A moment of your time…

Analysis of the CMDHB Community, NGO and Primary Workforce survey responses

Report to the CMDHB

December 2005

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

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authoritative analysis

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Preface

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NZIER was established in 1958.

Authorship

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Foreword

Primary health care is a key priority for Counties Manukau District Health Board (CMDHB). CMDHB has acknowledged that its own success is dependent on the health improvement services delivered through the primary sector and public health. For this reason CMDHB is heavily investing in primary health care and wishes to build on the constructive engagement to date which has resulted in a partnership approach between CMDHB and its primary health care providers.

Capacity of the primary care workforce is one of the key barriers to realisation of our vision of a good primary health care system. A Primary Care Workforce Development Action Plan was developed in November 2004 and one of the first priorities was to conduct a community workforce census to gain a better understanding of our workforce. The specific aims of the Community, NGO (Non-Government Organisation) and Primary Care Workforce Census were to:

1. Inform short, medium and long term workforce planning initiatives in the community, NGO and primary health care sectors and contribute to ensuring that our future workforce needs will be met;

2. Provide a census of the size, demographic characteristics, qualifications, experience and location of employment of the health workforce serving Counties Manukau residents for strategic planning; and

3. Identify key workforce development risks to implementing CMDHB's District Strategic Plan and service/health gain priorities.

The census has been successful in achieving these goals and continuing quarterly reporting of Full Time Equivalent (FTE) workforce numbers in primary care will assist in monitoring how successful we are with the workforce development initiatives that will follow.

I wish to acknowledge the work of 4PM Group in developing this census and collecting the data, the support from our many community, NGO and primary health care partners in providing data on their organisations and the work by the New Zealand Institute of Economic Research (NZIER) with analysing the data and producing this report.

Dr Allan Moffitt
Director Primary Care Development
Counties Manukau District Health Board

Executive Summary

Background

The Community, Non-Government Organisations (NGO) and the Primary Care Health Sector (the "community workforce", for short) is a large employer in Counties Manukau. Accordingly, there is a need to ensure that the characteristics and structure of the Community workforce are well understood, and that its development needs are identified and factored into CMDHB workforce planning. The health service needs of the local population will grow and change over time, and the Community workforce will need to be prepared to respond to these changes.

To assist workforce development, a district-wide data gathering exercise was instigated by CMDHB. This took the form of a census of the Community workforce.

The census had a number of explicit objectives. These were to:

- Inform short, medium and long term workforce planning initiatives in the community, NGO and primary health care sectors and contribute to ensuring that future workforce needs will be met;
- Provide a census of the size, demographic characteristics, qualifications, experience and location of employment of the health workforce serving the Counties Manukau residents for strategic planning; and
- Identify key workforce development risks to implementing CMDHB's District Strategic Plan and service/health gain priorities.

The census consisted of 2 separate surveys; a survey of organisations, and a survey of individual respondents. The census covered both clinical and management staff.

The questionnaire in the survey of organisations sought information about the organisation's status (in terms of relationships with PHOs), its work (e.g. what sectors it serves, specialty population group or community served), its staff (e.g. staff composition, vacancies), and it included questions about workforce development.

The questionnaire for the survey of individuals was broader in scope. It sought information about the respondent's job (e.g. occupational grouping, hours worked, employment contract), the respondent's education, training and skills, and demographic details such as ethnicity, age and gender.

The survey of organisations achieved 276 responses from an estimated 335 eligible organisations – a response rate of 82%. The organisations surveyed included amongst others: GP and dental practices; pharmacies; residential care providers; and other service providers, such as Plunket and Family

Planning. It excluded private providers, alternative health services and some voluntary organisations.

The questionnaire used in the survey of individuals was sent to 4,902 people and attracted 2,637 responses – a response rate of 54%. The responses covered a wide range of occupations, including doctors, nurses, social workers, care assistants and administrators.

This report presents the results of an analysis of both sets of responses. It also looks to put the results into the context by comparing the results with the results of the CMDHB's hospital workforce census and with pattern of employment in the wider Counties Manukau economy.

Key findings from the survey of providers

- The majority of organisations do not specialise in just one population group or community group.
- The majority of nursing staff employed by the organisations work in the primary health care or residential care sectors. Other clinical staff tend to be employed in the pharmacy, residential care and primary health care sectors. Social services employees work primarily in disability support and mental health (including drug, alcohol and addiction services). Other allied health workers also tend to work in the mental health sector.
- Around four fifths of organisations (83%) employ 10 or fewer permanent FTE staff.
- Only 56 of the organisations (15%) had job vacancies at the time of the census. The total number of vacancies was 125. For nursing and other clinical staff and those in the allied health group, any vacancies tended to have been open for only a relatively short period (< 3 months). The vacancies for the other clinical group had varying lengths.
- The pharmacy sector had the largest number of organisations with paid and permanent employees leaving in the last 12 months.
- There were a large number of volunteers operating – forming around 22% of all staff in non-PHO organisations.
- Around 70% of the organisations' surveyed indicated that they had no workforce development plan (or similar) in place.

Key findings from the survey of individuals

- The age distribution of workers for most occupational groups was fairly smooth and not clumped. The other clinical group had the most erratic distribution, with significant numbers in the 20-24 and 40-44 age groups.
- The majority of respondents were employed on a full-time basis (54%) with another 40% employed part-time. Casual/temporary staff and contracted/self-employed staff only accounted for 6% of respondents.
- Around 40% of those who provided information around qualifications, had a highest qualification of high school or lower (i.e. high school or no

formal qualification). A similar proportion had university level qualifications or higher.

- Out of all the occupational groups, the social services group is the most ethnically diverse, with New Zealand Europeans contributing only 34% of the total workers in this group. For other groups, particularly Nursing, the proportion of New Zealand Europeans is as high as 53%.
- A relatively large proportion of casual and temporary staff are not sure what contract they are signed up to. Nearly 40% of all contracted/self-employed staff state they have no formal employment contract.
- 64% of respondents noted that they are not currently undertaking any study or professional development in relation to their health career.
- A relatively small proportion of respondents noted that they experienced barriers to training. Where barriers exist they are mainly related to financial or time constraints. This picture is fairly consistent across ethnic groups. For staff who indicated that their access to timely and appropriate training was unsatisfactory, similar factors were identified.
- Approaching half of the respondents indicated that they need some form of up-skilling. For nursing staff, clinical training was by far the most common area cited for improvement, with academic training also prominent.

The census results in a wider context

- Around 83% of employees in both the community workforce and the CMDHB hospital workforce is female.
- Overall, the ethnic composition of the community workforce is not too different from that of the hospital workforce.
- However, compared to the hospital workforce, the community workforce comprises relatively large proportions of very young workers (less than 25 years old) and older workers (aged 50+). Conversely, the community workforce has relatively few 25-40 year olds.
- Compared to the hospital workforce, the employees in the community workforce are roughly twice as likely to have no qualifications or only school leaving qualifications. Conversely they are significantly less likely to have tertiary qualifications.
- The ethnic composition of the community workforce in the CMDHB area is broadly similar to the ethnic composition of the workforce in the local economy as a whole.
- However, the 84% of the community workforce is female, compared to around 46% in the wider local economy.
- The community workforce employs around 3.6% of all those aged over 15 in the Counties Manukau area classified as being employed.[1]

[1] This census identified 4,951 community workforce respondents. The CMDHB hospital census identified 5,236 respondents. The wider Counties Manukau area has just over 137,000 aged over 15 classified as employed.

These points, and others resulting from the following analysis will be valuable in allowing the CMDHB to identify potential sources of risk in planning the future workforce, and to identify key risks for the CMDHB strategic plan.

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1. Introduction

1.1 Background to the census

In late 2004 the Counties Manukau District Health Board (CMDHB) undertook proceedings to develop and run a workforce census of the Community, NGO and Primary Care Health Sector in the Counties Manukau region. The census went to:

- All organisation and independent providers that are funded and/or contracted by CMDHB (i.e. Māori, Personal Health, GP's, Pharmacies, Dental, Mental Health and Health of Older People providers)
- Other independent providers i.e. Lead Maternity Carer midwives
- Selected Health and Disability NGO providers who provide primary health care services to CMDHB residents and have workforce located within the CMDHB boundaries; and
- Other selected organisations funded by the Ministry of Health/Government who provide primary health care services to CMDHB resident and have workforce located within the CMDHB boundaries.

The CMDHB acted as the project sponsor for the survey, with a number of individuals from within the CMDHB and the primary health care community forming the wider governance group. 4PM Group provided much of the resource in terms of the implementation of the census, with the census results being delivered in early August 2005. In this report we use the shorthand title of the "community workforce" when referring to the workforce in the Community, NGO and Primary Care Health Sector.

1.2 Objectives of the workforce census

As a district-wide data gathering tool, the census had a number of explicit objectives. These were to:

- Inform short, medium and long term workforce planning initiatives in the community, NGO and primary health case sectors and contribute to ensuring that our future workforce needs will be met;
- Provide a census of the size, demographic characteristics, qualifications, experience and location of employment of the health workforce serving the Counties Manukau residents for strategic planning; and
- Identify key workforce development risks to implementing CMDHB's District Strategic Plan and service/health gain priorities.

1.3 Census approach

The census consisted of 2 separate surveys; a survey for organisations, and a survey for individual respondents. The census covered both clinical and management staff.

The organisational survey questionnaire was to be filled out by the manager of the organisation/provider and sought information around the organisation's work (e.g. what sectors it serves, specialty population group or community served), its staff (e.g. staff composition, vacancies) and questions around workforce development.

The individual survey was broader in scope and covered details and conditions around the respondent's job (e.g. occupational grouping, hours worked, employment contract), information around the respondents education, training and skills, and demographic details such as ethnicity, age and gender.

The survey of organisations achieved 276 responses from an estimated 335 eligible organisations – a response rate of 82%. The organisations surveyed included amongst others: GP and dental practices; pharmacies; residential care providers; and other service providers, such as Plunket and Family Planning. It excluded private providers, alternative health services and some voluntary organisations.

The questionnaire used in the survey of individuals was sent to 4,902 people and attracted 2,637 responses – a response rate of 54%. The responses covered a wide range of occupations, including doctors, nurses, social workers, care assistants and administrators.

1.4 Objectives of this report

This report looks to analyse and interpret the census results by providing single and multi-variable breakdowns of survey responses. Analysis of single characteristics of the census populations provides us with a high level over-view of the workforce, with the multi-variable analysis allowing a more refined breakdown of subgroups of the population. It is at this point that some comparisons are made with the results of the CMDHB hospital workforce census undertaken in 2003.

The report also puts employment by the organisations covered by the census into a regional context, by comparing key characteristics against the wider Counties Manukau workforce. We also look at the employment contributions of the surveyed organisations in relation to other sectors in the Counties Manukau economy.

Where the data permit, inferences are then made with respect to potential risks or issues in workforce planning or development that arise from this initial examination of the survey data.

1.5 Note about non-disclosure

The voluntary nature of the surveys meant that not all respondents submitted comprehensive and complete responses to all questions.

As with many workforce surveys, the number of non-respondents tends to be high when asking questions around age, ethnicity and qualifications. For this reason, some of the analysis presented in this report (i.e. when describing the survey population "of those who responded") cannot be guaranteed to replicate reality, in that the distribution of people who did disclose their ethnicity (for example) will not necessarily reflect the distribution of people who did not disclose their ethnicity. This should be taken into account when considering the information presented here. Where possible, we attempt to 'shed light' on other characteristics of people who did not disclose some information.

4PM group who carried out the survey, notes[1] that a response rate of 82% was achieved for the Organisational Survey, with a response rate of 54% for the Individual Survey. The table below details further the level of response by health sub-sector, as identified by 4PM Group.

[1] 4PM Group, September 2005, *"Workforce census of the Community, NGO and Primary Care Health Sector Final Report"*,p.9

Table 1 Response rates by health sub-sector

	Organisational survey	Individual survey
Dentistry	93%	74%
General Practitioners	75%	61%
PHO's	75%	36%
Health of Older People	82%	46%
Maori	80%	50%
Mental Health	85%	47%
Regional Providers	88%	30%
Personal Health	81%	64%
Pharmacy	85%	68%
Total	82%	54%

Source: 4PM Group

2. The Organisation workforce survey

This section presents simple single factor, and multi-variable cross tabulations of the Organisational survey responses. As noted above, not all the respondents answered all of the questions. Unless explicitly stated otherwise, all of the data shown in tabular or graphical form include only those answering the particular question i.e. the proportion of non-responses is not shown.

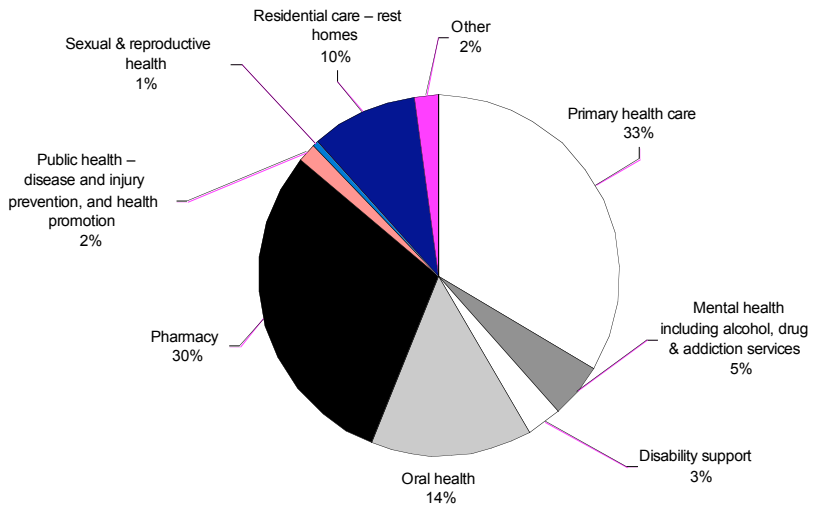
2.1 Single factor analysis

2.1.1 Type of work

This question focussed on the health sector area that the respondent's organisation worked ***mainly*** in. Respondents were only permitted to select one main health sector of work, which should reflect the area in which the greatest number of hours was spent.

