Royal Australasian College of Surgeons

Surgical workforce 2024 census report

Royal Australasian College of Surgeons
2024 Surgical Workforce Census Summary Report

This summary, and other Workforce Reports, are available at the Royal Australasian College of Surgeons website: www.surgeons.org

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ABBREVIATIONS

~	Not Applicable
%	Percentage of respondents
AoNZ	Aotearoa New Zealand
AMA	Australian Medical Association
ACT	Australian Capital Territory
AUS	Australia
CAR	Cardiothoracic surgery
CPD	Continuing Professional Development
F	Female
GEN	General surgery
IQR	Interquartile range
M	Male
N	Number of Fellows that responded to the Census question
NEU	Neurosurgery
NSW	New South Wales
NT	Northern Territory
ORT	Orthopaedic surgery
OTO	Otolaryngology Head and Neck surgery
PAE	Paediatric surgery
PLA	Plastic and Reconstructive surgery
QLD	Queensland
RACS	Royal Australasian College of Surgeons
SA	South Australia
SD	Standard deviation
SET	Surgical Education and Training Program
TAS	Tasmania
URO	Urology
VAS	Vascular surgery
VIC	Victoria
WA	Western Australia

INTRODUCTION

The Royal Australasian College of Surgeons (RACS), formed in 1927, is a non-profit organisation that is responsible for training surgeons and maintaining surgical standards across Australia and Aotearoa New Zealand. RACS' purpose is to be the unifying force for surgery in Australia and Aotearoa New Zealand, with FRACS standing for excellence in surgical care.

The Surgical Workforce Census commenced in 2005 and is conducted every two years. The Census is an important tool to assist RACS in its workforce planning and advocacy. It also provides additional information regarding a range of factors that affect surgeons in their day-to-day work. This allows RACS to build a picture of the challenges facing the surgical workforce and to help identify those areas in which RACS needs to advocate and find solutions.

This is the ninth Surgical Workforce Census conducted by RACS. Reports on our previous Censuses can be found on our website (www.surgeons.org).

KEY FINDINGS

Work Patterns

- Fellows employed full time worked an average of 45.6 hours per week.
- Fellows who work full time reported a preference to work 1.8 hours less than their current average of 45.6 hours per week.
- Part time Fellows reported a preference to work 1.5 hours more when comparing weekly hours worked and preferred hours. Locums preferred to work on average 2.7 hours less than they currently work.
- Fellows in the private sector reported working longer hours in consulting work than their public sector counterparts. Time spent on procedural work was similar in private and public sectors, however Fellows in the public sector spent more time on administration.
- Almost a quarter of Fellows were involved in other forms of paid employment such as clinical education/ assessment and medico legal work.

Rural and Regional Practice

- Almost 15% of Australian Fellows reported working exclusively in a regional, rural or remote location. For Aotearoa New Zealand Fellows, 15.6% reported working exclusively in a regional, rural or remote location. This increases to 18.6% for Australia and 18% for Aotearoa New Zealand when including those Fellows who mainly work in a regional or rural location with outreach to other regional, rural or remote area(s).
- Of the Fellows who worked in regional, rural or remote locations only, 80% were full time and reported working on average 39.4 hours per week. This is slightly less than the overall average hours per week recorded for all full time respondents (45.6 hours).
- The majority of Fellows indicated no intention to change their future work hours in rural or regional settings.

Pro Bono Work

- Sixty-five percent of Fellows participated in pro bono or volunteer work in 2024.
- Fellows reported working on average 11 hours per month on pro bono activities.
- The most frequently reported pro bono activities were contributions to RACS, including the SET Program, followed by clinical education not related to RACS.
- For RACS focused activities, contributing as an educational instructor/ examiner, SET Program supervisor and surgical mortality assessor were the most frequently reported pro bono contributions made by Fellows.
- Approximately 21% of Fellows engaged in outreach services monthly, including both metropolitan and rural based Fellows.
- The majority of Fellows indicated no intention to change their future work hours in rural or regional settings.

Wellbeing

- Administrative regulation and processes continue to rate as a high to extreme source of stress for Fellows, rating higher than workplace culture and the threat of litigation.
- Over three quarters of Fellows monitored their health in the last two years, visiting a medical doctor for a health check-up or at regular intervals as dictated by existing medical conditions (78.1%).
- Almost one in ten Fellows reported seeking professional assistance for stress or mental health issues in the last two years.

Future Work Intentions

- Fellows across all age ranges intend on reducing their preferred weekly work hours gradually over the next 10 years.
- For Fellows aged 40 – 59 years, male Fellows have a preference to work slightly more hours in future years than female Fellows. For Fellows aged 60 years and older, male and female respondents reported similar preferences for current and future hours worked.
- Almost 62% of Fellows aged 50 years old and over plan to retire from all forms of paid work within the next ten years.
- Most Fellows aged 65 years or older who intend to continue in paid employment will maintain work predominately because they are doing work that they enjoy.

METHOD

Surgeon Eligibility Criteria

All surgeons who are Fellows of RACS and whose usual workplace is in Australia and Aotearoa New Zealand were eligible to participate in the 2024 Surgical Workforce Census. RACS Fellows are admitted to Fellowship in one of the following specialties: Cardiothoracic surgery (CAR), General surgery (GEN), Neurosurgery (NEU), Orthopaedic surgery (ORT), Otolaryngology Head and Neck (OTO), Paediatric surgery (PAE), Plastic surgery (PLA), Urology (URO) or Vascular surgery (VAS). Surgeons that trained in the specialties of Ophthalmology or Obstetrics and Gynaecology and RACS Fellows working outside Australia or Aotearoa New Zealand were not eligible to participate in the Census.

A Fellow may be defined as 'Active' or 'Retired' (i.e., no longer registered to practise medicine). At the time of the Census commencement, there were 7637 Fellows in Australia and Aotearoa New Zealand eligible to participate. Eligible Fellows excluded those with no email address registered with RACS or who have a no communication request. Of the 7637 eligible Fellows, 203 had previously opted out of survey communication and a further 1227 did not have their email invitation successfully delivered. As a result, the final survey invitation was issued to 6207 Fellows.

Table 1.1: 2024 Surgical Workforce Census target population

	Total
All Active and Retired Fellows eligible	7637
Less no email delivered/ opted out	1430
Total no. of Census invitations	6207

Census Questionnaire and Tools

The Census consists of a set of core questions that are relevant to the Fellows' day-to-day work, future work intentions and wellbeing. More specifically, Fellows were asked to reflect upon their workforce status, weekly hours of work at present and as intended in the future, frequency of emergency on-call work, private billing practices (where applicable), retirement intentions, leave taken, stressors, health monitoring, and pro bono roles, including contributions to RACS. SurveyMonkey was the survey tool used to collect data via an online survey. Microsoft Excel was used to conduct the statistical analysis. Co-Pilot Premium was used to assist with identifying the most frequently reported themes for a new question on barriers to working more in rural, regional and remote areas.

Data Analysis

When a question elicited a 'not applicable' answer, the response was excluded from the total. Respondents that did not answer a question were excluded from analysis of that question. At the time of survey, a small proportion of valid responses (2.0%) were from Fellows reporting that they currently live outside of Australia or Aotearoa New Zealand; these were also excluded from further analysis.

Table 1.2: Summary of respondents excluded from analysis

Total number of respondents	1582	
Number of respondents overseas (excluded)	31	2.0%
Number of unusable, partially complete respondents (excluded)	111	7.0%
Final number of valid respondents	1440	

Data were analysed (where applicable) by segments including sex (male/ female/unspecified), age (≤39, 40-49, 50-59, 60-69, 70-79, ≥80), location (8 Australian states/ territories/ Aotearoa New Zealand), country (Australia, Aotearoa New Zealand), surgical specialty (CAR, GEN, NEU, ORT, OTO, PAE, PLA, URO, VAS) and workforce status (full time, part time, locum). Unless otherwise stated, descriptive statistics presented in this report are based on results of the respondent population, imputation or weighting methods have not been applied.

Chapter 1 – Descriptive Statistics

RACS achieved a 23.2% response rate (n=1440) for the 2024 Surgical Workforce Census, a similar response rate recorded for the 2022 Surgical Workforce Census (24%).[1] The country-specific response rate was 17% of Australian Fellows and 31% of Aotearoa New Zealand Fellows. For 496 Fellows, the online survey response status was recorded as 'unopened'. As a result, the response rate could be between 23.2% (from 6207 invitations) and 25.2% (from 5711 invitations).

Out of 1440 respondents, 1292 were in Active practice, while 148 reported in the survey they were Retired.

To establish representativeness of the results, the Active respondents were compared with Active Fellows from the RACS 2024 Activities Report.[2] The respondents represent a consistent demographic profile to that of the RACS Active Fellowship population, with similar age group, sex and surgical specialty profiles. In addition, all Australian states and territories and Aotearoa New Zealand were broadly represented in the Census data set when compared to the wider Fellowship (Figure 1.1 to Figure 1.4).

Figure 1.1: Sex profile of Active Census respondents and Active RACS Fellows

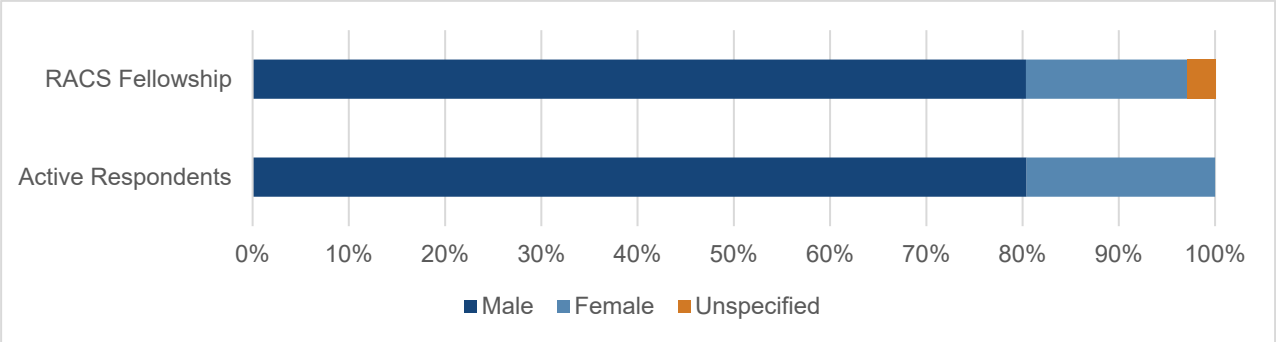


Figure 1.2: Age profile of Active Census respondents and Active RACS Fellows

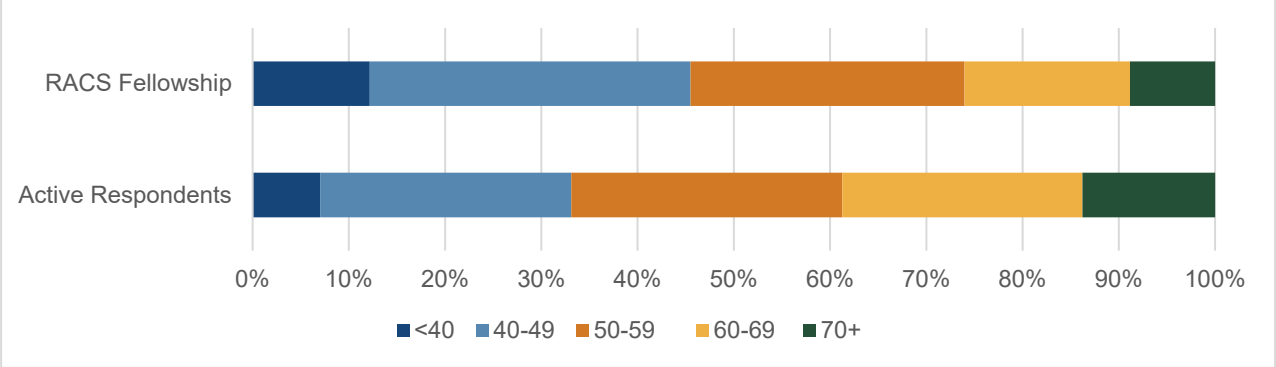
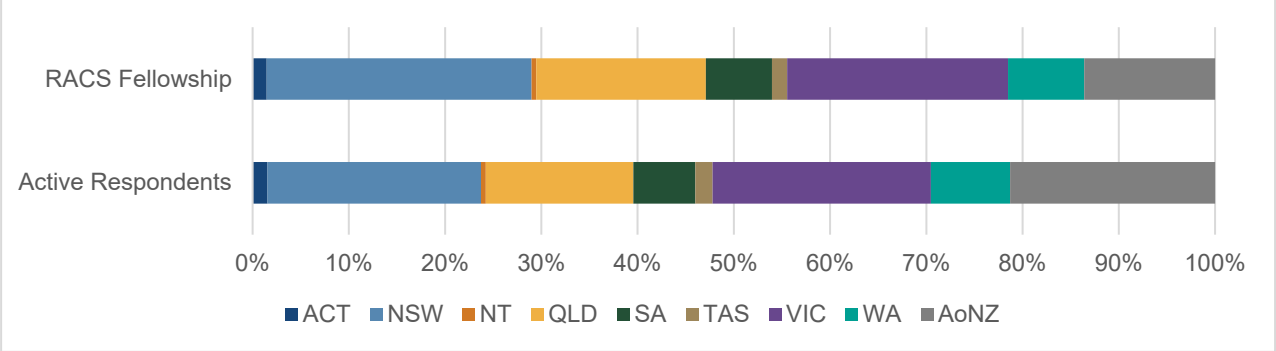
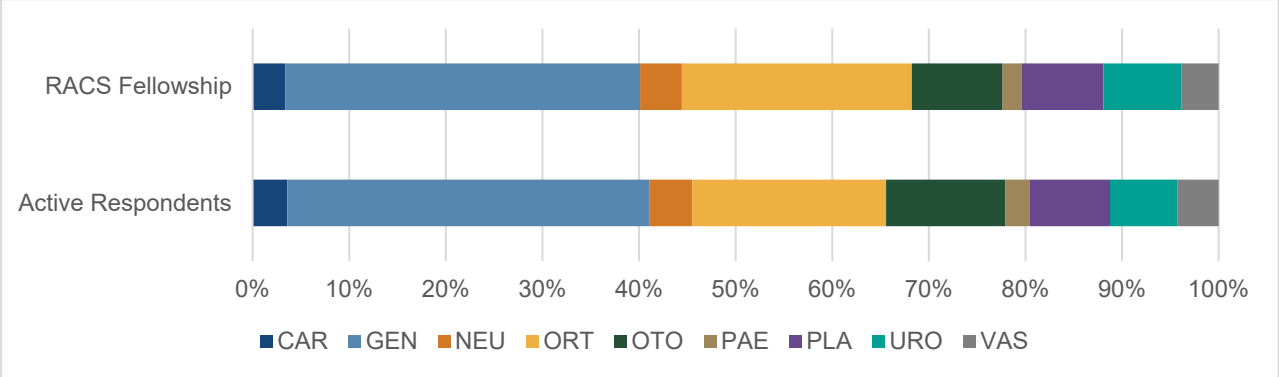


Figure 1.3: Location profile of Active Census respondents and Active RACS Fellows



