The Public Health Medicine Workforce 2023

NEW ZEALAND COLLEGE OF PUBLIC HEALTH MEDICINE

Report by the

New Zealand College of Public Health Medicine

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Abbreviations

AFPHM – Australasian Faculty of Public Health Medicine (Royal Australasian College of Physicians)

APC – Annual practising certificate

ASMS – Association of Salaried Medical Specialists

SECA – Single Employer Collective Agreement

CPD – Continuing professional development

FTE – Full-time equivalent

MCNZ – Medical Council of New Zealand

MOoH – Medical Officer of Health

NPHS – National Public Health Service

NZ – New Zealand

NZCPHM – New Zealand College of Public Health Medicine

PHM – Public health medicine

PHMS – Public Health Medicine Specialist

PHO – Primary Health Organisation

KEY FINDINGS

The survey was sent to all current and retired Fellows of the New Zealand College of Public Health Medicine (NZCPHM, 217 Fellows). A total of 130 responses were received, a response rate of 60%. Responses described in this report are for those respondents currently working in public health medicine in New Zealand – 105 respondents (81%). The report also includes data drawn from the Medical Council of New Zealand (MCNZ) workforce survey and registration information.

Size of the workforce

After a period of decline from 2015 to 2018, MCNZ data shows that the Public Health Medicine Specialist (PHMS) workforce who hold a current, active practising certificate has increased to 190 doctors as at January 2024 (173 in 2019). This growth has been needed; however, it has not been at the same rate as other medical scopes (having grown only by 7.9% in the period since 2015, compared with 31% for the total specialist workforce). Projections show that at the current rate of entry and exit to the profession, the proportion of PHMSs per 100,000 population (currently at 3.7) will decline over the next ten years.

Demography

The proportion of the PHMS workforce who identify as Māori in MCNZ data is 10.7%, and those who identify as Pacific Peoples is 4.6% (prioritised ethnicity). In both cases, these proportions are significantly higher than those of the total medical specialist workforce (2.1% and 1.1% respectively). The PHMS Workforce Survey sample underrepresents the proportion of both Māori and Pacific Peoples in the PHMS workforce – 4.8% Māori and 3.8% Pacific.

The proportion of female Public Health Medicine Specialists in MCNZ data, now at 62.2%, has risen since 2015, when it was 54%. Since the female proportion of the workforce is, on average, younger than the male proportion, this trend is expected to continue.

The mean age of respondents to the PHMS Workforce Survey is 54.9 years. This has increased since 2015, when the mean age was 51. MCNZ data shows that 20% of the workforce is currently 65 years or older.

Qualifications

Of the survey respondents who are currently practising in public health medicine, 81.9% obtained their primary medical qualification in New Zealand. Of those who did their primary medical degree outside of the country, 57.9% did their postgraduate medical training in New Zealand.

Employment

In 2023, Te Whatu Ora | Health New Zealand was the largest employer of Public Health Medicine Specialists (56.2% of the survey respondents). The universities (collectively) are the second largest employer (23.8%), and Manatū Hauora | Ministry of Health is the third largest employer (8.6%).

The number of survey respondents indicating that they hold Medical Officer of Health roles (across both Te Whatu Ora | Health New Zealand and Manatū Hauora | Ministry of Health), was 34 (32.4% of survey respondents).

Eighty one percent of survey respondents indicate that they are working 30 hours or more per week, with 52.4% working full-time. The proportion of full-time equivalents to survey respondents in active

practice was 82.4%. While there are limitations to the assumptions involved, extrapolating this figure to the total workforce of 190 PHMSs in active practice suggests that there may be around 157 full-time equivalent positions for Public Health Medicine Specialists countrywide.

Across all respondents (full-time and part-time), 64 respondents (61.0%) indicated that they were working 40 hours per week or more. Twenty-two respondents (21.0%) are working 50 hours or more a week.

The proportion of respondents indicating that they spent at least some time on advocacy activities at their primary worksite has dropped to 39.0% in 2023 (from 51.2% in 2019). In the management area, 34.5% indicated involvement in 2019; this has dropped to 17.1% in 2023.

Very few respondents in 2023 (6.0%) are not working remotely at all. Whilst a large proportion (37%) work remotely for 20% or less of their time, a few respondents work entirely remotely (2%).

Satisfaction

Overall job satisfaction was rated high or very high by 52.5% of survey respondents. This is a sharp drop from the findings of the 2019 survey, when the percentage was 74.1%. Comments provided in the survey suggest this result reflects the impact, first of the COVID-19 pandemic, and then of the system reform process. Survey respondents were least satisfied with employer support for their role (40.6%), and workload (31.3%).

For the Medical Officer of Health respondents (across both Te Whatu Ora | Health New Zealand and Manatū Hauora | Ministry of Health), only 27.3% reported high or very high overall job satisfaction with similarly low proportions reporting high or very high satisfaction for workload (27.3%). Even fewer of these respondents reported high or very high satisfaction with work/ life balance (18.2%) and employer support for the role (21.2%).

Wellbeing

The proportion of respondents who rated their level of burnout at seven or more out of ten was 27.3% (slightly increased from the 2019 finding of 23.5%). The proportion was highest for Medical Officers of Health (36.4%). However, a large proportion of respondents also indicated a low level of burnout, with 54.6% of respondents indicating a level of four or below.

Impact of health system reforms

In late 2023, when the survey took place, there was still some uncertainty about how roles and functions would change as a result of the health system reforms and system restructuring; however, the majority of respondents to the survey indicated that they were working in much the same role as prior to the reforms (54.2%).

A fairly high proportion of respondents indicated that the system reform process had led them to look for a different public health medicine role (35.2%). Whilst some recognised that system restructuring has provided opportunities that were not available before (19%), the majority of respondents raised concerns. These included: dissatisfaction with the restructuring process (31.0%); limited understanding of public health by decision-makers (21.4%); and an undervaluing of the PHMS role (16.7%). The uncertainty and stress resulting from the system reform and restructuring process and low resulting morale were also frequently mentioned (26.2%).

Retirement intentions

A high proportion of those responding to the survey (51 doctors, 48.6%) indicated that they intend to retire in the next ten years. If this proportion is extrapolated to the full Public Health Medicine Specialist workforce, up to 92 doctors (of 190 with active practising certificates) may retire in the next ten years.

A high proportion of the survey respondents who are university-employed intend retiring in the next ten years. (14 of 25 doctors, 60.9% of respondents in this category). Of the Medical Officer of Health respondents, 48.3% intend to retire in the next ten years.

Ideal size of the PHM workforce

Nine and a half percent of the respondents to the survey indicated that their unit or department was critically short of Public Health Medicine Specialists. Most respondents also felt that the current number of Public Health Medicine Specialists per 100,000 population should be higher (53.3%), with an even greater proportion believing that the number of Medical Officers of Health per 100,000 population is too low (63.8%).

INTRODUCTION

The Public Health Medicine Workforce Survey has been run three times: in 2015[1], 2019[2] and 2023. The survey is circulated to all Public Health Medicine Specialists (PHMSs) on the New Zealand College of Public Health Medicine's (NZCPHM's) database, and others for whom the College has obtained contact details, and data collected from survey responses is supplemented by data available from the Medical Council of New Zealand (MCNZ).

Results of the survey are useful for tracking trends, and projecting workforce needs. Findings of the survey in 2015 were that there were 179 PHMSs on the MCNZ register with an active practising certificate, with an average age of 51 years. The female proportion of the workforce was 54%. In 2019, the number of PHMSs with an active practising certificate had fallen to 173. The mean age had risen to 53 years, and the female gender proportion had risen to 60%. In 2023, survey findings indicate that the number of active PHMSs on the register had risen to 190, with a mean age of 55 and a female proportion of 62%. The workforce is aging, with 20% of the workforce in 2023 being 65 years or above.

The results of the 2023 Public Health Medicine (PHM) Workforce Survey are presented below.

SURVEY SAMPLE AND METHOD

The 2023 PHM Workforce survey was based on questions used in previous Public Health Medicine Workforce Surveys,[1,2] with minor modifications made to individual questions (for example, to reflect

[1] New Zealand College of Public Health Medicine. The Public Health Medicine Workforce 2015. Wellington: NZCPHM. 2015.
[2] New Zealand College of Public Health Medicine. The Public Health Medicine Workforce 2019. Wellington: NZCPHM. 2020

changes in workplace roles), and additional sections included to elicit information about the impact of the health system reforms on the respondent's role, and on the size of the PHMS workforce.

The survey largely used a multi-choice question format, with some open-ended questions to provide further insight. Appropriate question logic was applied to reduce the length of the survey as much as possible.

The survey was set up on Survey Monkey and sent to all current and retired Fellows of the NZCPHM (217 Fellows) on 16 November 2023, remaining open until 14 December 2023, with three reminders sent.[3] The distribution list included all except 28 of the 196 currently practising vocationally registered specialists on the MCNZ register. (Of these 28, nine are NZCPHM Fellows, but Fellowship has been awarded after the survey was sent, and 19 PHMSs are not Fellows of the NZCPHM, or have resigned from NZCPHM membership. Twelve of these are current Fellows of the Australasian Faculty of Public Health Medicine).[4] Registrars were not included in the survey.

A total of 130 responses were received. This is a survey response rate of 59.9%. This is a higher response rate than received in 2019 (where the response rate was 53.7%), but lower than that received for the 2015 PHM workforce survey (75.9% response rate).

Of the 130 survey responses, 18 respondents (13.8%) indicated that they are not currently working in public health medicine. The majority of these respondents are retired (11 respondents, 61.1% of this group), with the remainder on parental leave, taking a break from practice, unable to find a job, or working in a different medical scope. An additional four survey respondents (3.1% of the total survey respondents) indicated that they are not currently working in New Zealand (two of these respondents hold a current New Zealand practising certificate). Further information about these 22 respondents not working in public health medicine, or in public health medicine in New Zealand, is provided in Appendix A.

Responses below are reported only for those respondents currently working in public health medicine in New Zealand. One hundred and five survey respondents (80.8%) indicated that they are currently working in public health medicine in New Zealand. All of these respondents, except one who indicated that he is semi-retired, hold a current New Zealand practising certificate.