Figure 1 below presents the responses of the surveyed organisations. Just under half of all the organisations surveyed provided a response to this question, which includes those who listed a main area of work outside of the defined ones i.e. 'other'.

Figure 1 Organisations' main type of work



Source: NGO & Community Workforce survey, NZIER

Question: In what health sector does your organisation **mainly** work in? 187 respondents.

Of those organisations that did respond, just over one-third work mainly in the primary health care area. Another 30% work primarily in pharmacy. Oral health care and residential care (rest home care) form the next biggest

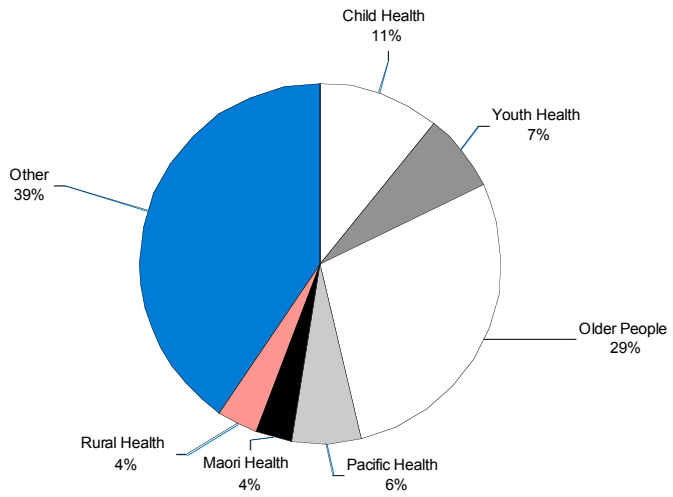
groups of respondents, contributing 14% and 10% of total respondents to this question respectively.

2.1.2 Groups served

This question looked to identify what population group or specific community group the organisations surveyed specialised in. For this question, respondents were able to select multiple areas if applicable.

The chart below indicates the primary population group or community selected by the respondents.

Figure 2 Population group or community speciality
Primary population group or community speciality



Source: NGO & Community Workforce survey, NZIER

Question: What population groups or communities does your organisation specialise in? 84 respondents.

The chart indicates that just under 30% of those who responded to this question specialise in care for older people. A significant proportion of respondents also specialised in care for children.

While this figure identifies the primary group or community specialised in by respondents, as we noted earlier respondents could select more than one community group specialisation. Just over half (55%) of respondents to this question selected more than one area of specialisation, and they tended to indicate that they cared for a large number of sub-groups of the population i.e. the majority of respondents to this question indicate they care for a wide variety of patients. Those who responded with 'Other' tended to note that they served a large number of the sub-groups listed.

The table below summarises this single factor analysis for the organisational survey.

Table 2 Summary of single factor analysis – organisational survey

Shares of total respondents

Organisations main type of work	
Primary health care	34%
Pharmacy	30%
Oral health	14%
Residential care – rest homes	10%
Mental health including alcohol, drug & addiction services	5%
Disability support	3%
Other	2%
Public health – disease and injury prevention, and health promotion	2%
Sexual & reproductive health	1%

Community group/population served	
Other (including multiple groups)	40%
Older People	29%
Child Health	11%
Youth Health	7%
Pacific Health	6%
Maori Health	4%
Rural Health	4%

Source: NGO & Community Workforce survey, NZIER

2.2 Cross tabulations

This section of the report examines cross tabulations of key variables derived from responses to the Organisational census survey. Again it should be borne in mind that all of the tables and graphs which follow are based only on those answering the particular question.

2.2.1 Occupational groupings for different health sectors

A question in the survey asks managers to identify the number of **paid** staff in each occupational group[2] – where the occupational groups stated are: Nursing, Other clinical, Admin/management, Social Services and Other allied health. Various sub-groups were also provided within the main occupational groups. 3,235 paid staff were identified by the respondents in total.

By cross tabulating this information with the responses about the particular health sector the organisations work in, we can gain a better idea about the spread of occupational groups across various areas of health care. The table below presents this information.

[2] Including contracted and casual staff. Each staff member is only counted once.

Table 3 Occupational groupings for paid staff by health sector grouping

Number of staff (including contract and casual staff)

	Occupational group				
Health Sector	Nursing	Other clinical	Admin/ management	Social Services	Other allied health
Primary health care	329	163	221	36	22
Mental health including alcohol, drug & addiction services	8	3	95	217	159
Disability support	5	0	20	233	2
Oral health	2	122	32	0	0
Pharmacy	1	331	17	0	4
Public health – disease and injury prevention, and health promotion	9	0	8	14	6
Sexual & reproductive health	0	0	10	7	7
Diabetes	0	0	0	0	0
Residential care – rest homes	263	169	84	7	34
Other	17	75	21	146	14
Did not respond (to health sector question)	56	86	68	55	57
Total	690	949	576	715	305

Source: NGO & Community Workforce survey, NZIER

Questions: List the number of paid staff in each of the occupational groups & In what health sector does your organisation **mainly** work in?

According to the responses, the largest proportion of paid staff are employed in primary health care, with nursing and admin/management being the largest occupational groups for staff in this sector.

A large proportion of all paid staff (17%) work in residential care, with nearly half of the staff being nurses (as we would expect). Over three quarters of all residential care paid staff are either nurses or other clinical staff.

There are also a significant number of paid staff involved in the mental health area (including alcohol, drug and addiction services) – around 15% of all paid staff identified in the Organisational survey. Again, given the nature of the sector it is not surprising that nearly half of the staff in this area work in social services, with three quarters of staff being in social services or other allied health care.

The majority of the staff whose organisation identified their health sector as 'other' work in social services. Of those who did not provide a response at all to the health sector question, but who identified staff occupational groups, there is a fairly even spread of staff across the occupational groups.

Across all the health care sectors, the largest occupational group is for other clinical (i.e. non-nursing) staff (29%), with staff in social services contributing 22%. Nurses form nearly the same proportion (21%) of all paid staff identified, with those in admin/management and other allied health contributing the remaining 18% and 9% respectively.

2.2.2 Breakdown of paid FTE permanent staff

A number of questions in the Organisational survey elicit responses on the number of paid permanent staff (i.e. excluding casual staff and contractors), in particular the number of full time equivalent (FTE) staff. The total number of FTE identified was 1,731.

The tables below identify the number of organisations with various sized paid permanent FTE staff against a number of other variables.

Table 4 identifies the FTE permanent paid staff data and the identified health care sectors to see the spread of FTE size across health care sectors.

Most organisations have less than 10 FTEs. There were 7 organisations identified in the primary health care sector with more than 10 FTEs, with one employing between 50 and 100 FTEs. The organisations in the mental health sector had a wider spread of FTE sizes, with two organisations having more than 100 permanent FTEs. The organisations involved in residential care also have a wide spread of FTE size, with a relatively large proportion of organisations possessing between 20 and 100 permanent FTEs. Organisations who identified themselves as being involved in pharmacy tended to have less than 10 permanent FTEs.

Table 4 FTE size by health care sector

Number of organisations

	FTE size				
Health care sector	1 - 10	11 - 20	20 - 50	50 - 100	100+
Primary health care	41	5	1	1	0
Mental health including alcohol, drug & addiction services	4	0	2	1	2
Disability support	3	0	1	1	0
Oral health	23	2	0	0	0
Pharmacy	50	1	2	0	0
Public health – disease and injury prevention, and health promotion	2	0	0	0	0
Sexual & reproductive health	1	0	0	0	0
Diabetes	0	0	0	0	0
Residential care – rest homes	9	1	4	1	0
Other	1	0	2	1	0
Did not note health sector	8	0	0	3	0
Total	142	9	12	8	2

Source: NGO & Community Workforce survey, NZIER

Questions: What is the total number of paid FTE staff & In what health sector does your organisation **mainly** work in?

Table 4 identifies the size (in terms of permanent FTEs) of organisations by the population or community group they specialise in. As noted before, given that respondents could identify multiple groups, here we use the primary group they identified[3]. It should also be noted that responses to the population/community group served were quite low, so caution should be applied when interpreting this table. There seems to be a reasonable mix of FTE sizes across most of the population/community groups being serviced. Again, the limited number of responses makes interpretation difficult.

[3] i.e. the Health Sector they noted as their main area of work.

Table 5 FTE size by primary population/community group served

Number of organisations

	FTE size				
Primary population/community group	1 - 10	11 - 20	20 - 50	50 - 100	100+
Child Health	5	1	2	1	0
Youth Health	3	0	2	0	0
Older People	11	1	4	2	0
Pacific Health	3	1	1	0	0
Maori Health	3	0	0	0	0
Rural Health	3	0	0	0	0
Other	27	2	0	0	0

Source: NGO & Community Workforce survey, NZIER

Questions: What is the total number of paid FTE staff? & What population groups or communities does your organisation specialise in?

2.2.3 Breakdown by contract type

Questions were also asked of managers about the type of contract that staff were employed under i.e. were they full-time, part-time, casual or temporary, contracted or self-employed or voluntary. The following information examines the number of staff in each of these categories across a number of other key variables.

It should be noted that the numbers represent a 'head count' of staff rather than FTE numbers. The head count also includes both paid and non-paid staff (e.g. volunteers and contractors).

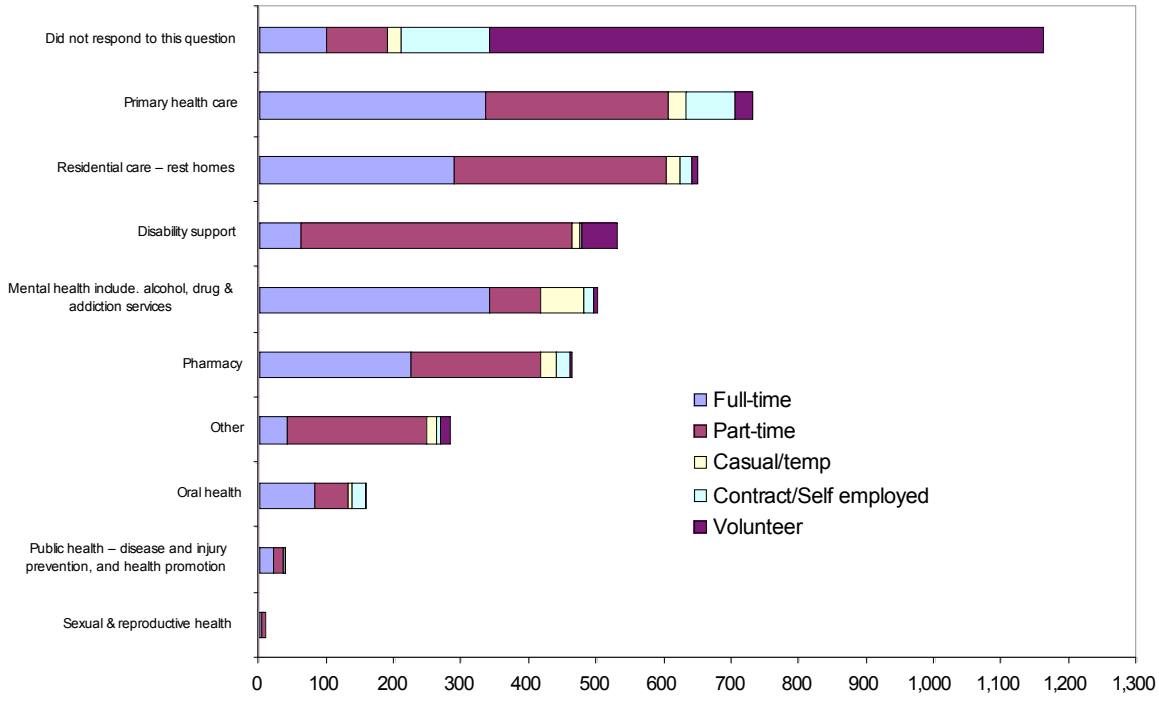
Around 4,500 “staff” members were identified in the 'head count' with over 90% being employed by organisations who were not PHOs.

For PHOs, most staff were either full or part-time, with relatively small proportions of other contract types. For non-PHOs, part-time staff slightly outnumbered full-time staff, although these groups still dominated total staff numbers. There were however a large number of volunteers operating – forming around 22% of all staff in non-PHO organisations. Casual/temporary staff and contractors/self employed workers are not heavily employed by either PHOs or non-PHOs.

The following chart presents the different mix of contract types of employees by the sector of health care they work in. This allows us to

identify particular sectors where certain contract types are more/less prevalent.

Figure 3 Contract type by health care sector



Source: NGO & Community Workforce survey, NZIER

Questions: Write the number of staff next to the categories shown (full time, part time, casual or temporary, contracted or self employed, volunteers) & In what health sector does your organisation **mainly** work in?

The two largest health care groups (in terms of those who responded to these questions); primary health care and residential care, tend to be dominated by full and part-time staff. The prevalence of other contract types is fairly minor for these sectors. Although not as large in terms of absolute numbers employed, the pharmacy sector has a similar distribution of contract types to these two large sectors.

For those employed in disability support the contrast is much more stark, with a significant proportion of staff employed on a part-time basis. Volunteers also make a noticeable contribution to total staff numbers in this sector.

In the mental health sector the picture is different again, with a significant proportion of staff numbers being employed on a full-time basis. The remainder of the workforce in this sector is dominated by part-time and casual/temporary workers.