Note: Refer to Table A1.1 to A1.3 in Appendix A for the tabulated data

Figure 1.4: Surgical specialty profile of Active Census respondents and Active RACS Fellows

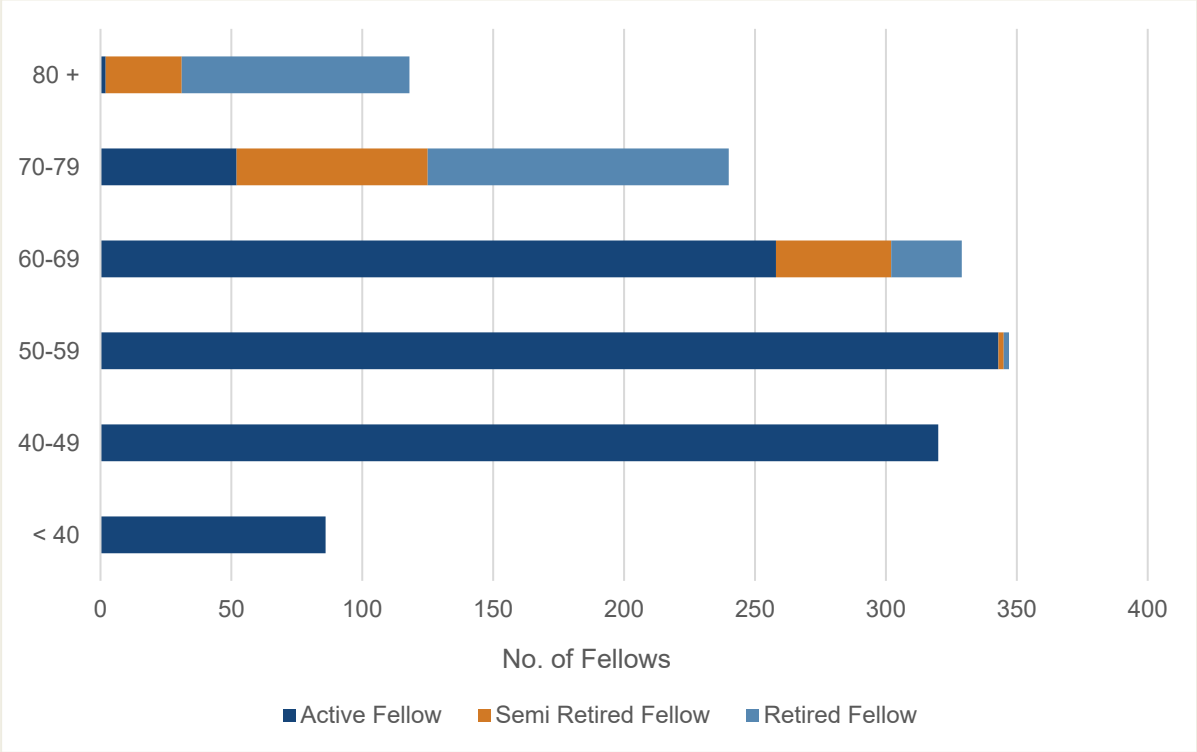


Note: Refer to Table A1.4 Appendix A for the tabulated data

In terms of Fellowship status, 73.7% of respondents reported they were an Active Fellow, 16% as a Semi-retired Fellow and 10.3% a Retired Fellow (Figure 1.5).

The mean age of respondents (Active and Retired) was 59.3 years. With the mean age of 50 years, female Fellows were 11 years younger on average than their male counterparts.

Figure 1.5: Age distribution and Fellowship status of Census respondents



Note: Refer to Table A1.5 and A1.6 in Appendix A for the tabulated data

Chapter 2 – Work Patterns

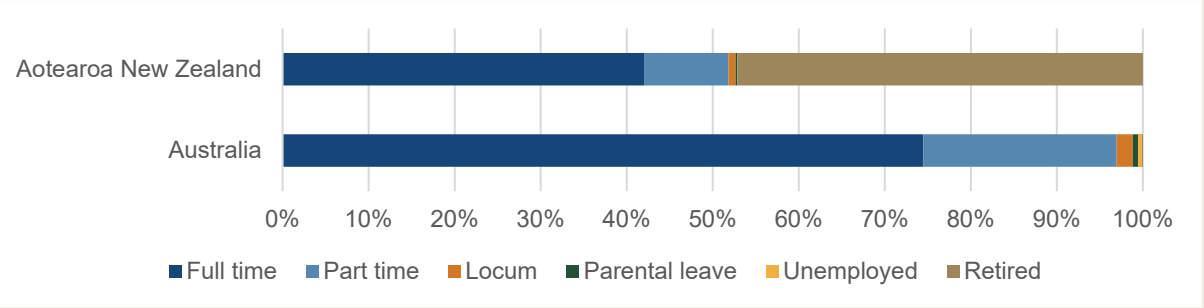
Summary

- Fellows employed full time worked an average of 45. 6 hours per week.
- Fellows who work full time reported a preference to work 1.8 hours less than their current average of 45.6 hours per week.
- Fellows who work part time reported a preference to work 1.5 hours more when comparing weekly hours worked and preferred hours (19.9 and 21.5 respectively).
- Locums preferred to work on average 2.7 hours less than they are currently working.
- Fellows in the private sector reported working longer hours in consulting work than their public sector counterparts. Time spent on procedural work was similar in private and public sectors, however, Fellows in the public sector spent more time on administration.
- In the public sector, one in ten Fellows worked more than the recommended emergency on-call period of 1:4.
- Almost a quarter of Fellows were involved in other forms of paid employment such as clinical education/ assessment and medico legal work.

Employment Status

Just over 75.5% of Active Fellows reported that they were working full time (Figure 2.1). Only one respondent aged 59 years or less reported that they were unemployed at the time of the Census.

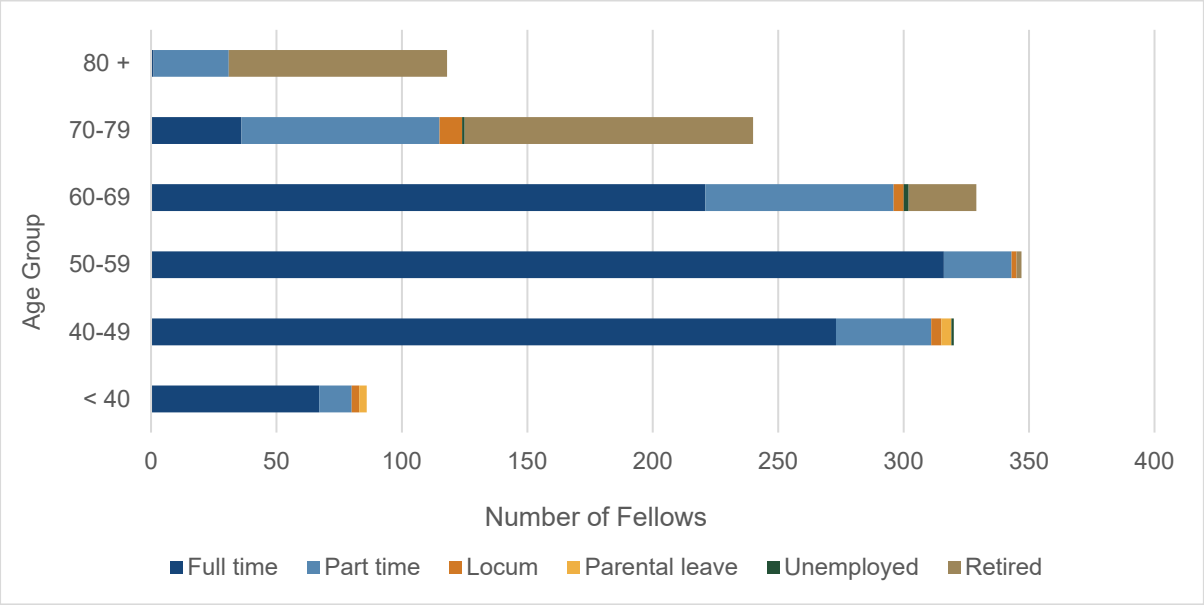
Figure 2.1: Employment status of Fellows by country



Note: Refer to Table A2.1 in Appendix A for the tabulated data

Almost 22 percent of Active Fellows reported they were working in a part time capacity, with the majority of these part time Fellows (n=184) aged 60 years and over, reflecting a career transition into retirement. Locum work was undertaken by a very small proportion of Active Fellows, 1.8% of respondents (Figure 2.2).

Figure 2.2: Employment status of Fellows by age group

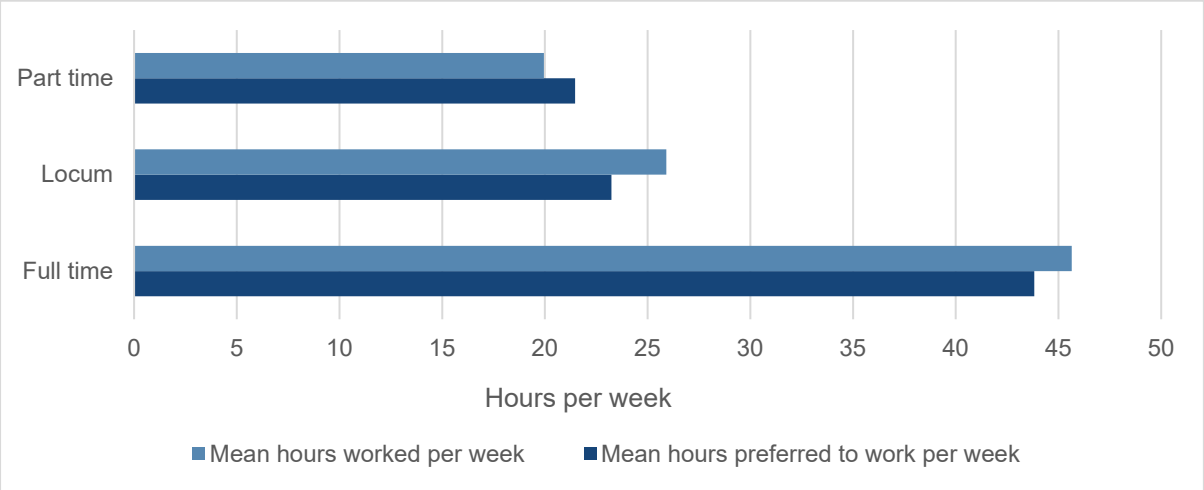


Note: Refer to Table A2.2 in Appendix A for the tabulated data

Work Hours

Fellows employed full time reported working an average of 45.6 hours per week, although they preferred to work almost 2 hours less a week (Figure 2.3). Part time Fellows worked on average 19.9 hours per week and reported a preference to work similar hours to those currently worked (21.5 hours). Locums reported working on average 25.9 hours per week, with a preference to work 2.7 hours less.

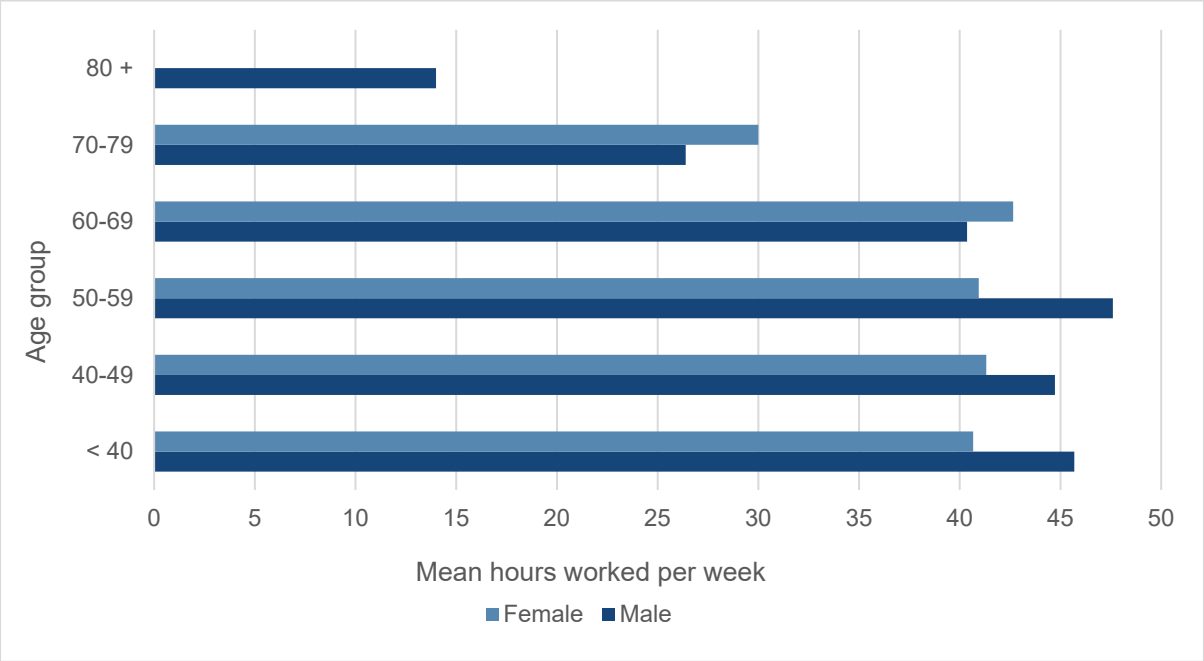
Figure 2.3: Mean hours worked per week and preferred weekly work hours by workforce status



Note: Refer to Table A2.3 in Appendix A for the tabulated data

Until the age of 60 years, female Fellows worked on average 41.0 hours a week, while male Fellows reported working on average 46 hours a week. Compared to other female age groups, female Fellows aged 60-69 worked the longest average hours per week (42.6 hours), while male Fellows in the 50-59 years age bracket reported working the longest hours on average (47.6 hours) when compared to other male age groups. Fellows aged 70-80+ years (male and female) had the lowest average hours worked per week (23.5 hours), a slight increase from 2022 (15.1 hours) (Figure 2.4).