1. SIZE OF THE PHMS WORKFORCE

According to data drawn from the MCNZ register, in January 2024 there were 245 vocationally registered PHMSs in New Zealand[5], of whom 190 held a current, active practising certificate, with a further three holding a current inactive practising certificate. This is an increase from the number

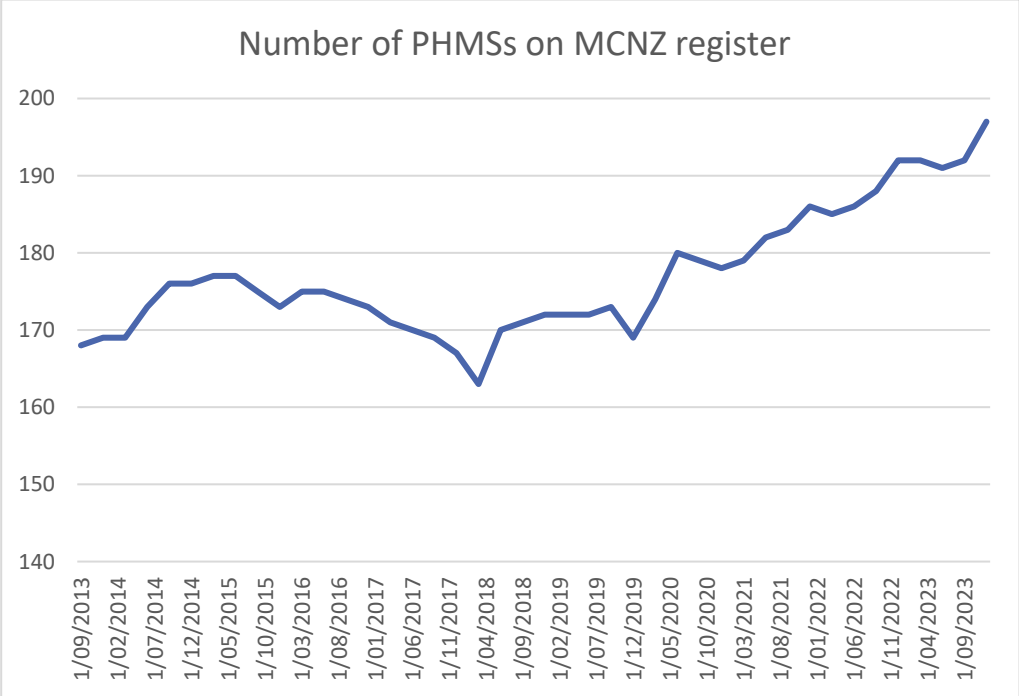
[3] Of the 217 survey invitations originally sent out, eleven were undeliverable. This may have been due to an institutional firewall block of survey monkey emails – the survey was thus re-opened as a weblink for these eleven invitees on 4 January 2024, remaining open until 24 January 2024.
[4] The Australian Faculty of Public Health Medicine was invited to circulate the survey to its New Zealand members but did not take up the invitation.
[5] Not including those on Provisional Vocational registration.

reported in the 2019 PHMS Workforce survey: at that time there were 224 vocationally registered PHMSs in New Zealand, of whom 173 held a current practising certificate.

Of the 193 PHMSs who hold a current practising certificate, 180 are NZCPHM Fellows. 12 doctors have Fellowship only of the Australasian Faculty of Public Health Medicine, and one doctor does not hold Fellowship of either College.

MCNZ data shows a five-year increase in the number of PHMSs with an active practising certificate of 14.5% (based on data taken on 31 December 2023).[6,7] However, this follows period of decline in PHMS numbers in the 2018 – 2019 period, shown in Figure 1 below.

Figure 1: Number of PHMSs on the MCNZ Register



Data from the New Zealand Medical Workforce 2023 report (see Table 1) shows that the growth in the number of public health medicine specialists since 2015 is lower than that in other vocational medical scopes: since 2015, the public health medicine workforce has grown by 7.9%. Over the same period, the growth in all other vocational medical scopes was over 18% (with general practice, at 18.5%, being the next lowest), and 31% for the total specialist workforce.

Table 1: Growth in vocational scope numbers[8]

Medical scopes	2005	2010	2015	2020	2023	Percent change 2015 - 2023
Anaesthesia	488	577	737	879	972	31.9%

[6] Data taken from the MCNZ Data Dashboard https://www.mcnz.org.nz/about-us/our-data/new-registrations-vocational/

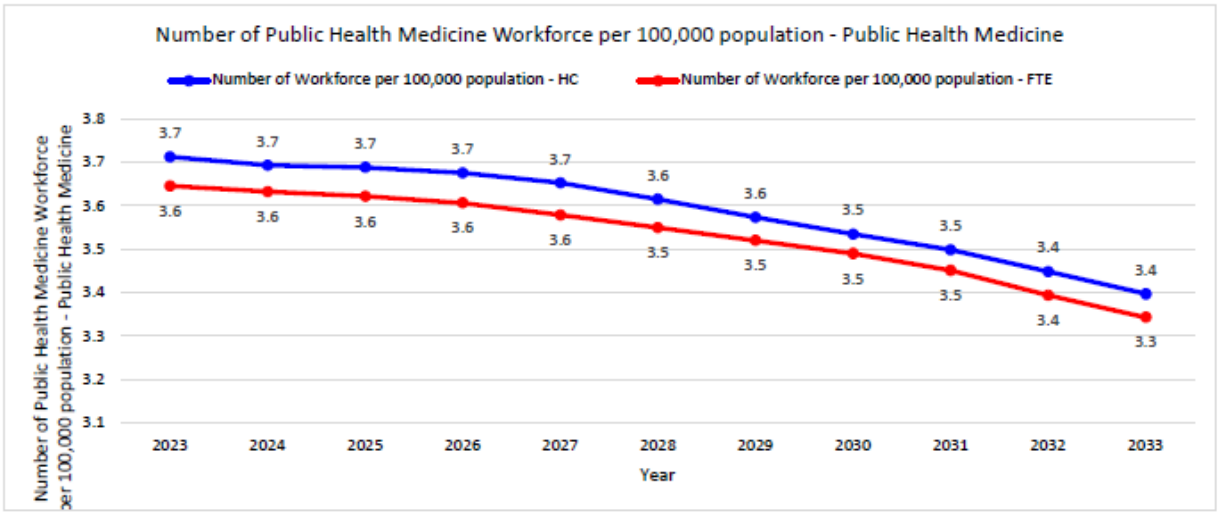
[7] Population growth over this period was around 6.6%. National Population Estimates https://www.stats.govt.nz/information-releases/national-population-estimates-at-30-june-2023/

[8] Table drawn from: Medical Council of New Zealand. The New Zealand Medical Workforce 2023 (with the final column modified to give the change in workforce numbers since 2015).

Diagnostic and interventional radiology	266	303	448	570	740	65.2%
Emergency medicine	88	135	224	350	436	94.6%
General practice	2,446	2,701	3,303	3,748	3,915	18.5%
General surgery	227	235	262	298	329	25.6%
Intensive care medicine	44	58	81	111	117	44.4%
Internal medicine	656	761	958	122	1403	46.5%
Obstetrics and gynaecology	223	234	280	337	358	27.9%
Ophthalmology	107	124	134	166	176	31.3%
Orthopaedic surgery	211	237	273	311	330	20.9%
Otolaryngology head and neck surgery	85	97	108	119	132	22.2%
Paediatrics	219	289	353	422	468	32.6%
Pathology	225	238	278	324	343	23.4%
Psychiatry	425	489	559	671	709	26.8%
Public health medicine	130	157	177	180	191	7.9%
Rural hospital medicine	-	26	105	128	147	40.0%
Urgent care	103	119	136	249	296	117.6%
Total	**6,389**	**7,310**	**9,069**	**10,863**	**11,901**	**31.2%**

In 2023 the number of PHMSs with an active practising certificate per 100 000 population was 3.7.[9] This is a slight increase from the finding of 3.6 at the time of the 2019 PHMS Workforce Survey. However, projections are that at the current rate of entry and exit to the profession, this proportion will decline in the period to 2033 (see Figure 2).

Figure 2: Projected PHMSs per 100,000 population[10]



HC – Headcount; FTE – Full-time equivalent

[9] 190 PHMSs, New Zealand's national population estimate in December 2023 was 5,305,600. https://www.stats.govt.nz/information-releases/national-population-estimates-at-31-december-2023/#:~:text=At%2031%20December%202023%3A,was%2039.0%20and%2037.1%20respectively.

[10] Graph provided in 2023 by Te Whatu Ora | Health New Zealand – Analysis and Intelligence, People and Communications Directorate

2. DEMOGRAPHICS

ETHNICITY

SURVEY RESPONDENTS

The ethnicities identified by survey respondents[11] reported as total response Level 1 ethnicities[12] are shown in Table 2 below. A small number of respondents indicated multiple ethnicities; the majority of those indicated two ethnicities which were classified into the same level 1 category.

Table 2: Ethnicity of respondents working in PHM in NZ

Total Response Ethnicity	Respondents	
	n	%
Māori	5	4.8%
Pacific peoples	4	3.8%
Asian	5	4.8%
Middle Eastern / Latin American / African (MELAA)	2	1.9%
Other ethnicity	0	0%
European	91	86.7%
Number of respondents*	105	

*Some respondents indicated more than one ethnicity

MCNZ FIGURES AND COMPARISON

The MCNZ uses 'a simplified version of Stats New Zealand's prioritisation standard', whereby each doctor is assigned to one ethnic group only, determined by a priority listing.[13] A comparison of the ethnicities for the medical workforce as a whole, the specialist workforce as a whole, and the Public Health Medicine Specialist workforce as reported by the MCNZ is shown in Table 3 below.

[11] The ethnicity question and answer options used in the survey was drawn from the 2023 NZ Census question. Unfortunately, when the survey was distributed, the survey software sorted the answer responses alphabetically rather than in the original order. This error was picked up and corrected after 78 respondents had completed the survey and the stem question was revised to the ethnicity data protocols standard.

[12] Ministry of Health (2017) HISO 10001:2017 Ethnicity Data Protocols. Wellington: Ministry of Health

[13] The method and priority order can be found in The New Zealand Medical Workforce 2023 report, p 45. The order in Table 3 above reflects the NZMC order.

Table 3: MCNZ data on ethnicity

Prioritised ethnicity according to MCNZ method	Total medical workforce %*	Total specialist workforce %*	PHMS %**
Māori	4.7%	2.1%	10.7%
Pacific Peoples	2.3%	1.1%	4.6%
Chinese	6.7%	4.6%	0.5%
Indian	6.4%	5.6%	3.6%
Other (non-European)	12.4%	8.2%	7.1%
Other European	19.1%	18.7%	7.7%
NZ European / Pākehā	44.9%	57.4%	65.8%
Not answered	3.5%		

*Data from the New Zealand Medical Workforce 2023 report[8]
** Data from the MCNZ dashboard 31.03.2024[6]

As the table above shows, the proportions for Māori and Pacific Peoples are higher for public health medicine than for the medical workforce as a whole, or the medical specialist workforce as a whole. The proportion of those with a NZ European ethnicity is also higher and reflects the lower proportion of those identifying with Asian and Other groups. This may in part reflect the lower proportion of Specialist International Medical Graduates in public health medicine than in other scopes (see p.13).

The ethnicity data of PHMS Workforce survey respondents using the 'prioritised ethnicity' method used by the Medical Council of New Zealand is shown in Table 4 below.

Table 4: Survey respondent ethnicity using the MCNZ prioritised ethnicity method

	Respondents	
	n	%
Māori	5	(4.8%)
Pacific peoples	4	(3.8%)
Indian	5	(4.8%)
Other non-European	2	(1.9%)
Other European	10	(9.5%)
NZ European / Pākehā	79	(75.2%)
Number of respondents	105	

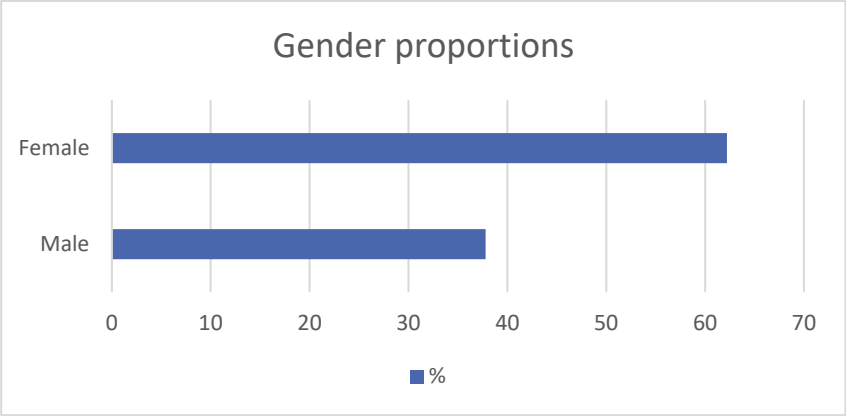
Comparing these figures with those of Table 3 above, it is evident that the survey sample underrepresents the proportion of both Māori and Pacific Peoples, and also those identifying as Other non-European groups, in the PHMS workforce, and overrepresents the NZ European category.[14]

GENDER

In June 2024, the MCNZ data dashboard[6] shows the gender breakdown for the vocational scope of public health medicine as being 122 female (62.2%), and 74 male (37.8%).[15]

[14] Of note, the proportion of Māori registrars on the training programme is currently 20.6%, and Pacific registrars is 6.3% (prioritised ethnicity method).
[15] Note that the total number in June 2024, at 196, is higher than the figure of 190 at the end of 2023.