A large number of organisations did not respond to the question around the health sector they operate in, but using the cross-tabulation we can see that a large proportion of workers in these organisations work on a voluntary basis

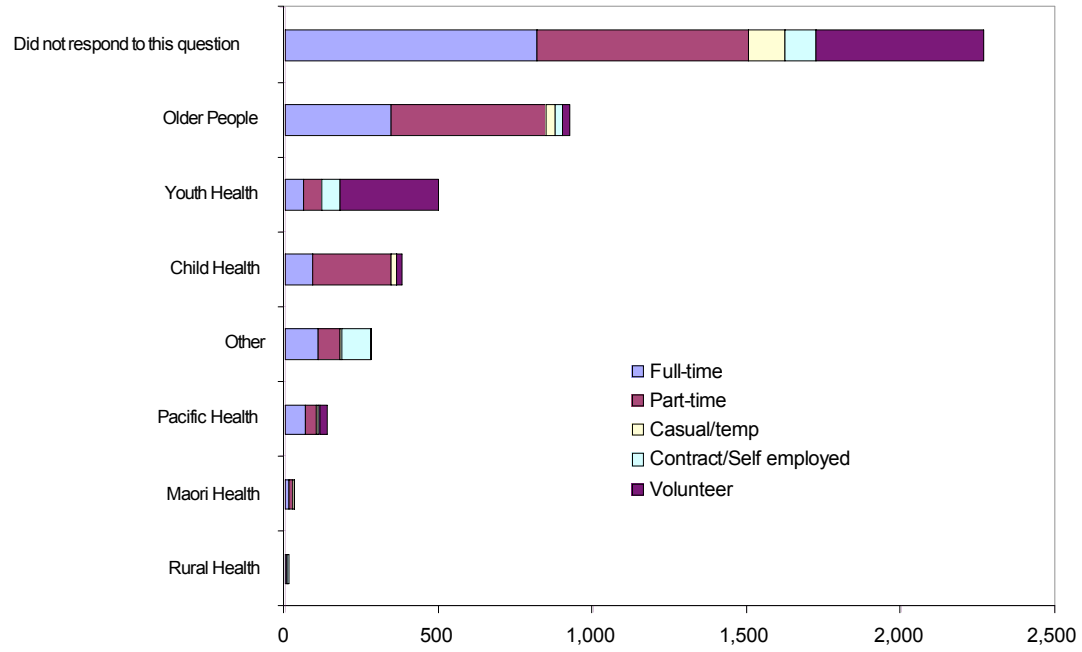
– just over 70%. There are only a small number of workers employed in these organisations on a full or part-time basis.

We can also examine the contract type breakdown in terms of the population or community group that each of the respondent organisations specialises in. As noted before, given that respondents could identify multiple groups of specialisation, here we use the primary group they identified.

The figure below shows that the population/community group with the largest number of employees attributed to it is for older people. This group is dominated by workers of full and part-time status, particularly part-time. The next largest groups; youth health and child health are dominated by volunteers and part-time workers respectively.

As we mentioned earlier, there were a significant number of organisations who did not respond to the question around the population/community group specialisation, and as such the information contained in the chart should be interpreted with caution. Most of the staff for whom their was no population/community group assigned are full and part-time, although there is also a significant number of volunteers.

Figure 4 Contract type by population/community group speciality



Source: NGO & Community Workforce survey, NZIER

Questions: Write the number of staff next to the categories shown (full time, part time, casual or temporary, contracted or self employed, volunteers) & What population groups or communities does your organisation specialise in?

2.3 Vacancies

A number of questions in the organisational survey enquired as to the presence, and extent, or any vacancies within the respondent's organisation.

Of the organisations who submitted a census response, only 15% noted that they had job vacancies at the time of filling out the census. The total number of vacancies identified at the time of filling in the responses was 125.

In terms of vacancies and PHO status, of the PHOs identified in the census, the proportion with a vacancy at the date of filling in the survey was around 12%. For non-PHOs the rate was slightly higher at 15%. The total number of vacancies open was 7 and 118 for PHOs and non-PHOs respectively.

2.3.1 Length of vacancy by occupational group

The survey elicited responses around how many vacancies there were in terms of the length of the vacancy. The questions required the respondent to assign these vacancies to the prescribed occupational groups. This enables us to get an idea of not only where vacancies exist (in terms of occupational groups) but also the duration being experienced across groups. This is shown in Table 6 below.

The nursing and other clinical occupational groups contain the most vacancies in absolute terms, contributing around 50% of the total vacancies. For the nursing group, the majority of the vacancies are relatively short term (less than 3 months). The 32 vacancies represent around 5% of the total paid staff numbers in this occupational group identified earlier.

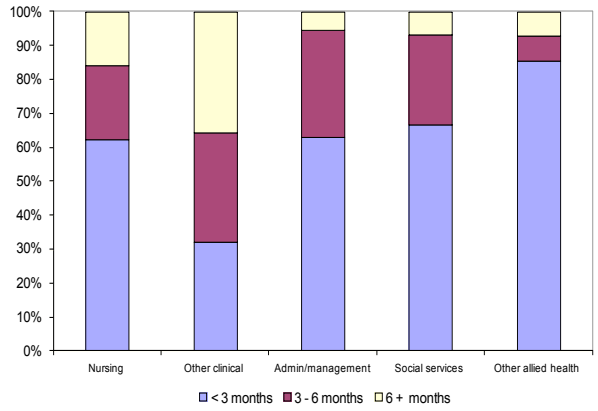
For the other clinical group there is a fairly even spread of vacancy length. The 31 vacancies represent around 3% of the total paid staff in this occupational group.

The other allied health occupational group is also a relatively large contributor to the total number of vacancies. Nearly all of its 28 vacancies are relatively short term (less than 3 months). This number represents around 9% of the total current paid staff in this occupational group which is noticeably high.

Vacancies in the social services and admin/management groups are generally short term and are relatively small in absolute terms.

Table 6 Number and length of vacancies by occupational group

	Number of vacancies by length		
Occupational group	< 3 months	3 - 6 months	6 + months
Nursing	20	7	5
Other clinical	10	10	11
Admin/management	12	6	1
Social services	10	4	1
Other allied health	24	2	2
Total	76	29	20



Source: NGO & Community Workforce survey, NZIER

Questions: Write how many vacancies you have today depending on the type of vacancy and length of time it has been vacant (gives broad occupational groupings and lengths shown above)

2.3.2 Recent attrition

The Organisational survey asks the respondent about the number of paid permanent staff who have left in the last 12 months. In total, 556 paid permanent staff were noted as having left the surveyed organisations in the last 12 months. By cross-tabulating these numbers with other key variables, we are able to see what sector they worked in and the primary population/community group they specialised in.

The following table looks at the pattern of exits of paid permanent staff in the last 12 months against the various health sectors in terms of the number

of exits as a share of the total number of paid staff. Each individual organisation's share is calculated, then the shares are averaged by health sector across each organisation.

On average, the Pharmacy health sector has the highest average number of exits as a share of paid permanent staff at 31%. So in total for the Pharmacy sector, the number of people who have exited in the last 12 months is nearly one-third of the size of the current number of paid staff in that sector. The rate is also relatively high for the residential care and oral health sectors. The largest group, in terms of absolute number of organisations in that sector – the primary health sector, has the equal lowest proportion at 8%.

Table 7 Exits of paid permanent staff by health sector

Number of exits in last 12 months / total paid permanent staff (averaged by health sector)

Health Sector	Average share of total staff who have left
Primary health care	8%
Mental health including alcohol, drug & addiction services	16%
Disability support	19%
Oral health	23%
Pharmacy	31%
Public health – disease and injury prevention, and health promotion	10%
Sexual & reproductive health	8%
Residential care – rest homes	26%
Other	8%

Source: NGO & Community Workforce survey, NZIER

Question: What is the total number of paid permanent staff who have left in the last 12 months?

2.4 Workforce planning

A question in the survey asks whether the organisation has a workforce development plan (or similar).

In terms of the PHO status of the respondents, the split between those with and without workforce development plans is even for PHOs. However, for non-PHOs nearly three quarters of the organisations do not have a workforce development plan or similar.

Of the respondent organisations that noted which health sector they operate in, the primary health care and oral health care sectors have the lowest proportion of organisations with a workforce development plan. In terms of the remaining health sectors, on average 85% of the organisations have a workforce development plan or similar. For those that did not provide an indication of the health sector they work in, the large majority do not have workforce development plans in place.

2.5 New roles

A survey question asked whether the organisation was developing, or planned to develop new roles or jobs and any subsequent details on these roles/jobs. The following table summarises the responses to this question in terms of the health sector the organisation operates in. Only 29 individual organisations noted that a role was being developed, or being planned to be developed. Most of the roles being developed (that were identified by respondents) sit within the Disability Support sector.

Table 8 New roles being developed or planned

Health Sector	Roles	Positions required
Primary health care	9	8
Mental health including alcohol, drug & addiction services	5	5
Disability support	14	10
Oral health	6	6
Pharmacy	7	6
Residential care – rest homes	1	1
Did not note health sector	6	6
Total	48	42

Notes: (1) An organisation could note more than 1 role

(2) The number of positions required will not necessarily match the number of roles required. One role may require a number of positions (e.g. GP is a role, but an organisation may require more than one GP. Also, some organisations noted the role will likely be filled via existing staff (i.e. no additional positions required). Where they did not note this, or the number of positions required, it was assumed to be one.

Source: NGO & Community Workforce survey, NZIER

Question: If you are developing, or planning to develop new roles or jobs, please describe.

2.6 Organisational survey summary

The following strike us as being the key points arising from the survey of organisations:

- The majority of organisations do not specialise in just one population group or community group.
- The majority of nursing staff employed by the organisations work in the primary health care or residential care sectors. Other clinical staff tend to be employed in the pharmacy, residential care and primary health care sectors. Social services employees work primarily in disability support and mental health (including drug, alcohol and addiction services). Other allied health workers also tend to work in the mental health sector.
- Around four fifths of organisations (83%) employ 10 or fewer permanent FTE staff.
- There were however a large number of volunteers operating – forming around 22% of all staff in non-PHO organisations.
- Only 56 of the organisations (21%) had job vacancies at the time of the census. The total number of vacancies was 125. For nursing and other clinical staff and those in the allied health group, any vacancies tended to have been open for only a relatively short period (< 3 months). The vacancies for the other clinical group had varying lengths.
- The pharmacy sector had the largest number of organisations with paid and permanent employees leaving in the last 12 months.
- Around 70% of the organisations' surveyed indicated that they had no workforce development plan (or similar) in place.

3. Individual staff survey

This section presents simple single factor, and multi-variable cross tabulations of the 2,637 individual census responses. The individual census was completed only by paid staff members, i.e. volunteers and other non-employed "staff" were excluded.

As was the case with the survey of organisations, not all the respondents answered all of the questions. Unless explicitly stated otherwise, all of the data shown in tabular or graphical form include only those answering the particular question, i.e. the proportion of non-responses is not shown.

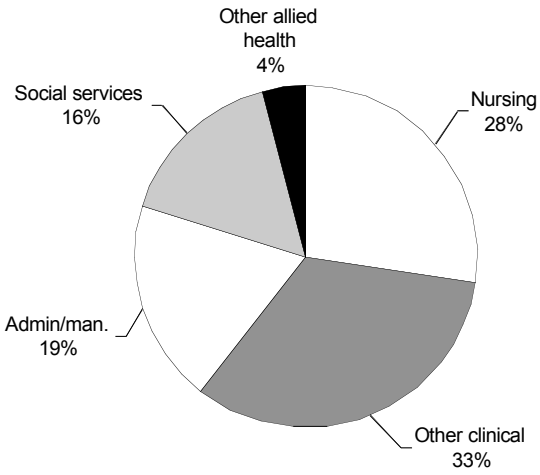
3.1 Single factor analysis

3.1.1 Occupational group

Individuals were asked to classify their job in terms of a number of prescribed occupational groups – the same groups as were used in the Organisational survey: Nursing, Other clinical, Admin/management, Social services and Other allied health.

A third of the individual respondents classified themselves as other clinical staff, with another 28% classified as nurses. Just over half of the nurses also classified themselves as registered nurses. Nearly 20% of the respondents classified themselves as management or administrative staff, with around half also further classifying themselves as receptionists or clerical staff.

Figure 5 Paid staff numbers by occupational group



Source: NGO & Community Workforce survey, NZIER

Question: What is your occupational group based on the lists provided? 1,785 respondents

3.1.2 Gender

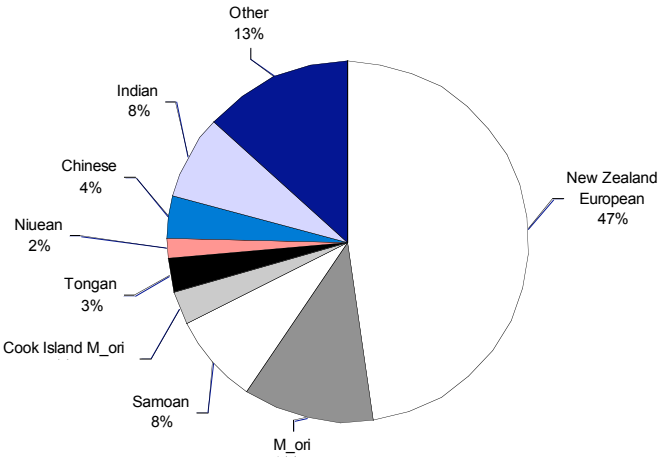
Of those answering, only 13% were male, with the workforce being dominated by females (87%).

3.1.3 Ethnic group

In order to identify the various ethnicities of respondents, they were asked to identify which ethnic group they belonged, and were able to select multiple groups if relevant.