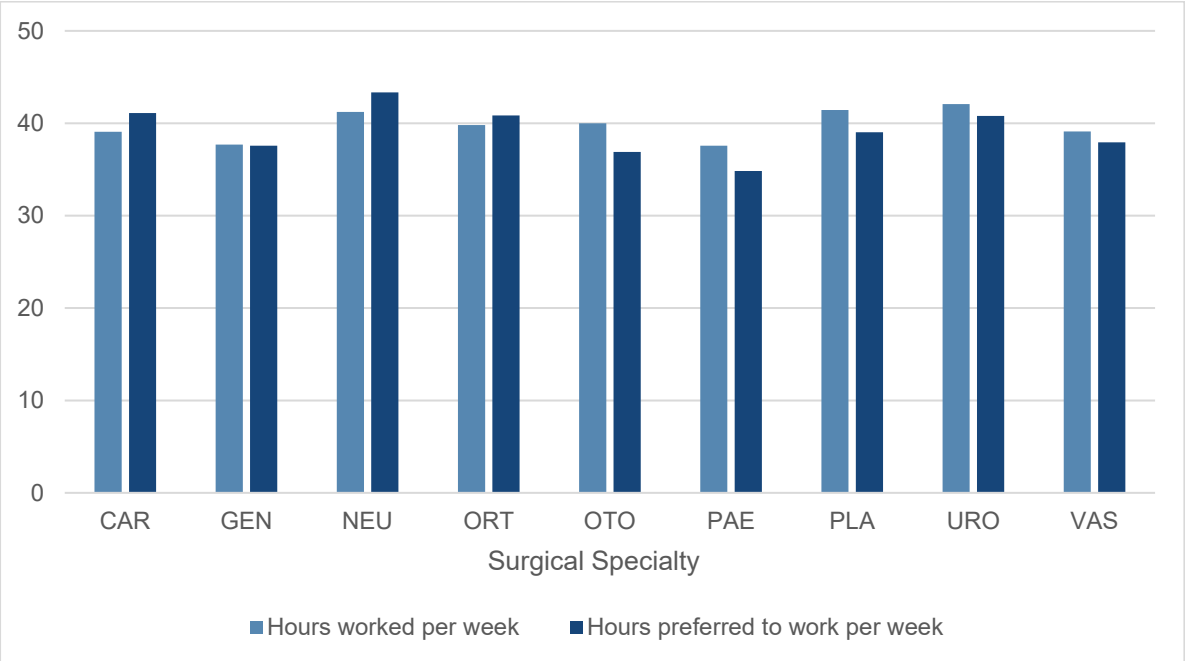
Figure 2.4: Mean hours worked per week by age group



Note: Refer to Table A2.4 in Appendix A for the tabulated data

For all Active Fellows (full time, part time and locum combined), Urologists reported the longest average hours worked per week (49.6 hours) and Paediatric surgeons reported the shortest average hours worked per week (42.1 hours) (Figure 2.5). General surgeons reported working on average similar hours to their preferred working hours. The biggest difference between weekly hours worked and preferred hours was reported by Otolaryngology Head and Neck surgeons, preferring to work on average 3.1 hours less per week than the 40 hours on average reported.

Figure 2.5: Mean hours worked per week and preferred weekly work hours by surgical specialty



Note: Refer to Table A2.5 in Appendix A for the tabulated data

Public and Private Sector Employment

Fifty-four percent of respondents reported working in public and private practice. Paediatric surgery had the highest percentage of respondents who only worked in public practice (46.7%). Conversely, Plastic and Reconstructive surgery had the highest percentage of respondents who only worked in private practice (41.2 %). The highest percentage of reported mixed practice was Otolaryngology (66%) (Figure 2.6).

Figure 2.6: Fellows working in public or private practice by surgical specialty

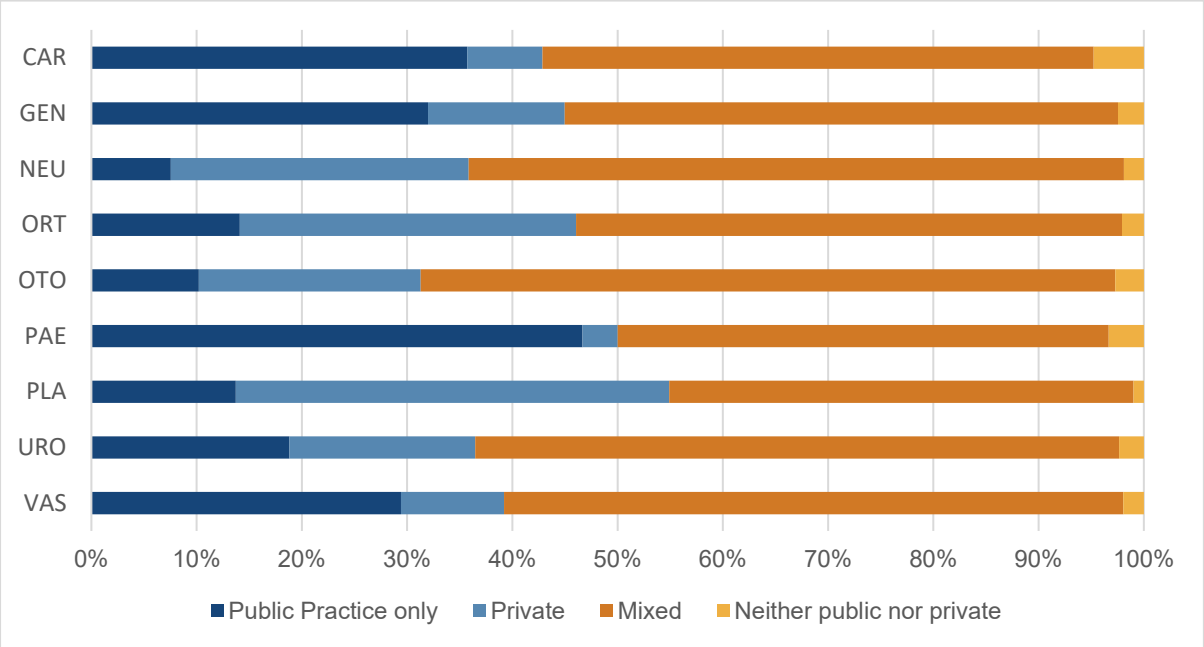
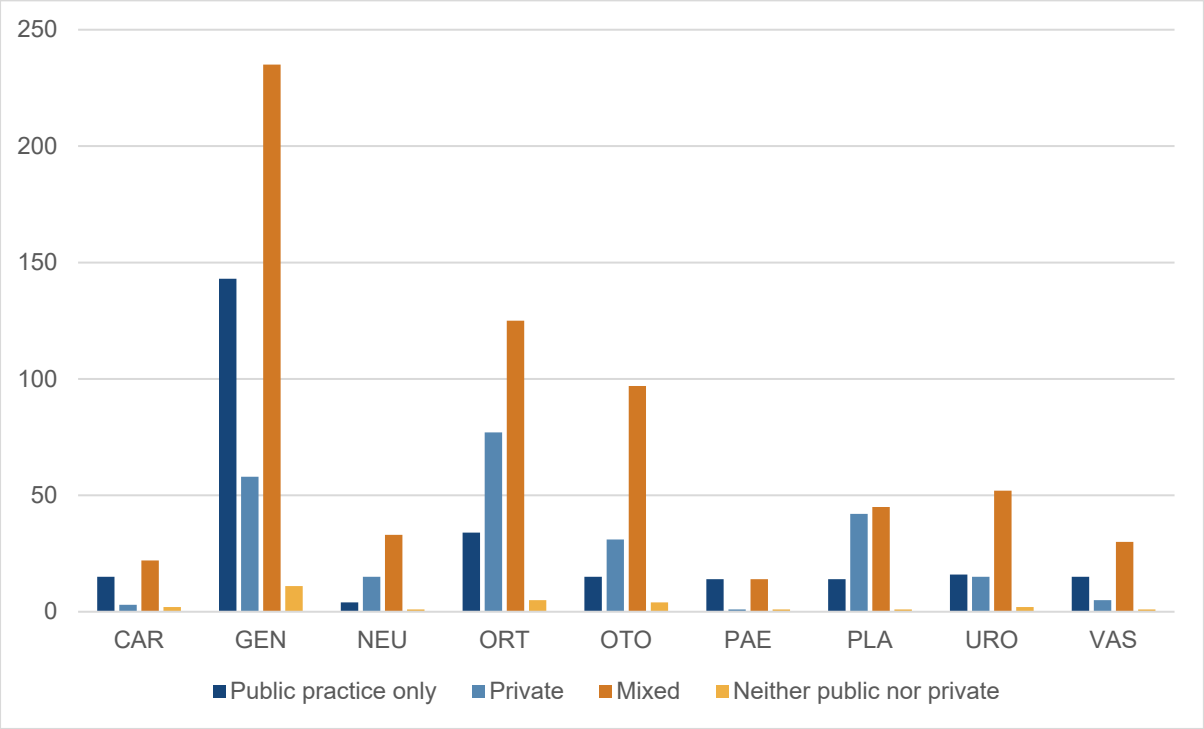


Figure 2.7: Number of Fellows working in public or private practice by surgical specialty



Note: Refer to Table A2.6 and A2.7 in Appendix A for the tabulated data

Fellows were asked to report on their average number of hours worked per week for consulting, procedural and administrative work (Table 2.1 and 2.2). Compared to 2022 Census results, the median hours spent on consulting, procedural work and administration remains stable for both public and private sectors.

Fellows in the private sector reported working more hours per week consulting than their public sector counterparts, with a median of 12 hours per week, compared to 7.5 hours a week consulting in the public sector. The median weekly hours spent on consulting work were higher in the private sector for all specialties. The largest differences of median hours worked between public and private practice were recorded for Otolaryngology, Neurosurgery and Plastic and Reconstructive surgery.

Fellows in the public sector reported spending more time on administrative work, reporting a median of four hours on average per week, compared to two hours per week in private practice.

The median hours per week recorded for procedural work was the same for respondents working in the public and private sector.

Table 2.1: Median hours per week with interquartile range (IQR) Fellows spent on consulting, procedural work and administrative work in the public sector by surgical specialty

	Consulting (IQR)	Procedural work (IQR)	Administration (IQR)
CAR	7 (4 – 13.5)	16 (11 - 24)	6 (3.5 – 10.5)
GEN	8 (4 - 12)	10 (8 - 16)	5 (2 – 10)
NEU	4 (4 – 8)	10 (7.5 - 12)	4 (2 - 8)
ORT	7 (4 - 10)	8 (4 - 12)	3 (2 - 6)
OTO	6 (4 - 10)	6 (4 - 8)	2 (1 - 5)
PAE	10 (8 – 12.75)	10 (8 – 17.5)	8 (5 – 12)
PLA	5 (4- 10)	9.5 (5 – 15.25)	4 (2 - 6)
URO	7 (4 – 10)	8 (5 – 10)	3 (2 – 5)
VAS	6 (4 - 10)	10 (5 – 10)	4 (2 – 7.5)
TOTAL	7.5 (4 - 10)	10 (5 - 10)	4 (2 - 8)

Table 2.2: Median hours per week with interquartile range (IQR) Fellows spent on consulting, procedural work and administration in the private sector by surgical specialty

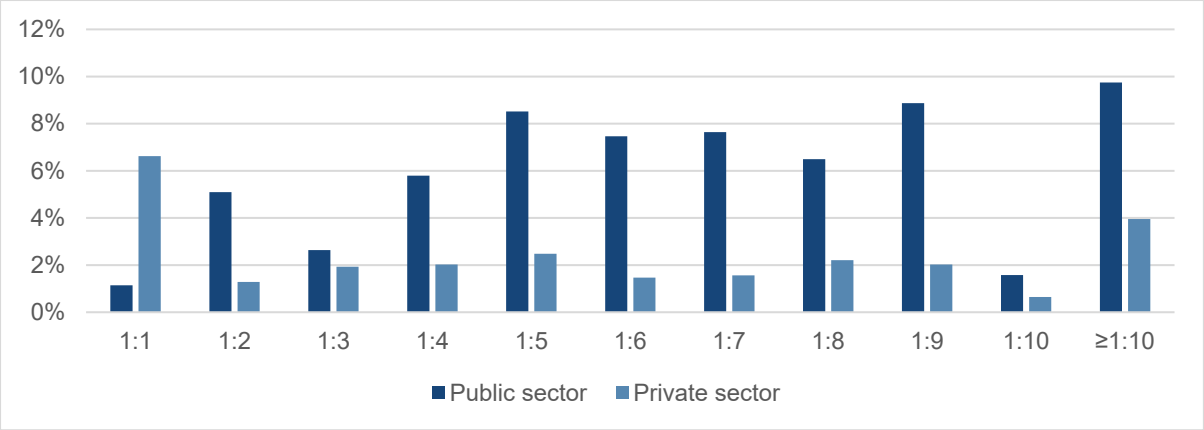
	Consulting (IQR)	Procedural work (IQR)	Administration (IQR)
CAR	12 (2 – 10.5)	10 (7.5 - 20)	1 (1 – 4.5)
GEN	10 (5 - 14)	9 (5 - 14)	2 (1- 4)
NEU	17 (8.5 – 24.75)	10 (8 - 15)	2 (1 - 4)
ORT	15 (10 - 20)	12 (8 – 17.75)	2 (1 - 4)
OTO	20 (12.25 - 25)	9 (6 - 12)	2 (1 - 4)
PAE	5 (4 - 8)	4 (2 - 6)	2 (1 - 4.25)
PLA	15 (8 - 18)	16 (12 - 20)	2 (1 - 4)
URO	15 (10 - 21)	12 (7.25 – 17.75)	2 (1 - 3)
VAS	14.5 (8 - 16)	10 (5 – 15.5)	2 (1 - 4)
TOTAL	12 (8 - 20)	10 (6 - 16)	2 (1 - 4)

Fewer Fellows in the private sector reported undertaking emergency on-call work compared to the public sector. Almost 74% of Fellows in the private sector reported they do not undertake emergency

on call work, compared to 35% of Fellows working in the public sector. Of those doing on-call work in the public sector, one in ten Fellows undertook emergency on-call more frequently than the recommended 1:4 rotation [3] (Figure 2.8).

Almost 7% of respondents who undertook emergency on-call work in the private sector did so at 1:1 frequency. This is likely to reflect the permanent 'on-call' state Fellows maintain for their patients in private hospitals.

Figure 2.8: Frequency of emergency on-call Fellows undertook by work sector

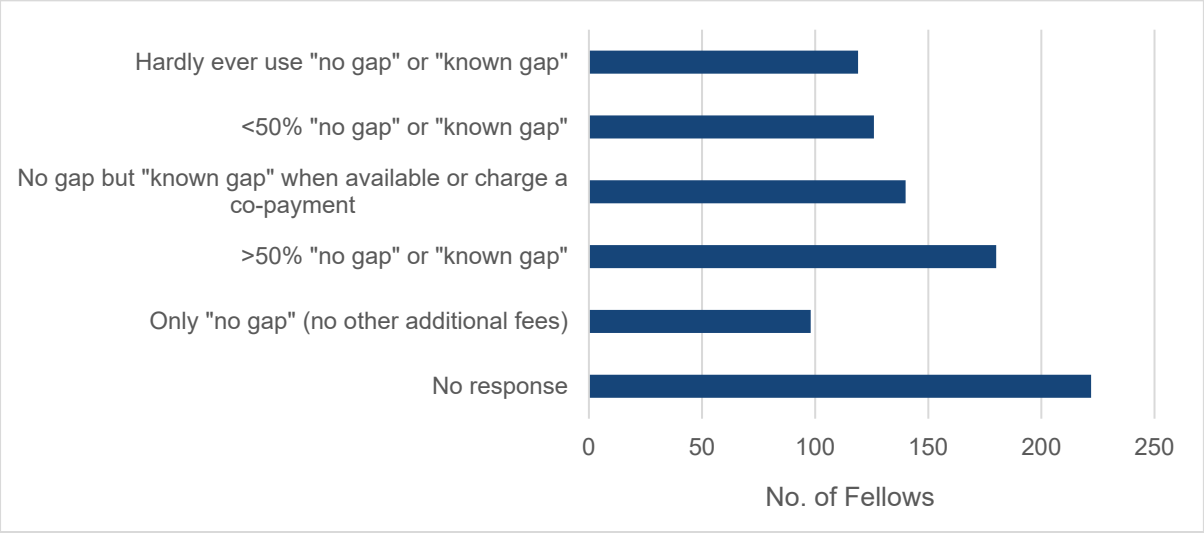


Note: Refer to Table A2.8 in Appendix A for the tabulated data

Private Billing Practices in Australia

The Surgical Workforce Census collects data on private billing practices. Australian Fellows who work in the private sector were asked to describe how their procedural billing is obtained, considering their total private procedural income. Responses were spread across the range of options, with 20.3% of Fellows selecting >50% "no gap" or "known gap", 15.8% selecting "no gap" but "known gap" when available or charge a co-payment and 11% selecting only "no gap" (no other additional fees). Just over 14% reported <50% "no gap" or "known gap" and a further 13.4% advised they hardly ever use "no gap" or "known gap" (Figure 2.9).

