



ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

ASMS submission on the Voluntary Bonding Scheme 2017 to Health Workforce New Zealand

17 June 2016



Background

The ASMS is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent more than 4,000 members, mostly employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all DHB-employed senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Introduction

We note Health Workforce New Zealand's (HWNZ) request for feedback on the Voluntary Bonding Scheme (VBS) for 2017 suggests submission should consider:

- Are there specialties or communities that should be, or should no longer be, considered hard-to-staff for doctors? If so, why?
- Low numbers of doctors per head of population
- High vacancy rates
- Poor match to the population demography
- The age distribution of the existing workforce
- High use of casual staff
- High use of locums
- Numbers of and need to recruit overseas trained staff
- Workforce projected demand
- Workforce implications of Health and Disability Strategy objectives.

As usual with requests for feedback on proposed government activities and policies, not enough time has been allowed for the ASMS to properly examine or analyse the relevant matters related to the proposal. We do, however, have some general points to make that are critical to what this particular policy aims to achieve.

The Voluntary Bonding Scheme in the context of medical specialist shortages in general

Shortages of medical specialists in general have been acknowledged by HWNZ in its report *The Role of Health Workforce New Zealand*. Specifically:

The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.

The 2012 Review of the Voluntary Bonding Scheme listed 16 specialties and sub-specialties 'identified as vulnerable and critical in the model'.¹ The 2014 report *Health of the Health Workforce*, noting the high numbers of senior medical officers (SMOs) approaching retirement age, identified an additional 10 specialties and sub-specialties where the ratio of trainees to SMOs was 0.2 or less and therefore vulnerable.² The Department of Immigration's long-term and immediate skills shortage lists add yet another half-dozen specialties where there are 'sustained and ongoing shortage...both globally and throughout New Zealand', or where 'there are no New Zealand citizens or residents available'.³ Together they reflect medical specialist shortages across the board. This is reinforced in OECD data showing New Zealand has the third-lowest number of specialists (including trainees) per head of population in the OECD, ahead of Turkey and Chile.⁴

The current VBS, however, includes only five specialties that are considered hard to staff.

We note also that only eight district health boards, along with the Southland region and three provincial hospitals are considered hard-to-staff locations. The general information on the specialist workforce capacity gathered by ASMS in regular meetings with DHB management and day-to-day work across all DHBs indicates that while shortages are more severe in some areas than others, shortages exist in all DHBs.

We assume therefore that the limited number of specialties and locations identified as hard to staff in the VBS represent only what HWNZ considers the most severe cases.

ASMS has no issue in principle with prioritising activities to address workforce shortages. We have seen too often, however, that this can lead to non-priority areas being neglected and in this case there are compelling arguments for addressing specialist workforce shortages *as a whole* as a priority. This requires not only that the VBS is made more widely available (subject to an evaluation, as discussed below), but that additional, more extensive recruitment and retention policies are implemented, including those that address immediate needs.

New Zealand's specialist workforce is especially vulnerable because of our heavy dependency on international medical graduates (43% of the specialist workforce), which HWNZ has also acknowledged and indicated this needs to be reduced to around 15%. The relatively poor retention rates of IMGs are well documented in the Medical Council's annual Medical Workforce Surveys. This places New Zealand in a precarious position when considering looming international specialist shortages. Our dependency on IMGs is especially significant when taking into account that the medical workforces in most other OECD countries are even older than New Zealand's. OECD data show in 2013 that 25% of New Zealand doctors were aged 55 or over whereas the OECD average was 33%.⁵

ASMS is keen to work with HWNZ to develop a range of recruitment and retention policies and implementation plans as a matter of urgency.

Evaluating the Voluntary Bonding Scheme

Intuitively the VBS appears a potentially positive policy initiative that in the medium to longer term could alleviate some of the specialist shortages in hard-to-staff areas, notwithstanding our comments above. However, the only review to date on the VBS – in 2012 – identified some weaknesses in the scheme, raised many questions, and made a number of recommendations of which the outcomes in some cases remain unclear.

We note 'hard to staff' is defined in the 2012 review as "those communities or specialties that are characterised by factors including, but not limited to, high vacancy rates, high locum use, high proportion of overseas trained health professionals and understaffing resulting in longer waiting periods for treatment compared to other services or communities".

Aside from vacancy rates, which are influenced by DHB budget decisions as much as real staff shortages, we agree these factors are important for assessing staffing shortfalls, but an assessment of local unmet health need should also be included. We also agree with the review's recommendation that assessments of hard-to-staff specialties and locations should include factors such as the use of casual staff and projected workforce shortages and involve a 'consultative process'. What this consultative process means is unclear, however. We would expect HWNZ, as the government agency with responsibility for health workforce development, to undertake this consultation at the hospital and DHB levels and involve, crucially, the clinical leaders covering all DHB specialties. However, if this present call for feedback on the scheme is the 'consultative process' being referred to, then as indicated above it is unrealistic. ASMS does not have the resources to gather all the detailed information and data required at the hospital level in the space of four weeks, in addition to its existing work. We doubt whether most other organisations being consulted would be in any better position.

Aside from the scheme's limitations, it is unclear how effective it is in improving medical staffing in hard-to-staff areas. We note that a 2012 survey of the first year's (2009) intake to the scheme found 97% of medical respondents planned to work in a hard-to-staff specialty in the long term and 35%

intended to work in a hard-to-staff location in the long term. However, the survey respondents represented only 37% of the doctors in the scheme and it is not clear as to what extent being on the scheme had influenced their intentions. A particular concern is the low numbers reporting intentions to work in hard-to-staff locations.

We further note the reported high attrition rates of the scheme. The VBS review indicates that at the time of the report in 2012, less than half of the 862 doctors, nurses and midwives on the scheme in 2009 were confirmed as still being on the scheme – 102 (12%) had advised they had opted out, a further 321 (37%) had not responded to letters or reminder emails asking them to confirm their current status with the scheme, and a further 65 participants (8%) were not eligible to continue. The review notes that clearer information about the scheme's retention rates would be available in 2013, though this information does not appear to have been published.

Conclusion

Based on the available information the current Voluntary Bonding Scheme could potentially alleviate medical specialist shortages in hard-to-staff specialties and locations, but only marginally. Its effectiveness remains largely unknown and a thorough evaluation of the scheme is needed urgently to determine whether it needs an overhaul, including to what extent it should be resourced.

At best, the scheme may play only a relatively small part in alleviating future medical specialist workforce shortages. More extensive and wide ranging policies are urgently needed to address these shortages. The ASMS would welcome an opportunity to work with HWNZ to develop such policies.

References

¹ HWNZ. *Review of the Voluntary Bonding Scheme*, October 2012.

² Ministry of Health. *Health of the Health Workforce 2013 to 2014*, November 2014.

³ Immigration NZ. Long-term Skill Shortage List & Immediate Skill Shortage List, 2016. Available: <http://skillshortages.immigration.govt.nz/>

⁴ OECD Health Statistics 2015.

⁵ Ibid