. These questions were not mandatory in the survey, so the number of respondents answering does change for each question. In this report 'pre COVID-19 lockdown' refers to the period prior to the Level 4 COVID-19 lockdown, and 'post-COVID-19' refers to the period after the Level 4 lockdown. This distinction was made explicit in the questionnaire. Importantly, this question set does not allow us to detail how GPs and medical practices changed following the less restrictive lockdowns, so we have no way of knowing how many maintained these new ways of working in the latter half of 2020. The 2022 GP workforce survey will carry a selection of key ways of working questions, allowing us to test the durability of remote technologies and new working models.

11.1. Frequency of using technologies when engaging with patients

These questions capture practice-level capacity, so separating out by the demographic variables makes little sense. Table 48 shows how the frequency of technology use changed as a result of the COVID-19 lockdown. These results are summarised in Figure 18, which showed a significant increase for all the technologies queried, with the greatest changes seen in video conferencing (VDO) going from 11 percent using video conferencing in their practice pre-lockdown, to 54 percent using this technology post-lockdown, with another similarly little used technology, phone messaging, also increasing - 13 percent pre-lockdown were using phone messaging increasing to 22 percent using this technology post-lockdown.

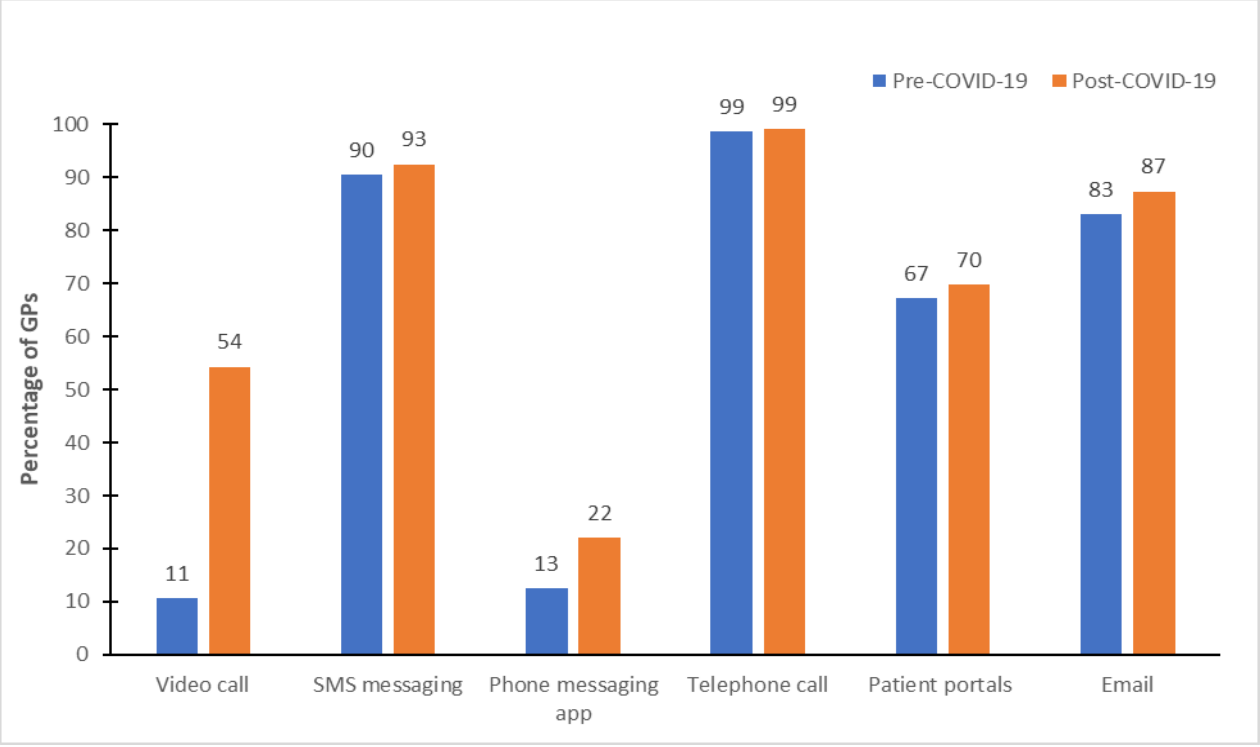
Other remote communication technologies that were being used to some degree pre-lockdown showed smaller but still significant changes, with SMS messaging going from a 90 percent using this technology pre-lockdown to 93 percent post-lockdown, patient portal use also increasing (67 percent pre-lockdown to 70 percent post-lockdown), and email use going from 83 percent pre-lockdown to 87 percent using post-lockdown. Telephone use changed less than the other technologies, with fewer seldom using telephone calls post-lockdown (7 percent) compared to 24 percent pre-lockdown and increasing the other more frequent categories (often, usually, always).