Figure 2.9: Method used to obtain private billing income, considering total private procedural income, Australia

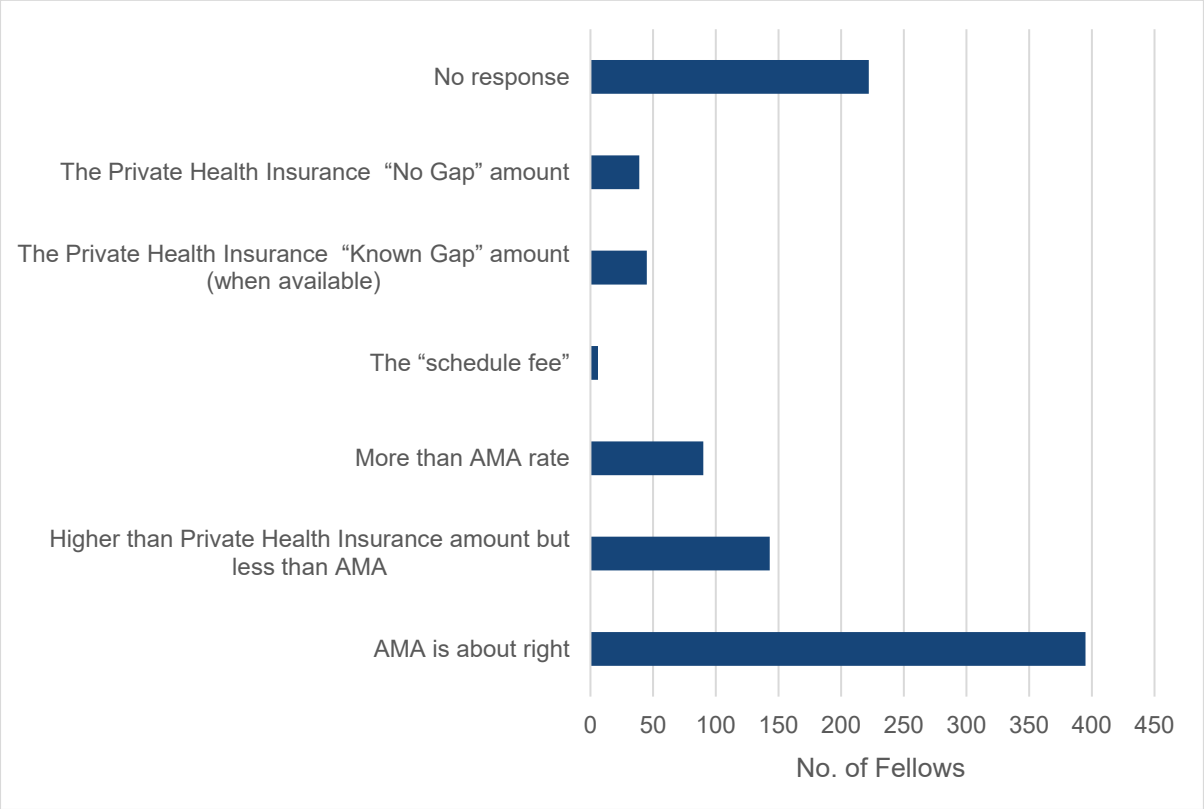


Note: Refer to Table A2.9 in Appendix A for the tabulated data

Fellows were also asked what they consider to be a fair professional fee, ignoring their current billing practice (Figure 2.10).

Almost 42% of respondents reported that the Australian Medical Associating (AMA) fee is about right as a fair professional fee (n=395). The second most frequently selected option was higher than the private health insurance amount, but less that the AMA (15.2%).

Figure 2.10: Consideration of fair professional fee, ignoring current private billing practices, Australia



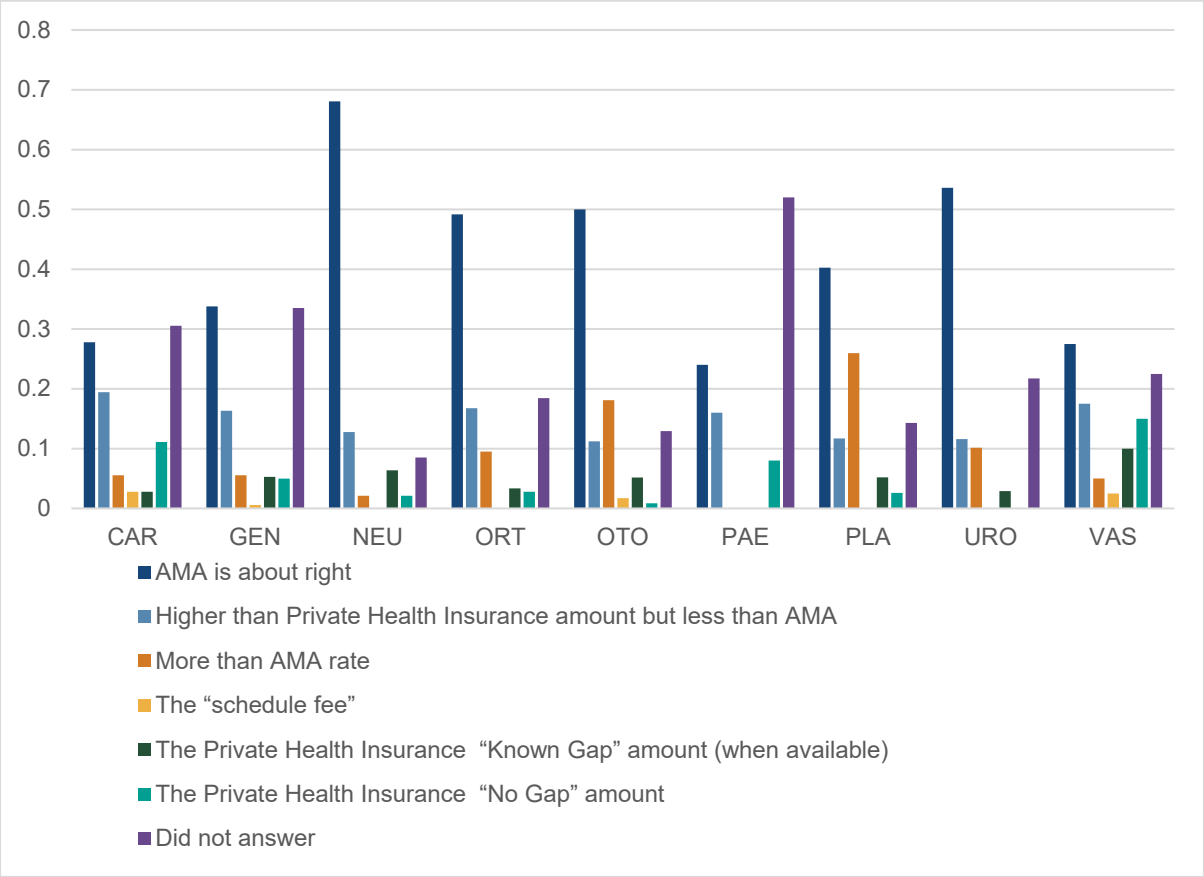
Note: Refer to Table A2.10 in Appendix A for the tabulated data

Of the 395 Fellows who reported that they consider the AMA to be about right in terms of a fair professional fee, the most frequently selected options for obtaining private billing income were >50% "no gap" or "known gap" (n=104) and <50% "no gap" or "known gap" (n=88). For a crosstabulation of the results for how private billing is obtained and what Fellows considered to be a fair professional fee, refer to Table 2.10a in Appendix A.

The results for consideration of fair professional fee were reviewed by each surgical specialty (Figure 2.11).

When comparing specialties, Neurosurgeons agreed with the statement that the AMA is about right the most frequently (68%) of compared to 34% of General surgeons and 24% of Paediatric surgeons. The lack of support for the "schedule fee" as a fair professional fee was consistent across the surgical specialties.

Figure 2.11: Consideration of fair professional fee, ignoring current private billing practices by surgical specialty, Australia

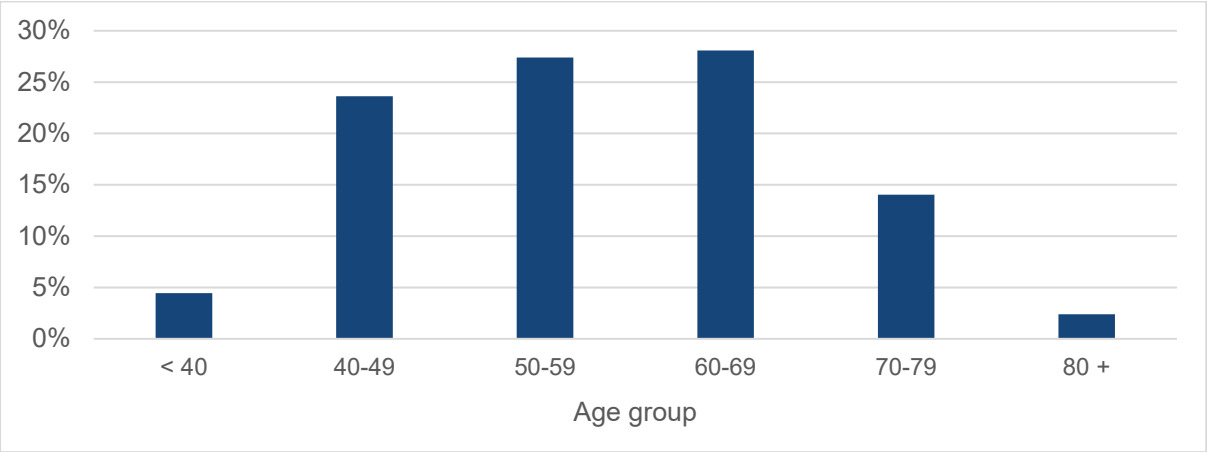


Note: Refer to Table A2.11 in Appendix A for the tabulated data

Other Paid Employment

A quarter of Active Fellows reported that they are involved in other forms of paid employment (n=292) (Figure 2.12). Fellows aged 60 – 69 reported the highest rate of involvement in other forms paid employment.

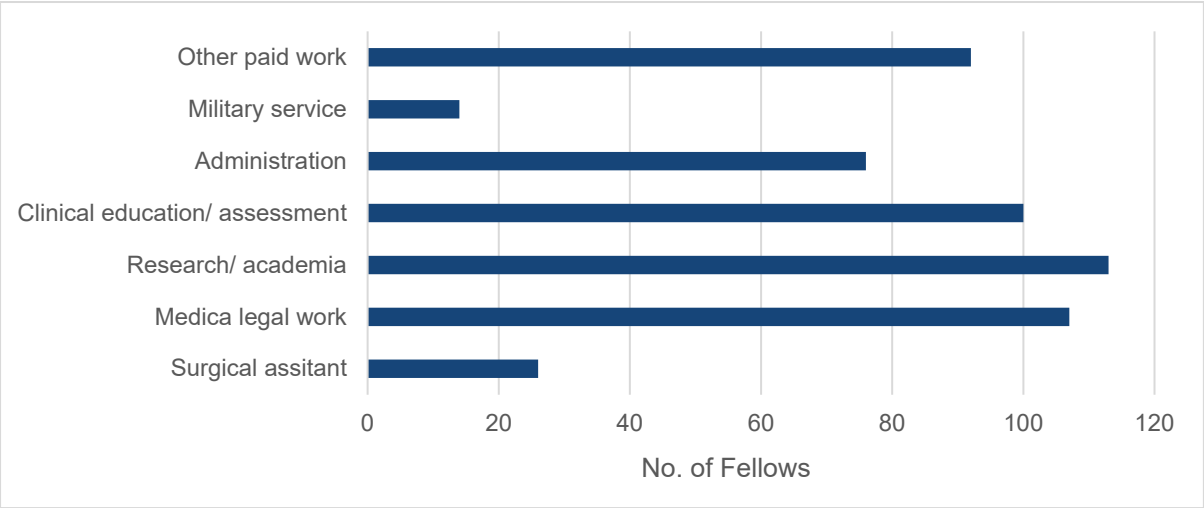
Figure 2.12: Active Fellows involved in other forms of paid employment by age group



Note: Refer to Table A2.12 in Appendix A for the tabulated data

The most common forms of other employment Fellows are engaged in research/ academia, clinical education/ assessment and medical legal work (Figure 2.13).

Figure 2.13: Other forms of paid employment for Active Fellows



Note: Refer to Table A2.13 in Appendix A for the tabulated data

Chapter 3 – Regional, Rural and Remote Practice in Australia and Aotearoa New Zealand

Summary

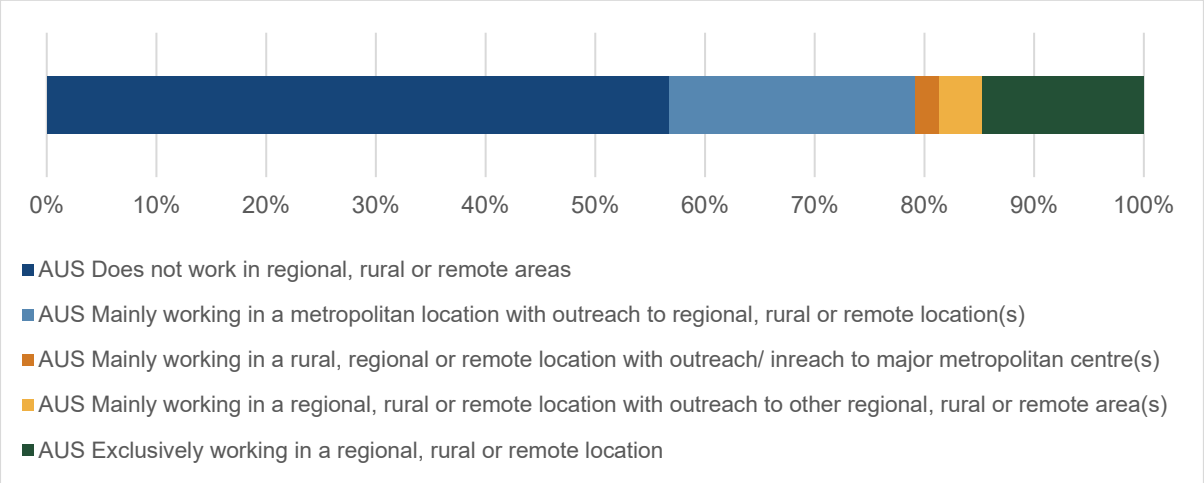
- Almost 15% of Australian Fellows reported working exclusively in a regional, rural or remote location. For Aotearoa New Zealand Fellows, 15.6% reported working exclusively in a regional, rural or remote location. This increases to 18.6% for Australia and 18% for Aotearoa New Zealand when including those Fellows who mainly work in a regional or rural location with outreach to other regional, rural or remote area(s).
- Of the Fellows who worked in regional, rural or remote locations only, 80% were full time and reported working on average 39.4 hours per week. This is slightly less than the overall average hours per week recorded for all full time respondents (45.6 hours).
- Approximately 21% of Fellows engaged in outreach services monthly, including both metropolitan and rural based Fellows.
- The majority of Fellows indicated no intention to change their future work hours in rural or regional settings.

