




JULY 11, 2022

**WORKFORCE CRISIS SURVEY 2022**  
NEW ZEALAND WOMEN IN MEDICINE

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*Kotahitanga me manaakitanga  
Celebrating strength in our unity, supporting our community*

New Zealand Women in Medicine Charitable Trust  
Registered Charity CC59278

11 July 2022

*'The system is beyond a crisis. I feel sorry for new grads coming into this crisis. It will break many.'*  
SMO

## Introduction

The New Zealand Women in Medicine Charitable Trust was formed in 2021. The leadership team includes doctors with experience working in clinical leadership roles in primary care, secondary care and the Ministry of Health. The Trust is developing an increasingly high profile as a pan-professional organisation with membership across all areas and stages of medicine.

Its core objectives are

- *Kotahitanga me manaakitanga*: celebrating strength in the unity of the female medical profession to better support the health of the public of New Zealand
- *Te Tiaki Whaiaro* (self care): providing peer support, networking and advice
- *Te Tōkeke* (equity): advocating for equitable access to medical services and health outcomes
- *Whakahāngai* (to implement, update): promoting and developing innovation and leadership in medicine

## Why a survey?

Public statements from decision makers that there is 'no crisis' in the health system have seemed increasingly out of step with doctors' experience on the ground over the past 12 months. There is a high level of distress among the medical workforce, who are witnessing first-hand the impact of a health system crisis which has been largely unacknowledged. Concerns have been diminished and dismissed; a 'lack of listening' has led to a disconnect between decision makers and those working within the system.

Whilst Te Whatu Ora (Health NZ) has prioritised a Workforce Taskforce, little thought appears to have been given to the health and wellbeing of the workers at the coalface. This is disappointing, after two years in which the workforce has delivered an exemplary service through the Covid-19 pandemic.

[Health NZ's website](#) states:

*'Aotearoa New Zealand's health sector is the largest single employer in the country, made up of about 220,000 highly skilled, dedicated, and professional people who are the turanga/foundation of our health system.*

*There is commitment to making sure the health workforce is supported through any changes...one of the key workstreams within the Transition Unit is the development of the NZ Health Charter...A key focus is on the wellbeing of staff and being safe in their work environment.'*

The New Zealand Health Charter is purportedly being developed to reflect the health workforce's core values and motivations and to support them. However, clinicians are yet to be invited to participate in its development, and no details of this charter have been made available.<sup>1</sup>

## Survey – introduction

Survey of doctors across primary and secondary care, surveyed over 10 days.

911 responses split evenly across primary (n=446) and secondary (n= 446) care; 6 respondents reported working at an academic institution such as a university.

Within secondary care, 34 specialties were represented.

Questions included:

- Do you feel there is a healthcare 'workforce crisis' in New Zealand?
- Are there currently any specific workforce issues in your workplace?
- How have workforce issues impacted you personally?
- What risks do you feel the current workforce issues present?
- What changes or innovations would you like to see in the new system to address the health workforce crisis?

## Results

*'I no longer believe it can be fixed. I see no way out without respect and acknowledgement and listening.'*

Medical officer

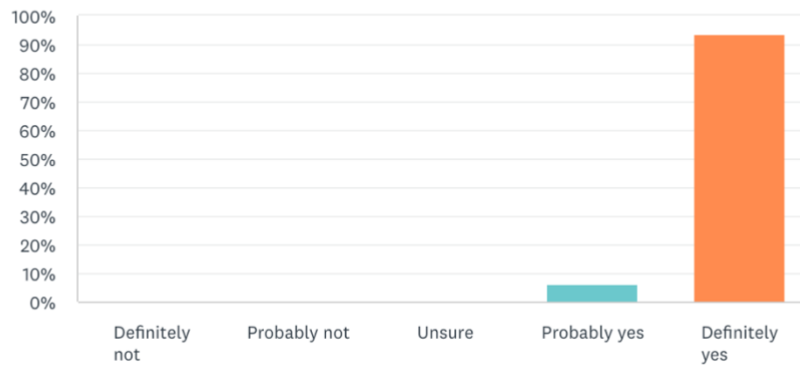
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<sup>1</sup> <https://dpmc.govt.nz/publications/update-transition-unit-thursday-17-june-2021>

### Question 1

Do you feel there is a healthcare 'workforce crisis' in New Zealand?