Nearly half of those answering indicated a New Zealand European ethnicity, with the aggregate 'other' group being the next largest contributor. The other group contained a very diverse range of ethnic groups other than those specified. The Māori and Samoan ethnic groups accounted for 12% and 8% of the total responses respectively. Collectively though, Pacific peoples (Niuean, Tongan, Cook Island Māori and Samoan groups) accounted for 16% of total responses.

Figure 6 Ethnic composition



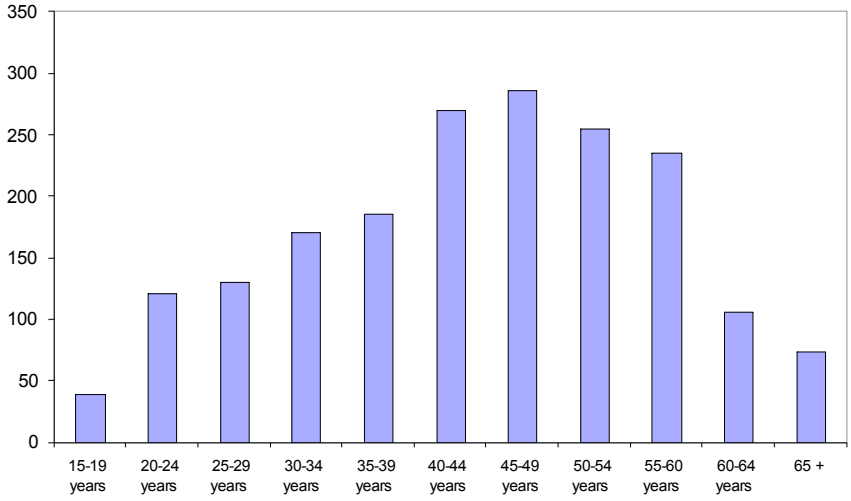
Source: NGO & Community Workforce survey, NZIER

Question: Which ethnic group do you belong to? (tick as many as apply) 2,021 respondents.

3.1.4 Age

Of those specifying their age, the largest proportion are aged between 45 and 49 years, with 51% of total respondents being aged 45 or older. The age distribution is relatively smooth and does not initially indicate any major 'clumping' around particular age groups, or significant gaps of concern in terms of progression. These issues will be considered further in the cross-tabulations will follow later in the report.

Figure 7 Age-group composition

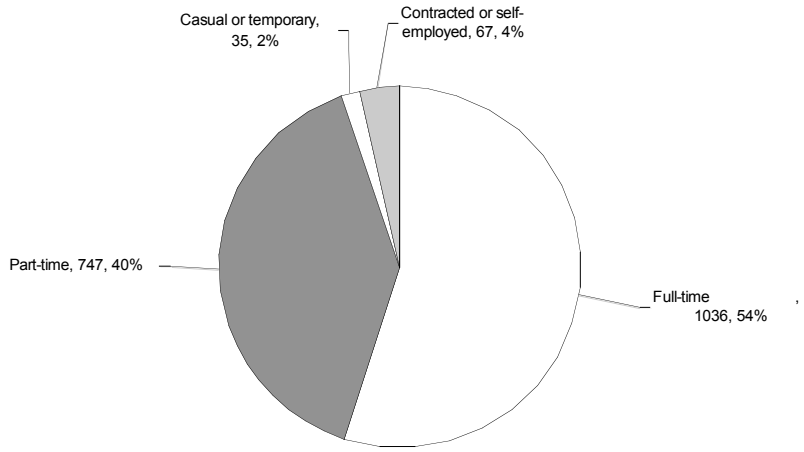


Source: NGO & Community Workforce survey, NZIER
Question: What is your age? (5 year age groups provided) 1,878 respondents

3.1.5 Employment status

The respondents were asked to provide an indication of their employment status – i.e. whether they were a full-time, part-time, casual/temporary, or contracted/self-employed employee. Figure 8 below shows that the majority of respondents were employed on a full-time basis (54%), with another 40% employed part-time. Casual/temporary staff and contractors/self-employed workers only accounted for 6% collectively.

Figure 8 Employment status composition



Source: NGO & Community Workforce survey, NZIER

Question: Circle ONE category on the rights that most describes your work (Full time, part time, casual or temporary, contracted or self employed) 1,885 respondents.

3.1.6 Qualifications

Respondents were also asked about their highest academic qualification. Again, they were provided with a number of pre-defined response options, as well as being given the opportunity to specify 'other' qualifications.

The following table identifies the shares of each of the pre-defined highest academic qualifications amongst respondents.

Table 9 Highest academic qualification

Share of total respondents

Highest academic qualification	Share of total respondents
No formal qualification	10%
Fifth form (Year 10) qualification	13%
Sixth Form (Year 12) qualification	8%
Higher School (Year 13) qualification	4%
Overseas secondary school qualification	6%
Vocational training (e.g. apprenticeship)	3%
Hospital/Technical Institute trained nurse	12%
Undergraduate Certificate or Diploma	12%
Bachelor's degree	15%
Post-graduate qualification	8%
Master's degree	3%
Doctorate	1%
Other	6%

Source: NGO & Community Workforce survey, NZIER

Question: What is your highest academic qualification? 1,832 respondents.

Around 40% of all respondents had a highest qualification of high school level or lower (including those with no formal qualification). A similarly sized proportion (39%) had university level qualifications or higher. 15% have vocational training or hospital/technical institute training.

The following table summarises the primary information from the single factor analysis for respondents of the Individuals survey.

Table 10 Summary of single factor analysis – individual survey

Shares of total respondents

Gender	Share of total respondents
Male	13%
Female	87%

Ethnic group	
New Zealand European	48%
Maori	12%
Samoan	8%
Cook Island Maori	3%
Tongan	3%
Niuean	2%
Chinese	4%
Indian	8%
Other	13%

Age group	
15-19 years	2%
20-24 years	6%
25-29 years	7%
30-34 years	9%
35-39 years	10%
40-44 years	14%
45-49 years	15%
50-54 years	14%
55-60 years	13%
60-64 years	6%
65 +	4%

Occupational group	
Nursing	28%
Other clinical	33%
Admin/management	19%
Social services	16%
Other allied health	4%

Employment status	
Full-time	55%
Part-time	40%
Casual or temporary	2%
Contracted or self-employed	4%

Source: NGO & Community Workforce survey, NZIER

3.2 Cross tabulations

While the single factor interpretations above provide us with a useful initial snap-shot of the census respondents, cross-tabulations allow us to find out more about particular sub-groups within the respondents.

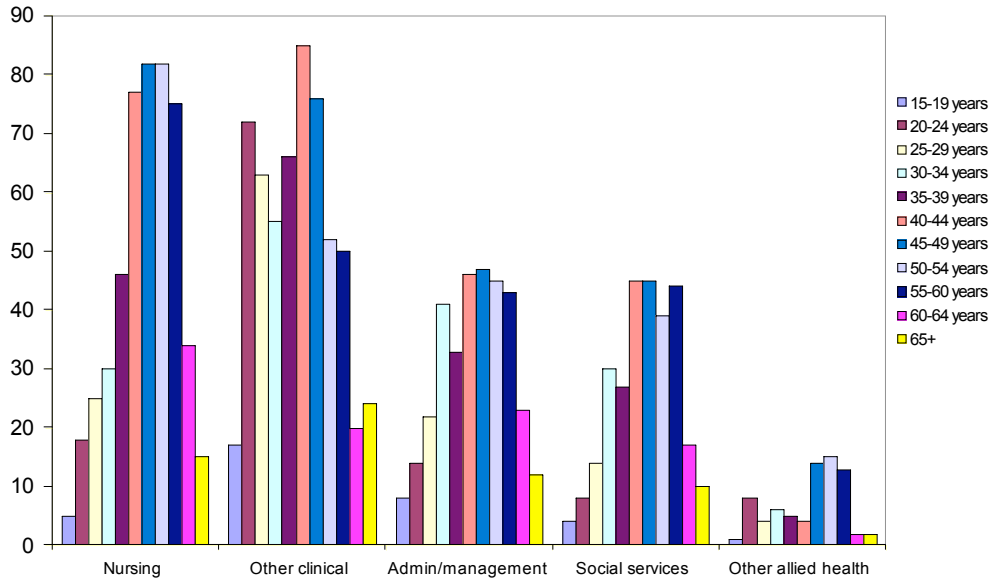
3.2.1 More about the workforce

It is useful to be able to identify the composition of different occupational groups by age. This can be a rudimentary indicator of potential succession risk for particular occupational groups: for example, are there large numbers of people 'clumped' around particular age groups such as those over 65 years, potentially nearing retirement.

Figure 9 below shows the distribution of workers by age group for the various occupational groups. It should be noted that only roughly 65% of those taking part in the survey answered both the age and occupational group questions.

The age distributions shown are fairly 'bell-shaped' indicating age spreads that shouldn't be too much cause for concern in terms of workforce planning. While it can never be assumed that those in younger age groups will progress through time in the same occupational group, we would typically look for a fairly bell shaped distribution amongst age groups. The other clinical group seems to have the most irregular age distribution, with significant numbers in the 20-24 and 40-44 age groups.

Figure 9 Occupational groups by age



Source: NGO & Community Workforce survey, NZIER

Questions: What is your occupational group based on the lists provided? & What is your age? (5 year age groups provided)

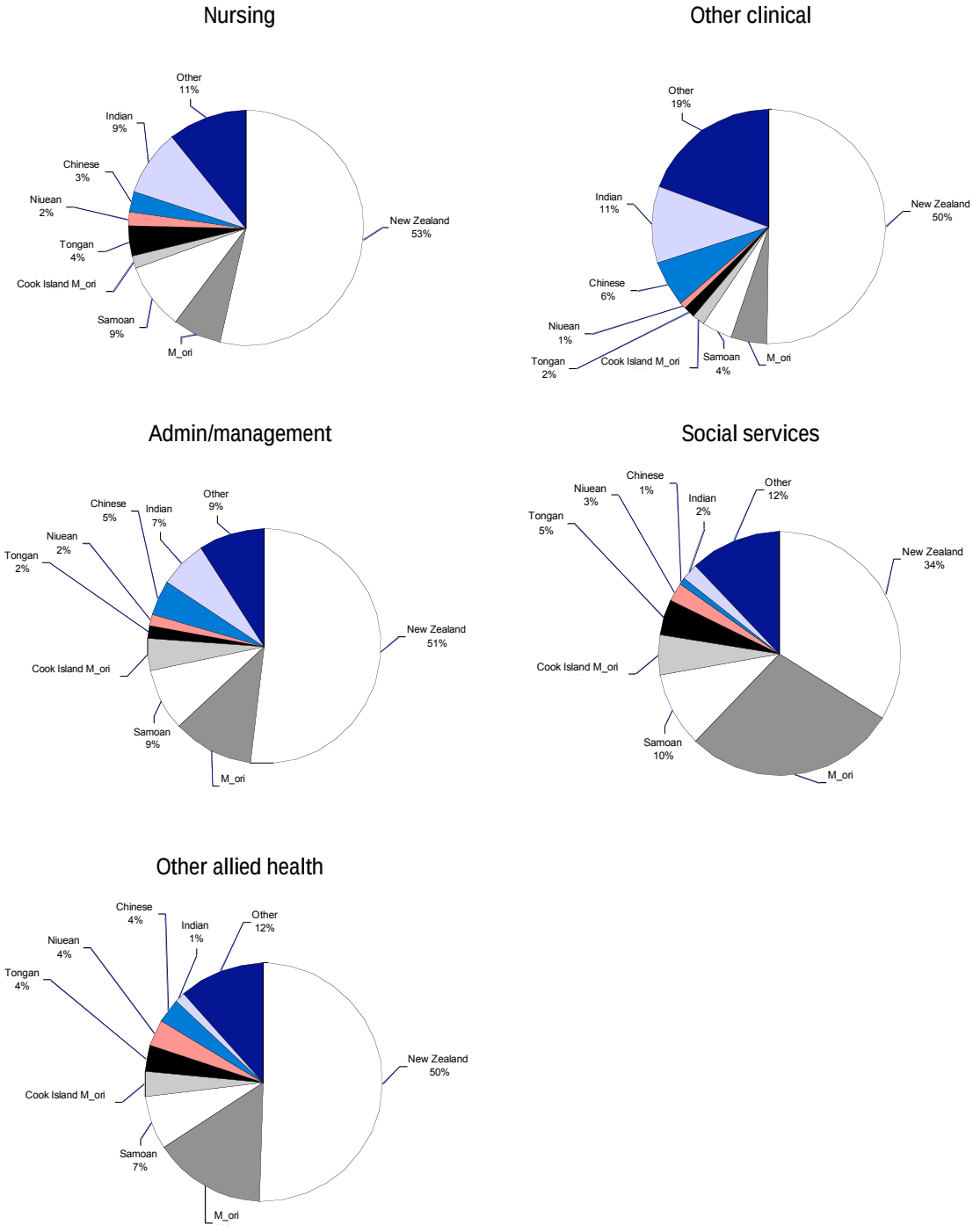
Looking at the occupational groupings by ethnicity is also of interest, in that we can see whether any particular ethnic groups tend to dominate particular occupations. The charts below show the breakdown of occupational group by ethnicity, for those who provided a response to both questions (i.e. listed an occupational group and an ethnicity (including other)).

New Zealand Europeans dominate the nursing group, with the contributions of the other ethnicities being quite diverse. Those listing their ethnicity as 'other' contributed 11% with Samoans and Indians each contributing 9%. The distribution amongst ethnic groups for nursing is very similar to that of the admin/management and other allied health staff who provided responses.

New Zealand Europeans make up half of the other clinical staff (who provided a response) with 'other' being the next most dominant ethnic grouping. Again, Indians contribute noticeably to this category (11%).