Characteristics of the Regional, Rural and Remote Workforce

Approximately 43% of Australian and 42% of Aotearoa New Zealand respondents reported that they worked in a regional, rural or remote location; this includes those practising in both metropolitan locations and regional, rural or remote location(s). Examples of metropolitan locations in Australia are Melbourne, Geelong, Canberra, Sydney, Newcastle, Wollongong, Brisbane, Gold Coast, Sunshine Coast, Adelaide, Perth. For Aotearoa, New Zealand metropolitan locations are Auckland, Hamilton, Wellington, Christchurch, Dunedin and Tauranga.

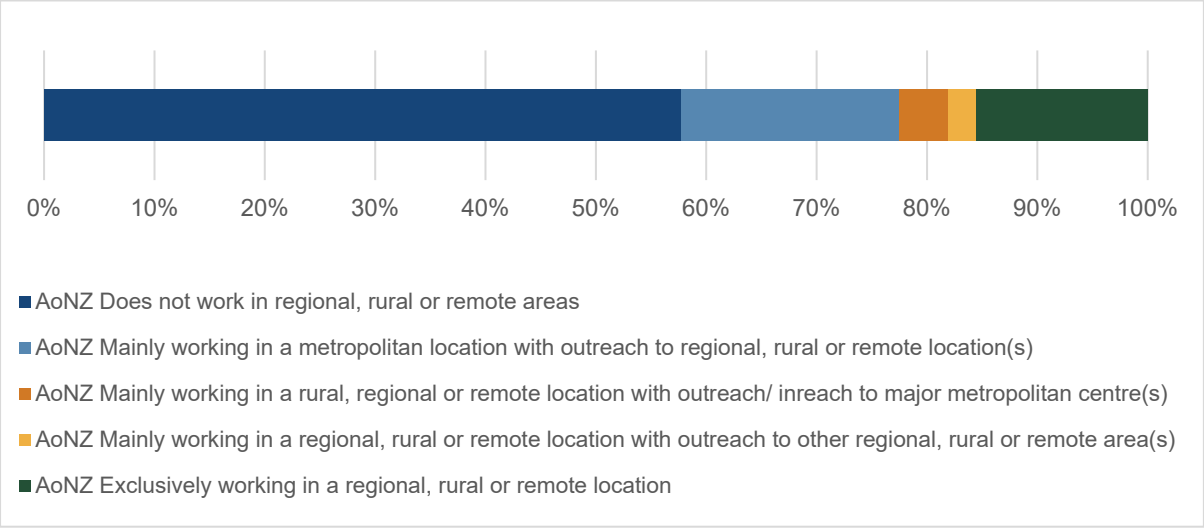
For Australia, the proportion of Fellows reporting that they worked exclusively in a regional, rural or remote location was 14.7%. This increases to 18.6% when including those Fellows who mainly work in a regional or rural location with outreach to other regional, rural or remote area(s). For Aotearoa New Zealand, the proportion of Fellows reporting they worked exclusively in a regional or rural location was 15.6%. This increases to 18% when including those Fellows who mainly work in a regional/ rural location with outreach to other regional, rural, remote area(s).

Figure 3.1a: Location of work for Active Fellows, Australia



Note: Refer to Table A3.1 in Appendix A for the tabulated data

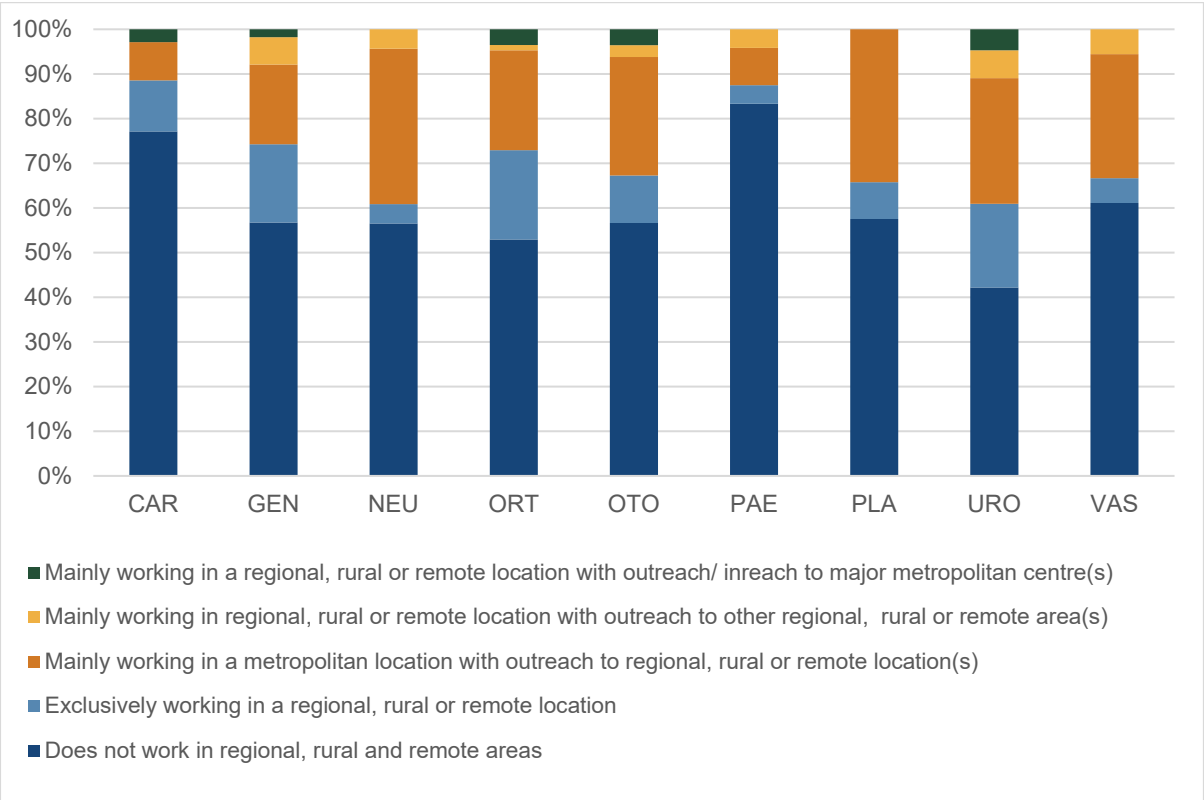
Figure 3.1b: Location of work for Active Fellows, Aotearoa New Zealand



Note: Refer to Table A3.1 in Appendix A for the tabulated data

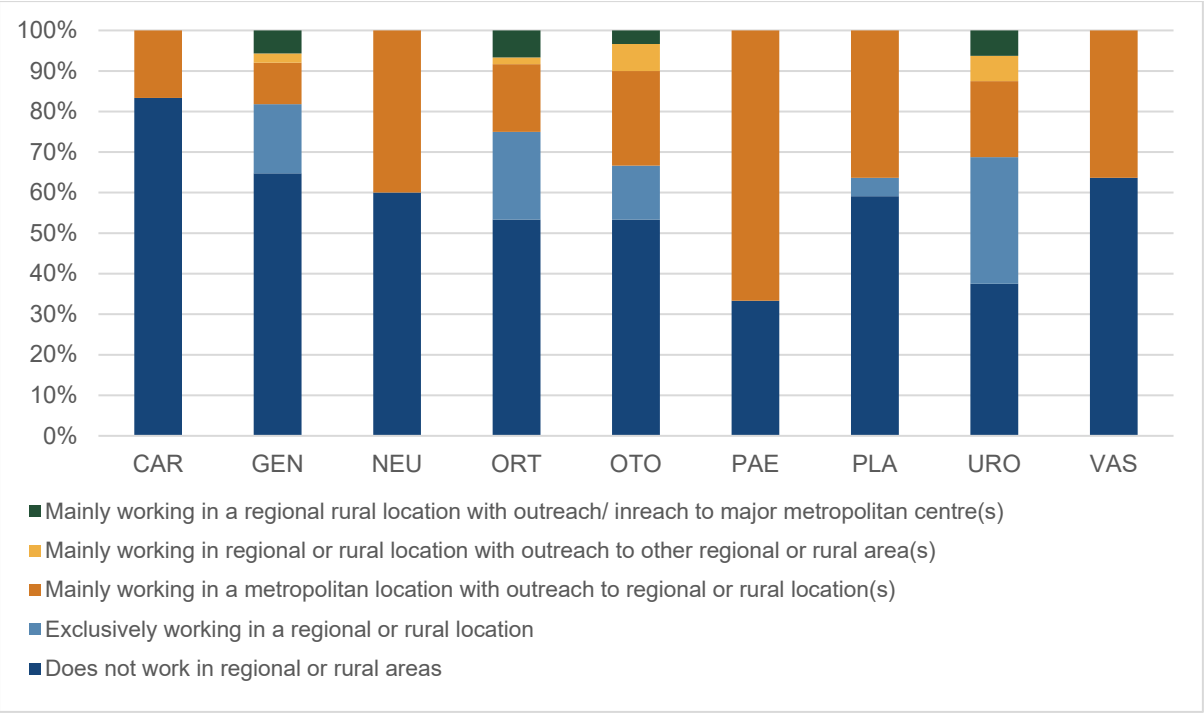
For respondents residing in Australia, the highest proportion of Fellows who worked exclusively in a regional, rural or remote location were Orthopaedic surgery (20%), Urology (18.7%) and General surgery (17.5%). For respondents residing in Aotearoa New Zealand, the highest proportion of Fellows who worked exclusively in a regional or rural location were Urology (31.3%), followed by Orthopaedic surgery (21.7%) and General surgery (17%). (Figure 3.2a and 3.2b)

Figure 3.2a: Fellows working in a regional, rural or remote location by surgical specialty, Australia



Note: Refer to Table A3.2a in Appendix A for the tabulated data

Figure 3.2b: Fellows working in a regional, rural or remote area by surgical specialty, Aotearoa New Zealand



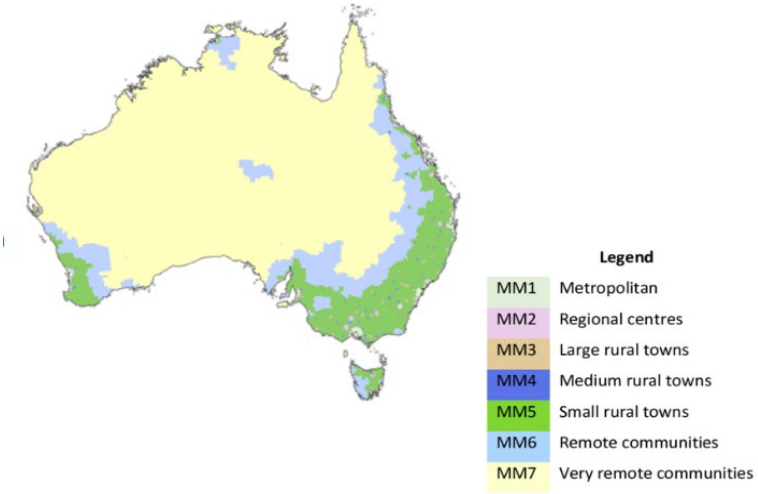
Note: Refer to Table A3.2b in Appendix A for the tabulated data

Rural Location Classifications

To further investigate the number of surgeons that provide care outside major metropolitan centres, Fellows were asked to provide the postcode of their main practice location and other practice location(s) in order of FTE (full time equivalent). Postcodes were mapped to national location classifications.

At the time of the 2024 Census, Australia applied the Modified Monash Model (MMM) 2019 to classify metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics and town size.[6] The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

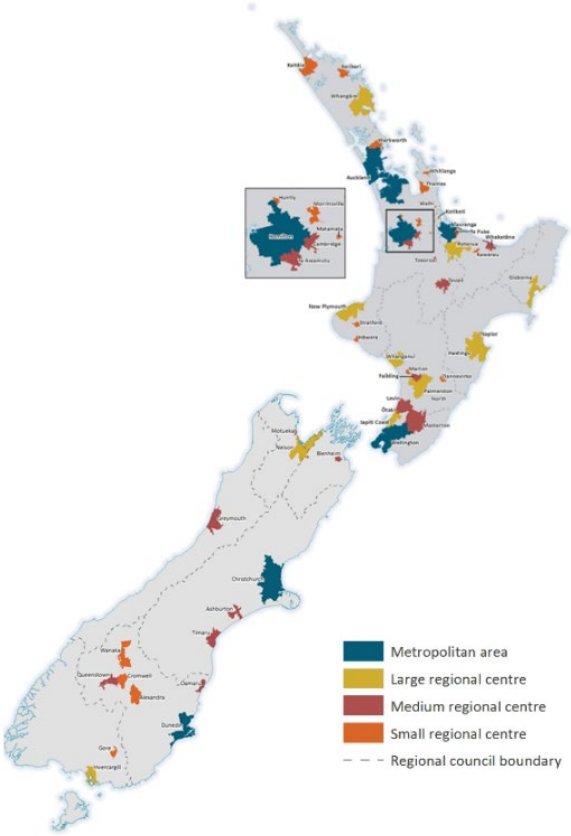
Australian Modified Monash Model (2019)



Source: Australian Department of Health and Aged Care

Aotearoa New Zealand uses the Functional Urban Areas (FUA) classification (2022) developed by Stats NZ to identify small urban areas and rural areas that are integrated with major, large, and medium urban areas to create Functional Urban Areas.[7] FUA types are categorised as metropolitan area, large regional centre, medium regional centre, small regional centre and land outside FUAs.

Aotearoa New Zealand Functional Urban Areas (2022)



Source: Stats New Zealand

Using the Monash Modified Model (2019) to establish regional, rural and remoteness, of the Australian Fellows who reported working a regional, rural or remote location, 52.3% of respondents recorded their main practice location in a metropolitan setting (MM1) and almost 23% in a regional centre (MM2). Just over 11% of Fellows had their main practice location in large rural town (MM3) and 10% in a small rural town (MM5). Almost 2 % of Australian Fellows had a main practice in either a remote or very remote community (MM6 – 7) and a further 1.6% in a medium rural town (MM4). (Figure 3.3a)

Using the Functional Urban Areas (2022) classification to establish rural and regionality, of the Aotearoa New Zealand Fellows who reported working in a regional, rural or remote location, 49.5% of respondents recorded their main practice location in a metropolitan area and almost 34% in a large regional centre. A further 7.8% had their main practice location in a medium regional centre, almost 6% in land area outside FUA and almost 3% in a small regional area. (Figure 3.3b)

Of the 494 active Australian and Aotearoa New Zealand Fellows who reported that they worked in a full time, part time, or locum capacity in a regional, rural or remote location, it should be noted that 10.3% of Fellows (n=26) provided postcodes for a primary that were classified as metropolitan areas only (i.e. MM1 and FUA Metropolitan area). Therefore, the results differ when comparing location of work based on the four options for regional/ rural/ remote practice featured in Figures 3.1a and 3.1b and the location classification results using the Modified Monash Model and Functional Urban Areas (Figures 3.3a and 3.3b).

