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Health Workforce

The idea that the public appeal to the Whanganui District Health Board (DHB) over the shortage of obstetricians and gynaecologists has made the slightest jot of difference is ludicrous. In an under-supply and over-demand situation as currently exists and following on from the major overtime payment changes of the late 1980s a major factor influencing medical practitioners choice of work places is the lifestyle and on-call requirements.

In 1984, Wanganui had 3 obstetrician/gynaecologists, no obstetrics and gynaecology (O&G) registrars, and 1 O&G house surgeon. Palmerston North had 4 O&G specialists, 1 full-time registrar, 1 GP who also performed minor gynaecological operations and Caesarean sections, and 3 O&G house surgeons who were doing the then 6-month rotation to complete the requirements for the Diploma of O&G before entering general practice.

At that time all hospital doctors from trainee interns to specialists were on a unified pay scale regulated by the higher salaries commission which also set the pay for judges and MPs. In 1984, house doctors working a 1 in 3 roster were on-call and worked every third weekend from 8 am Friday till 5 pm Monday when the award required them to have a regulated 8 hrs rostered off duty. For rosters of greater than 72 hours per week, house surgeons received their basic pay plus overtime payments of a maximum of 42% for hours on-call and worked during the call period. The consultants worked a 1 in 4, sometimes a 1 in 5, and sometimes a 1 in 3 if covering leave.

With the Nurses Amendment Act 1989, taxpayer funding for private obstetrics dried up and in a low socioeconomic area like Wanganui few young couples could afford the $4000 plus that a private obstetrician needed to charge. For the last 20 odd years there has been no private obstetrics in most of New Zealand. The same act also has virtually killed off GP obstetrics in New Zealand which has further reduced a potential workforce for performing Caesarean sections.

Most Wanganui GPs now only see women (who are pregnant) requesting terminations. Because of vocal resistance to these being performed locally around 150 Wanganui women a year travel 400 km to a tertiary centre for these to be carried out. The Whanganui DHB funds the operations and 60,000 km travel out of its O&G budget.

The changes to the Employment Acts of the late 1980s and early 1990s saw the hospital doctors' terms and conditions of employment turned upside down with the formation of the Resident Doctors' Association (RDA) and the Association of Salaried Medical Specialists (ASMS). The RDA reasoned that working an extra 32 to 80 hrs for 42% of base salary was nuts and negotiated the overtime pay rate up to 200% of base salary for a 1 in 3 roster.

The net outcome of that was that hospitals needed to employ twice as many junior doctors as before the changes to do the same workload. To meet roster requirements

and avoid paying 300% to 1 junior doctor for an 80-hour week it was cheaper to employ 2 doctors and pay 200% of the base rate. The problem with that was that the supply of junior doctors had not doubled overnight to match the fiscal and physical demand. Consequently many junior doctors moonlighted for other Crown Health Enterprises on their days off commanding high locum rates, but they couldn't be required to work the same hours for their main hospital employer.

Jump forward 20 years to 2012 and those junior doctors of the 1980s are now older specialists and for a rapidly decreasing proportion of the group, business owning General Practitioners. The specialists have had 20 years of not doing call without junior medical staff screening the brunt of the work load overnight and on weekends. Rosters of less than 1 in 4 or preferably 5 are no longer considered normal or acceptable working conditions for the majority of doctors. There is a requirement for registrar cover, specialist doctors in training to work between the undifferentiated house officers and the consultants, which lessens the burden of call.

According to the Medical Council, Palmerston North has 8 resident O&G specialists, there are 4 or 5 registrars and a number of house surgeons. Following on from the RDA roster negotiations of the 1990s the Diploma of Obstetrics went from a 6-month residency to a 9-month residency in order to provide enough clinical experience.

The 1986 Census had the combined population of Manawatu/Wanganui at 220,000. In 2012 the estimated population of the region has increased to 232,000, not enough to provide sufficient work for a large Wanganui-based work force in order to provide reasonable after hours rosters and work loads. The private surgical pool is miniscule in comparison to larger centres like Auckland, and unlike orthopaedics, ACC is not a big payer in the private O&G market. Statistics New Zealand expects the regional population to decrease in the future. The Primary Health Organisation 3-monthly registers on the Ministry of Health website are showing the local population is decreasing by several hundred a year.

Over the years, Wanganui has employed solo vascular surgeons, psychogeriatricians, pathologists, ENT surgeons, eye surgeons and radiologists but the small population base and changing work expectations and conditions means some of these positions will have gone forever and others are provided at the beneficence and goodwill of the incumbent individuals albeit at a premium in some cases. Supervision means employing 2 people to do the work of 1 until the Medical Council, the supervisor and the employers are happy that the standard of work and level of expertise are commensurate with the position filled.

Health Workforce New Zealand doesn't seem to have managed to rationalise the training and work force with the places and positions of need and it is largely the clinicians who hold all the trump cards in dictating their terms and conditions of employment. It is not possible to bond medical students to progress to certain specialties or general practice to fill a perceived need and the time lag from student to fully qualified GP or specialist is at least 10 to 12 years.

Shorter periods of student allowances and higher student costs will inevitably push up the required levels of remuneration and that will further strain the relationship between cash-strapped medical employers and the increasingly casualised and short-term locum work force seeking to pay off student loans at the same time as having the

ideal work/life balance. This balance is pushed by many of the increased number of locum agencies, each of which takes their fee for making the locum's life easier.

Distorted financial returns and risks have (in the past) led to shortages of hospital midwives, house surgeons, ultra-sonographers, physiotherapists, paediatricians, other specialists, and GPs to name but a few.

What is bizarre is that often it is the taxpayer representatives, in the guise of ACC or the Ministers of Health with unrealistic goals, that are creating the pay discrepancies. It is as if the left hand and right hand are not connected and communicating with their one integrated brain.

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