[5] https://rnzcgp.org.nz/gpdocs/new-website/publications/gp-workforce/Workforce-Survey-2016TechnologyReport-HR.pdf
[6] https://www.telehealth.org.nz/assets/nztrc/170818-NZTRC-Step-5-Sample-Performance-Monitoring-Plan-User-Satisfaction.docx

Table 48. Frequency of using technologies when engaging with patients pre- and post-COVID-19 Lockdown

	Unweighted base	Never	Seldom	Often	Usually	Always	Total
Pre-COVID 19 Lockdown		%	%	%	%	%	%
Video call	2650	89	8	2	0	0	100
SMS messaging	2694	10	16	42	15	17	100
Phone messaging	2680	87	8	3	1	1	100
Telephone call	2706	1	24	46	16	13	100
Patient portals	2680	33	21	28	10	8	100
Email	2699	17	51	22	6	4	100
Post- COVID 19 Lockdown							
Video call	2676	46	42	11	1	0	100
SMS messaging	2697	7	12	45	18	17	100
Phone messaging	2670	78	14	6	2	1	100
Telephone call	2704	1	7	52	25	16	100
Patient portals	2679	30	17	31	13	9	100
Email	2698	13	41	32	9	5	100

Figure 18. Use of the technologies when engaging with patients pre- and post-COVID-19 Lockdown



11.2. Confidence in using technologies as a method of communicating with patients

This question was taken from the 2016 GP workforce survey and assesses GPs' confidence in using common technology for communicating with patients. Unsurprisingly confidence in using a telephone is very high (97 percent confident or very confident), as is SMS use (74 percent were confident or very confident), and email use (72 percent were confident or very confident).

Of the newer technologies (Table 49), around half (51 percent) of the respondents report being confident or very confident using a patient portal - up from 22 percent in 2016, and 49 percent confident or very confident in using Video conferencing – up dramatically from 2016 (12 percent).

Table 49. Confidence in using technologies as a method of communication

	Video call	Email	Patient portal	SMS messaging	Telephone
Unweighted base	**2703**	**2685**	**2689**	**2700**	**2702**
	%	**%**	**%**	**%**	**%**
Not at all confident/Not confident	24	10	21	10	1
Neither	17	13	15	10	2
Confident/very confident	49	72	51	74	97
Don't know/Not applicable	10	6	13	6	0
Total	100	100	100	100	100

11.3. Health Care Home model

A range of questions were asked relating to the adoption of the Health Care Home[7] model of working, related ways of working, and pro-active management of at-risk patients. These questions capture practice-level capacity so separating out by the demographic variables makes little sense. An additional caution when interpreting the results are that some indicators may be over-estimated, for example larger practices are more likely to have a nurse practitioner on the team and to have more GPs responding to the survey, with a consequent multiple-count of the same nurse practitioner. We are not able to report this data at a practice level as we did not collect medical practice identifiers for anonymity purposes.

What is of primary interest for this analysis is the change in the application of the Health Care Home model at as a result of the COVID-19 lockdown.

Table 50 shows that over a quarter (26 percent) of the respondents report that their practice was a Health Care Home practice pre-lockdown, increasing to 29 percent post-lockdown. Almost a

[7] https://www.healthcarehome.org.nz/

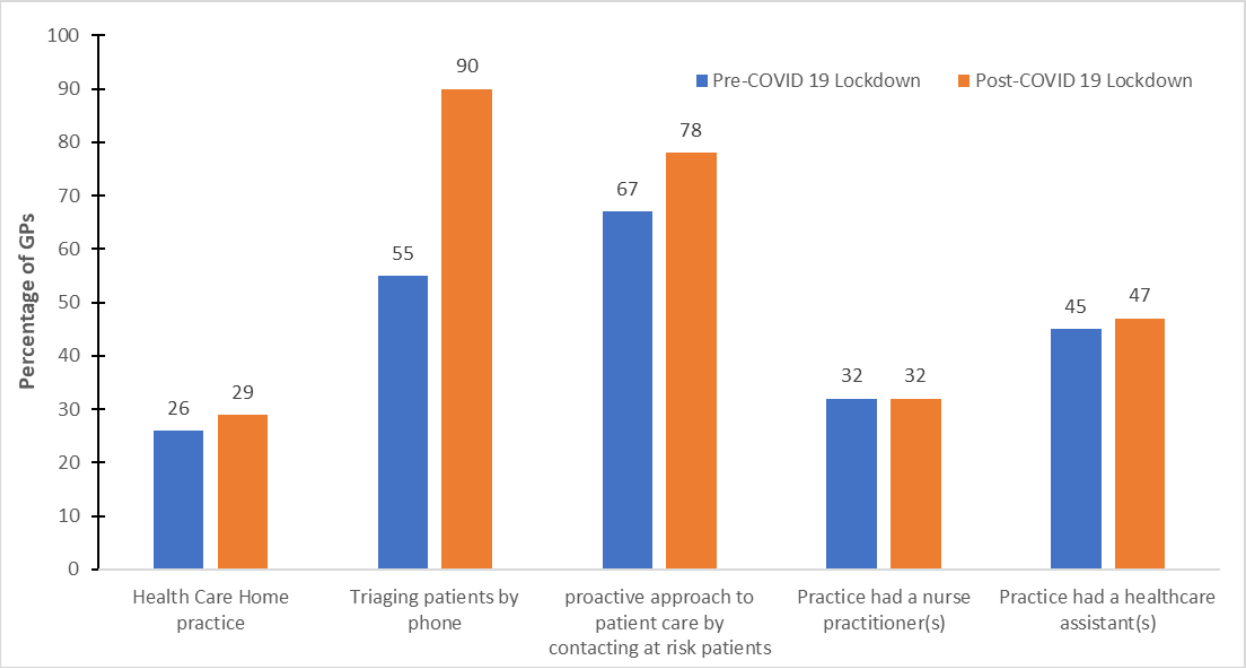
third (32 percent) report having a nurse practitioner at the practice, which did not change over the lockdown period, with 45 percent reporting having a healthcare assistant pre-lockdown rising slightly to 47 percent post-lockdown; it is important to note that these figures are not reflection of the actual number in medical practices across New Zealand. There was also a significant increase in how many respondents reported taking a proactive approach to patient care from two-thirds (67 percent) pre-lockdown to over three-quarters (78 percent) post-lockdown.