Of the 494 active Fellows who reported that they worked in a full time, part time or locum capacity in a regional, rural or remote area, 252 respondents (51.2%) provided postcodes for primary practice location in a metropolitan area (combined Australia and Aotearoa New Zealand).

Figure 3.3a: Location of work using Monash Modified Model classification for Fellows in Australia

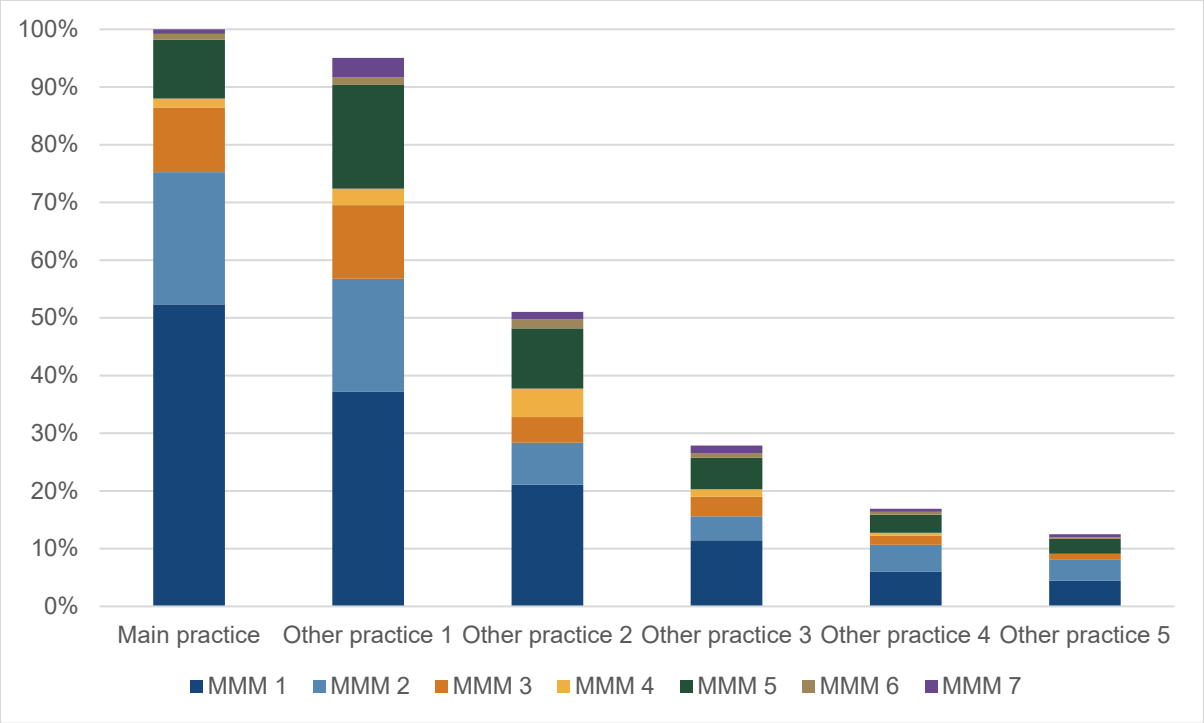
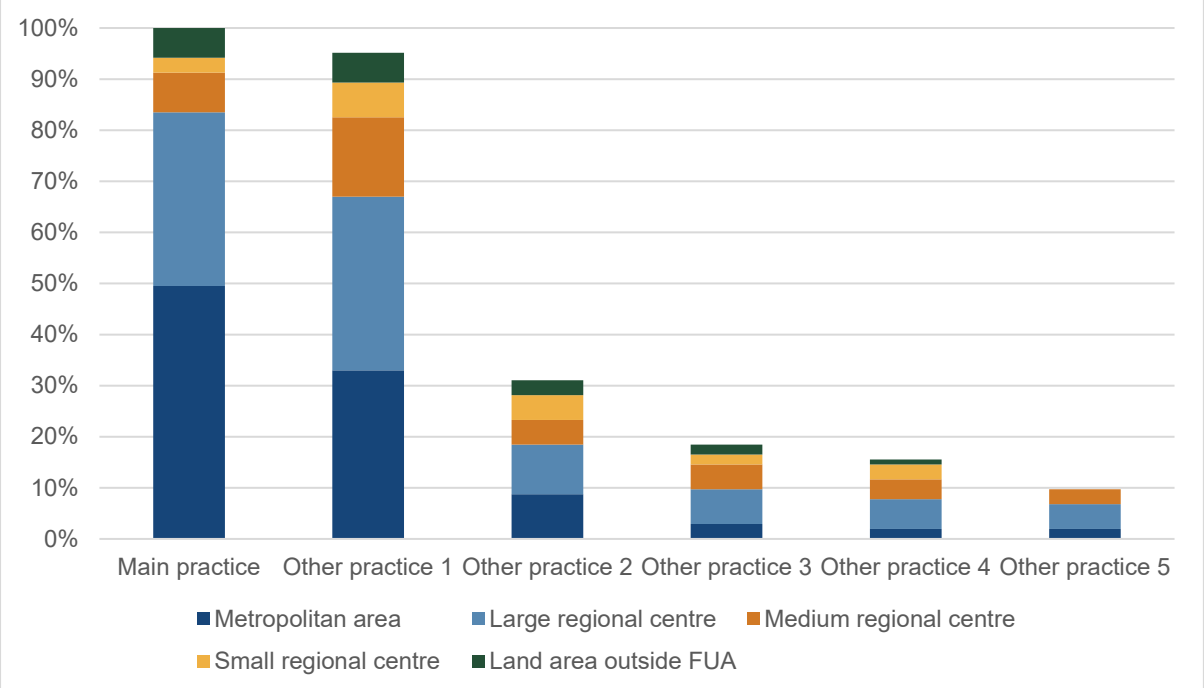


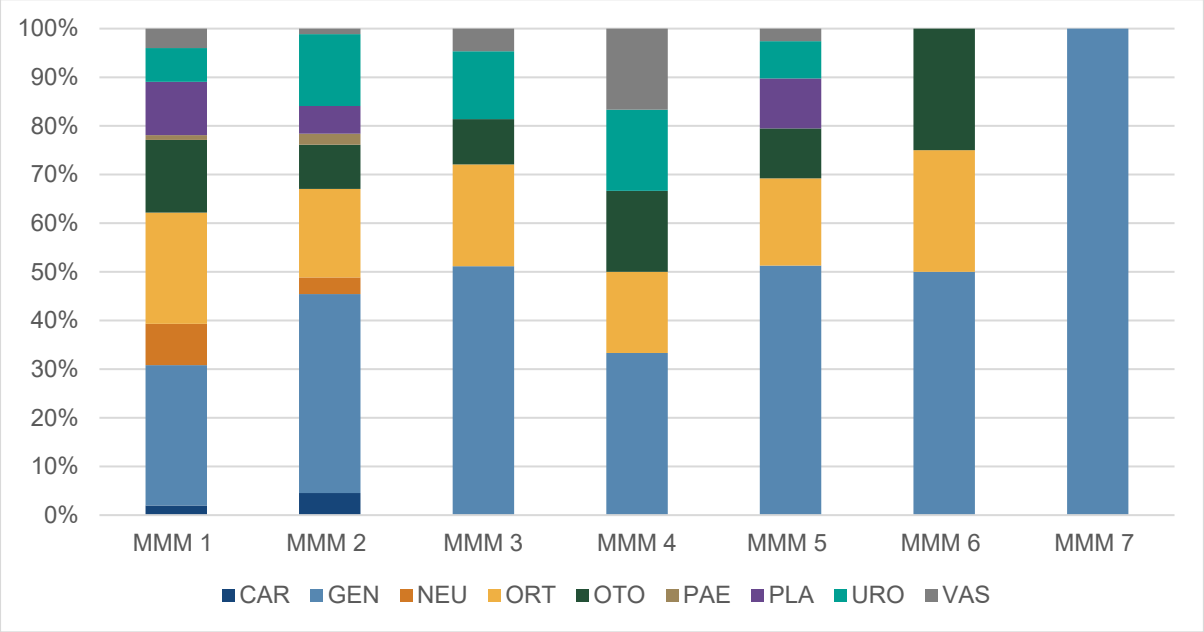
Figure 3.3b: Location of work using Functional Urban Areas classification for Fellows in Aotearoa New Zealand



Note: Refer to Table A3.3a and A3.3b in Appendix A for the tabulated data

For Australian Fellows who worked in a regional, rural or remote location, Monash Modified Model classifications for main practice location were reviewed by surgical specialty. All nine surgical specialties were featured for metropolitan (MM1) and regional centre (MM2) main practice locations, then number of specialties reduce for MM3 – MM7 (large rural towns to very remote communities).

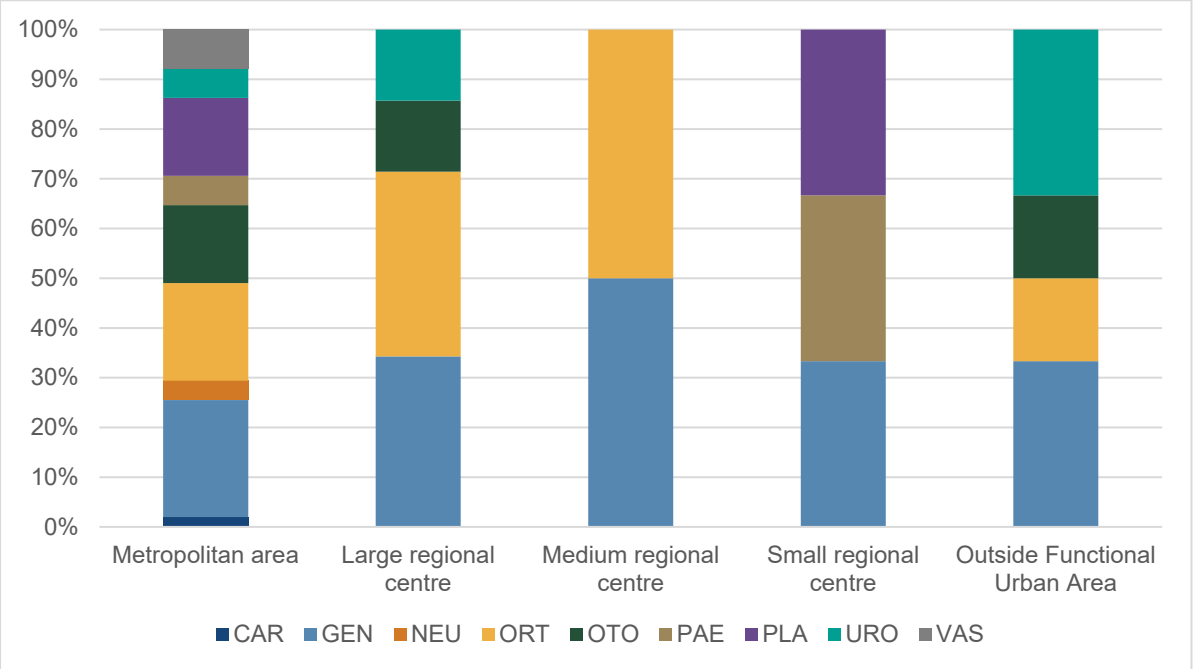
Figure 3.3c: Monash Modified Model main practice location by surgical specialty, Australia



Note: Refer to Table A3.3c in Appendix A for the tabulated data

For Aotearoa New Zealand Fellows who worked in a regional or rural location, Functional Urban Areas classifications for main practice location were also reviewed by surgical specialty. All specialities were represented in the Metropolitan area classification (n=51), but not the subsequent classifications of Larger, Medium, Small regional centres or for main practices located on land Outside Functional Urban Areas.

Figure 3.3d: Functional Urban Areas main practice location by surgical specialty, Aotearoa New Zealand

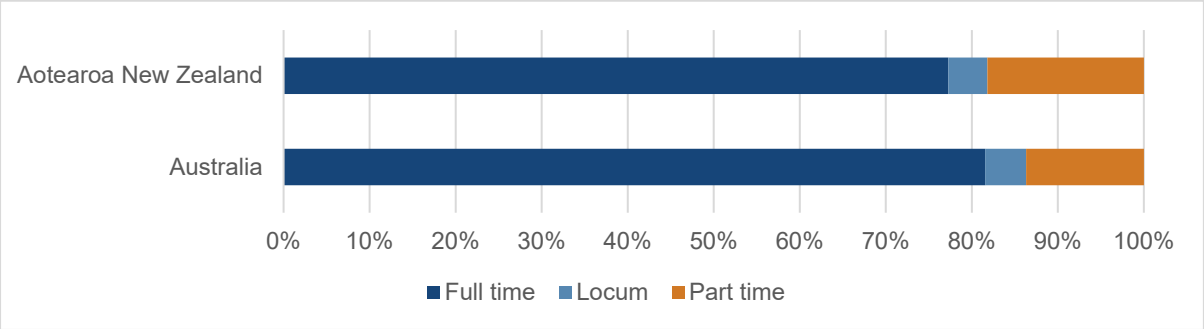


Note: Refer to Table A3.3d in Appendix A for the tabulated data

Rural Employment Status

For Fellows who reported working regional, rural or remote locations only, (n=168 Australia, n=44 Aotearoa New Zealand), 80.7% were working on a full time basis (Figure 3.4).

Figure 3.4a: Employment status of Fellows who work in a regional, rural or remote location only



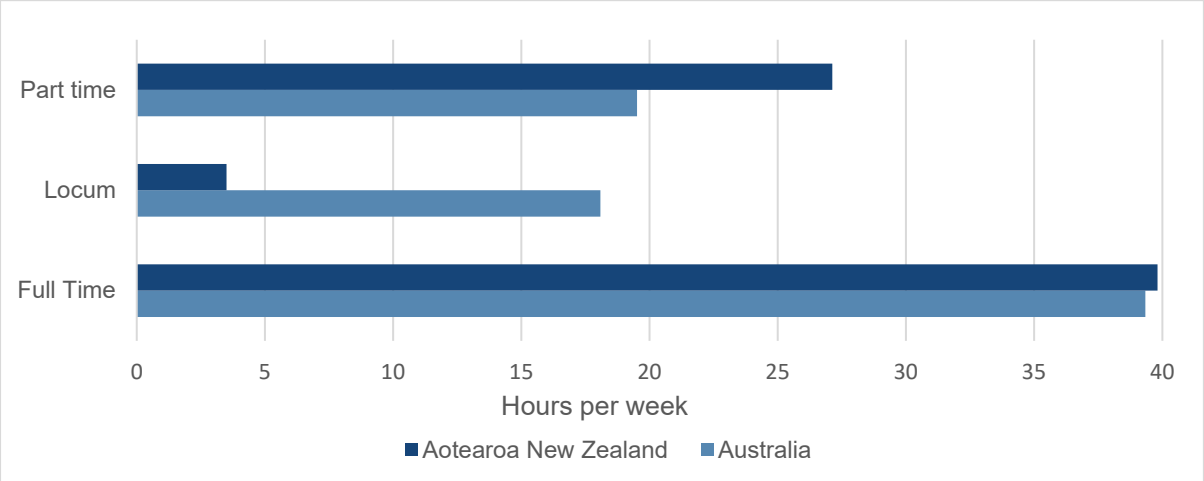
Note: Refer to Table A3.4a in Appendix A for the tabulated data

For this subset of Fellows who reported working in regional, rural or remote location only, their full time average hours worked per week was 39.4 hours (compared to 39.9 hours recorded in 2022). This is slightly less than the overall average hours per week for all full time Census respondents (45.6 hours on average per week) in 2024.