Figure 3: Workforce gender proportions



In comparison, the proportion of women in the medical workforce as a whole in 2023 was 48.5%.[8] This figure has been steadily increasing since 1980, with numbers of female doctors expected to exceed the number of male doctors in 2025. Of the other vocational scopes, the female proportion of doctors exceeds that of public health medicine only for Obstetrics and Gynaecology (73.5%) and Palliative Medicine (70.9%).[8]

Of the respondents to the PHMS Workforce who are currently working in public health medicine in New Zealand, 62 (59.0%) were female, with 42 (40.0%) being male (there was one 'unknown' response). (Since survey findings regarding the female proportion are lower than the MCNZ figure of 62.2%, the survey sample is likely to be slightly weighted towards male respondents.) No respondent chose the 'another gender' category.

The survey findings are similar to those obtained in the 2019 PHMS workforce Survey, where 60.2% or respondents were female (increased from the 2015 survey results of 54% female).

AGE

MCNZ data shows that in 2023, 20% of the public health medicine workforce was aged 65 or above.[16]

Respondents to the PHMS Workforce survey ranged in age from 34 to 82, with a mean age of 54.9 (this is slightly increased from the 2019 survey, where the mean age was found to be 53.1%, and the 2015 survey, mean age 51).

Table 5: Mean age by ethnicity level 1

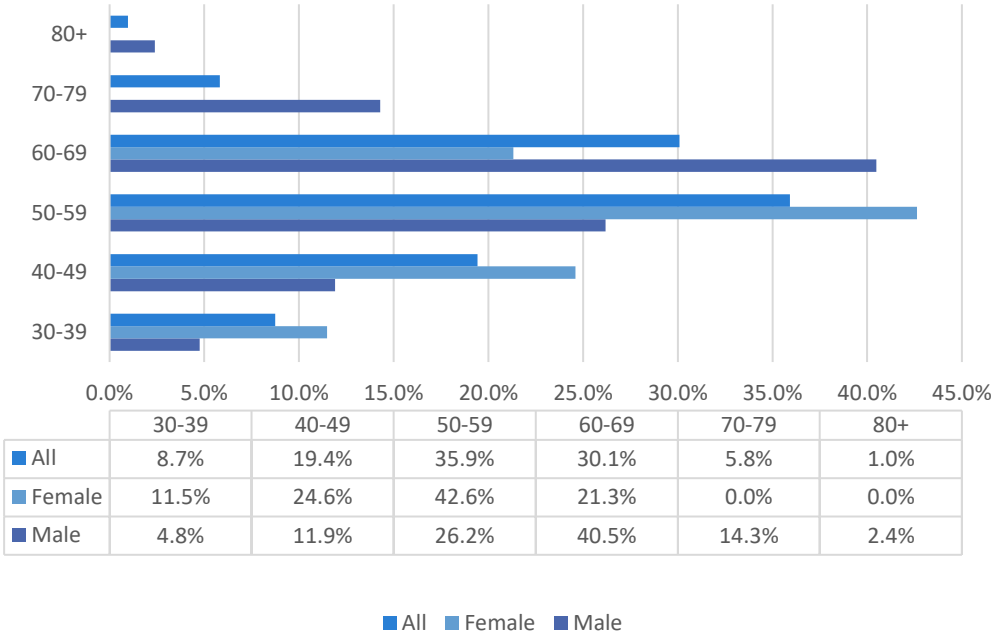
	Mean age
European	55.2
Māori	61.0
Pacific peoples	51.0
Asian	42.6
Number of respondents	105

[16] Data provided by Te Whatu Ora | Health New Zealand People and Communications directorate.

The mean age of the Māori respondents to the survey is considerably higher than that of the European respondents. However, the number of Māori respondents to the survey was small and is unlikely to be representative of the workforce as a whole: since the survey was circulated, two Fellowships have been awarded to young Māori doctors.

The age distribution of respondents, broken down by gender, is shown in Figure 4 below. The data shows the prevalence of females in the workforce in younger age groups, with the mean age for female respondents to the survey being 51.8 and for male respondents being 59.3. This is a pattern that is likely to continue: data from the PHMS training programme shows that in 2024, 80.9% are female and 19.1% are male.

Figure 4: Age by gender



	30-39	40-49	50-59	60-69	70-79	80+
All	8.7%	19.4%	35.9%	30.1%	5.8%	1.0%
Female	11.5%	24.6%	42.6%	21.3%	0.0%	0.0%
Male	4.8%	11.9%	26.2%	40.5%	14.3%	2.4%

(Proportions shown are for the total number of responses for the row.)

3. QUALIFICATIONS

FIRST MEDICAL DEGREE

Respondents were asked in which country they gained their first medical degree. Eighty-six respondents (81.9%) indicated that they obtained their primary medical qualification in New Zealand (2019: 83.9%; 2015: 77%). All except three of these respondents did their postgraduate public health training in NZ (these three did their training in England / Scotland / other United Kingdom).

A total of 19 respondents (18.1%) did not get their first medical degree in New Zealand. The majority of these (14 respondents, 13.3% of the respondents currently working in public health medicine in New Zealand and 74% of those who did their primary medical degree overseas) came from England / Scotland / other United Kingdom. Of the 19 respondents who did their primary medical training elsewhere, eleven (57.9%) did their postgraduate public health medicine training in NZ, and eight (42.1%) did their postgraduate training outside of NZ.

The proportion of international medical graduates in public health medicine is very low compared with this figure for the medical workforce as a whole (42.2%).[6]

Table 6: Country of training

	Country of primary medical degree		PG training in NZ	PG training outside NZ or NZ/other)
	n	%		
Australia	1	1.0%	-	1
England / Scotland / other United Kingdom	14	13.3%	11	3
Fiji	1	1.0%	-	1
Iraq	1	1.0%	-	1
New Zealand	86	81.9%	83	3
South Africa	1	1.0%	-	1
Sri Lanka	1	1.0%	-	1
Total	105		94	11

FELLOWSHIP AND VOCATIONAL REGISTRATION

PUBLIC HEALTH MEDICINE SCOPE

One hundred and four of the 105 currently practising PHMSs who responded to the PHMS Workforce survey (99.0%) hold a current annual practising certificate.

Of these respondents, 23 (21.9%) report holding Fellowship of both the NZCPHM and the Australasian College of Public Health Medicine (AFPHM), and 82 (78.1%) have Fellowship of the NZCPHM only. Since the survey was not circulated to AFPHM Fellows, there were no respondents who hold Fellowship of AFPHM only.

However, data from the MCNZ register in January 2024 showed a total of 12 PHMSs who hold a current practising certificate who have Fellowship of AFPHM but not of the College.

OTHER SCOPES

Ninety nine of the 105 (94.3%) currently practising PHMSs who responded to this survey are registered only in the scope of public health medicine. Six respondents (5.7%) are registered in an additional scope: three in general practice, two in medical administration (one of whom also holds registration in two other scopes), and one in internal medicine.

MCNZ data shows that, of the 190 currently practising PHMSs on the register, 166 (87.4%) hold vocational registration in Public Health Medicine only. Sixteen doctors (8.4%) hold vocational registration in public health medicine and general practice, with three of these doctors also holding vocational registration in another medical scope (sexual health medicine, palliative medicine, and urgent care). Three doctors (1.6%) hold vocational registration in public health medicine and medical administration (two of these doctors also hold vocational registration in a third scope – paediatrics, and internal medicine). Two doctors hold vocational registration in occupational medicine along with public health medicine (1.1%) and one doctor in each of psychiatry and internal medicine holds dual registration with that scope and public health medicine.

4. EMPLOYMENT

EMPLOYER AND ROLE

ALL EMPLOYMENT ROLES

All 105 respondents provided information about their primary employment role. 18 respondents (17.1%) indicate that they work for a second employer, and only two respondents (1.9%) indicate that they have a third employer also. No respondent had more than three employers.

Table 7: Employment (employer /role)

	Main (primary) employment		Second role	Third role	Total employment	
	n	(%)	n	n	n	(%)*
Independent consultancy	5	(4.8%)	5	1	11	(10.5%)
International organisation			1		1	(1.0%)
Manatū Hauora |Ministry of Health - MOoH role**	4	(3.8%)			4	(3.8%)
Manatū Hauora|Ministry of Health - other role (non-MOoH)	5	(4.8%)			5	(4.8%)
Non-governmental agency / not for profit	1	(1.0%)			1	(1.0%)
Non-health-related government agency	2	(1.9%)	1		3	(2.9%)
Other health-related government agency	5	(4.8%)			5	(4.8%)
Primary health organisation / general practice / locality	1	(1.0%)			1	(1.0%)
Research institute other than a university				1	1	(1.0%)
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	29	(27.6%)	1		30	(28.6%)
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	11	(10.5%)			11	(10.5%)
Te Whatu Ora | Health New Zealand - Other	2	(1.9%)	3		5	(4.8%)
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	13	(12.4%)			13	(12.4%)
University	23	(21.9%)	2		25	(23.8%)
Other***	1	(1.0%)	4		5	(4.8%)
(blank)	3*	(2.9%)	1		4	(3.8%)
Total	105	(100%)	18	2		

*Proportions are taken from the total number of respondents to the question. Since some respondents have more than one role, the column total is greater than 100%.