The largest impact is seen in phone triaging use by practice, with respondents reporting over half (55 percent) pre-lockdown rising to 90 percent post-lockdown (Figure 19).

Table 50. Health Care Home Model pre- and post-COVID-19 Lockdown

Thinking about the practice you work in:	Pre-COVID 19 Lockdown				Post-COVID 19 Lockdown			
	Unweighted base	%			Unweighted base	%		
		Yes	No	Don't know		Yes	No	Don't know
Was your practice a Health Care Home practice?	2,681	26	58	16	2,666	29	54	17
Was your practice triaging patients by phone?	2,691	55	43	2	2,674	90	9	2
Was your practice employing a proactive approach to patient care by contacting at risk (any health issues) patients?	2,685	67	23	10	2,673	78	13	9
Did your practice have a nurse practitioner(s)?	2,688	32	67	1	2,674	32	66	2
Did your practice have a healthcare assistant(s) in the team?	2,687	45	53	2	2,677	47	51	2

Figure 19. Health Care Home Model pre- and post-COVID-19 Lockdown



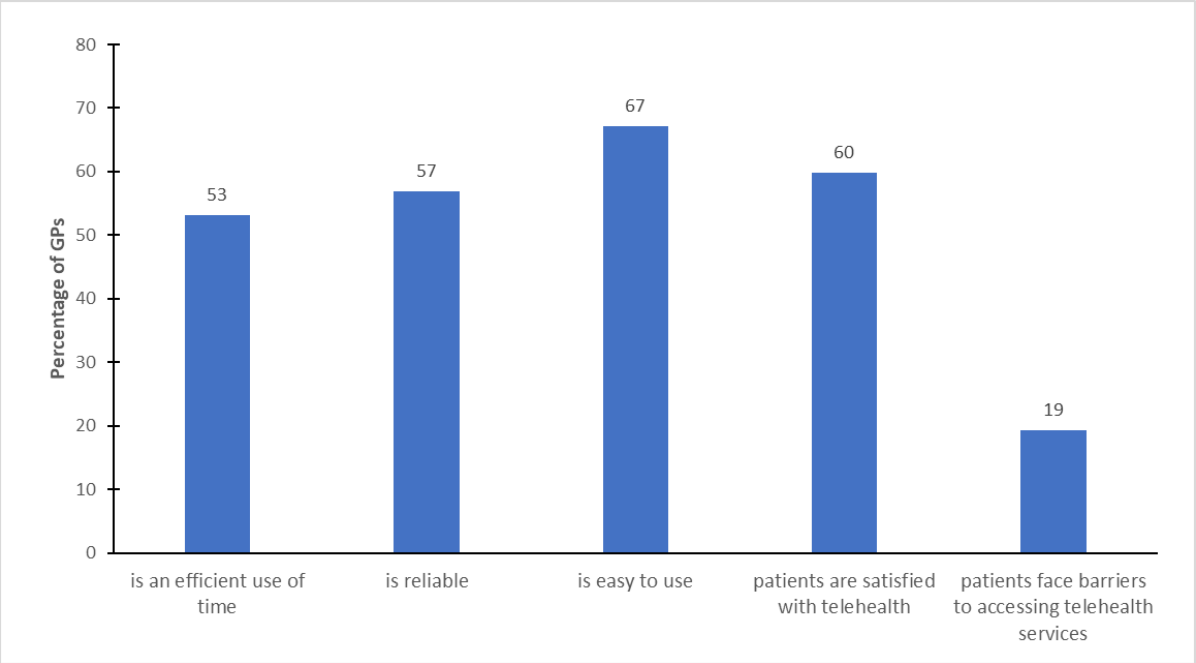
11.4. Consult using telehealth rather than in person

Looking at respondents' experience of telehealth (Table 51), when thinking about use of time, reliability, ease of use and satisfaction, the majority (over 95 percent) of the respondents feel that telehealth was positive sometimes or more of the time. When asked about respondents rating of the barriers their patients face in accessing telehealth, a concerning 19 percent report that their patients face these barriers often or always (Figure 20).