Answered: 911 Skipped: 0

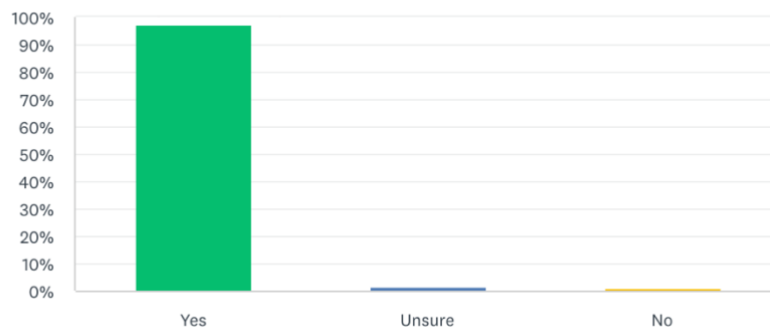


Definitely not 0.11%  
Probably not 0.11%  
Probably yes 6.26%  
Definitely yes 93.52%

### Question 2

Are there currently any specific workforce issues in your workplace?

Answered: 909 Skipped: 2



No 1.21%  
Unsure 1.65%  
Yes 97.14%

## Specific workforce issues: Secondary care

- Severe, acute on chronic staffing crisis at all levels – medical, nursing and midwifery, allied health
- Lack of retention and succession planning within departments, absent recruitment drives
- Severe shortage of nursing staff further limiting care
- Lack of support staff such as anaesthetic technicians, ultrasonographers – impacts service delivery
- Deferred care for all but life-threatening illness (eg. patients with cancer; and even cancers are being stratified)
- Increasing patient acuity when they do present, due to deferred care: often requiring protracted hospital stays
- Long delays to discharge to rest home/community hospital care due to staffing issues in the community
- Doctors having to work extra hours and shifts to cover staffing shortfalls, often at very short notice
- Clinical risk arising from having high clinical load and insufficient time
- Little understanding from managers and a blame culture: not a ‘team player’ if do not take on extra shifts or put in a payment claim for extra hours worked; reliance on goodwill for cover.
- Fewer teaching opportunities and lack of supervision of medical students and trainee positions due to stretched staffing. This will impact on safety and quality of our future workforce

*‘So many [nurses] off sick (and some of them because of burnout) that we have to close areas of the department or work there on our own with no nursing support... our triage nurses are so afraid that someone will die in the waiting room - so they are all resigning as well.’*

Doctor, Emergency Department

*‘I went for over 6 months with all annual leave declined, while working in a department that was 4 FTE short at registrar level - told no funding for extra locums or to hire new doctors. Given this job involved working 60 hrs a week, this led me to become burnt out, meaning I now am not sure I want to continue in medicine.’*

DHB Registrar

*‘I have poured many hours into trying to recruit - multiple overseas applicants have pulled out at the last minute. We have additional on call duties that need to be filled every week. I have been picking up the majority of these as one colleague has needed stress leave, and another is not far behind.’*

SMO

*‘I receive bulk-sent text messages multiple times per day asking if I can pick up additional medical duties that are uncovered... This includes being asked to cover adult wards despite having not worked in adult medicine for 8 years.’*

Registrar, Paediatrics

*‘I’ve just put in [a claim] for additional duties and was told I’m being ‘petty’ and how can I expect the taxpayers to foot this bill?’*

SMO, General Medicine

*'We are critically understaffed in terms of relievers and are regularly declined almost all leave we apply for. We were told at our very first day at orientation in February this year "I hope you have all applied for your leave because it's all already been allocated."'*

**Subspecialty Medical Registrar**

*'Ward full, extreme staff shortages, ED full and seeing little babies (as young as 7 weeks old) waiting >2 hours outside in tents for a bed in the department, or to be seen and an attempt at an exam made in the tent'*