The social services occupational group is the most diverse out of all the occupational groups. In this group, New Zealand Europeans only contribute 34%, with Māori being a significant contributor at 28%. Samoans and 'other' ethnic groups are also relatively significant contributors.

Figure 10 Occupational groups by ethnicity



Source: NGO & Community Workforce survey, NZIER

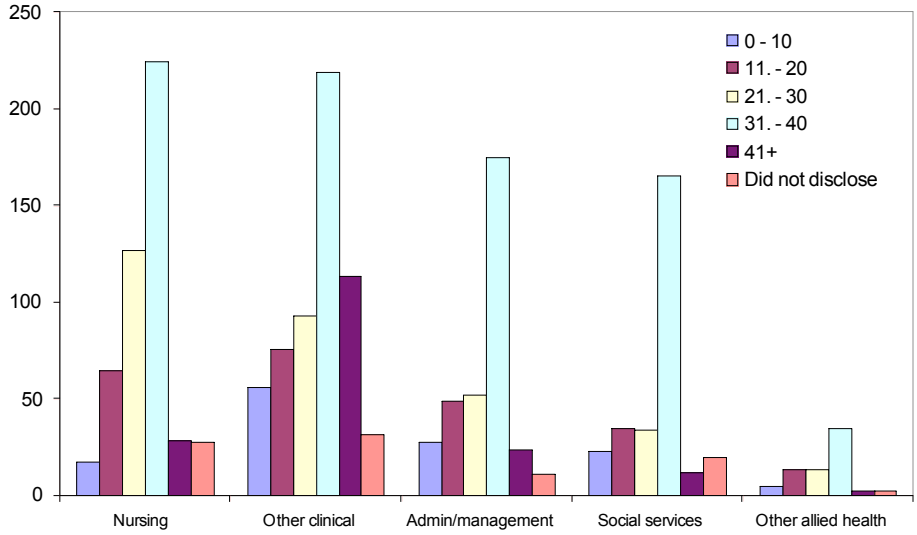
Questions: What is your occupational group based on the lists provided? & Which ethnic group do you belong to? (tick as many as apply)

The questions in the census also allow us to identify how many hours people work (in terms of paid hours) in a 'normal' working week.

Figure 11 below indicates the distribution of hours of paid work across the different occupational groups (for those who identified an occupational group). Across all the occupational groups, the majority of workers work between 31 and 40 hours per week (i.e. are technically full-time). The nursing, other clinical and other allied health occupational groups have distributions which are less skewed than those for admin/management and social services. The presence of people working less than say 30 hours per week is much more noticeable in these groups.

Figure 11 Hours of work by occupational group

Number of people by hours of work grouping



Source: NGO & Community Workforce survey, NZIER

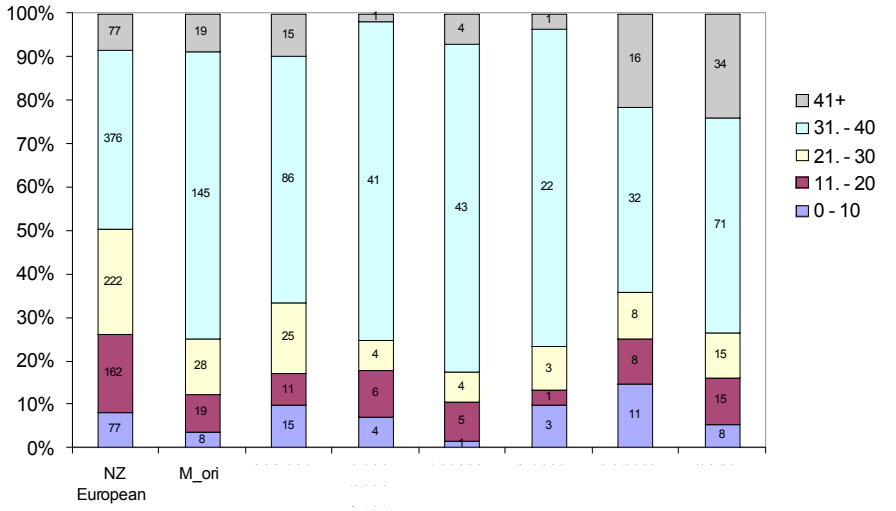
Questions: In a normal week, how many hours are you in 'paid' employment at this organisation? & What is your occupational group based on the lists provided?

The distribution of paid hours worked by ethnic group is also interesting to see graphically. The figure below shows for each ethnic group (excluding other) the distribution of hours of paid work for a normal week.

Again we see the dominance of 31-40 hours per week across all ethnic groups. Noticeable deviations are the relatively large proportion of Chinese and Indians working more than 40 hours per week, and the wider distribution of hours worked amongst New Zealand Europeans.

Figure 12 Hours of work by ethnicity

Absolute numbers shown on bars



Source: NGO & Community Workforce survey, NZIER

Questions: In a normal week, how many hours are you in 'paid' employment at this organisation? & Which ethnic group do you belong to? (tick as many as apply)

As well as the hours worked, the survey questions also sought to elicit responses on the type of employment contract each individual has with their organisation – whether it is an individual contract, a collective contract, whether they don't have one at all, or whether they are not sure. .

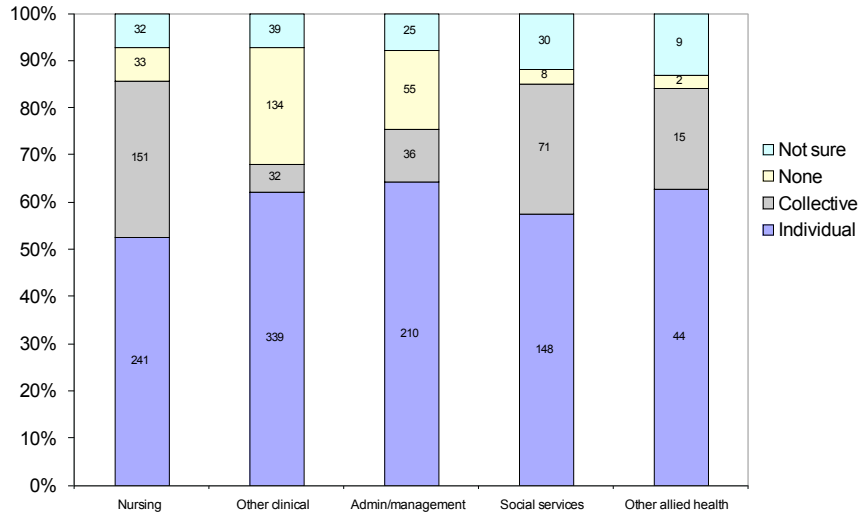
The figure below shows the distribution of responses to the contract type question by the various occupational groups.

Over all the occupational groups individual contracts form the majority, however the distribution of the other contract types (i.e. non individual) varies quite noticeable amongst occupational groups.

Collective contracts are an important contributor for the nursing occupational group, while a reasonably large proportion of other clinical and admin management staff seem to have no employment contract at all. For employees in the social service and other allied health groups, collective contracts play a relatively large role, but a number are not sure what sort of employment contract they are signed up to.

Figure 13 Contract type by occupational group

Absolute numbers shown on bars



Source: NGO & Community Workforce survey, NZIER

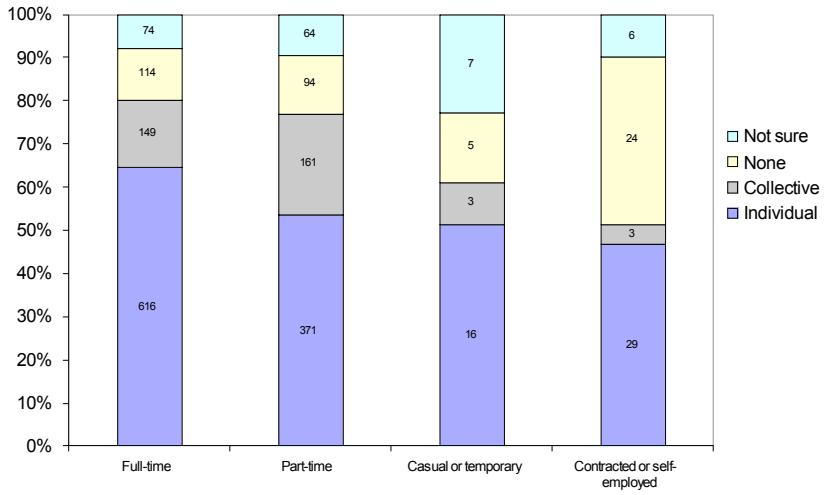
Questions: What kind of employment contract do you have? & What is your occupational group based on the lists provided?

The distribution of different contract types amongst different employment types (i.e. full-time, part-time, casual/temporary, contracted or self-employed) is also of interest.

For all but the contracted and self-employed workers, individual contracts dominate. For full and part-time workers, collective contracts are also relatively common. A relatively large proportion of casual and temporary staff are not sure what contract they are signed up to. Nearly 40% of all contracted or self-employed staff have no formal employment contract that they are aware of, although self-employed people would not be expected to have a contract.

Figure 14 Contract type by employment type

Absolute numbers shown on bars



Source: NGO & Community Workforce survey, NZIER

Questions: What kind of employment contract do you have? & Circle ONE category on the rights that most describes your work (Full time, part time, casual or temporary, contracted or self employed)

Another survey question looked to find out the different languages that respondents spoke, and how fluent they were in speaking and writing these languages.

Around 1,360 respondents provided an answer to this question. In summary:

- 640 (47%) spoke 1 language only, hence 53% speak more than 1
- 495 people spoke 2 languages, with 427 speaking 3 or more languages
- For all languages, the average level of written fluency was between conversational and fluent
- For all languages, the average level of spoken fluency was between conversational and fluent
- 8 people noted that they were interpreters
- The greatest number of respondents speaking more than one language came from the other clinical occupational group and tended to be New Zealand European, Samoan or Indian.

3.2.2 Training

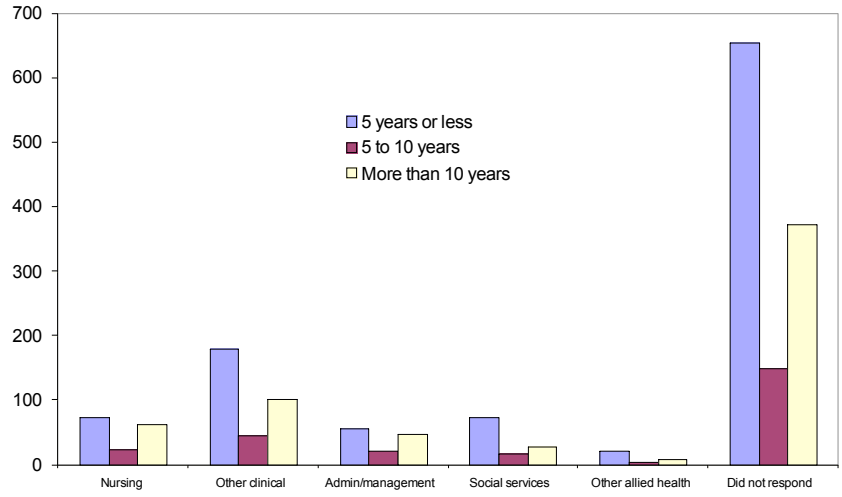
A number of questions in the individual worker's census survey revolved around education, training and skills.

One question looked to elicit responses about the specific training and qualifications workers have completed for their **current** job. In order to put the results into a useable and interpretable format, below we consider this job specific training in terms on the number of years since the training was

undertaken – i.e. was the training undertaken 5 or less years ago, 5 to 10 years ago or more than 10 years ago. This will give us an idea of how up to date workers' training is, and by using cross-tabulations we can identify which groups or sub-population have more/less recently undertaken training.

The figure below indicates the distribution of job specific training by occupational group. It also shows the distribution of job specific training for those who did not provide an occupational group, as this group is significant. For each occupational group the level of training tends to be highest in the 5 years of less category. The general distributions are interesting in that the job specific training seems to have been undertaken either quite recently (5 years or less ago) or more than 10 years ago. The other clinical group has a large proportion of staff who have undertaken recent job specific training.

Figure 15 Job specific training by occupational group



Source: NGO & Community Workforce survey, NZIER

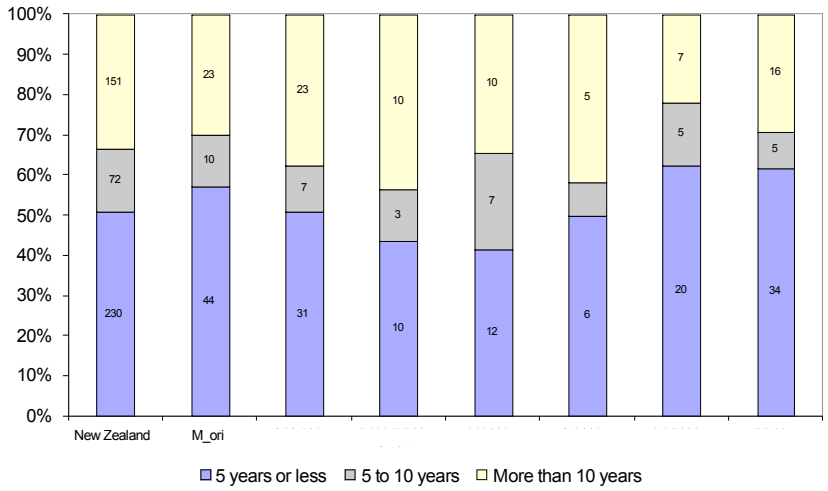
Questions: List the specific training and qualifications you have completed **for your current job** (time groups devised by NZIER for ease of presentation) & What is your occupational group based on the lists provided?