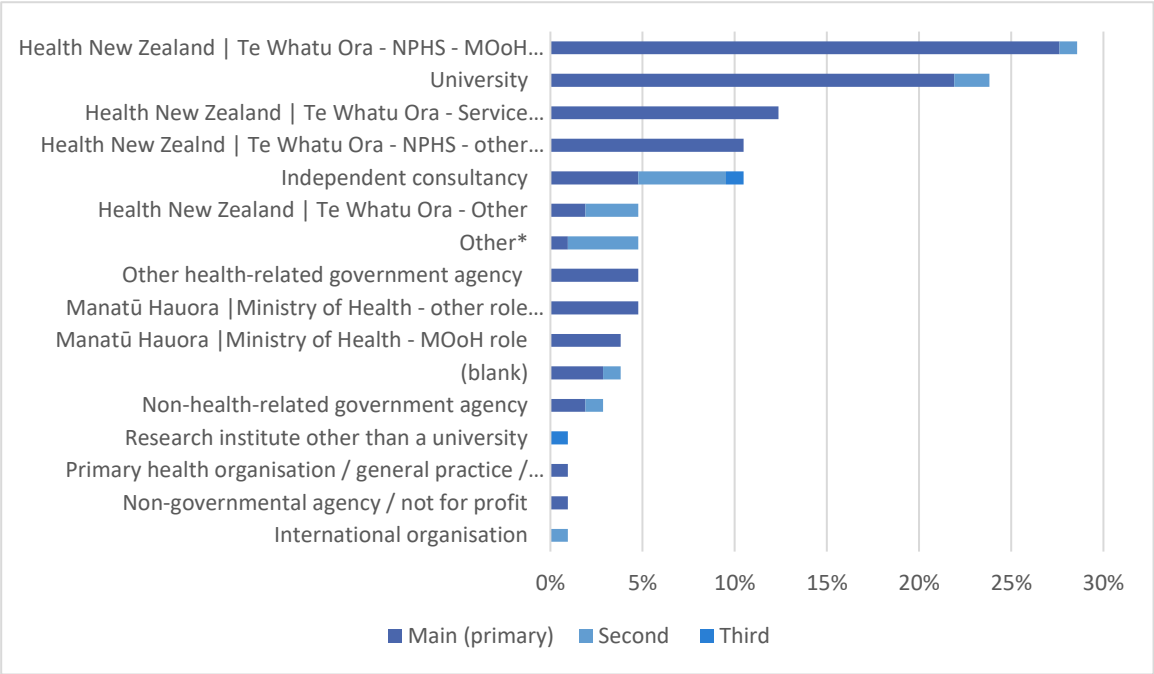
**Note that since there are only three Medical Officers of Health employed by Manatū Hauora | Ministry of Health, at least one of these respondents must have misread the question. It is possible they are employed by Te Whatu Ora as a Medical Officer of Health.

***Includes Public Service Commissioner, NZCPHM, self-employed, Te Pukenga

No respondents indicated that they were working for Te Aka Whai Ora,[17] for a research institute other than a university, or for a commercial company.

The distribution across workplaces is shown below.

Figure 5: Workforce distribution



In 2023, 59 survey respondents (56.2% of respondents) had roles with Te Whatu Ora | Health New Zealand: this was the largest employer of PHMS respondents. In comparison, the finding from the 2019 PHMS Workforce survey was that the District Health Board-employed proportion of respondents (roughly equivalent to Te Whatu Ora | Health New Zealand employment in the current survey) was at 50% (48% in 2015).

The universities (collectively) are the second largest employer, employing 25 respondents (23.8%). In comparison, in 2019, the proportion working at universities was 31.8% (28 respondents, main employer only). This drop in proportion reflects a higher number of non-university employed respondents in the 2023 survey.

Manatū Hauora | Ministry of Health is the third largest employer, with nine respondents across all roles (8.6%).

The number of respondents indicating that they hold Medical Officer of Health roles, across both Te Whatu Ora | Health New Zealand and Manatū Hauora | Ministry of Health, was 34: this is 32.4% of the total respondents.

REGION OF EMPLOYMENT

Respondents' region of work for their primary employment roles are shown in Table 8 below:

[17] No longer in existence, but it was at the time of the survey.

Table 8: Regions of work

	Northern North Island	Te Ikaroa (Central North Island)	Te Manawa Taki (Midland region)	Te Waipounamu (South Island)	Blank
Independent consultancy	2	2			1
Manatū Hauora - Ministry of Health - MOoH role		1	2	1	
Manatū Hauora - Ministry of Health - other role (non-MOoH)	1	3		1	
Non-governmental agency / not for profit	1				
Non-health-related government agency		2			
Other health-related government agency		5			
Primary health organisation / general practice / locality				1	
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	8	8	6	6	1
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	3	4	1	2	1
Te Whatu Ora | Health New Zealand - Other			1		1
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	12			1	
University	6	4	1	12	
Other		1			
(blank)		1			2
Total	33 (31.4%)	31 (29.5%)	11 (10.5%)	24 (22.9%)	6 (5.7%)

VOCATIONAL REGISTRATION REQUIREMENTS

91 out of 105 respondents (86.7%) indicated that the role that they are in is a public health medicine role. This included all Medical Officer of heath roles and all Ministry of Health roles. Five of 23 respondents (21.7%) employed by universities indicated that their role was not specifically a public health medicine role.

Vocational registration was indicated as a requirement for their position by 64 respondents (42.7%), with a further 27 respondents (25.7%) indicating that although vocational registration is not required for the role, it is an advantage. This is a lower proportion than in the 2019 survey (61.4% indicating the vocational registration was a position requirement, 30.7% indicating that it is an advantage).

Table 9: Vocational Registration required for primary employment

	Yes	No	Not technically*	Blank
Independent consultancy	1	2	2	
Manatū Hauora - Ministry of Health - MOoH role	4		0	
Manatū Hauora - Ministry of Health - other role (non-MOoH)	3		2	

Non-governmental agency / not for profit	1		0	
Non-health-related government agency		1	1	
Other health-related government agency (not including Manatū Hauora - Ministry of Health)	3	1	1	
Primary health organisation / general practice / locality		1	0	
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	29	0	0	
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	8	1	2	
Te Whatu Ora | Health New Zealand - Other		1	1	
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	10	1	2	
University	4	3	16	
Other		1		
Blank	1			2
Total (n=105)	64 (42.7%)	12 11.4%)	27 (25.7%)	2

*Full wording given in the question "It is not technically required but it is an advantage as the role requires many public health medicine competencies and / or adds credibility".

LENGTH OF TIME IN ROLE

Respondents were asked how long they had spent in their current role. Of those who responded to this question (100 respondents):

- 51 indicated that they had been in their current role fewer than 5 years,
- 20 had spent five or more, but less than 10 years in the role
- 11 had spent 10 years or more, but less than 15 in the role
- 18 had been in their current role for 15 years or more.

Examination of the length of time in role by employer shows that, although there is a high proportion of respondents in Te Whatu Ora | Health New Zealand Medical Officer of Health roles who have been in the role for fewer than five years (37.9%), there is also a high proportion of those in this role who have been in the role for 15 or more years (27.6%). Similarly, although a large proportion of respondents in university roles have been in their positions for fewer than five years (30.4%), a high proportion have also been in their role for 15 or more years (26.1%).

This pattern is not found for Te Whatu Ora | Health New Zealand – NPHS – other roles, where the majority of respondents have been in their positions for less than five years (81.8%). There was a similar finding for Manatū Hauora | Ministry of Health – other roles (80%), and to less extent also, for roles in Te Whatu Ora | Health New Zealand – Service Improvement and Innovation.

FULL-TIME EQUIVALENTS AND WORK HOURS

WORKING FEWER THAN 30 HOURS PER WEEK

Of the 105 PHMS Workforce survey respondents who are currently working in PHM in NZ, 85 (81.0%) are working 30 hours or more per week, with 20 (19.0%) working fewer than 30 hours per week.

Reasons given for working fewer than 30 hours included:[18]

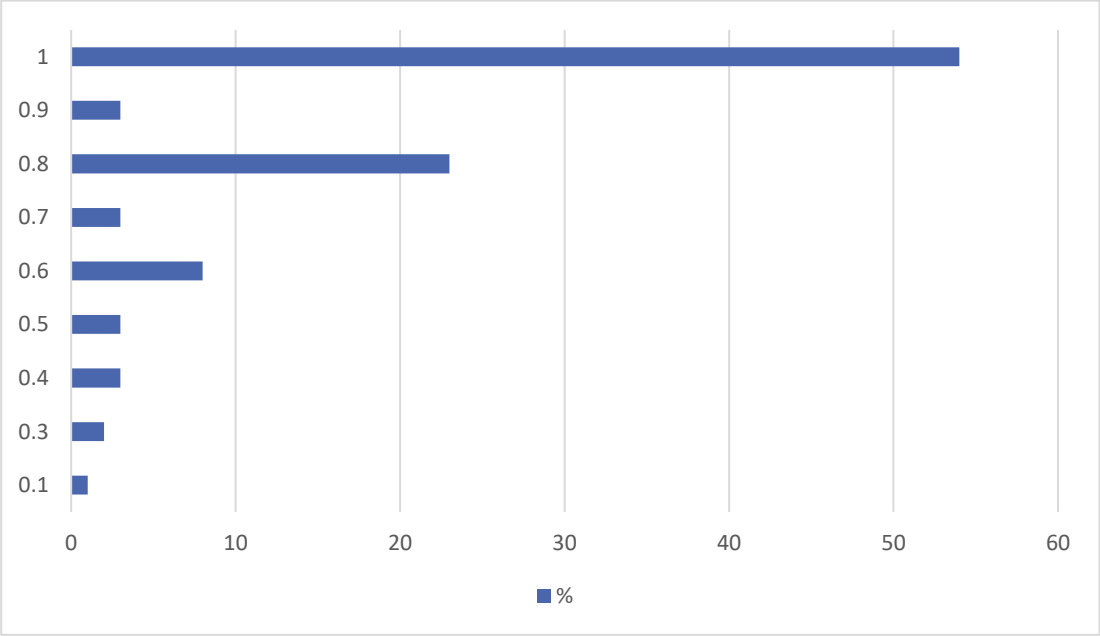
- Busy with academic study (2 respondents)
- Caring for dependents (7 respondents)
- Lifestyle choice (5 respondents)
- Seeking additional employment (1 respondent)
- Working in another medical scope (2 respondents)
- Semi-retired (6 respondents)

Of these 20 respondents, 14 (70.0%) indicated that the role that they are working in is a PHMS role, with 4 (20%) indicating that their role is health-related, but not a PHMS role (two respondents in this category did not reply to this question).

FULL-TIME EQUIVALENTS

The proportion of respondents working at each Full-time Equivalent (FTE) is shown in Figure 6 below.

Figure 6: Full-time equivalent proportion



In total, 55 respondents (52.4%) work at 1.0FTE, with 81 (77.1%) working at 0.8FTE or above in their primary employment role (this is similar to the findings of the 2019 survey, where 53.4% were working at 1 FTE, and 78.4% at 0.8FTE or above). Female respondents are slightly less likely to work at 0.8FTE or above than males (74.2% versus 83.0%).

The FTEs worked by survey respondents by employer/role is shown in Table 10 below.

Table 10: Respondents' employed FTE

	n	FTE	(%)
Independent consultancy	5	2.1	(2.4%)

[18] More than one option could be selected

Manatū Hauora - Ministry of Health - MOoH role	4	3.8	(4.4%)
Manatū Hauora - Ministry of Health - other role (non-MOoH)	5	5	(5.8%)
Non-governmental agency / not for profit	1	1	(1.2%)
Non-health-related government agency	2	2	(2.3%)
Other health-related government agency (not including Manatū Hauora - Ministry of Health)	5	3.1	(3.6%)
Primary health organisation / general practice / locality	1	0.4	(0.5%)
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	29	26.7	(30.9%)
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	11	9.1	(10.5%)
Te Whatu Ora | Health New Zealand - Other	2	1.8	(2.1%)
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	13	11	(12.7%)
University	23	18.9	(21.9%)
Other	1	1	(1.2%)
(blank)	3	0.6	(0.7%)
Total	105	86.5	(100)

While there are limitations to the assumptions involved, extrapolating this figure to the total workforce of 190 PHMSs in active practice suggests that there may be around 157 full-time equivalent positions for Public Health Medicine Specialists countrywide.

CONTRACTED AND ACTUAL HOURS

Respondents' contracted hours per week, and actual hours worked are shown in Table 11 below.