**Registrar, Paediatrics**

*'We don't have enough clinics to safely manage high risk pregnant patients, leading to admissions to hospital that otherwise would not have needed to happen. Low morale, desperation, chronic stress. Impossible to promote my speciality to juniors in this state.'*

**Obstetrics SMO**

*'On a general medical take day I get multiple referrals of elderly people who aren't managing at home but can't get in to see their GP to organise respite care or can't access the respite care they are entitled to due to lack of beds. Patients await placement on the ward for days and days, which is both risky for them and for the people lying in the ED unable to get onto the ward.'*

**Registrar, General Medicine**

*'Immense pressure to pick up extra shifts when already on a 65+ hr roster.'*

**RMO**

### **Specific workforce issues: Primary Care**

- Long term (up to a year) vacancies for all practice roles – GP, practice nurses, reception staff.
- Clinical risk arising from high clinical load and insufficient time to safely manage complex problems.
- Very difficult for small practices to manage cover for sickness and leave, especially rural practices
- Currently a job seekers market; the rates required for staff retention are not sustainable from business continuity point of view (as it is impossible to raise fees to generate enough income)
- Difficulties attracting new graduates to general practice (lack of pay parity, devaluing of role, unsustainable model)
- Restrictions and rules from Immigration and Medical Council of New Zealand (MCNZ) are impacting on the ability to have international medical graduates fill the vacancies
- Increased patient complexity and a rise demand for appointments (from deferred care at both primary and secondary level) is putting huge pressure on available staff. This includes repeated appointments for unresolved issues after referred patients have been declined by secondary care.
- Chronic secondary service deficits in particular specialties such as mental health is escalating the volume and severity of unmet need. High acuity patients are being managed in primary care – e.g. complex mental health, eating disorders. Lack of access to psychology or other support services adds to the burden of care in general practice.
- Unacceptably long waits for GP appointments with up to six weeks being common.
- Clinical paperwork and administration are increasing exponentially; this typically does not generate income, therefore done unpaid and in clinician's own time

- Debt write-offs (sometimes tens of thousands of dollars per year) for those who cannot afford the care that is provided are common. This impacts on the financial security of the general practice business.
- Practice financial insecurity due to rising infrastructure costs, particularly with covid (PPE, extra staff to manage streaming, enabling telemedicine etc)
- Devaluing of the role of the General Practitioner suggesting equivalence with Nurse Practitioners – these roles need clearly defining, as the skill sets are different, and they are not interchangeable
- General practitioners are retiring early as they are burnt out from excessive workload.
- General practitioners leaving their practices to retrain in other specialties or leaving medicine altogether long before retirement age.

*'The system is broken.'*

GP

*'We are specialists in everything, and gate keep so much. We are efficient compared to the hospital system. We are grossly underfunded, under resourced and understaffed.'*

GP

*'6 months ago, a senior GP at my practice resigned with no job to go to...They were not able to be replaced. Three of the four nurses left for a variety of reasons. Another long-established senior GP just didn't come back to work one day. The patient load fell on the staff remaining. My patients wait 6 weeks for a booked appointment at the moment. The practice manager has resigned now...A colleague recently came into my room distressed and requiring Mental Health Crisis team involvement. I wonder grimly who will resign next? I worry frequently about the patients caught in the middle.'*

GP

*'I am constantly considering leaving the profession of general practice because it doesn't make sense for myself and my family to work half my hours for free.'*

GP

*'Due to staff shortage I have not been able to take holiday for more than two years. I am totally exhausted both physically and psychologically. '*

GP

*'No leave of any sort for 3 years... Filling in for nurse as required, more being sent from secondary care. Funding levels dropped, income reducing. No respect as a specialist. Feels like we have no voice in anything.'*

GP

*'GPs are moving from one stretched practice to the next, trying to find somewhere where they can stay without burning out. Most GPs I know regret becoming GPs, not because they don't enjoy the clinical work, but because they are sick of being spread dangerously thin or working all hours of their personal time to keep on top of their admin. And quite rightly wonder why they chose this profession.'*

GP

*'I have made the desperate decision to sell my practice of 14 years to a corporate. I won't be working by the time I reach 50 yrs which is a shame and a great loss to the NZ GP rural workforce.'*