Table 51. Consult using telehealth rather than in person

When you consult using telehealth rather than in person…		Rarely or never	Sometimes	Often	Always	Don't know/Not applicable
	Unweighted base	%	%	%	%	%
is it an efficient use of time?	2,694	4	34	43	10	8
is it reliable?	2,687	2	33	52	5	9
is it easy to use?	2,677	2	23	50	17	8
are your patients satisfied with telehealth?	2,691	1	22	53	7	17
how often do your patients face barriers to accessing services by telehealth?	2,692	14	46	18	1	21

Figure 20. Consult using telehealth rather than in person (often or always)



12. RURAL HOSPITAL MEDICINE WORKFORCE – DEMOGRAPHICS

This section of the report presents the responses of the doctors who indicate they are working in rural hospital medicine in the three months prior to the survey (n=114) and the doctors who are training towards registration in the vocational scope of rural hospital medicine but who are not working in rural hospital medicine at the time of the survey (n=21). The responses of all 135 respondents are included in the analysis, except where the question was only appropriate for those 114 who are currently working in rural hospital medicine. The tables and figures in this section of the report take account of the subgroups defined above. Please refer to the title or footnote provided at the base of each table and figure.

12.1. Age and gender

The median age of respondents working in rural hospital medicine or training towards FDRHMNZ is 49 years, with most (91 percent) between the ages of 25 and 64 years of age (Table 52). Relatively few respondents are between 35-39 year (8 percent) or 65 years and over (10 percent). For the remaining age groups, the percentage in each five-year age band is reasonably even.

Table 52. Age profile of respondents working or training in rural hospital medicine (n=135)

	Total
Unweighted base	**135**
	%
25–29 years	10
30–34 years	12
35–39 years	8
40–44 years	14
45–49 years	10
50–54 years	13
55–59 years	12
60–64 years	12
65–69 years	7
70–74 years	3
> 74 years	0
Total	100
Mean age	**47.6**
Median age	**49.0**

Total may not sum to 100% due to rounding.

Table 53 shows that a higher percentage of respondents who are either working in rural hospital medicine or who are registrars training towards FDRHMNZ identify as male (56 percent), compared with the female (44 percent).

Table 53. Gender profile of respondents working or training in rural hospital medicine (n=134)

	Total
Unweighted base	**135**
	%
Male	56
Female	44
Total	100

Total may not sum to 100% due to rounding

* Sample does not include respondents who selected the 'I prefer not to specify my gender' or the 'gender diverse' options.

12.2. International medical graduates (IMGs)

Table 54 shows that nearly half (46 percent) of the respondents working or training in rural hospital medicine state they gained their first medical degree overseas, compared to the over half of respondents (54 percent) who state they gained their first medical degree in New Zealand. In contrast, 36 percent of GPs obtained their first medical degree overseas and 63 percent obtained it in New Zealand.

Table 54. Origin of first medical degree for respondents working or training in rural hospital medicine and general practice

	Total rural hospital doctors	Total GPs	Total doctors
Unweighted base	**135**	**2830**	**2875***
	%	%	%
New Zealand	54	63	62
Overseas	46	37	38
Total	100	100	100

Total may not sum to 100% due to rounding.

* 99 respondents had worked in both rural hospital medicine and general practice setting

The most common country in which respondents indicated that they had gained their first medical degree overseas (Table 55) was the United Kingdom (42 percent), with South Africa next most common (19 percent), followed by Australia (6 percent), India (6 percent) and Germany (3 percent).

Table 55. Country of origin of first medical degree of respondents working or training in rural hospital medicine who obtained their degree overseas (n=62)

	IMGs in RHM
Unweighted base	**62***
	%
United Kingdom	42
South Africa	19
Australia	6
India	6
Germany	3
Other European country	8
Other Asian country	3
Other	11
Total	100

Total may not sum to 100% due to rounding.

* Sub-sample based on those rural hospital doctors who gained their first medical degree overseas.

All respondents were asked to indicate how long ago they 'gained registration in New Zealand as a medical practitioner'. Table 56 shows that nearly a third of respondents working or training in rural hospital medicine (31 percent) first gained medical registration in New Zealand in the past 10 years.

Table 56. Years since first gained registration in New Zealand as a medical practitioner for respondents working or training in rural hospital medicine (n=135)

	Total	New Zealand	Overseas
Unweighted base	**135**	**73**	**62**
	%	**%**	**%**
0-5 years	10	16	3
6-10 years	21	21	21
11-20 years	30	27	32
21 or more years	39	36	44
Total	100	100	100

Total may not sum to 100% due to rounding.