Table 11: Comparison of FTE, contract hours and actual hours

FTE	n*	Contract hours		Actual hours	
		mean	(range)	mean	(range)
0.3	2	18.0	(12-24)	18.0	(12 – 24)
0.4	3	14.0	(10 – 16)	18.0	(16 – 20)
0.5	3	19.5	(19 – 20)	27.5	(25 – 30)
0.6	8	24.0	(24 – 24)	24.9	(24 – 30)
0.7	3	28.0	(28 – 28)	29.3	(28 – 30)
0.8	23	32.2	(30 – 36)	36.2	(32 – 50)
0.9	3	35.7	(34 – 37)	41	(37 – 44)
1.0	54	39.9	(36 – 46)	46.5	(40 – 65)

*Numbers reported only for categories where there was more than one response

Across all respondents (full-time and part-time), 64 respondents (61.0%) indicated that they were working 40 hours per week or more. MCNZ data shows that this compares with general practice where 59% of doctors work at 40 hours a week or more.[8] The same data shows that in general practice, the average number of hours worked per week is 35.2, and in public health medicine is 38.3.

A total of 22 respondents (21.0%) indicated that they work 50 hours a week or more.

Of those respondents working at 1 FTE, 14 are working for 40 hours per week (25.9%), 20 are working 41 - 45 hours (37.0%), 11 are working 46 – 50 hours (20.4%), and nine are working more than 50

hours per week (16.7%: four of these respondents work for universities, four for Te Whatu Ora | Health New Zealand in various roles, and one for the Public Services Commissioner).

As Table 11 shows, those contracted at 0.5 FTE also tend to work considerably more hours than they are contracted for.

ON CALL RESPONSIBILITIES

Respondents were asked whether they had any on call responsibilities in their primary employment role. 40 respondents (38.1%) indicated that they do.

Those that do have on call responsibilities are typically rostered on one in four weeks, although this varies widely as shown in Table below.

Table 12: On call roster

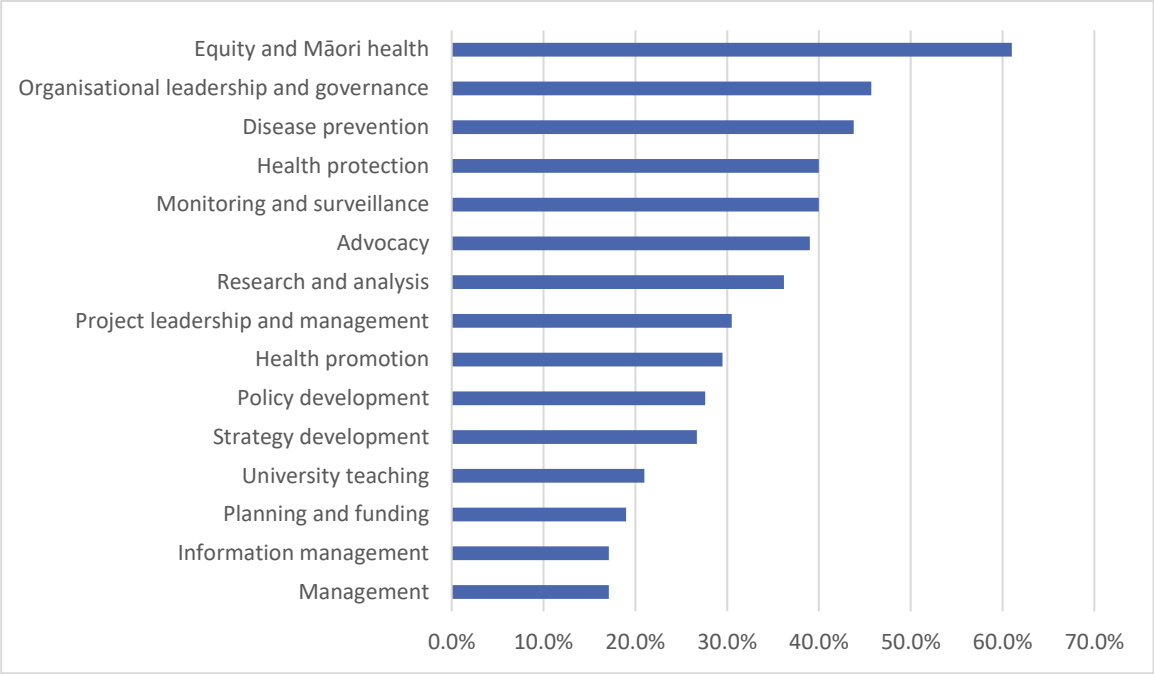
Approximately	**n**	**(%)**
Continually on call or available for emergencies	3	(7.5%)
1 in 2 weeks	4	(10.0%)
1 in 3 weeks	9	(22.5%)
1 in 4 weeks	13	(32.5%)
1 in 5 to 8 weeks	5	(12.5%)
1 in 9 to 12 weeks	4	(10.0%)
During organisation's shutdown period over Christmas and New Year holidays	1	(2.5%)
Locum basis	1	(2.5%)
Total	**40**	

ACTIVITIES AND FOCUS

Respondents were asked to indicate which activities from the list shown in Figure 7 below best describe what they do in their primary employment role. More than one option could be selected.

Equity and Māori health was the option most frequently selected (61.0%), followed by organisational leadership and governance (45.7%) and disease prevention (43.8%).

Figure 7: Activities undertaken in primary employment role



Results in the figure above are not directly comparable with findings from the previous survey, as choices have been renamed / reviewed.[19] However, in the areas that can be compared there are two significant differences: the proportion of respondents indicating that they spent at least some time of advocacy activities at their primary worksite in 2019 survey was 51.2%. This has dropped to 39.0% in 2023. In the management area, 34.5% indicated involvement in 2019; this has dropped to 17.1% in 2023.

Table 13 below shows the proportion indicating that they undertake each activity type, by employer / role.

Table 13: Activities undertaken by employer / role

Activity	**All**		**MOoH roles within Te Whatu Ora | Health**	**Other Te Whatu Ora | Health New Zealand**	**All Ministry of Health roles**	**University roles**	**Independent consultancy roles**
	n	**(%)***	**%****	**%****	**%****	**%****	**%****
Advocacy	41	(39.0%)	51.7%	11.5%	44.4%	52.2%	60.0%
Disease prevention	46	(43.8%)	72.4%	38.5%	77.8%	21.7%	0%
Equity and Māori health	64	(61.0%)	69.0%	57.7%	77.8%	52.2%	40.0%
Health promotion	31	(29.5%)	55.2%	7.7%	55.6%	21.7%	40.0%
Health protection	42	(40.0%)	100%	3.8%	66.7%	13.0%	20.0%
Information management	18	(17.1%)	20.7%	23.1%	11.1%	17.4%	0%
Management	18	(17.1%)	17.2%	15.4%	11.1%	21.7%	0%

[19] For example, 'research and teaching' was the option that received the greatest proportion of responses in 2019 (67.8% at primary employer). This has been refined in the 2023 survey to provide separate categories for 'research and analysis' and 'university teaching' (the latter specified as it was felt that previous results may have been skewed by respondents involved in registrar training).

Monitoring and surveillance	42 (40.0%)	62.1%	38.5%	66.7%	13.0%	20.0%
Organisational leadership and governance	48 (45.7%)	58.6%	50.0%	44.4%	30.4%	40.0%
Planning and funding	20 (19.0%)	3.4%	46.2%	0%	8.7%	20.0%
Policy development	29 (27.6%)	6.9%	26.9%	44.4%	26.1%	60.0%
Project leadership and management	32 (30.5%)	27.6%	34.6%	33.3%	39.1%	20.0%
Research and analysis	38 (36.2%)	17.2%	26.9%	0%	91.3%	60.0%
Strategy development	28 (26.7%)	17.2%	30.8%	66.7%	21.7%	20.0%
University teaching	22 (21.0%)	10.3%	0%	0%	82.6%	0%
Total n	105	29	26	9	23	5

*Proportion of the total respondents

** Proportion cited for each role type is the proportion of those employed in that role.

5. SALARY AND BENEFITS

EMPLOYED ON ASMS SECA

Survey participants were asked whether they were employed on an Association of Salaried Medical Specialists' Single Employer Collective Agreement (ASMS SECA). Table 14 shows the responses.

Table 14: Employed on ASMS SECA

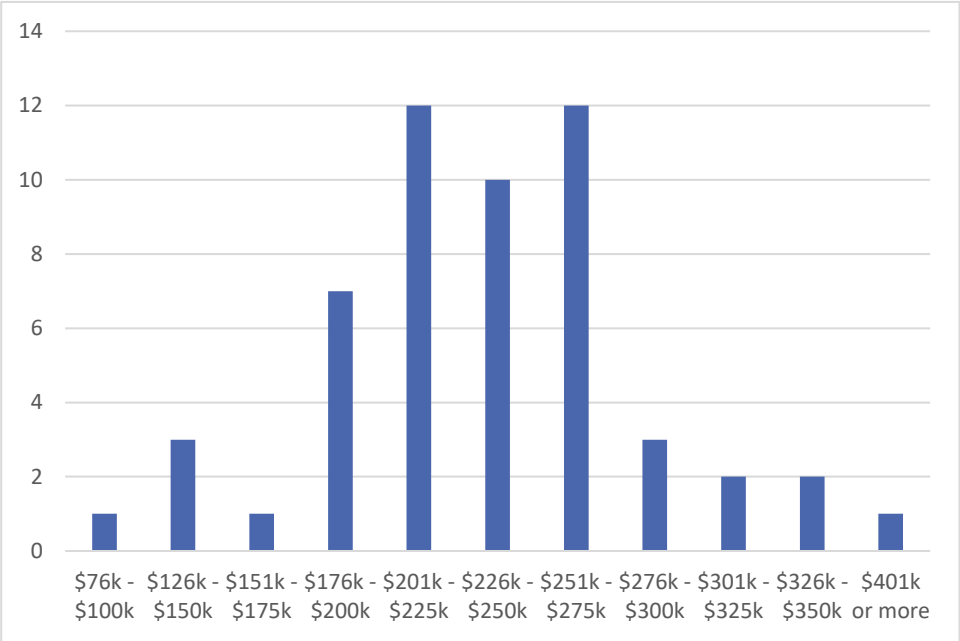
	Yes	No	Total
Independent consultancy		5	5
Manatū Hauora - Ministry of Health - MOoH role	3	1	4
Manatū Hauora - Ministry of Health - other role (non-MOoH)	1	4	5
Non-governmental agency / not for profit		1	1
Non-health-related government agency		2	2
Other health-related government agency (not including Manatū Hauora - Ministry of Health)	1	4	5
Primary health organisation / general practice / locality		1	1
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	27	2	29
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	9	2	11
Te Whatu Ora | Health New Zealand - Other	1	1	2
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	10	3	13
University		23	23
Other		1	1
Blank	1		3
Total	**53 (50.5%)**	**50 (47.6%)**	**105**

The proportion of survey respondents indicating that that are employed on an ASMS SECA was 50.5%: the majority of these respondents are employed by Te Whatu Ora | Health New Zealand (although eight Te Whatu Ora | Health New Zealand employed respondents are not on an ASMS SECA).

SALARIES

Salaries for full-time employed respondents – for those primary employment locations at which there was more than one respondent at 1FTE.