The next figure provides us with similar information about job specific training, but this time as a cross tabulation of the distribution of training against ethnic group (the main ethnic groups listed in the survey).

The ethnic group breakdown mirrors the occupational group breakdown in terms of a tendency to be quite recent (5 years ago or less) or more than 10 years ago. There seems to be a relatively high level of recent training across most ethnic groups.

Figure 16 Job specific training by ethnic group

Absolute numbers shown on bars



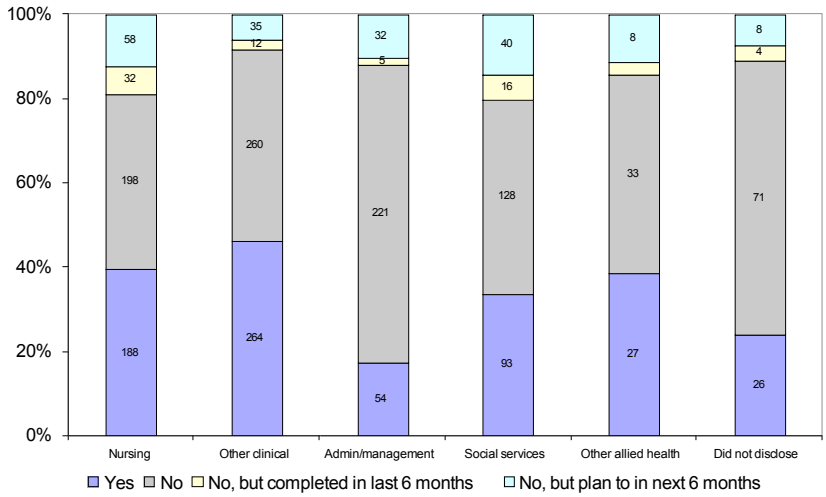
Source: NGO & Community Workforce survey, NZIER

Questions: List the specific training and qualifications you have completed **for your current job** (time groups devised by NZIER for ease of presentation) & Which ethnic group do you belong to? (tick as many as apply)

A subsequent survey question asked respondents whether they were currently undertaking any study or professional development in relation to their health career.

Figure 17 shows the shares of responses to the study/professional development question by occupational group. Very few respondents who are not undertaking study or professional development intend to do so in the next 6 months, regardless of the occupational group. Also, an even smaller proportion have completed study in the last 6 months. In general, most respondents are either undertaking study or professional development, or are not (and have not in the last 6 months, and don't intend to in the next 6 months). The other clinical occupational group is the one where the largest proportion of respondents are currently undertaking study or professional development.

Figure 17 Study or development by occupational group
Absolute numbers shown on bars

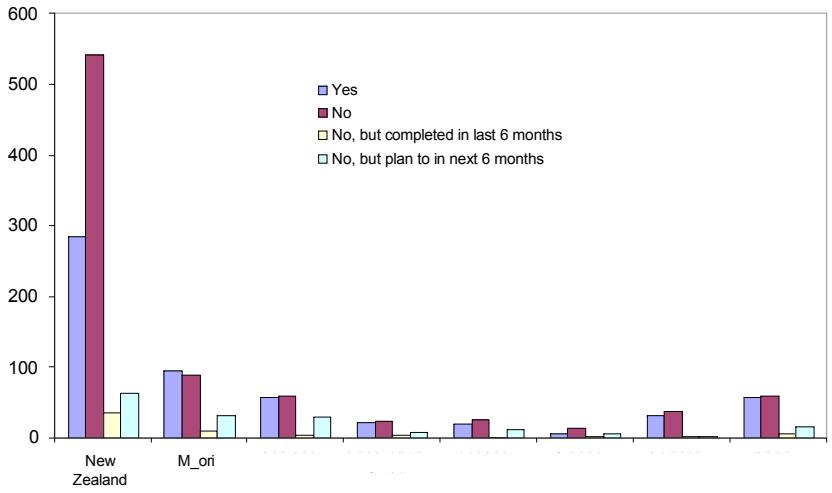


Source: NGO & Community Workforce survey, NZIER

Questions: Are you currently undertaking any study or professional development in relation to your health career & What is your occupational group based on the lists provided?

Figure 18 shows the distribution of responses by ethnic group. The distribution of responses for New Zealand Europeans is probably the most of interest, in that a significant proportion of respondents are not undertaking current study or professional development (and have not in the last 6 months, and don't intend to in the next 6 months). For the other ethnic groups, the share between those responding 'yes' and 'no' tended to be fairly similar.

Figure 18 Study or development by ethnic group



Source: NGO & Community Workforce survey, NZIER

Questions: Are you currently undertaking any study or professional development in relation to your health career & Which ethnic group do you belong to? (tick as many as apply)

In association with the study or professional development question, respondents were also asked about the presence (or lack of) any barriers to training for their current job.

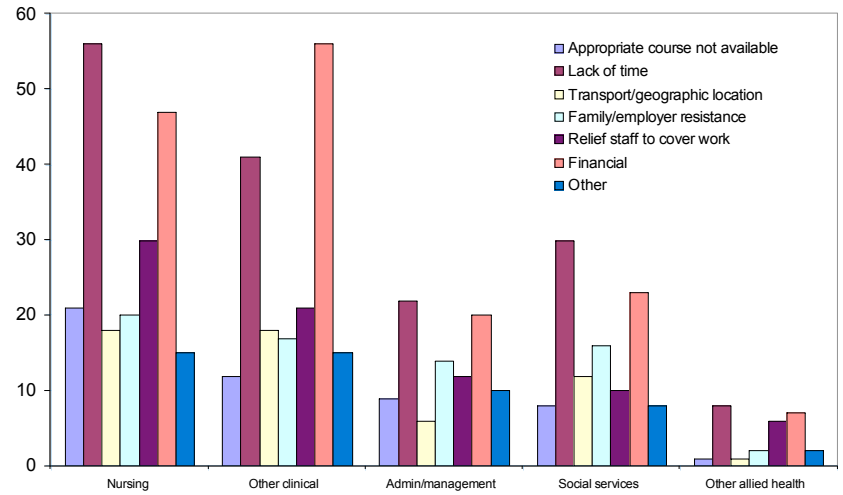
335 individuals (13% of respondents) noted that they did experience some barriers. Respondents facing barriers were able to select more than one barrier to training, and on average, they selected around 2 barriers. The figures below indicate the prominence of each of the barriers mentioned; the first in terms of which occupational groups respondents belong to, the second, in terms of the ethnic group of respondents.

Figure 19 shows that for nurses, the most common barrier was a lack of time, followed by financial constraints. For other clinical staff, the same barriers were prominent, but for this occupational group the financial one was more prominent.

For admin/management staff and those involved in social services financial and time constraints are again highly prominent, with family or employer resistance also featuring strongly.

In general it seems that a lack of time and financial barriers are the most common barriers to workers undertaking training for their current job.

Figure 19 Barriers to training by occupational group



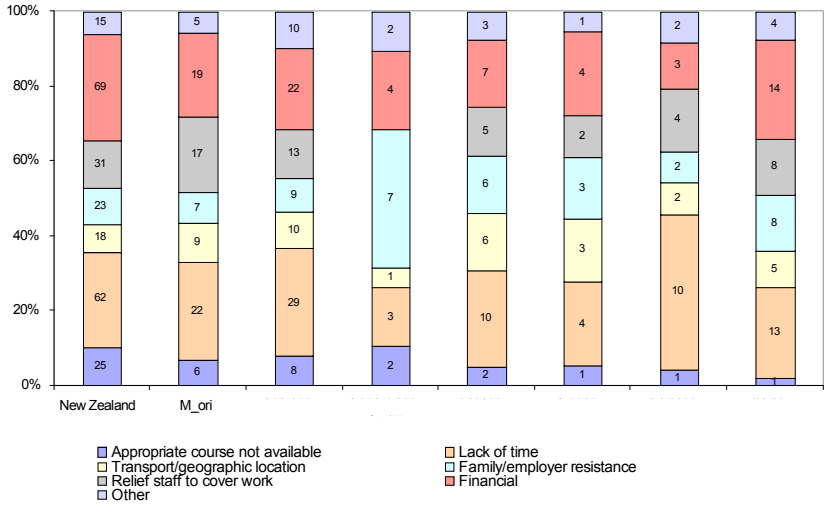
Source: NGO & Community Workforce survey, NZIER

Questions: Did you encounter any barriers when training for your current job? & What is your occupational group based on the lists provided?

In terms of barriers for different ethnic groups the picture is relatively similar, in terms of financial and time constraints being the main barriers to training for respondents' current jobs. Other notable barriers are transport/geographic location for Tongans and Niueans and for Cook Island Māori, a significant proportion of respondents experienced a barrier related to family or employer resistance.

Figure 20 Barriers to training by ethnic group

Absolute numbers shown on bars



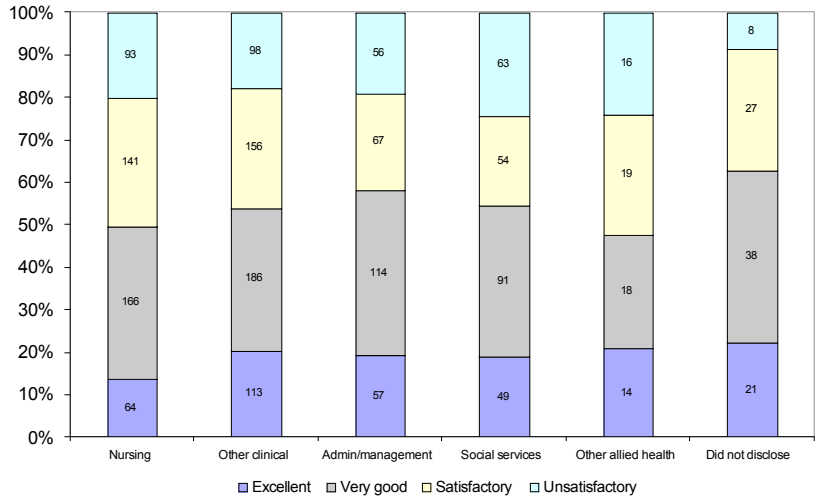
Source: NGO & Community Workforce survey, NZIER

Questions: Did you encounter any barriers when training for your current job? & Which ethnic group do you belong to? (tick as many as apply)

This question was furthered by another question which asked how the respondent rated their ability to access appropriate and timely training. Respondents were offered a choice of excellent, very good, satisfactory, unsatisfactory or 'other'. If their ability to access it was unsatisfactory, they could circle any number of relevant areas as to why it was unsatisfactory. For each of the occupational groups, only around 20% of respondents thought that their ability to access appropriate and timely training was unsatisfactory.

Figure 21 Ability to access training by occupational group

Absolute numbers shown on bars



Source: NGO & Community Workforce survey, NZIER

Questions: How would you rate your ability to access appropriate and timely training? & What is your occupational group based on the lists provided?

For those who indicated that their ability to access timely and appropriate training was unsatisfactory, the reasons for this were very consistent with those identified earlier in terms of generally being because of financial or time constraints. These two reasons tended to account for around 60 to 65% of all responses in the unsatisfactory category.

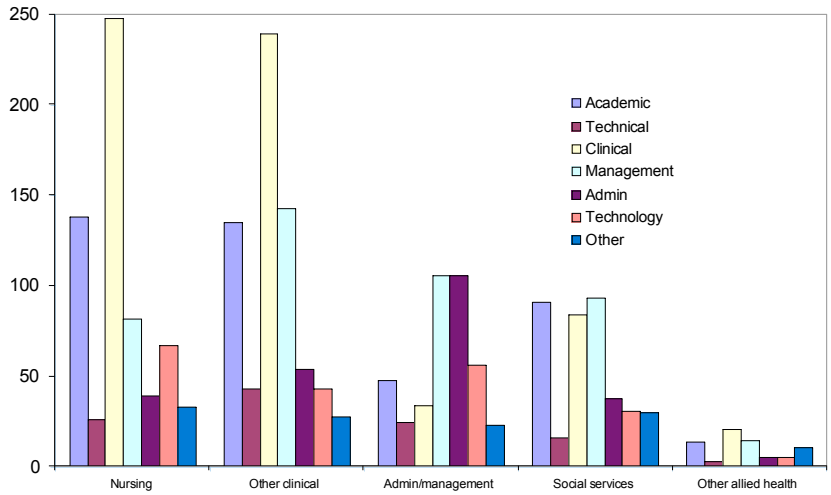
The survey continued with questions around training, also enquiring as to the respondents' need to up-skill, and which area they thought they needed to up-skill in. Options provided (in terms of areas requiring up-skilling) include; academic, technical, clinical, management, administrative, technology, or 'other'. Again, respondents were asked to select 'yes' or 'no' in terms of whether they need to up-skill or not, and if the answer was yes, which areas they need to up-skill. Again, they could select as many areas as they require.

A little under half of respondents indicated they needed up-skilling in some area, and on average they felt they needed up-skilling in nearly 2 areas.

Figure 22 below looks at the areas that were indicated as requiring up-skilling in terms of the respondents occupational groupings. For nursing staff, clinical training was by far the most common area that was identified as requiring up-skilling, with academic training also featuring prominently. For other clinical staff, clinical training was also identified as being needed, but management training also featured quite significantly. For admin/management staff, the most common areas noted as requiring training were in management and administration themselves. Management

training, academic training and clinical up-skilling were common areas noted by respondents in other occupational groups, and in general were the most commonly quoted areas requiring up-skilling.