12.3. Training and teaching

Respondents who work in rural hospital medicine or who are rural hospital medicine registrars were asked to indicate if they are registered in a vocational scope in New Zealand.

Table 57 shows approximately 76 percent state they are registered in a vocational scope, most frequently in general practice (54 percent) and/or rural hospital medicine (42 percent).

Please note that while most registrars are not registered in any vocational scope (82 percent), some state they were registered in general practice or rural hospital medicine (13 percent and 3 percent respectively). This suggests those registrar respondents were working towards completing registration requirements for an additional vocational scope of practice.

Table 57. Vocational registration status of respondents working or training in rural hospital medicine (n=135)

	Total	GPEP or DRHM registrar	Non-registrar
Unweighted base	**135**	**39**	**96**
	%	**%**	**%**
Registered in general practice (FRNZCGP)	54	13	71
Registered in rural hospital medicine (FDRHMNZ)	42	3	58
Registered in urgent care (FRNZCUC)	6	0	8
Registered in another vocational scope	4	3	4
Not registered in any vocational scope	24	82	0

Total may exceed 100% because of multiple responses.

Nearly one-third of respondents (30 percent) state they are enrolled in a vocational training programme (Table 58); of these, 95 percent are training towards FDRHMNZ and 64 percent towards FRNZCGP.

Table 58. Vocational training programme enrolment among respondents working or training in rural hospital medicine (n=135)

	Total	GPEP or DRHM registrar	Non-registrar
Unweighted base	**135**	**39**	**96**
	%	**%**	**%**
General practice (training towards FRNZCGP)	19	64	0
Rural hospital medicine (training towards FDRHMNZ)	27	95	0
Urgent care (training towards FRNZCUC)	2	3	2
Other vocational training programme	0	0	0
Not enrolled as a registrar in a vocational training programme	70	0	98

Total may exceed 100% because of multiple responses.

Table 59 shows 92 percent of respondents who are working in rural hospital medicine identify themselves as trainers, most frequently as teachers of undergraduate medical students (74 percent).

Thirty-two percent also identify themselves as a teacher or educational facilitator for the rural hospital medicine training programme.

Table 59. Teaching responsibilities of respondents working in rural hospital medicine (n=114)

	Total
Unweighted base	**114***
	%
Teacher of undergraduate medical students	74
Teacher or educational facilitator on the DRHM programme	32
Other health professional training	27
Supervisor of house officers doing postgraduate community-based runs	18
Nurse Practitioner training	16
GPEP1 teacher	11
Mentor of a registrar in GPEP2/3	8
GPEP medical educator	4
Pharmacist training	0
Provide at least one training	92
Provide no training	8

Total may exceed 100% because of multiple responses.

* Subsample based on non-registrar respondents working in rural hospital medicine

13. WORKING IN RURAL HOSPITAL MEDICINE

13.1. Rural hospital level

Rural hospitals are classified as Level 1, 2, or 3. (Level 1 rural hospitals have visiting medical cover. Level 2 rural hospitals have on-site medical cover during normal working hours, and Level 3 rural hospitals have on-site 24-hour medical cover.)

Table 60 shows that around two-thirds (68 percent) of the respondents who work in rural hospital medicine state they work in a Level 3 rural hospital. Another 16 percent work in a Level 2 rural hospital and very few in a Level 1 rural hospital (4 percent).

Four percent of respondents provided an 'other' response including primary care clinics.

Table 60. Rural hospital level (n=114*)

	Total
Unweighted base	**114***
	%
Level 1 (visiting medical cover)	4
Level 2 (on-site medical cover during normal working hours)	16
Level 3 (on-site 24-hour medical cover)	68
Other e.g., primary care clinics	4
Don't know	9
Total	100

Total may not sum to 100% due to rounding.

* Subsample based on respondents working in rural hospital medicine.

13.2. Hours worked in rural hospital medicine per week

Survey respondents who state they had worked in rural hospital medicine in the three months prior to the survey were asked about the hours they work in rural hospital medicine per week. They were asked to include the time spent on clinical and non-clinical work relating to rural hospital medicine, as well as time worked when on-call.

Based on respondents' answers to this question, the average number of hours worked in rural hospital medicine was 28.4 hours per week (Table 61).

More than half of respondents (55 percent) state they work up to and including 35 hours per week in rural hospital medicine. Another 40 percent of all respondents state they work 36 hours per week or more in rural hospital medicine, with 8 percent working 51 hours or more per week.

Table 61. Weekly hours worked in rural hospital medicine (n=104*)

	Total
Unweighted base	**104**
	%
1–10 hours per week	19
11–20 hours	14
21–30 hours	19
31–35 hours	3
36–40 hours	13
41–45 hours	11
46–50 hours	8
51–55 hours	2
56–60 hours	3
61–70 hours	1
71 hours or more	2
Don't know	6
Total	100
Average hours per week	28.4

Total may not sum to 100% due to rounding

* Subsample based on non-registrar respondents working in rural hospital medicine.