Figure 8: Salary bands at primary employer for respondents employed at 1FTE



There are two ASMS SECAs which apply: the Manatū Hauora | Ministry of Health SECA, for which the starting salary in the lowest 'doctor' band scale is $119,704 and the Te Whatu Ora | Health New Zealand SECA, where the starting salary on medical specialist scale is $170,369.

Table 15: Respondent salaries

	n*	Salary range
Manatū Hauora - Ministry of Health - MOoH role	3	$201k - $350k
Manatū Hauora - Ministry of Health - other role (non-MOoH)	5	$126k - $250k
Non-health-related government agency	2	$176k - $275k
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	18	$151k - $275k
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	5	$176k - $325k
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	6	$201k - $350k
University	12	$76k - $250k
Total	51	($76k - $350k)

*Reported only for those categories in which there was more than one respondent

CONTINUING PROFESSIONAL DEVELOPMENT

On the Manatū Hauora | Ministry of Health SECA, doctors are entitled to 10 working days leave for continuing professional development (CPD) a year, with costs covered to a maximum of $12,000 per year.

On the Te Whatu Ora | Health New Zealand SECA, medical specialists are entitled to 10 working days of CPD leave a year, and cost covered up to $16,000 per annum (with $500 extra for those in two CPD programmes).

The CPD annual monetary entitlement allowances for non-SECA employed respondents is shown in Table 15 below.

Table 16: CPD allowances for non-SECA employed respondents

Amount	n	(%)
$10,000 +	10	(20.0%)
$8,001 – 10,000	1	(2.0%)
$6,001 - $8,000	0	(0%)
$4,001 – 6,000	2	(4.0%)
$2,001 – 4,000	2	(4.0%)
$500 – 2,000	5	(10.0%)
Less than $500	1	(2.0%)
Negotiated on a case-by-case basis	12	(24.0%)
None (any CPD costs are a personal expense)	16	(32,0%)
(blank)	1	(2.0%)
Total	**50**	

There is no discernible pattern by employer, except that no university CPD allowance is over $6,000.

The annual entitlement for paid leave for CPD activities for non-SECA employed respondents is provided in Table 16 below. This ranges widely, with no discernible pattern by employer. Table 17 provides information on whether College membership fees are paid by the employer for non-SECA employed respondents.

Table 17: CPD leave entitlement for non-SECA employed respondents

CME Days	n	(%)
>10 days	4	(8.0%)
5 - 10 days	11	(22.0%)
1 - 4 days	2	(4.0%)
Not specified/ negotiated on a case-by-case basis	18	(36.0%)
None	15	(30.0%)
Total	**50**	

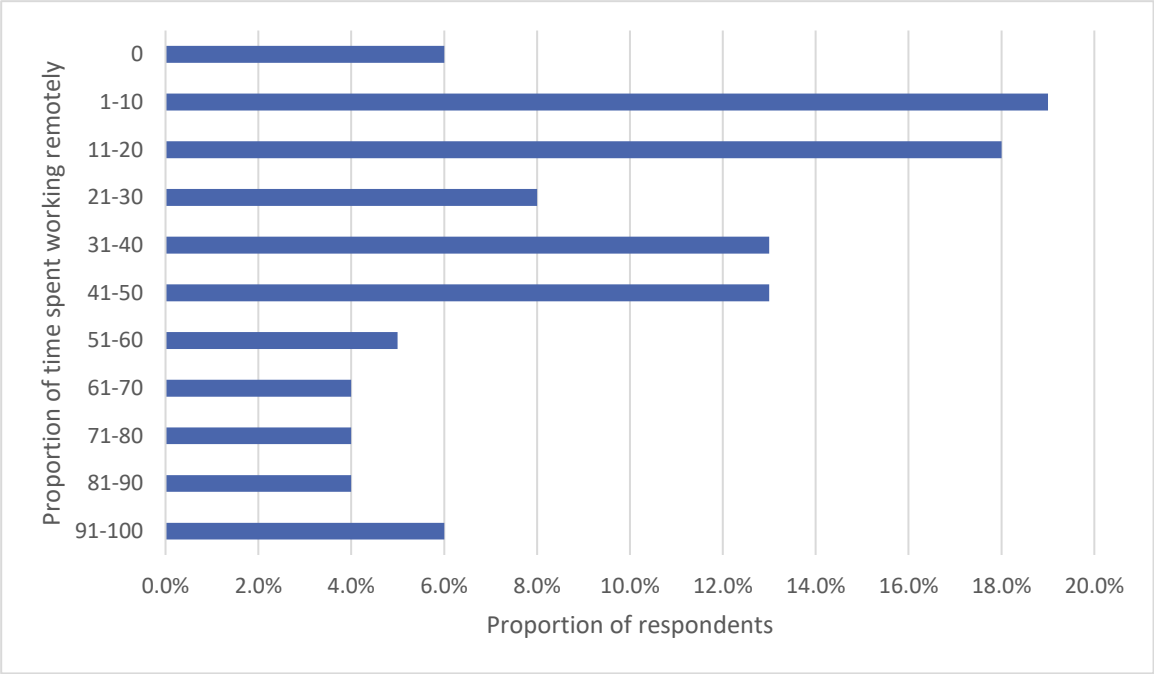
Table 18: College membership fees paid by employer for non-SECA employed respondents

College fees paid	n	(%)
Yes	37	(74.0%)
No	9	(18.0%)
Not applicable	3	(6.0%)
(blank)	1	2.0%)
Total	**50**	

6. REMOTE WORKING

Participants were asked to estimate the proportion of time that they spend working remotely. Very few respondents (6.0%) are not working remotely at all. The highest proportion of respondents (19.0%, and 18%) spend 1 - 10% or 11 – 20% of their time working remotely. Very few respondents work entirely remotely (2%), or almost entirely remotely (7.0% at 90 – 99%). These proportions are shown in Figure 9 below.

Figure 9: Proportion of time spent working remotely



Respondents were also asked what proportion of time they would spend working remotely, if they had a choice. Table 19 below shows desired versus actual proportion of time spent working remotely. The highest number of respondents (21%) indicated that 41 – 50% was the most desired proportion of time to be spending working remotely: many of those respondents working remotely for less than this proportion of their time would value more remote work. However, a reasonable proportion of those working remotely for 81% or more of their time would prefer less remote work (but never less than 41%).

Table 19: Desired versus actual time spent working remotely

Actual	Desired											
	0	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	Total
0	3 50%		2									6
1-10	1	5 26%	5	1		6	1					19
11-20		1	9 50%	5	3							18
21-30				6	1	1						8

				75%								
31-40					7 54%	4	2					13
41-50				1		8 62%	2		1		1	13
51-60							3 60%		2			5
61-70								4 100%				4
71-80									4 100%			4
81-90						1			1	2 50%		4
91-100						1	1		1		2 33%	6
Total	**4**	**6**	**16**	**13**	**11**	**21**	**9**	**4**	**9**	**2**	**3**	**100**

7. SATISFACTION AND WELLBEING

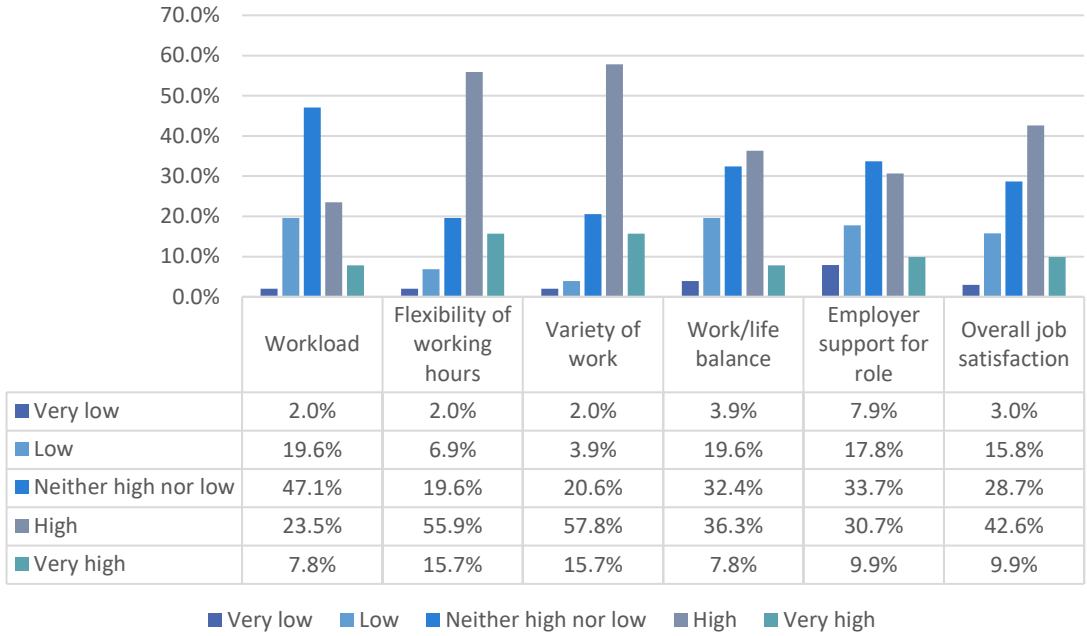
JOB SATISFACTION

Overall job satisfaction was rated high or very high by 52.5% of participants. This is down from 74.1% in 2019. Dimensions with the greatest proportion of respondents reporting high or very high satisfaction ratings were the variety of work (73.5%) and flexibility of working hours (71.6%). Dimensions with the lowest proportion of respondents reporting high or very high satisfaction ratings were employer support for their role (40.6%) and workload (31.3%).

Seventeen out of 23 university respondents (73.9%) had high or very high levels of satisfaction with their roles, although in keeping with the 2019 findings, fewer of these respondents reported high or very high satisfaction levels with work/life balance (43.5%).

For the Medical Officer of Health respondents (across both Te Whatu Ora | Health New Zealand and Manatū Hauora | Ministry of Health), only 27.3% reported high or very high overall job satisfaction with similarly low proportions reporting high or very high satisfaction for workload (27.3%). Even fewer of these respondents reported high or very high satisfaction with work/ life balance (18.2%) and employer support for the role (21.2%).

Figure 10: Satisfaction ratings by participants



	Workload	Flexibility of working hours	Variety of work	Work/life balance	Employer support for role	Overall job satisfaction
Very low	2.0%	2.0%	2.0%	3.9%	7.9%	3.0%
Low	19.6%	6.9%	3.9%	19.6%	17.8%	15.8%
Neither high nor low	47.1%	19.6%	20.6%	32.4%	33.7%	28.7%
High	23.5%	55.9%	57.8%	36.3%	30.7%	42.6%
Very high	7.8%	15.7%	15.7%	7.8%	9.9%	9.9%

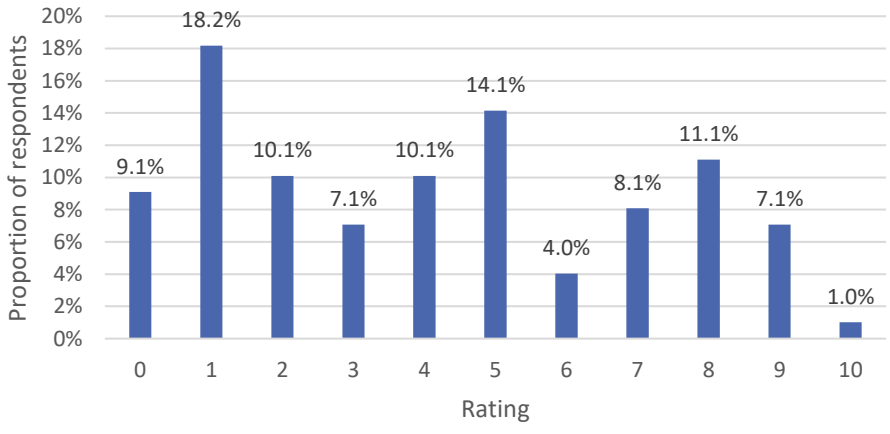
WELLBEING

Survey respondents were asked to rate their wellbeing, on a scale from 0 – 10 where 0 = 'not at all burnt out' and 10 = 'extremely burnt out'.