GP

*'I am a GP owner and I feel disheartened that I could not pay my staff better for their hard work and I do worry that they will leave as due to current funding model we cannot compete with the hospital.'*

GP practice owner

*'With great sadness I am leaving the GP workforce in the next few months to retrain. I love being a GP, but its future looks bleak, and I don't see anyone 10 or 20 years ahead of me who is happy.'*

GP

*'I work double my allocated consulting hours to get all the work done.'*

GP

*'We are only fighting fires for acute issues now. There's no capacity for chronic condition management'*

GP/Urgent care

*'Recalls are de-prioritised because these are largely a nursing function. Likely the usual harder-to-reach are missing out on vaccinations, cx smears, CVD risk assessment and management.'*

GP

*'Someone has to do the mahi. It has fallen on our shoulders. We are all doing huge hours, many more than we have our lives set up for. No end in sight. I've missed so much of my young school aged kids lives in the last 2 years, and things are only getting worse. Lack of certainty regarding funding and constantly changing expectations from the Ministry of Health announced to the media effective immediately with no advanced warning ...also makes it hard to try to hire anyone to help with the workload. I'm exhausted. And I'm only at the start of my career in general practice. How long can I do this role?'*

GP

## Workforce issues not specific to service

- Long term lack of workforce planning is now obvious. This is not the fault of the pandemic but has been exposed by the pandemic
- Chronic understaffing, no allowance in the system for sickness (encouraging presenteeism), no replacement of those who have left
- Clinicians unable to take any leave as there is no one to cover
- Increased rate of attrition of skilled experienced clinicians (returning to home country, burnout, parental leave, leaving for Australia)
- Underinvestment in infrastructure, technology, efficient systems, and communication.
- Lack of clinical input into cohesive system design

*'I have spent my entire career trying to get a fully functioning pain clinic running well, but as I near retirement I have given that dream up. I am aware that my HOD is attempting to replace me, but with very little success so far- no trainees in the specialty are interested in the part time half-baked clinic and service that we have here.'*

SMO, Pain medicine



*'Because of a lack of workforce planning we frequently recruit from overseas, offer no orientation to the NZ context or working effectively with Māori and then expect health outcomes to be equitable.'*

GP

### How have workforce issues impacted you personally?

- Additional hours and duties to cover for deficits
- Having to do nursing or more junior doctor roles as well as own role to cover; in primary care, having to do nursing or receptionist duties if staff not available
- Colleagues all levels and roles stressed, exhausted, burning out
- No time for self-care due to long hours
- Extra hours impacting on ability to continue professional development or study and keep up with CME (continuing medical education) requirements
- High levels of anxiety and depression reported
- High levels of guilt & moral injury at having to decline referrals, defer or cancel treatment
- Sleeplessness, exhaustion
- Impact on relationships and family, e.g. hardly seeing their young children.
- Cutting hours or number of sessions to manage workload – both primary and secondary care
- Leaving medicine for 9, 12 months or more to recover from burn out, depression or anxiety. Many returning part time or not at all.
- Many respondents considering leaving medicine altogether or have already left / moved to other roles
- Retraining in other areas of medicine – this was reported most frequently in primary care respondents

*'Patients are suffering and dying in an underfunded health system. As a doctor this suffering affects me personally and deeply. It hurts even more to be told that there is nothing wrong with the system.'*

GP

*'Heartbroken for patients' unmet needs. Morally compromised. Despair. Exhaustion. Hopelessness.'*

GP

*'I don't have the words to describe how awful work has become. I am yet to see an article that comes even close to reflecting the reality of what it feels like to work in health at the moment.'*

ED Registrar

*'Had two weeks off earlier this year for burnout (first time ever in a career of more than 25 years), still feeling fragile but hanging in there as no one else to cover. Actively planning to leave primary care as I cannot fix the system and cannot continue working like this.'*

GP

*'I am lucky that we don't 'see' the details of patients who don't make it into theatre operating lists. They are invisible to me [...] If I knew them by name, had looked them in the eye[...] I would be a broken human and be leaving medicine.'*