Locums who worked in regional, rural or remote settings reported working on average approximately 15.2 hours per week (compared to 16.8 hours per week in 2022). This is less than the overall average hours per week for all locums in 2024, 25.9 hours.

Part time Fellows who worked in regional, rural or remote settings reported working on average 21.5 hours per week (compared 19.1 hours per week in 2022) (Figure 3.4b). This is similar to the overall average hours worked per week for all part time respondents in 2024 (19.9 hours per week).

Figure 3.4b: Mean weekly hours worked for Fellows who work in a regional, rural or remote location only by employment status



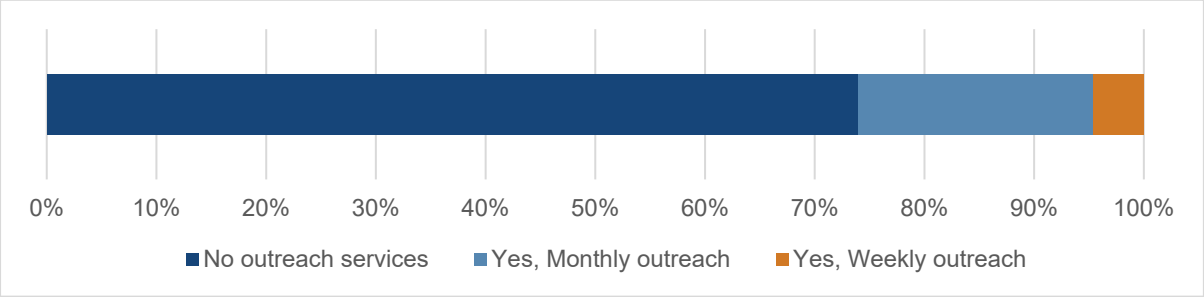
Note: Refer to Table A3.4b in Appendix A for the tabulated data

Outreach Surgery

Respondents who worked in regional, rural or remote locations in any capacity were asked about their outreach activities. Outreach surgery is defined as performing surgery in a town where the surgeon is not a resident and may not be available in person for ongoing post-operative care or follow up.

Just over 21% of Fellows reported engaging in outreach services on a monthly basis (working on average 9.7 hours a month) and less than 5% reported working in outreach services weekly basis (on average 9.9 hours a week) (Figure 3.5). Of the approximately 21% engaged in monthly outreach, 84% of respondents are from Australia and 16% (n=17) are from Aotearoa New Zealand.

Figure 3.5: Outreach services for Fellows who work in regional, rural or remote only and rural and metropolitan locations



Note: Refer to Table A3.5a in Appendix A for the tabulated data

When reviewing frequency of outreach surgery by work location, the highest proportion of Fellows who provided per monthly outreach services were those who mainly working in a metropolitan location with outreach to regional, rural or remote location(s) (n=86) (refer to A3.5b in Appendix A).

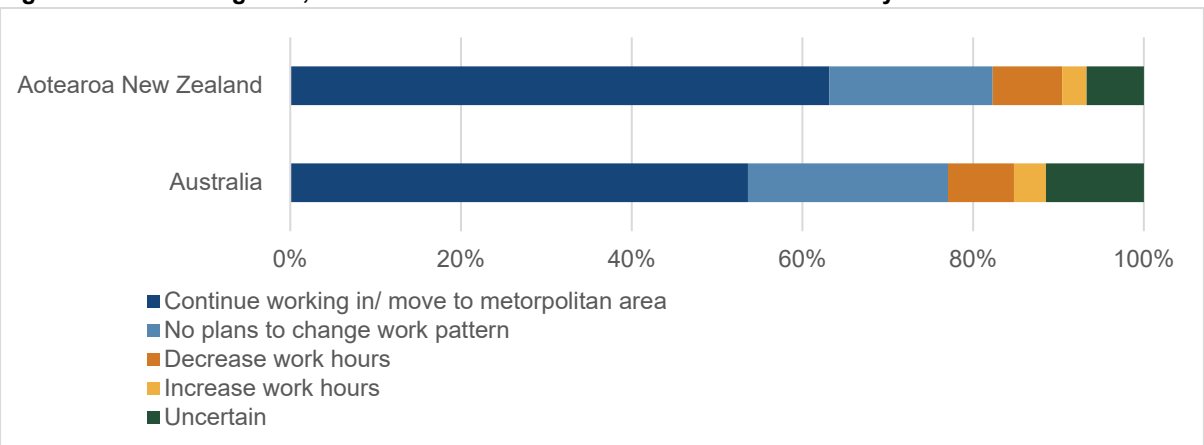
Future Regional, Rural and Remote Work Intentions

Fellows who work in regional, rural or remote location(s) were asked about their future work intentions in regional, rural and remote settings over the next five years, including those who work in both metropolitan and rural based locations.

The majority of Fellows reported no intentions to change their regional or rural workload over the next five years.

More than half of respondents (55.5%) reported they plan to remain practising in a metropolitan setting and just over 22% reported they will continue working in regional, rural or remote areas without change. Approximately 4% reported they intend on increasing their hours and almost 8% reported they plan to decrease their working hours in regional and rural settings (Figure 3.6). This is a similar result to the 2022 Census.

Figure 3.6: Future regional, rural or remote work intentions over the next five years



Note: Refer to Table A3.6 in Appendix A for the tabulated data

Obstacles for Regional, Rural and Remote Work

Respondents who worked in regional, rural or remote locations in any capacity were asked about the obstacles that they face in working more hours in regional, rural and remote areas. Over 900 qualitative responses were received.

Personal and lifestyle factors (family, time and travel) were the most frequently raised barriers, followed by systemic issues (resourcing, staffing, financial incentives). Surgical specialty specific limitations were also identified by respondents as playing a significant role, particularly surgeons in highly specialised fields.

The below summary provides an overview of the most frequently raised themes.

Family commitments
This was the most frequently identified obstacle. Respondents frequently cited responsibilities related to children, partners and family as limiting their ability to travel or relocate for regional, rural or remote work.

Time constraints
Many respondents indicated that they are already working at full capacity in a metropolitan setting, leaving little or no time for additional rural commitments.

Travel and distance
Long travel times, fatigue and the logistical challenges of being away from home were major issues identified.

Surgical specialty limitations
Highly subspecialised surgeons reported that their work requires tertiary facilities, which are not available in regional or rural areas.

Hospital resources
Lack of adequate infrastructure, theatre access, ICU facilities and equipment in rural hospitals was a frequently identified obstacle.

Professional isolation
Respondents expressed concerns about limited collegial support, lack of multidisciplinary teams and feeling professionally isolated.

Lifestyle preferences
Many respondents reported that they prefer metropolitan living for social, educational and professional reasons.

Staff shortages
Shortages of anaesthetists, nurses and allied health professionals make regional and rural work more challenging.

Financial issues
Poor renumeration and lack of funding for travel and accommodating were identified by respondents as disincentives for working more hours in regional and rural settings.

Employment contracts
Respondents reported that inflexible metropolitan public appointments and lack of formal appointments hinder surgeons from taking on more regional and rural work.

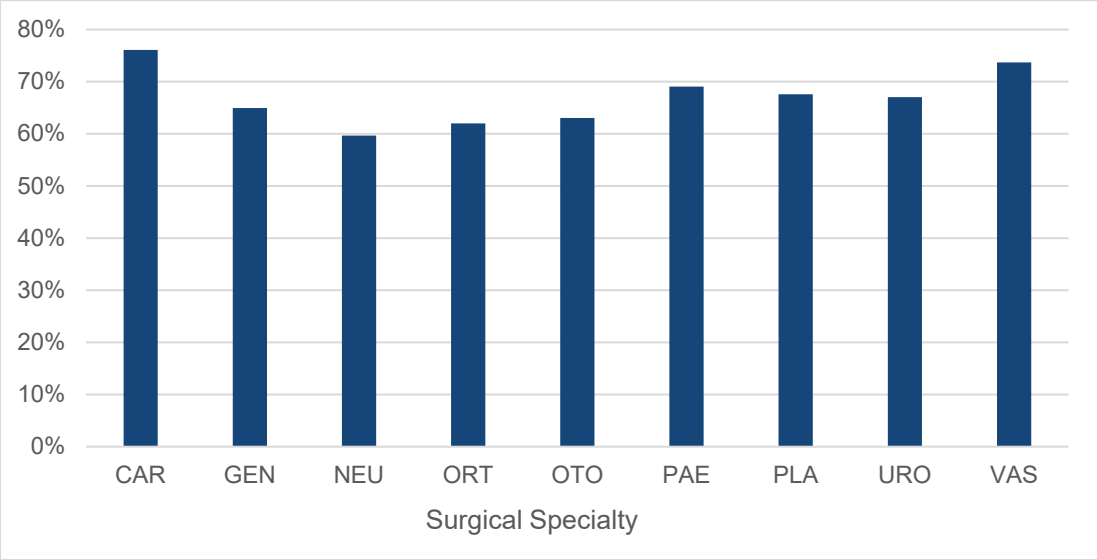
Chapter 4 – Pro Bono Work

Summary

- Sixty-five percent of Fellows participated in pro bono or volunteer work in 2024.
- Fellows reported working on average 11 hours per month on pro bono activities.
- The most frequently reported pro bono activities were contributions to RACS, including the SET Program, followed by clinical education not related to RACS.
- For RACS focused activities, contributing as an educational instructor/ examiner, SET Program supervisor and surgical mortality assessor were the most frequently reported pro bono contributions made by Fellows.

In 2024, 65.1% of Active and Retired Fellows reported undertaking pro bono work or volunteer work. By surgical specialty, the largest proportions were Cardiothoracic surgery, followed by Vascular surgery (Figure 4.1).

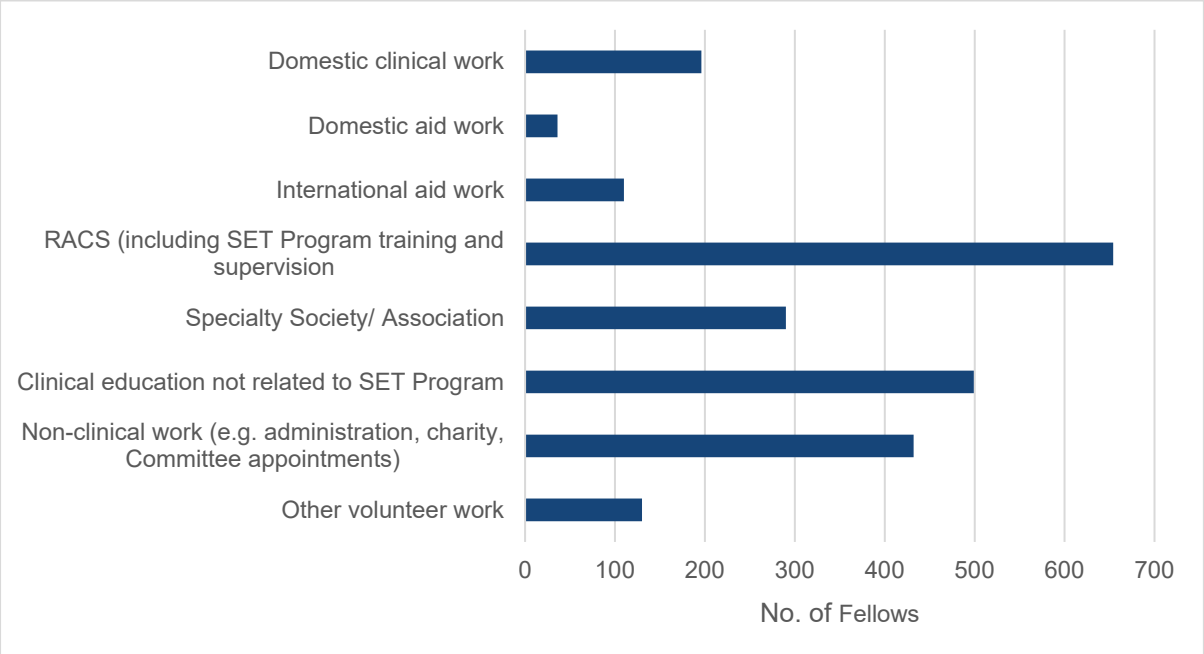
Figure 4.1: Proportion of Fellows who undertake volunteer or pro bono work by surgical specialty



Note: Refer to Table A4.1 in Appendix A for the tabulated data

Almost three quarters of Fellows undertaking pro bono activities reported contributing to RACS, including the Surgical Education and Training (SET) Program (n=654). Just over fifty six percent of Fellows undertook clinical education not related to SET (n=499) and almost half of the respondents are engaged in non-clinical work (e.g. administration, charity work and committee appointments) (n=432). Thirty three percent of Fellows contributed in a pro bono capacity for a specialty society (n=290) and 22% of Fellows undertook domestic clinical work (n=196).

Figure 4.2: Types of pro bono or volunteer activities Fellows participate in

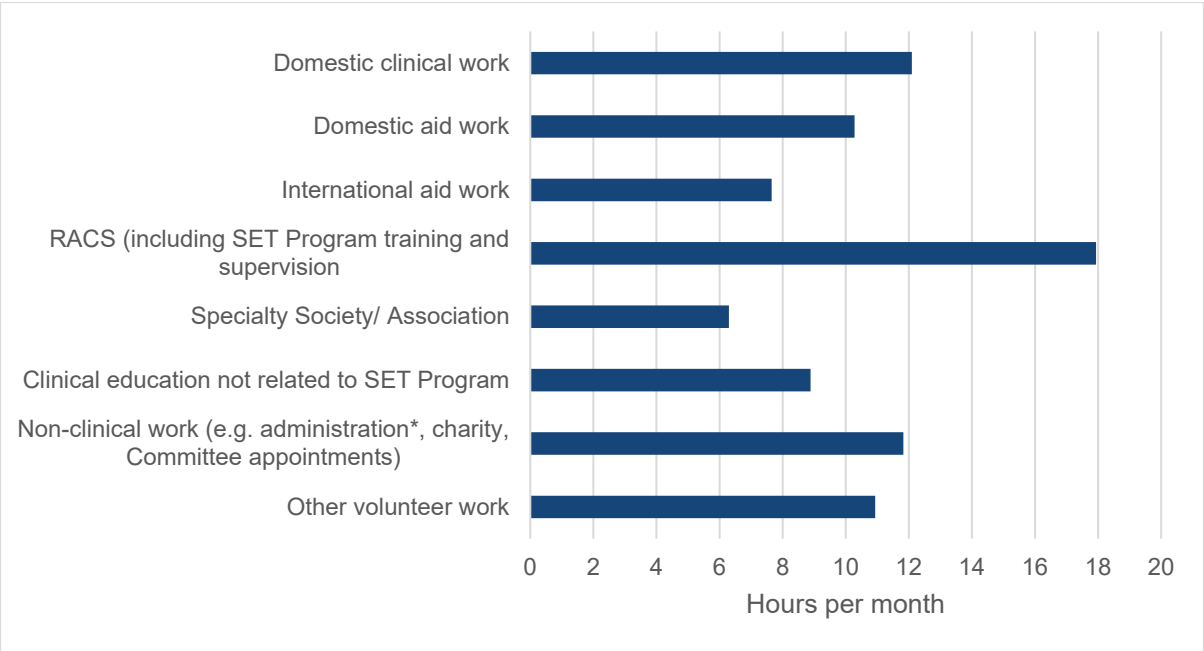


Note: Refer to Table A4.2 in Appendix A for the tabulated data

Fellows were asked about the number of hours they spent on various pro bono activities. Respondents reported spending on average 11 hours a month on pro bono services.