Figure 22 Areas requiring up-skilling by occupational group

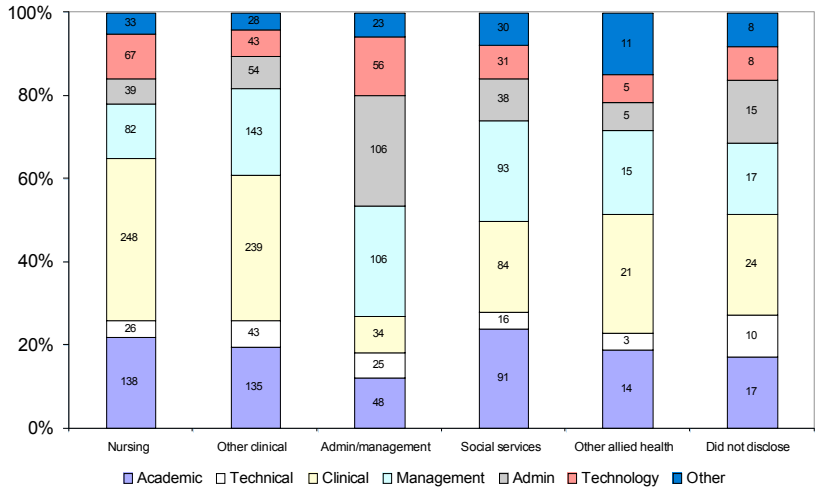


Source: NGO & Community Workforce survey, NZIER

Questions: Do you need to, or would like to up-skill in any areas to complement or enhance your job? (No, Yes – options for different areas as above) & What is your occupational group based on the lists provided?

Figure 23 Areas requiring up-skilling by occupational group – percentages

Absolute numbers shown on bars

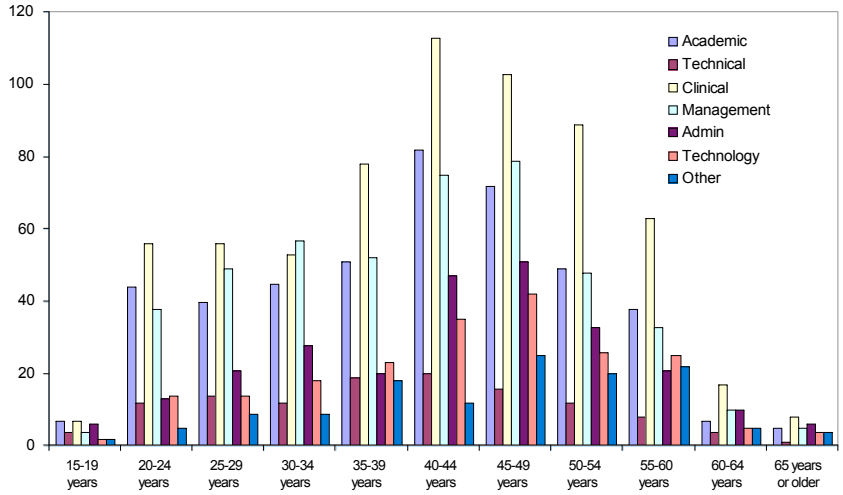


Source: NGO & Community Workforce survey, NZIER

Questions: Do you need to, or would like to up-skill in any areas to complement or enhance your job? (No, Yes – options for different areas as above) & What is your occupational group based on the lists provided?

The presence of the need for up-skilling in the areas of academia, clinical and management are common when considering responses by ethnicity also. Theses areas feature prominently across all ages groups, with technical training also featuring.

Figure 24 Areas requiring up-skilling by age group



Source: NGO & Community Workforce survey, NZIER

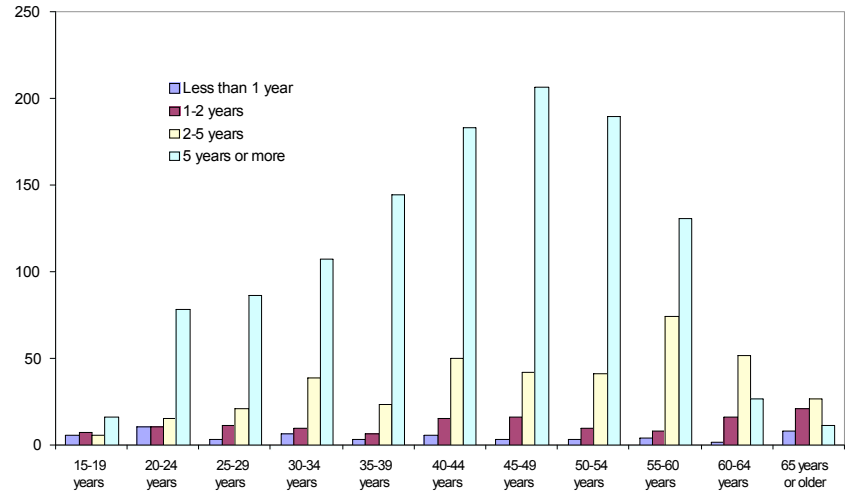
Questions: Do you need to, or would like to up-skill in any areas to complement or enhance your job? (No, Yes – options for different areas as above) & What is your age? (5 year age groups provided)

3.2.3 Staying in health care

A question put to respondents asked how long they intended to remain working in health care. This could provide useful information for workforce development in terms of succession planning.

Amongst respondents to this question, the picture is fairly consistent across most age groups. While, as we might expect, a noticeable proportion of older age groups intent to stay in health care for between 1 and 5 more years (possibly those approaching retirement) it is consistently the case that people aged less than 60 intend to stay in health care for 5 years or more. This trend is the most prominent for those in the 45 – 49 year old age group.

Figure 25 Staying in health care – by age group



Source: NGO & Community Workforce survey, NZIER

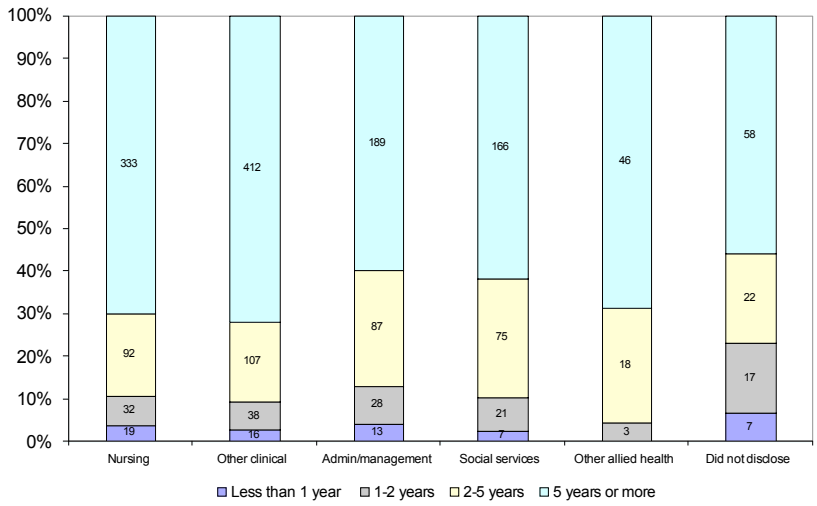
Questions: How long do you intend to remain working in health care for? (groups provided above provided) & What is your age? (5 year age groups provided)

This picture is consistent with a cross tabulation of intent to stay in health care against occupational group. Across all occupational groups, around 60 to 70% intend to stay for at least 5 years, with around 20% intending to stay for 2 – 5 years – again across all occupational groups.

Around 15 of those who noted they are intending to leave in the next 12 months are Registered or Other nurses. 17 people in Receptionist/Clerical positions have noted their intention to leave within the next 12 months.

Figure 26 Staying in health care – by occupational group

Absolute numbers shown on bars



Source: NGO & Community Workforce survey, NZIER

Questions: How long do you intend to remain working in health care for? (groups provided above provided) & What is your occupational group based on the lists provided?

3.3 Individual survey summary

The following summarises what we see as the key points arising from the survey of individuals:

- The age distribution of workers for most occupational groups was fairly smooth and not clumped. The other clinical group had the most erratic distribution, with significant numbers in the 20-24 and 40-44 age groups.
- The majority of respondents were employed on a full-time basis (54%) with another 40% employed part-time. Casual/temporary staff and contracted/self-employed staff only accounted for 6% of respondents.
- Around 40% of those who provided information around qualifications, had a highest qualification of high school or lower (i.e. high school or no formal qualification). A similar proportion had university level qualifications or higher.
- Out of all the occupational groups, the social services group is the most ethnically diverse, with New Zealand Europeans contributing only 34% of the total workers in this group. For other groups, particularly Nursing, the proportion of New Zealand Europeans is as high as 53%.
- A relatively large proportion of casual and temporary staff are not sure what contract they are signed up to. Nearly 40% of all contracted/self-employed staff state they have no formal employment contract.
- In terms of job specific training, any training that has been undertaken tends to have happened in the last 5 years (i.e. rather than rather than

being 5 to 10 years ago, or more than 10 years ago). Very few respondents who are not already undertaking study or professional development intend to in the next 6 months.

- A relatively small proportion of respondents noted that they experienced barriers to training. Where barriers exist they are mainly related to financial or time constraints. This picture is fairly consistent across ethnic groups. For staff who indicated that their access to timely and appropriate training was unsatisfactory, similar factors were identified as constraints – i.e. time and financial constraints.
- Approaching half of the respondents indicated that they need some form of up-skilling. For nursing staff, clinical training was by far the most common area cited for improvement, with academic training also prominent.

3.4 Comparison with the CMDHB hospital workforce census

The CMDHB hospital workforce census undertaken in September 2003 and written up in the NZIER report *"Under the microscope – Analysis of the 2003 hospital workforce census" (April 2005)* provides us with useful point of comparison for the community workforce results. The following sub-sections present direct comparisons of the relevant survey results from both census'.

It should be noted that while the CMDHB workforce census was undertaken around 2 years ago, but we would not expect the distributions identified to have changed markedly since then.

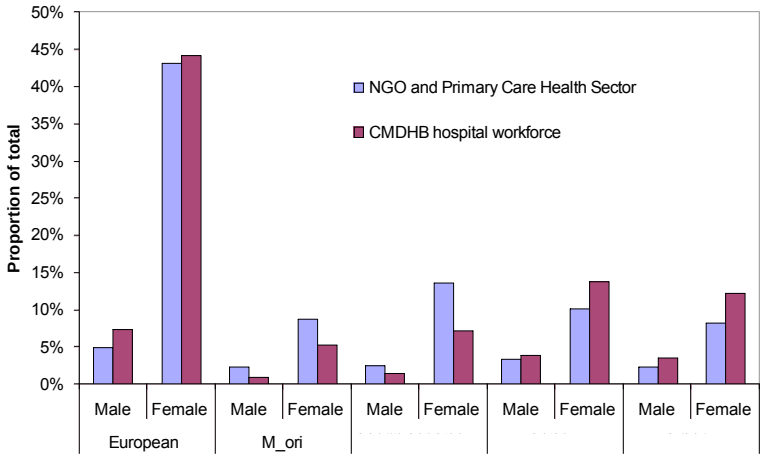
3.4.1 Gender

In terms of the employment of males vs. females, both the community workforce census and the hospital workforce census indicate that 83% of staff are female and 17% are males.

3.4.2 Ethnicity and gender

A comparison of the ethnic group by gender breakdowns in the two sets of census results is presented below. The pattern is relatively similar for most ethnic group by sex combinations, although the community workforce seems to comprise slightly larger proportions of female Māori and Pacific Peoples. Conversely, the hospital workforce comprises slightly larger proportions of Asian and Other females.

Figure 27 Ethnic group comparison – NGO and Primary Care Health Sector vs. CMDHB hospital workforce

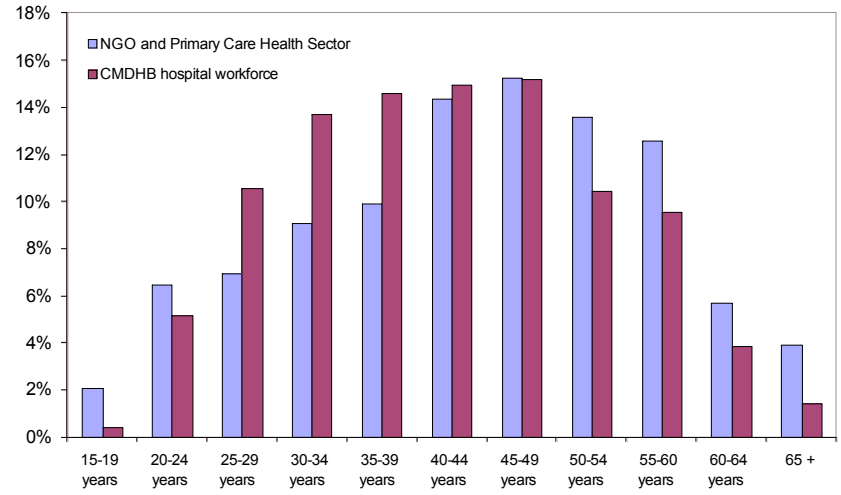


Source: NGO & Community Workforce survey, CMDHB, NZIER

3.4.3 Age

Figure 28 compares the age distribution of the two workforces. The community workforce appears to employ slightly more workers at both ends of the age spectrum. That is to say, compared to the hospital workforce, it has more under 25 year olds and more 50+ year olds. Conversely, it has a markedly lower proportion of 25-40 year olds.