13.3. Use of technology in rural hospital medicine

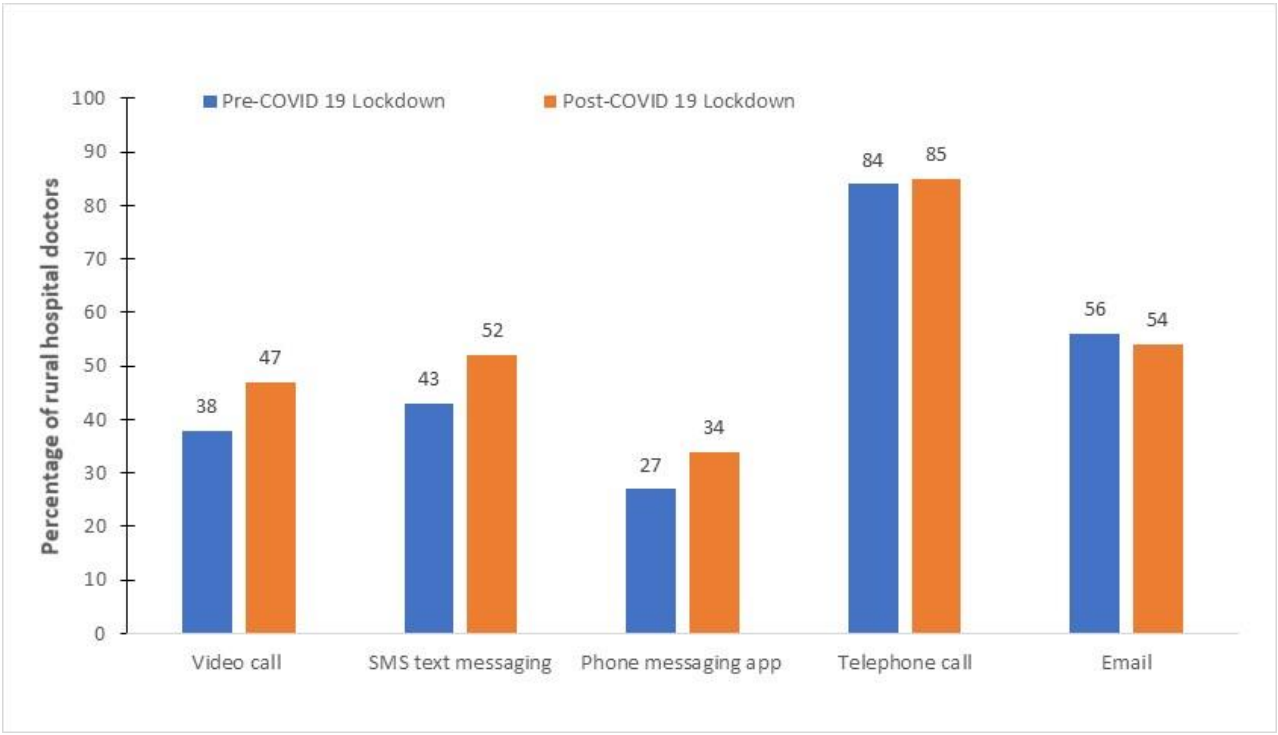
Rural hospitals already face unique challenges in servicing a large and widely distributed client base, with already high use of some technologies compared to general practice usage.

Table 62 shows responses in detail, while the bar graph summarises these responses by combining seldom, often, usually, and always into a single 'used technology' proportion. There was a trend for all but email use to have increased, with video call use increasing from 38 percent pre-lockdown to 47 percent post-lockdown, similarly SMS messaging increased from 43 percent to 52 percent, the use of phone messaging apps went from 27 percent to 34 percent, and telephone use went up marginally from 84 percent to 85 percent pre- and post-lockdown. Interestingly, email use went down – dropping from 56 percent pre-lockdown to 54 percent post-lockdown.

Table 62. The use of technology in rural hospital medicine pre- and post-COVID-19 lockdown (n = 114)

Thinking about the rural hospital where you work, how often did you use these technologies:	Unweighted base	Never	Seldom	Often	Usually	Always	Don't know/refused	Total
Pre-COVID 19								
Video call (e.g., Video link to ICU specialist in theatre)	114	54	34	3	1	0	8	100
SMS (text messaging)	114	50	28	11	4	0	8	100
Phone messaging app (e.g. Whatsapp, Viber, Messenger etc)	114	64	18	7	2	0	9	100
Telephone call	114	10	25	30	18	11	8	100
Email	114	35	32	18	4	2	8	100
Post-COVID 19								
Video call (e.g Video link to ICU specialist in theatre)	114	46	38	6	2	1	8	100
SMS (text messaging)	114	39	33	14	4	1	9	100
Phone messaging app (e.g. Whatsapp, Viber, Messenger etc)	114	58	22	10	1	1	9	100
Telephone call	114	6	25	32	18	10	10	100
Email	114	37	27	21	3	3	10	100

Figure 21. Comparison between pre and post COVID 19 lockdown for the use of technology within rural hospital (n = 114)



14. RETIREMENT INTENTIONS IN RURAL HOSPITAL MEDICINE

14.1. Retirement intentions

Almost one-half of respondents working or training in rural hospital medicine (47 percent) state they planned to retire from rural hospital medicine in the next 10 years – 29 percent in the next one to five years, and 15 percent in the next one to two years (Table 63).