A reasonably high proportion of respondents (27.3%) rated their level of burnout at seven or above: this is slightly increased from the findings of the 2019 survey (23.5%). The proportion was highest for Medical Officers of Health (Te Whatu Ora | Health New Zealand and Manatū Hauora | Ministry of Health), 36.4% of whom reported burnout at levels of seven and above.

However, a large proportion of respondents also indicated a low level of burnout, with 54.6% of respondents indicating a level of four or below.

Figure 11: Participant burnout ratings



The main factors cited as contributing to burnout included Te Whatu Ora | Health New Zealand restructuring and uncertainty, poor management and workplace issues, and exhaustion from the COVID-19 pandemic.

Table 20: Factors contributing to burnout

	n	(%)**
Te Whatu Ora | Health New Zealand restructuring and ongoing uncertainty	22	(18.0%)
Poor management and workplace issues	11	(9.0%)
Exhaustion from COVID pandemic	10	(8.2%)
Feeling undervalued, and lack of support from employer	9	(7.4%)
Workload	8	(6.6%)
Personal / family issues	4	(3.3%)
University underfunding	4	(3.3%)
Other	6	(4.9%)
Number of respondents	51*	

*Respondents indicated more than one area

**Proportions are calculated from the full respondent group of 105.

Other factors cited included low morale, a sense of futility (i.e. sense that work is having little or no impact on population health and wellbeing), and the sense that the work is reactive, with no ability to take a strategic approach.

8. IMPACT OF HEATH SYSTEM REFORMS

Respondents were asked whether their primary role had been impacted by the health system reforms and restructuring process. Fifty-eight respondents replied 'yes' to this question (55.2%).

The majority of these respondents indicate that they are working in much the same role after the restructure (54.2%), with 23.7% indicating that they are working in new roles, and 10.2% indicating that they are working in a different area of the health system. Some respondents were not sure, at the time of the survey, where they were likely to be working.

Table 21: Role and function changes following restructuring

	Functions haven't changed substantially	**Not yet clear how functions will change**	**Functions different to before**	**Total**	
				n	**(%)**
I am in the same role	17	11	4	32	(55.2%)
I am now working in a different area of the health system	0	4	2	6	(10.3%)
I am working in a new role	1	2	9	14	(24.1%)
Not sure yet	0	5	1	6	(1032%)
Total	**18 (31.0%)**	**22 (37.9%)**	**16 (27.6%)**	**58**	

Of those working in the same role, the majority indicated that their functions have not changed substantially, although some were unsure how their functions will change.

Of those who indicated that their functions are different to what they were before, two respondents indicated that they had lost their local clinical governance role. Two respondents spoke about the

'narrowing of scope' for Public Health Medicine Specialists, with less emphasis on population health broadly and more on health protection.

Respondents impacted by the health system reforms and restructuring process were asked whether their reporting line had changed following the restructuring process. There were 57 responses to this question: 46 respondents (80.7%) indicated that their reporting line had changed, with 10 (17.5%) indicating that their reporting line had stayed the same, and one being unsure.

All respondents were asked whether the health system reform process had led them, or provided them with the opportunity, to look for a different role, or change their retirement intentions. Responses are shown in Table 22 below.

Table 22: Opportunities provided by the system restructure process

	n	(%)**
To look for a different role in public health medicine	37	(35.2%)
To look for a different role outside of public health medicine	5	(4.8%)
To retire sooner than I might have done otherwise	8	(7.6%)
To wait longer than I had planned before retiring	2	(1.9%)
	105*	

* Respondents could indicate more than one option
**Proportion taken from the full respondent sample of 105

Forty-two respondents provided further thoughts on the impact of, or opportunities provided by, the health system reforms and restructuring. Whilst a small number of respondents recognised the benefits of a national organisation, and /or the opportunities that were not available before (mentioned by eight respondents, 19.0%), the majority of respondents raised concerns. These included: dissatisfaction with the restructuring process (31.0%); limited understanding of public health by decision-makers (21.4%); and an undervaluing of the PHMS role (16.7%). The uncertainty and stress resulting from the system reform and restructuring process and low resulting morale were also frequently mentioned (26.2%). Examples of comments received are provided in Appendix B.

9. RETIREMENT INTENTIONS

The impact of the system restructuring on respondent retirement plans was shown in Table 22 above, with 7.6% of respondents intending to retire sooner than they may have otherwise, and 1.9% of respondents indicating that they were now intending to wait longer than planned to retire.

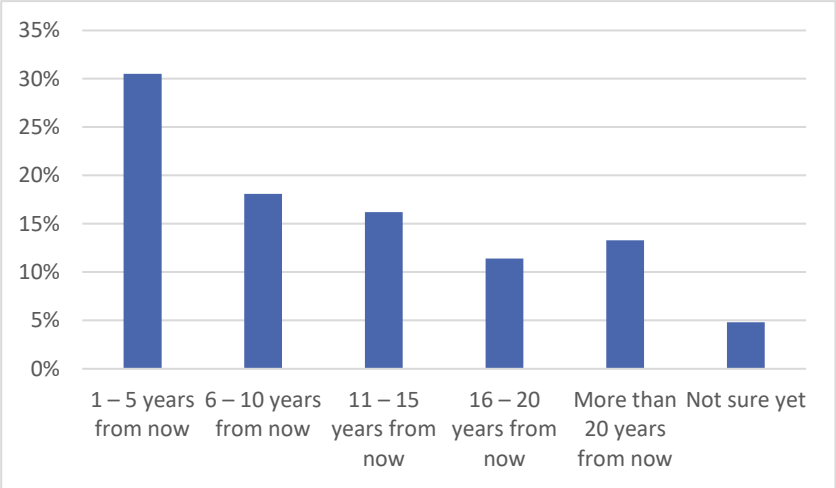
Respondents were also asked whether the experience of working through the COVID-19 pandemic had influenced their retirement plans in any way. As shown in Table 23 below, 12.4% indicated that they were now intending to retire sooner than planned (seven of these respondents, 58%, overlapped with those indicating that the system reforms had had the same effect), with 1% indicating that they intended to wait longer than planned before retiring (there was no overlap with the sample who indicated that the system reforms had led to a delay of retirement plans).

Table 23: Impact of COVID-19 pandemic on retirement plans

	n	(%)
COVID-19 has not affected my plans	83	(79.0%)
I intend to retire sooner than I had planned	13	(12.4%)
I intend to wait longer than I had planned before retiring	1	(1.0%)
(blank)	8	(7.6%)
Total	**105**	

Figure 12 below shows respondent intentions regarding retirement. Of concern is that 51 doctors, 48.6% of those responding to the survey, intend retiring in the next ten years. If this proportion is extrapolated to the full Public Health Medicine Specialist workforce, up to 92 doctors (of 190 with active practising certificates) may retire in the next ten years.

Figure 12: Retirement intentions



The sample size is not large, but of the 25 respondents who indicated that they are university employed, 14 (60.9% of respondents in this category) are intending to retire in the next ten years. Of the Medical Officer of Health respondents, 48.3% intend to retire in the next ten years.

Table 24: Retirement intentions - MOoH and University-employed respondents

	All		MOoH		Universities	
	n	(%)	n	(%)	n	(%)
1 – 5 years from now	32	(30.5%)	10	(34.5%)	8	(34.8%)
6 – 10 years from now	19	(18.1%)	4	(13.8%)	6	(26.1%)
11 – 15 years from now	17	(16.2%)	5	(17.2%)	6	(26.1%)
16 – 20 years from now	12	(11.4%)	3	(10.3%)	0	
More than 20 years from now	14	(13.3%)	2	(6.9%)	2	(8.7%)
Not sure yet	5	(4.8%)	4	(13.8%)	0	
(blank)	6	(5.7%)	1	(3.4%)	1	(4.3%)
Total	**105**	**(100%)**	**29**	**(100%)**	**23**	**(100%)**

Of those respondents who intend to retire in the next ten years, five respondents (9.8%) have already reduced their working hours in anticipation of retirement, and a further 23 respondents (45.1%)

intend to reduce their working hours as they approach retirement. This will exacerbate workforce shortages.

Table 25: Respondents anticipating reducing hours as moving towards retirement

	Have already reduced hours	Intend to reduce hours	Do not intend to reduce hours	Not sure	Total
	n	n	n	n	
1 – 5 years from now	4	14	5	9	32
6 – 10 years from now	1	9	2	7	19
Total	**5 (9.8%)**	**23 (45.1%)**	**7 (13.7%)**	**16 (31.4%)**	**51**

All respondents were asked to indicate what changes to their worksite or role might enable or persuade them to remain in the public health medicine workforce for longer. The theme most commonly raised (17.9% of respondents to this question) related to better workload and work flexibility. Examples of comments under these themes are provided below:

- More functional wider organisation, leading to reduced workload - current workload is high, due to managing change and dysfunction.
- Reduced hours, reduced on call.
- Flexible working hours, ability to take periods of unpaid leave.
- Greater flexibility with remote working.
- Remote working and flexibility of when and how hours are worked.
- More support, more flexibility to work from home, a less chaotic workplace.

Relatedly, 5.4% of respondents to this question indicated that the availability of part-time roles would be an important to keeping them in the role for longer.

Improved worksite management and clinical leadership was cited by 12.5% of respondents. Example responses in this theme included the following:

- Change in culture to have clinical management partnerships. The restructured system of siloed Directors is very hierarchical and needs to be more respectful and inclusive of their Senior Leadership Team and other senior colleagues. Need an increased understanding and effective implementation of clinical governance.
- Better clinical management partnership.
- Increased leadership and strategic capacity
- Greater focus on population health and wellbeing/proactive work.
- A different management approach, and different managers.

Increased valuing of the PHMS role, and greater autonomy in roles was also mentioned by 12.5% of respondents. Example comments are below:

- Acknowledgement of PHMS roles/function/capabilities and worth. Local autonomy and leadership opportunities.
- Feel valued, included in decision making.
- Clear strategic direction and a stronger sense of what the role is in this new system - a sense of being valued (it's not the $) and contributing to teams.
- The restructure in NPHS has devalued our roles considerably.

- Greater autonomy and reduced centralisation.

10. IDEAL SIZE OF THE PHM WORKFORCE

Respondents were asked to indicate whether the number of jobs available for PHMSs at the unit or department at which they worked has changed (regardless of whether filled or not) in the past five years. Thirteen respondents (12.4%) indicated that they were unable to answer as they are in a new role, and eight respondents chose not to answer this question. Responses for the remaining 83 respondents indicate that there has been no change (44.6%) or an increase in the number of PHMSs (37.3%), rather than a decrease (18.1%). Results also show a variety of responses from those in similar work organisation roles, as shown in Table 26 below. However, no university respondent indicated that numbers have increased.