Figure 28 Age comparison – NGO and Primary Care Health Sector vs. CMDHB hospital workforce



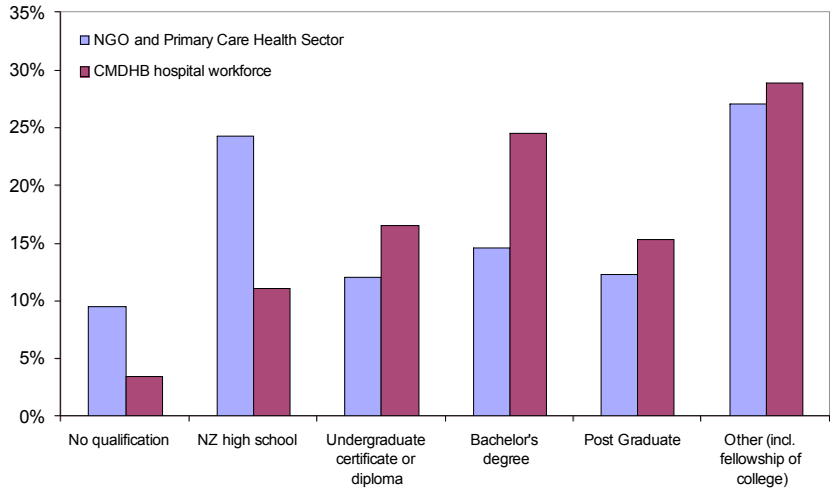
Source: NGO & Community Workforce survey, CMDHB, NZIER

3.4.4 Highest qualifications

A comparison of highest qualifications across the two workforces also highlights some striking differences. The findings here should be interpreted with a little caution as the response rates to the questions around qualifications were not particularly good in either census.

Figure 30 indicates that the community workforce has larger proportions of workers with lower level qualifications (i.e. either no qualifications or New Zealand high school qualifications only). Conversely, the hospital workforce has larger proportions of staff with tertiary qualifications.

Figure 29 Qualifications comparison – NGO and Primary Care Health Sector vs. CMDHB hospital workforce



Source: NGO & Community Workforce survey, CMDHB, NZIER

Our conclusions from these comparisons are: firstly, that they make the results of the census o the community workforce look plausible; and, secondly, that they highlight important differences between the community and hospital workforces in terms of their age distributions and qualifications.

4. The results in a local context

The information on the organisation and individual census results above have provided us with a useful insight into the characteristics of the Counties Manukau community health workforce. This section looks to put this information in the context of the wider Counties Manukau population and economy-wide workforce.

4.1 The local population

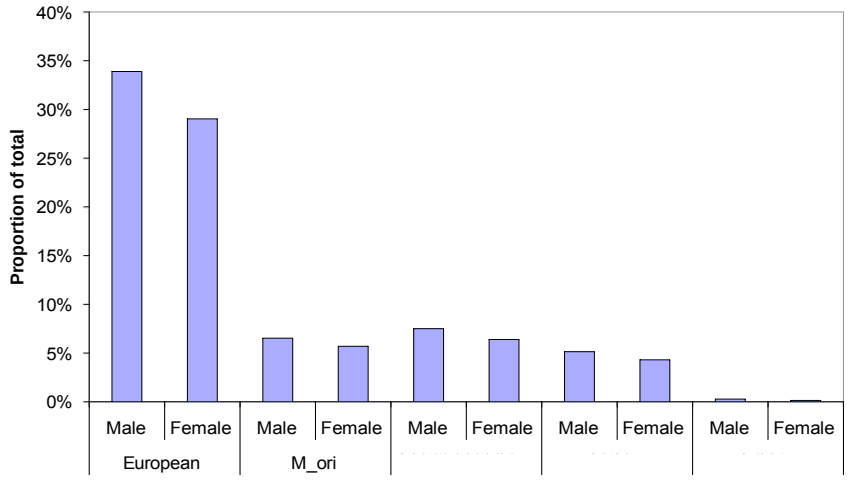
The availability of national population census data allows us to look at some of the major characteristics of the Counties Manukau population, and to compare these characteristics to those of the people employed in the community workforce.

Figure 30 below shows the employment split for the Counties Manukau population by ethnicity and gender. This information from the 2001 Census shows, for all those people classified as employed on Census night, how many were identified as European males, Māori females etc.

Collectively, Europeans employed in the area account for 63% of all people employed, with European males contributing around 34%. The next most predominant group of people employed is male Pacific peoples providing around 8% of all those employed in the Counties Manukau area. Combined, the area employs over 160,000 people who are classified as usually resident.

Figure 30 Employment split by ethnicity and gender for Counties – Manukau DHB area

2001 Census data



Source: Statistics New Zealand, NZIER

Again it should be noted that this information is from the 2001 Census. And, although we would not expect anything dramatic to have occurred, the

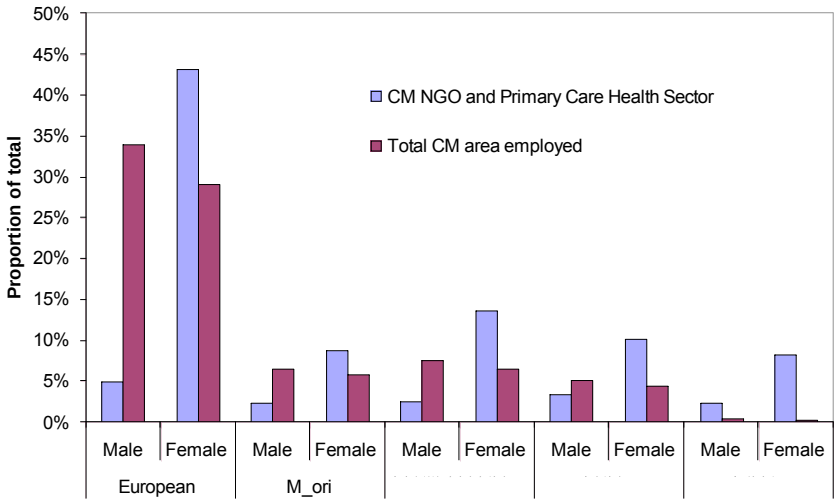
distribution of employment amongst ethnic groups and between genders may have changed since the census was undertaken. It provides us though with a useful (but only indicative) point of comparison against those employed in the community health workforce.

The relevant comparison is shown in Figure 31. This indicates much higher employment (in percentage terms) of females in all ethnic groups by the community workforce than in the wider Counties Manukau workforce, with lower contributions of employment by males generally (apart from the 'other' ethnic group). This reflects the fact that community workforce is 84% female, compared to only around 46% in the Counties Manukau area.

The community workforce comprises nearly the same proportion of Māori as are employed in the area overall (11% cf. 12%), and slightly more Pacific Island people than are employed in the area (16% cf. 14%).

Figure 31 Ethnicity/gender contributions to employment – CM area vs. CM NGO and Primary Care sector only

Census data 2001 (Total CM area employed) vs. Counties Manukau NGO and Primary Care Health Sector census.



Note: The figures for Total CM area employed includes only those who disclosed their ethnicity.

Source: NGO & Community Workforce survey, Statistics New Zealand, NZIER

We conclude from the comparisons here that the community workforce census results are plausible, allowing for the fact that employment in community health services is known to be more female than employment in the economy as a whole.

4.2 Contribution to local employment

It is also useful to look at the contribution (in terms of the number of people employed) that the community workforce makes to employment as a whole

in the wider Counties Manukau area. We are able to do this through analysis of business demographics data (from Statistics New Zealand) for the Counties Manukau area in terms of the resident population aged over 15 who are classified as employed.

The table below indicates the employment contributions made by each major industry grouping in the Counties Manukau area for 2004. The numbers shown are headcounts i.e. they do not differentiate between part and full-time employment, but still provide a useful indicator of contributions to total employment in the area.

Overall, the manufacturing sector provided the highest levels of employment in the area in 2004 – nearly 23% of all those employed. The wholesale and retail trade, property and business services and transport and storage sectors also contributed significantly in terms of providing employment – collectively (excluding manufacturing) contributing over 41% of jobs to the Counties Manukau area in 2004.

The wider Health and Community Services sector (which includes a small but significant number of people employed mainly in Veterinary Services) contributed under 10% of jobs. The community workforce, with a head count of 4,951, employs around 3.6% of all those aged over 15 in the Counties Manukau area classified as being employed.

It is also of interest to note that the headcount in the hospital workforce census was 5,236, which implies that the hospital and community workforces combined have a headcount of 10,187. This is equivalent to 7.4% of all employment in Counties Manukau measured on a headcount basis.

Table 11 Employment in the CMDHB area by industry (2004)

Headcount of employees

	CMDHB area
Total Industry	136,910
Agriculture, Forestry and Fishing	930
Mining	245
Manufacturing	31,040
Electricity, Gas and Water Supply	590
Construction	7,100
Wholesale Trade	12,030
Retail Trade	18,640
Accommodation, Cafes and Restaurants	6,250
Transport and Storage	12,290
Communication Services	1,670
Finance and Insurance	1,800
Property and Business Services	13,330
Government Administration and Defence	2,840
Education	10,730
Health and Community Services	11,290
Cultural and Recreational Services	2,230
Personal and Other Services	3,900

Counties Manukau NGO and Primary Care Health Sector census head count	4,951
Counties Manukau NGO and Primary Care Health Sector census head count (% of total)	3.6%

Source: Statistics New Zealand, NZIER, NGO & Community Workforce survey

4.3 Links to the CMDHB service needs and labour force projections

NZIER is conducting a simultaneous piece of research, focussing on projecting demand for labour in the CMDHB hospital sector, as well as possible scenarios for the CMDHB labour force from the supply side.

The projections rely relatively heavily on population projections for the Counties Manukau area, and use rates of incidence of particular medical diagnostic categories (MDC), and the different service areas operating within CMDHB to estimate possible pressure areas resulting from growth in various sub-groups of the local population[4]. For example, growth in the proportion of the Counties Manukau population aged over 65 could place increased stress on particular service areas, given the resource intensiveness of care for such patients, and the sheer volume of demand for services.

Table 12 below presents the population projections used in the estimations, broken down by ethnic group and aggregated age group. These are the population estimates used to project forward the various levels of demand by MDC and service group, and also to project forward estimates of the potential hospital workforce under certain assumptions.

The table highlights a number of key demographic changes to the Counties Manukau population which we expect are likely to occur in the near future:

- The widely discussed 'ageing of the population' comes through clearly in these projections, with the proportion of the population aged 65+ growing significantly across all ethnic groups. Given that high levels of demand for CMDHB services are likely to be associated with those in older age groups, this indicates potential pressure on CMDHB services.
- The ageing is more pronounced for some ethnic groups than others – for Māori the proportion aged over 65 is expected to double in size by 2016 compared to its 2001 level. The share of Europeans 65+ year olds is expected to increase to around 20% by 2016, compared to 12% in 2001.
- The Asian share of the total Counties Manukau population is expected to grow particularly strongly, as is the share of Pacific Peoples. This growth comes at the expense of the European population, whose growth rate is expected to be negative for the entire period out to 2016.

[4] These include differentiation by age, ethnic group and gender.

Table 12 Counties Manukau population projections by ethnicity

Medium projection – 2006, 2011 and 2016.

Maori	Resident Maori population	Population change	Average annual % change	Resident Maori age group distribution (%)			Median age (years)
				0-14	15-64	65+	
2001	69,200	-	-	38.5	59.2	2.4	21.4
2006	75,400	6,200	1.7	37.0	60.1	2.9	21.8
2011	81,400	6,000	1.5	35.0	61.4	3.6	22.6
2016	87,800	6,400	1.5	33.4	61.8	4.8	23.7
Pacific	**Resident Pacific population**	**Population change**	**Average annual % change**	**Resident Pacific ethnic age group distribution (%)**			**Median age (years)**
				0-14	15-64	65+	
2001	87,500	-	-	39.4	57.2	3.4	20.9
2006	101,500	14,000	3.0	37.9	58.2	3.9	21.1
2011	115,800	14,300	2.7	35.8	59.7	4.6	22.1
2016	131,300	15,500	2.5	34.0	60.6	5.4	23.1
Asian	**Resident Asian population**	**Population change**	**Average annual % change**	**Resident Asian ethnic age group distribution (%)**			**Median age (years)**
				0-14	15-64	65+	
2001	51,000	-	-	25.1	70.3	4.6	29.4
2006	78,800	27,800	9.1	23.4	71.6	5.0	29.0
2011	94,200	15,400	3.6	22.8	71.2	6.1	30.8
2016	107,000	12,800	2.6	21.8	70.5	7.8	33.2
European	**Resident European population**	**Population change**	**Average annual % change**	**Resident European ethnic age group distribution (%)**			**Median age (years)**
				0-14	15-64	65+	
2001	226,500	-	-	23.2	64.8	12.0	35.7
2006	224,500	-2,000	-0.2	21.9	64.3	13.8	38.2
2011	222,400	-2,100	-0.2	20.0	63.8	16.2	40.7
2016	218,700	-3,700	-0.3	18.1	62.3	19.6	43.1

Source: Statistics New Zealand

In terms of the potential links with the community, there are a number of potential considerations:

- Around 29% of organisations who responded to the question around which population or community group they specialise in had 'older people' as a primary group. Given the potential for significant increases in the share accounted for by those aged over 65 in the coming years, this

is likely to increase the need for resources required to cope with increasing demand.

- A survey question for organisations indicated that the second largest share of paid staff by occupational group was dedicated to residential care. 17% of paid staff were identified as working in the residential care, second only to primary health care (24%). Again, it is likely that additional resource (whether it be substituted from other areas, or new resource) in primary care and residential care will be required to cope with rising demands from an ageing population.
- The effect of this increased demand will need to be considered in terms of the characteristics of the workforce which tends to specialise or be associated with care for those aged over 65. Do they tend to be full/part time/contractors? Are there unfilled vacancies at present in these areas? Can resource be gained from other groups, or do additional resources need to be acquired?
- Initial estimates from the service needs and labour force modelling indicate that in order to meet the demand resulting from an ageing population (with the characteristics shown in the table above), the workforce will need to increase its share of the wider Counties Manukau working age population. This will mean its share needs to increase at the expense of other sectors in the Counties Manukau area. Clearly this presents issues around the need for CMDHB and associated organisations to attract, recruit and retain staff in order to meet the need for this increased share.