SMO Anaesthesia

*'This week, surgeons were sent an email asking us to prioritise current booked patients for next week. ...The email states "This is a very distressing process for all involved in the decision making as we know patients with life threatening problems are being deferred". If this doesn't spell out crisis, I don't know what does.'*

**SMO, General Surgery**

*'My part-time job has become a full-time job. It is exhausting, confusing and intrusive. My children, my health and my mental well-being are being stretched beyond acceptable limits.'*

**GP**

*'I have resigned from my DHB SMO job and am leaving the workforce (I am only in my early 50s)'*

**SMO**

*'No relief is on the horizon...solutions are non-existent. The all over feeling in general practice is one of despair, hopelessness, fatigue and burnout.'*

**GP**

*'I am working 12 hour days, 6 or 7 days a week for the last year.'*

**Specialist General Practitioner**

*'I am tired, I feel huge moral distress, I feel frustrated and sometimes angry. I feel we are unheard.'*

**SMO O&G**

*'Very sad to be retiring with such a feeling of hopelessness for the future of my specialty.'*

**SMO, pain medicine**

*'Patient safety is compromised on a daily basis. The ongoing moral injury to health workers from offering substandard care will take decades to recover from.'*

**ED SMO**

*'I went to the RMO office last week to make them aware that in 3 months' time I was going to hand in my resignation. They told me they have had multiple doctors in the same situation as me come and do the same.'*

**Registrar, general surgery**

*'I feel like I am working in a failing health system and failing patients.'*

**House officer**

*'We just can't do more. On several paydays this year, the owner GPs have not been able to be paid in order to cover wages for the rest of the staff. We're exhausted and demoralized, working on autopilot. And when something nice happens - a patient brought us flowers to apologise for getting angry that their appointment had to be postponed due to staff sickness - then we take a moment to cry. And then we take a deep breath, and start all over again.'*

**GP**

*'I am answering on behalf of my husband whose health and well-being I'm desperately concerned about. Before this covid outbreak they were overworked and in crisis. So short staffed with fewer safety nets of senior nurses on the ward and day ward. They tried to get the DHB to address the crises, were promised extra FTEs. The DHB after months of delays said they should never have been promised FTEs. He was told to cut services. They had to work out which patients to stop treating. The DHB have not told the community they have stopped some services for some people. It is soul destroying. He is disempowered and broken. He has done so many extra clinics and weekends and on call he can barely think straight. I have never seen him so demoralised.'*

**SMO**

## Risks identified by respondents as a result of the workforce crisis

- Delayed diagnoses
- Medical errors
- Unable to staff workplaces or departments because no one is prepared to take on the burden and risk
- Deferred care causing deconditioning of patients as their health declines. This in turn impacting on acuity at presentation and risk of poorer outcomes as a result.
- Loss of continuity of care (proven to be our strongest predictor of long-term health outcomes) for all, but particularly impactful on those with chronic medical conditions
- Upset and angry patients, abusive towards healthcare workers
- Poor job satisfaction leading to greater losses of skilled clinicians from the sector, making it more difficult to attract a workforce
- Smaller specialties have no succession planning and are in danger of falling over altogether. Whole regions already completely lack specific services eg. rheumatology, dermatology
- Loss of faith in the public system – by both doctors and their patients

*'Everyone is so exhausted; mistakes are being made endangering patient care'*

**Emergency Registrar**

*'Huge risks to patient safety and outcomes. Equity risk - we have so far to go to achieve equity and I fear we are going backwards very quickly'*

**Paediatric Senior House Officer**

*'System is on brink of utter collapse. Higher and higher demand with diminishing numbers of staff.'*

**Consultant physician**

*'Collapse of the healthcare system as we know it. Significant delayed diagnoses. Avoidable morbidity and mortality. Widening disparity.'*

**GP**

*'The Acute General Medicine Clinic and TIA [transient ischaemic attack] clinic have had to stop taking patients and these patients now add to acute presentations/admissions.'*