Table 26: Change in PHMS workforce establishment

	There has been no change	The number has decreased	The number has increased	Total
	n	n	n	n
Independent consultancy	3	0	0	3
Manatū Hauora - Ministry of Health - MOoH role	2		2	4
Manatū Hauora - Ministry of Health - other role (non-MOoH)	1	1	2	4
Non-health-related government agency	2			2
Other health-related government agency (not including Manatū Hauora - Ministry of Health)	2	2	1	5
Primary health organisation / general practice / locality	1	0	0	1
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	9	6	13	28
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	2	2	5	9
Te Whatu Ora | Health New Zealand - Other	0	0	1	1
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role	1	0	7	8
University	14	4	0	18
Total	37 (44.6%)	15 (18.1%)	31 (37.3%)	83

Respondents were also asked to indicate whether, in their opinion, the number of PHMSs employed by their unit or department is optimal (taking into account work that can be done by other members of the disciplinary team). Responses are shown in Table 27 below. Respondents in Te Whatu Ora | Health New Zealand NPHS roles are most likely to indicate that they are critically short of PHMS, whilst across all employers, the majority of respondents indicated that the number should ideally be increased (54.1%). However, a number of respondents commented on the fact that it is difficult to talk about ideal numbers in the context of a major system transformation.

Table 27: Optimal PHMS numbers employed

	Critically short	The number should ideally be increased	The number feels about right	The number could be deceased	Total
	n	n	n	n	n
Independent consultancy			2		2
Manatū Hauora - Ministry of Health - MOoH role		2	2		4
Manatū Hauora - Ministry of Health - other role (non-MOoH)		1	2		3
Non-health-related government agency		1	1		2
Other health-related government agency (not including Manatū Hauora - Ministry of Health)		2	3		5
Te Whatu Ora | Health New Zealand - NPHS - MOoH role	5	16	4	1	26
Te Whatu Ora | Health New Zealand - NPHS - other role (non-MOoH)	2	4	3		9
Te Whatu Ora | Health New Zealand - Other		1	1		2
Te Whatu Ora | Health New Zealand - Service Improvement and Innovation role		1	4	1	6
University		11	4		15
Total	7 (9.5%)	40 (54.1%)	26 (35.1%)	2 (2.7%)	74

For those indicating that the number should be increased, the primary factor preventing this was a lack of funding, as well as a lack of organisational support.

Table 28: Factors preventing additional PHMS roles

	n	%**
No organisational support for additional PHMS roles	22	21.0%
No funding available for PHMS roles	30	28.6%
No suitable applicants for advertised roles	11	10.5%
	63*	

*Respondents could choose more than one option
**% calculated from full survey sample of 105

Respondents were asked what additional PHMSs in their unit / department would enable them to do. Themes that emerged from the responses included that ability to be more proactive, to undertake more research, to do more work with the community and local government, to have more sustainable rosters and to maintain a better work / life balance.

Respondents were asked whether 3.7 PHMSs per 100 000 population and 0.76 Medical Officers of Health per 100 000 population was sufficient.[20] Most respondents felt that they could not comment

[20] These numbers were current at the time the survey was drafted.

on the specific numbers, but that they felt too low. This was particularly the case for the Medical Officer of Health roles (63.8% of respondents indicated that numbers should be higher.)

Table 29: Comment on PHMS and MOoH ratios

	Could be lower		About right		Should be higher	
	n	%*	n	%*	n	%*
PHMS ratio	2	1.9%	18	17.1%	56	53.3%
MOoH ratio	3	2.9%	14	13.3%	67	63.8%

*Proportions are from the total number of responses to the survey (105). Numbers don't include blanks.

Comments regarding the need for more Medical Officer of Health positions included:

- I am not really sure but given the frequency of significant public health events (beyond Covid) e.g. lead in Waikouaiti, campylobacter in Hawke's Bay, cyclone Gabrielle on top of the usual things, my impression is that there should be more per 100,000 population, but how many more, I am not sure.
- Ideal would be about 1.5 per 100,000.
- The ratio only works when there is no large, acute outbreak. It was clear in Covid that the numbers were insufficient.
- The role has continued to be downgraded, and it needs questioning whether this 19th century role is still required in the digital age; and if so, what are the specifics
- The role of the MOoH in environmental work and climate change is increasing alongside more frequent reactive communicable disease role. Note - the role of the MOoH can vary significantly across the different services/regions.
- This level sounds low to me, but it depends on the role that MOsH carry out. There has been a trend towards a reduced scope for health protection work overtime, with functions transferred to other arms of government, e.g. workplace safety, food safety, drinking water.
- We need more Māori and Pacific Medical Officers of Health. COVID showed this quite clearly.

One respondent referred to a paper produced on the PHMS workforce in Public Health Services:

> Our strong recommendation is to fully realise the comprehensive suite of skills, training, expertise and experience of public health medicine trained senior medical officers to influence and provide public health clinical leadership giving Aotearoa the best chance of achieving Pae Ora. Given varying complexities of communities, taking into consideration our commitment to Te Tiriti and improving equity, we suggest this should be a minimum of 1.5 PHMS/MOoH per 100,000 population in local Public Health Services in Aotearoa with a minimum of two PHMS for smaller services even if not meeting the population requirement.

APPENDIX A: RESPONDENTS NOT CURRENTLY WORKING IN PUBLIC HEALTH MEDICINE IN NEW ZEALAND

RESPONDENTS NOT CURRENTLY WORKING IN PUBLIC HEALTH MEDICINE

Of the 130 survey responses, 18 (13.8%) indicated that they are not currently working in public health medicine. The majority of these respondents are retired (11 respondents, 61.1% of this group), with the remainder on parental leave, taking a break from practice, unable to find a job, or working in a different medical scope.

Table 30: Respondents not currently working in public health medicine in New Zealand

	Respondents	
	n	%
I have formally retired	11	61.1%
I have left public health medicine and changed career within medicine	1	5.6%
I have left public health medicine and changed career outside of medicine	0	0%
I am on parental leave	2	11.1%
Other reason	3	16.7%
(blank)	1	5.6%
Total	18	100%

Of the eleven retired respondents, six are male, and five female. The majority have a NZ European ethnicity, with no Māori or Pacific respondents amongst the group. At the time of the survey, one of these respondents still held a current practising certificate

The age at which these doctors retired varied widely, with 65 to 69 being the most frequent response.

Table 31: Age of retirement for retired respondents

	Respondents	
	n	%
60 years or younger	0	0%
60 to 64 years old	3	27.3%
65 to 69 years old	5	45.5%
70 to 74 years old	2	18.2%
75 to 79 years old	0	0%
80 years old or older	1	9.1%
Total	11	100%

RESPONDENTS CURRENTLY WORKING OVERSEAS IN PUBLIC HEALTH MEDICINE

A total of four respondents (3.1% of the total survey respondents) are currently working overseas (there were five respondents in this category in 2019). Two of these respondents hold a current New Zealand practising certificate.

Of these respondents, two (50%) obtained their first medical degree in New Zealand, with two (50%) having obtained their first medical degree elsewhere. One of those who obtained their primary

medical qualification in New Zealand also completed their Public Health Medicine Specialist training in New Zealand, as did one of those who had obtained their primary qualification elsewhere. Of the four respondents in this category, two last worked in New Zealand more than a decade ago.

The primary reason given for leaving New Zealand was career advancement and work opportunities (two respondents, 50%); other reasons given were returning to home country and personal circumstances. No respondent indicated that the reason for working out of country is an interest in international public health – this was the primary reason given for working out of country in the 2019 survey (four respondents, 80% of those in this category), with no respondent in that survey indicating that they were returning to a home country.

Respondents were asked whether they are likely to return to New Zealand to work as a PHMS. One respondent indicated that they would like to return in the next 3 – 5 years. None of the other respondents have plans to return at this stage.

APPENDIX B: THOUGHTS ON THE SYSTEM RESTRUCTURING PROCESS

Themes raised in open-ended responses to the invitation to provide thoughts on the system restructuring process are provided below, with example comments. Note that these responses were provided at a particular point of time, in November 2023, when the system was still unsettled following a process of restructuring.

Table 32: Thoughts on system restructuring process

Theme	n	(%)	Example comments
Dissatisfaction with the restructuring process	13	31.0%	It is difficult when the whole system "reforms" at once because it is unclear what roles are going to be and how they will fit. Over time it will become clearer what the opportunities are, for now it is all quite chaotic. The process of the reforms is being managed very poorly, particularly with respect to the amazingly slow pace of change, and the reluctance to involve and listen to existing staff.
Limited understanding of public health by decision-makers	9	21.4%	Some decision makers have little understanding of Public Health Medicine Specialist training, roles, and capabilities. Been restructured to prepare for the reforms and again during the reforms, some of the HR people clearly don't know what public health physicians do, which has been stressful.
Undervaluing of PHMS role	7	16.7%	For people like me who decide to stay put, in part to maintain stability for community and staff, there is an undervalued of maintaining business-as-usual work and being there for surge support for the next national outbreak response. I'm grateful to those who've stepped up but it's challenging for those who stay behind to keep the wheels turning during the transition. I feel like we are losing PHMSs from the front line and I'm not sure where the new recruits are coming from or if our roles are an attractive proposition or valued any more. I thought being an MOoH was a career for life, but now feel unvalued and underutilised and so I am regretfully looking at opportunities elsewhere. Despite the rhetoric, it feels like roles like mine are undervalued and their scope and what we have to contribute to Pae Ora aren't well recognised.
Uncertainty and stress resulting from system reform and restructuring process	6	14.3%	A lot of uncertainty about whether my role will continue to be funded, and uncertainty in our organisation in general.
Low morale	6	14.3%	Significant impact on morale and job satisfaction. Would work in another profession if I could afford to. Feel trapped. Massive negative impact on morale. While the NPHS leadership consistently emphasise the intent of the restructuring is to give effect to Pae Ora, it is not clear how the redesigned structure will result in

			that outcome. Instead, experienced and talented people have been disestablished leading to considerable disenchantment and demoralisation of existing kaimahi.
Undervaluing of leadership role that PHMSs can play	4	9.5%	Really disappointed in the loss of local formalised clinical leadership at a district level. Unsure how the regional approach to leadership will serve the communities and staff at district level at this stage. PHMSs relegated out of leadership teams. Lack of clinical leadership throughout- no designated PHMS roles in at least one directorate.
Loss of institutional knowledge	3	7.1%	The cost of the reforms is significant- in terms of losing experienced people and leaders, wasted time, lack of direction, double handling and a lack of clarity around roles and responsibilities. Enormous personal toll for many colleagues - in and outside public health - especially commissioning colleagues - loss of many talented people and institutional knowledge.
Negative impact on equity	3	7.1%	Uncertainty over future of Te Aka Whai Ora … have heard of some resignations already which is a concern too. Things may get very fraught in my organisation…, particularly with the role of equity and te Tiriti.
Loss of autonomy for local public health services	3	7.1%	Loss of autonomy for local public health services.
Formation of new silos	2	4.8%	Potential for more siloes than ever before, so system dot joining (as a public health competency) is even more important.
Timing of restructuring	2	4.8%	A change of this magnitude was not a very good idea while still responding to a 1 in 100-year global pandemic.
Loss of advocacy role	1	2.4%	The loss of ability to advocate for those who now work for NPHS is a big issue