When the retirement intentions of vocationally registered rural hospital doctors only are analysed, these percentages increase to 50 percent in the next 10 years – 23 percent in the next one to five years and 8 percent in the next one to two years.

Table 63. Retirement intentions of respondents working or training in rural hospital medicine (n=125*)

	Total	Vocationally registered in rural hospital medicine
Unweighted base	**125***	**52**
	%	**%**
1–2 years from now	15	8
3–5 years from now	14	15
6–10 years from now	18	27
11–15 years from now	9	12
16 years or more from now	45	38
Total	100	100

Total may not sum to 100% due to rounding.

* Base excludes 10 respondents who did not provide a valid response due to partial completion of the survey.

15. BURN-OUT AND OPTIONS ABOUT A CAREER IN RURAL HOSPITAL MEDICINE

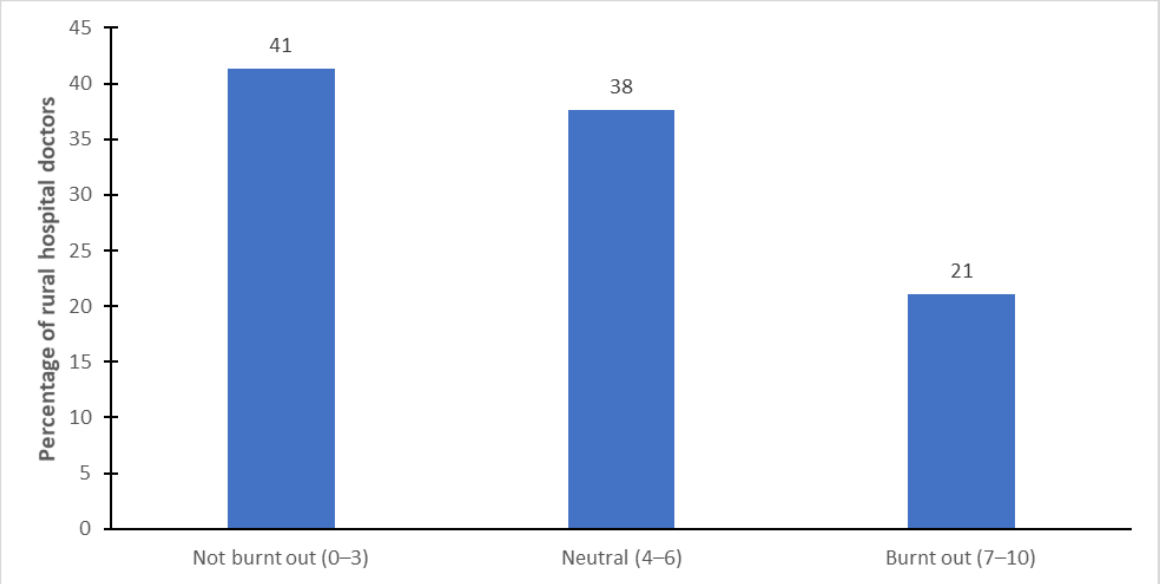
15.1. Burn-out

Using an 11-point scale, which ran from 'not at all burnt out' (0) through to 'extremely burnt out' (10), survey respondents were asked to rate the extent to which they felt burnt out with the following question: "How would you currently rate yourself on a 0 to 10 scale, where 0 = 'not at all burnt out' and 10 = 'extremely burnt out'."

Figure 22 shows that over one-quarter of respondents working or training in rural hospital medicine rate themselves as being burnt out to some degree (21 percent). This is based on a grouping of those respondents who rate themselves a 7–10 inclusive on the scale. This compares to the 31% of the national general practice workforce who report being burnt out on the same scale.

At the other extreme, 41 percent rate themselves as not being burnt out, based on a grouping of those who rated themselves 0–3 inclusive on the scale. This compares to 34% reported on this measure by the national general practice workforce. The remainder (38 percent) rated themselves 4–6 inclusive on the scale and are described as providing a 'neutral' response.

Figure 22. Burn-out among respondents working in rural hospital medicine (n=125*)



* Base excludes 10 respondents who did not provide a valid response due to partial completion of the survey.

15.2. Likelihood of recommending career in rural hospital

Using an 11-point scale, which ran from 'not at all likely' (0) through to 'extremely likely' (10), respondents were asked to rate their likelihood of recommending a career in rural hospital medicine.

Table 64 shows that 80 percent of respondents working in rural hospital medicine state they were likely to recommend a career in rural hospital medicine. This is based on a grouping of those who rate themselves a 7–10 inclusive on the scale.