**SMO, Acute / respiratory medicine**

*'Major risk, relying on partially trained staff as no qualified staff available. Used to have an experienced practice nurse to train any new recruits, can't find any of those. Exhausted staff are always a risk. System is not as efficient, short staffed so waiting times extended, that has its own risk. Adding to the mix cancelled secondary care clinics and surgeries all adding to the pressure. There is a serious crisis that is building up steam, like a storm working up to a tornado'*

**GP general practice owner**

*'Every day you go to work you are walking into a battle. Makes us feel like the patients are the enemy, when they are not'*

**Emergency physician**

*'I am perpetually scared of making mistakes or missing taking note of an abnormal result. I am rostered for 24hr on call 11 days this month alone including 2 weekends and I am absolutely exhausted... There is 100% a workforce crisis in New Zealand.'*

**Haematology SMO**

*'I am told to "avoid" admissions but we have few other options: GPs are working so very hard to manage complex patients in the community. I try and provide advice and support but that is still leaving the responsibility to GPs to manage in unpaid hours .... every single specialty I interact with are sinking with inadequate resources to manage increasing patient demand.'*

**SMO, Acute medicine**

*'I would walk out if I didn't have a mortgage and kids to provide for. I'm fairly broken at the moment. I absolutely hate going to work and I feel bullied and harassed and insulted by how we're being treated.'*

**SMO, General Medicine**

*'I genuinely feel anxious about my patients with limb threatening ischaemia who are waiting for long periods for limb salvage procedures. Their GPs are also advocating for them with follow up letters ... it is demoralising to have to reply to these explaining that the waitlist is significant and patients are prioritised accordingly... because they all have genuine need and priority.'*

**Vascular & transplant surgeon**

*'Patients are going to die on the wards. I don't trust the public health care system to look after my family or friends.'*

**Surgical registrar**

*'ED nurses are leaving in droves because it's so unsafe, and it's upsetting having to work in a system where patients are being let down daily.'*

**ED Registrar**

*'I'm scared I'll miss things as I don't have the time to do things properly, and then scared I'll still be to blame, and not the broken system.'*

**GP Registrar**

*'This is not going to be a long winter - this is going to be years of utter carnage. All my colleagues and friends talk about is "how are we going to cope, what are we going to do to get through each day... how can we care for the children under our care?"'*

**SMO Paediatrics**

*'We have created a generation of exhausted, jaded clinicians. Patients are not receiving timely care and there is barely time for that, let alone time to connect with patients, make them feel comfortable and address issues of inequity. There is no room for error or sickness and this ultimately places patients at the centre of more risk.'*

**GP**

*'Almost without exception the more experienced doctors are obviously burnt out. The younger doctors are all struggling and many are planning their escape from the career.'*

**GP**

## What did respondents suggest as solutions?

1. **Acknowledge that there is a crisis;** and that the pandemic exposed rather than caused this crisis.
2. Urgent long term strategy is needed for health workforce recruitment and retention.
3. Workforce Wellness strategy: the health and well-being of our healthcare workforce needs to be prioritized
4. Health NZ and the wider system needs to bear responsibility for physician health and wellbeing via safe working conditions, rather than the individual being seen to have 'failed' by suffering burnout.
5. Better pay & conditions for nurses and midwives to attract and retain them; being paid during training
6. Pay parity between primary and secondary care medical and nursing staff
7. Remove unnecessary barriers to visas and registration of IMGs (international medical graduates), nurses and allied health professionals.
8. "Nothing about us without us": bottom -up approach for system redesign. Include those with clinical operational frontline skills in designing the new health care system
9. Respect for the vital role of general practice and a plan for long term sustainability, increasing training positions and ensuring pay parity for trainees.
10. Do more to promote health and the social determinants of health so that doctors are not 'the ambulance at the bottom of the cliff'.
11. Service sizing – many secondary care departments reported having not had meaningful job sizing done for several years
12. Appreciation and recognition for the clinicians who take leadership roles eg. providing expert advice to national health bodies. Often doctors are the only members of these groups whose time is unpaid.
13. Compulsory community attachments as routine part of medical training and PGY (Post Graduate Years) rotations.
14. Incentives and bonding of locally trained health professionals to attract them to stay in rural communities.