At the other extreme, five percent rate themselves as unlikely to do so, based on a grouping of those who rate themselves 0–3 inclusive on the scale. The remainder (15 percent) rate themselves 4–6 inclusive on the scale and are described as providing a 'neutral' response.

There are no statistically significant differences in terms of recommendations by the extent to which respondents consider themselves to be burnt out.

Table 64. Career recommendation among respondents working in rural hospital medicine, by degree to which burnt out (n=125)

	Total	Not burnt out (0–3)	Neutral (4–6)	Burnt out (7–10)
Unweighted base =	**125***	**53**	**46**	**26****
	%	**%**	**%**	**%**
Unlikely (0–3)	5	8	2	4
Neutral (4–6)	15	11	22	12
Likely (7–10)	80	81	76	85
Total	100	100	100	100

Total may not sum to 100% due to rounding.

* Subsample based on respondents working in rural hospital medicine at the time of the survey.

** Caution: small subsample; results indicative.

16. CONCLUSIONS

This report gives a snapshot of the general practice and rural hospital medicine workforce in New Zealand in 2020. The survey results provide comprehensive information of our general practitioners, which includes demographics, work hours, income, employment status, ways of working and retirement intentions.

The findings show that the GP workforce faces an issue of ageing, with the average male and female GPs aged 53.6 and 48.0 years respectively. There is a large cohort of older GPs aged 50-65 and relatively fewer young GPs in the cohort aged 25-34 and mid-career GPs aged 35-49 Consequently, a large proportion of GPs are reaching their retirement age, nearly half of GPs are intending to retire in the next 10 years, and nearly one-third in the next 5 years. Over half of GPs now work part-time. These factors will potentially impact on the availability of GP services. With regard to gender, older GPs are predominantly male, younger GPs are predominantly female. This will impact on the demographic profile of the GP workforce for the foreseeable future and has implications for how more flexible working arrangements may be needed.

The survey results confirm that both Māori and Pasifika doctors continue to be under-represented in the GP workforce. International medical graduates (IMGs) make up more than one-third of GP workforce overall, but this increases to 50 percent among rural-based practices. On average, GPs work 34.8 hours per week, while male GPs work 7 hours more than female. Almost three out of five GPs have after-hours general practice commitments, with one out of five GPs having these commitments as often as every week or every second week. Those GPs who work longer hours are more likely to report feeling burnt-out.

Over one-third of GPs are currently an owner or partner in a general practice. Male GPs are more likely to be an owner or a partner in a general practice compared with female GPs. Nearly two-thirds of practice owners and partners are intending to retire in the next 10 years. A considerable number of practices and partnership will be available for purchase as a result of this.

Overall, the findings show that GPs currently make extensive and diverse use of technology to engage with patients. In particular, after COVID-19 lockdown, video conferencing has considerably grown in popularity, the uptake rate rose from 11 percent to 54 percent. Nearly half of GPs reported they feel confident in using video conferencing. The vast majority of GPs feel that the use of telehealth was positive.

More than one-quarter of respondents working in rural hospital medicine intend to retire within the next five years. One-fifth rate themselves as being burnt out to some degree.

17. RECOMMENDATIONS

We have 9 key recommendations:

1. Use the survey findings to advocate to Government, DHBs, PHOs, practices, universities, and the public about the urgent need to address the challenges in the GP workforce.
2. Use the findings of this and previous surveys to target support and resources to practices and individual members about ways to support the workforce, recognise burnout, minimise structural and functional stressors in the workplace, and help build organisational and personal resilience.
3. Advocate for Government, DHBs, PHOs, and practices to recognise the changing needs of the GP population and GP Practices, especially in relation to:
    - Providing additional childcare support and flexible work hours to GPs with young families.
    - Identifying practical pathways to practice ownership and/or becoming a partner for those who wish to do so.
    - Providing a support service within the College to support older GPs in implementing succession planning for their practice.
4. Recognise, publicise, and seek to address the impending workforce crisis of retiring GPs, through pro-active recruitment of medical graduates into GP education programmes, and novel ways to incentivise graduates to enter general practice.
5. Encourage Māori and Pasifika to study medicine and choose a career in general practice. For example by:
    - increasing scholarship opportunities for Māori and Pasifika medical students.
    - visibly and substantively supporting existing STEM initiatives in High Schools (e.g., Puhoro).
6. Use the findings of the 2020 survey to measure progress towards these targets in the.2017 RNZCGP Māori Strategy (He Rautaki Māori):
    - 22 percent of the total annual GPEP1 training intake is Māori by 2021.
    - Increase the number of Māori GPs practising in three agreed regions by 2021.
    - Increase the number of Māori GP Fellows by 50 percent by 2021.

7. Further investigate patient access to and acceptance of telehealth services.
8. Promote visibility of pay equity for female GPs and practice ownership/partnership pathways.
9. Undertake the analysis of the after-hours work commitments of the older GP cohort with reference to
    - The kinds of commitments.
    - What support or advice could be provided.