*'Shifting the focus to putting patient safety and by proxy staff wellbeing at the centre of everything.'*  
RMO

*'Meaningful financial investment in order to future plan - build for the services that will be needed in the next 20 years'*  
SMO

*'Emphasis on recruitment of Māori and Pasifika healthcare workers, right from school.'*  
GP

*'True assessment of job sizing, what is reasonable. Look at what is happening on the coal face, spend a day with me.'*

**SMO**

*'I would like one of their core values to be workforce wellbeing. This would include actually listening and trying to understand what the issues are and working collaboratively with us to address these.'*

**House officer**

*'Genuine consultation and recognition of 'front line' staff as experts (not just clinic experts but also in service delivery innovation) in the redesign of the health system.'*

**GP**

*'Teaching and training needs to be part of "service delivery". Cancelling teaching and limiting leave is not the way to build a future workforce. Workforce needs a 20-year plus view, as it takes so long to train a workforce.'*

**SMO**

*'General Practice is the key to the healthcare system functioning. Please include us in the discussions and allow us to be part of the future.'*

**GP**

*'Recognising the importance and value of "primary health care" as envisaged in the Alma Ata declaration and multiple studies showing that the most highly performing health systems internationally and based on excellent primary care'*

**GP**

*'Pay nurses more: they are integral and vital parts of our health service. Without nurses everything falls apart.'*

**SMO, acute/respiratory medicine**

*'Develop ideas from the ground up, not from the top down. Refresh some of the people involved or we'll just get the same old ideas from the same group of people with the same limited vision.'*

**GP**

*'More incentive to work in rural areas. Support of more training positions in provincial hospitals.'*

**SMO**

*'We need the socioeconomic determinants of health to be recognised and addressed at the source, not when they finally reach the health system...we face huge moral challenges being the gate keepers and front of house for the health system and no way to change it.'*

**GP**

*'More open dialogue with the public about what can be expected in a resource limited environment.'*

**GP**

## **Discussion**

New Zealand's health infrastructure is a fragile ecosystem. This large representative sample of the current medical workforce raises concerns about the possibility of the ecosystem's imminent collapse.

With respondents spanning almost every stage, grade and specialty and area of the country, the results are of huge concern. Only 11 of over 900 participants reported working in an area where they were not impacted by current workforce issues.

The personal impact of this crisis is vast. Expressions of despair and hopelessness are widespread, with a sense that no viable solutions are being proposed by the upcoming health reforms. Respondents reported that the health reforms had been held up as a 'mirage' over the past few years, given as a reason why no forward planning or innovation could take place in the intervening time within their workplace. Respondents across the system pointed to a lack of support staff – nurses, healthcare assistants, technicians - without which the system was non-functioning.

Also of concern is the demoralisation of the workforce extending to doctors at the very beginning of their career, with many reports of house officers and senior house officers already planning their exit from healthcare. This crisis will lead to long term difficulties with recruitment and retention of medical and nursing staff. We are seeing ghettos of healthcare that are becoming incapable of being staffed as chronic shortages and overwork makes them an unpopular option. Examples include mental health, rural general practice and midwifery.

Although over 95% of all patient contacts take place in primary care, the sector reports being consistently under resourced, undervalued, and undermined. Primary care has a leading role in containing health care costs for the nation whilst providing accessible quality care and supporting equitable outcomes. Alleviating pressure on primary care will in turn impact on the crisis in access to secondary care. Te Whatu Ora has stated that the focus of the health system will be to deliver more community care. However, there appears to be no clear plan to ensure there is a workforce in place to deliver it.

Aotearoa urgently needs to attract, retain and support a high-quality healthcare workforce.

*He aha te mea nui o te ao?*

*He tāngata, he tāngata, he tāngata*

## Key Recommendations

1. Acknowledge that there is a workforce crisis with a need for immediate innovative solutions to **address retention, recruitment and equity to all areas of healthcare**.
2. Create a **fit for purpose model with adequate funding for Primary Care**.
3. **Incorporate the expertise of clinical leadership** in the planning and collaborative design of equitable health services.
4. Develop a **Workforce Health, Safety and Wellbeing Strategy** that underpins the planning of Te Anamata o te Oranga (Future of Health).

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