Fellows contributed the largest amount of pro bono time to RACS (including SET Program training and supervision), reporting on average 18.3 hours per month. Fellows gave on average 12.3 hours a month to domestic clinical work, 12.1 hours a month to non-clinical work (administration, charity, committee appointments) and contributed 12.2 hours on average a month towards other volunteer work (Figure 4.3).

Figure 4.3: Mean hours worked per month on pro bono or volunteer activities

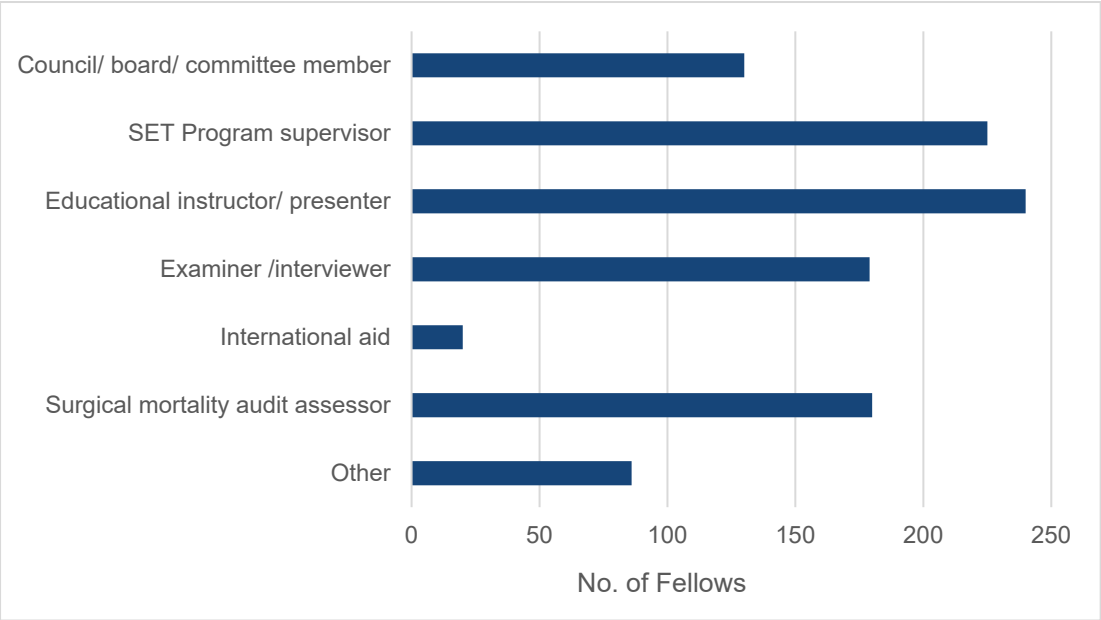


Note: Refer to Table A4.3 in Appendix A for the tabulated data

RACS Pro Bono Roles

Of the Fellows that reported they undertake pro bono work for RACS, the most frequently reported roles were educational instructor/ presenter (n=240) and SET Program supervisor (n=225), followed by surgical mortality audit assessor (n=180) and examiner/ interviewer (n=179) (Figure 4.4).

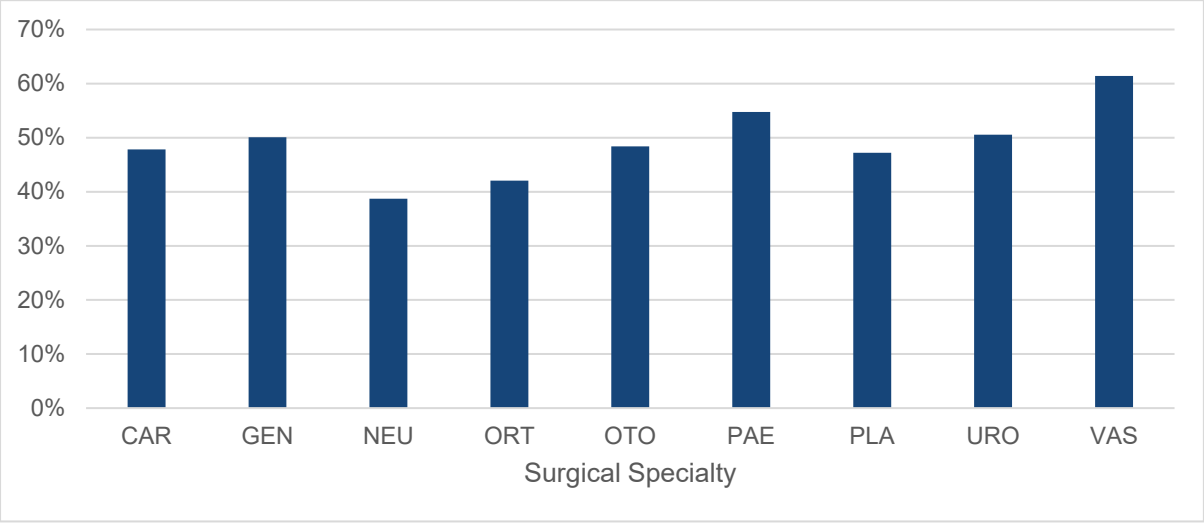
Figure 4.4: Types of RACS pro bono roles Fellows participate in



Note: Refer to Table A4.4 in Appendix A for the tabulated data

There is strong support from Fellows across all specialties to engage in RACS pro bono activities. Vascular surgery and Paediatric surgery had the highest proportion of representatives involved in RACS pro bono roles (Figure 4.5).

Figure 4.5: Proportion of Fellows involved in RACS pro bono work by surgical specialty



Note: Refer to Table A4.5 in Appendix A for the tabulated data

Chapter 5 – Wellbeing

Summary

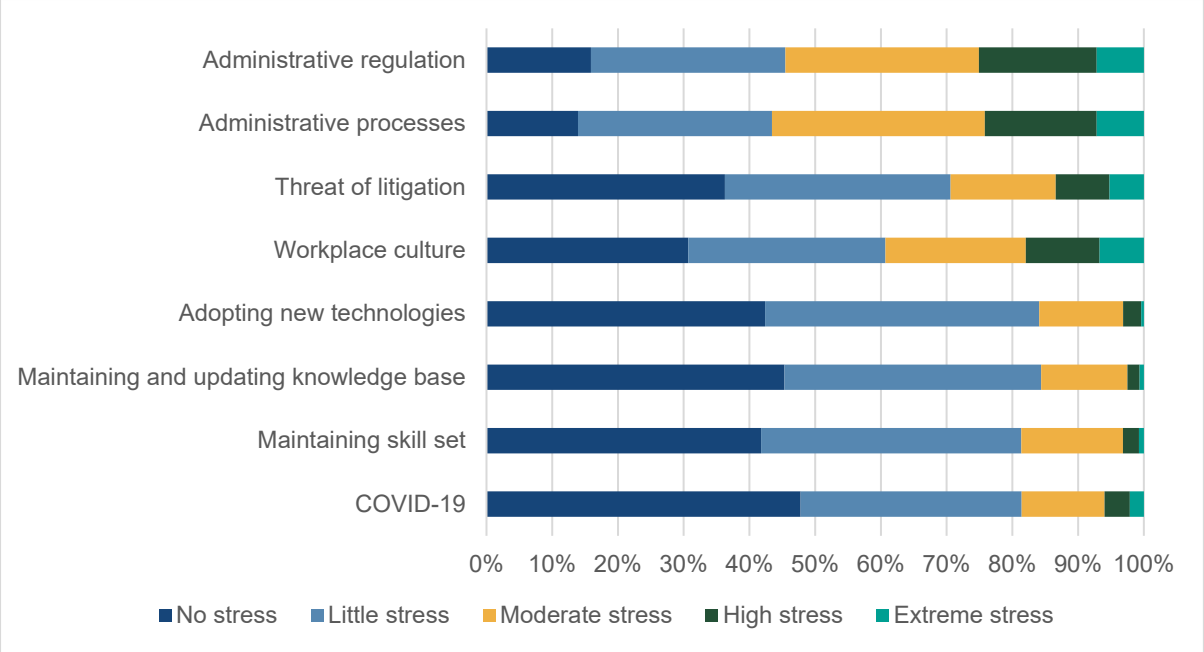
- Administrative regulation and processes continue to rate as a high to extreme source of stress for Fellows, rating higher than workplace culture and the threat of litigation.
- Over three quarters of Fellows monitored their health in the last two years, visiting a medical doctor for a health check-up or at regular intervals as dictated by existing medical conditions (78.1%), a slight increase from 2022 (72.6%).
- Almost one in ten Fellows reported seeking professional assistance for stress or mental health issues in the last two years.

Stress

Australian and Aotearoa New Zealand Fellows were asked to rate their stress levels experienced for a range of sources and issues.

High or extreme stress was reported most frequently for administrative regulation (25.1%) and administrative processes (24.2%). This was followed by workplace culture (18.0%) and threat of litigation (13.4%). For sources of little or moderate stress, Fellows rated administrative processes the highest (61.9%), followed by administrative regulation (59.0%) and maintaining skill set (55.0%) (Figure 5.1).

Figure 5.1: Workplace sources of Fellows' self-rated stress levels

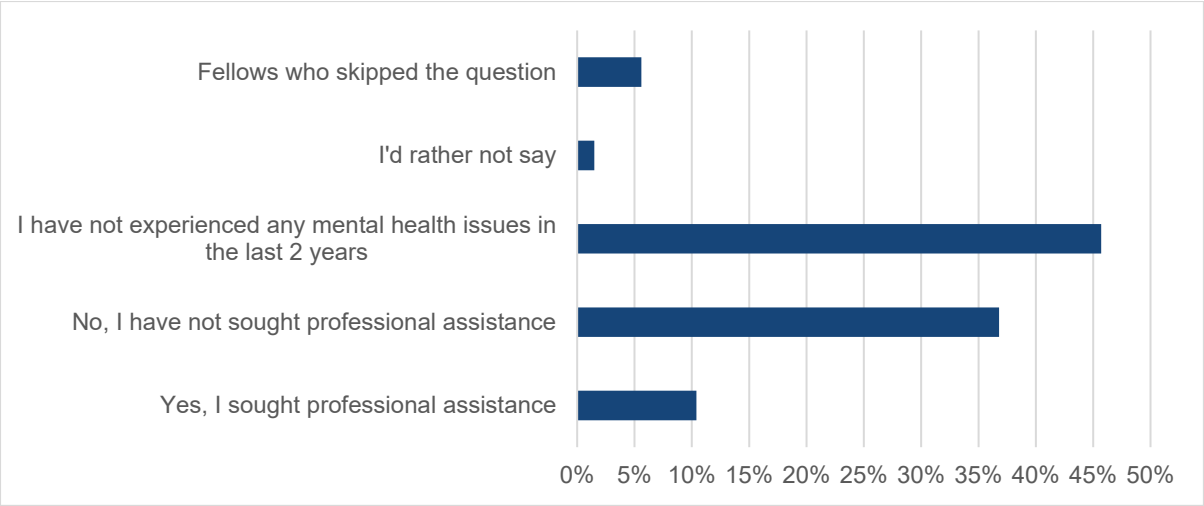


Note: Refer to Table A5.1 in Appendix A for the tabulated data

Health Monitoring and Support

Fellows were asked whether they have sought professional assistance to deal with stress or other mental health issues in the last two years. Around 46% (n=658) reported that they have not experienced any mental health issues and almost 37% (n=530) reported that they had not sought professional assistance. Just over 10% of Fellows (n=150) reported that they had sought professional assistance (Figure 5.2).

Figure 5.2: Proportion of Fellows who have sought professional assistance to deal with stress or a mental health issue in the last two years

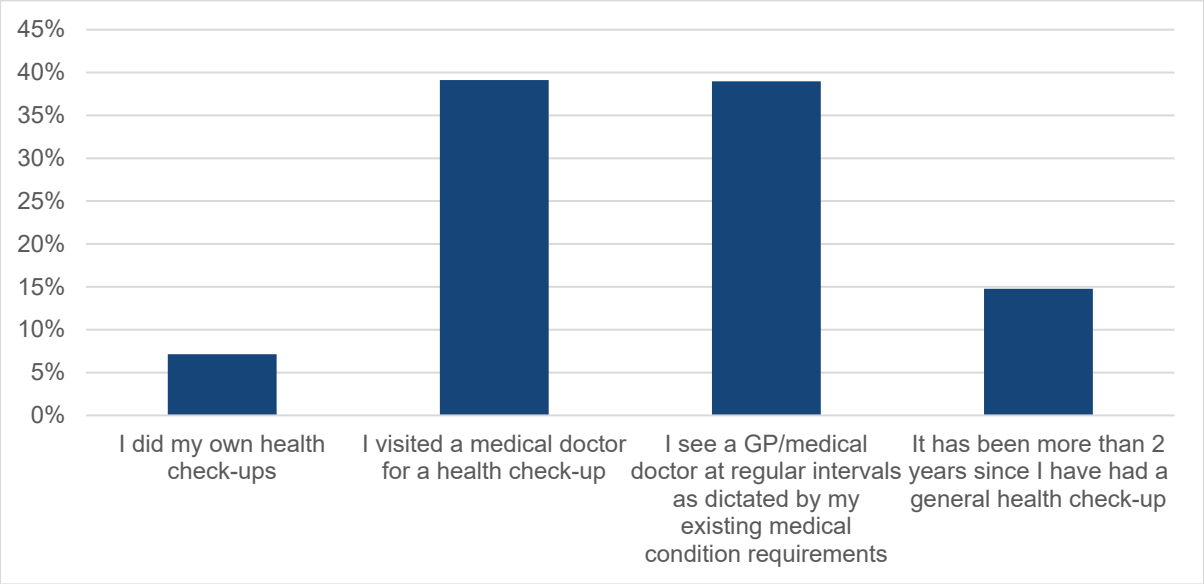


Note: Refer to Table A5.2 in Appendix A for the tabulated data

Most Fellows have had a physical health check-up in the last two years (Figure 5.3), with a total of 78.1% of Fellows either visiting a medical doctor for a check-up or reporting that they see a GP/ medical doctor at regular intervals, a slight increase from 72.6% recorded in 2022.

Almost 15% of percent of Fellows reported that it has been more than two years since their last general health check-up. There continues to be a small percentage of Fellows reporting that they do their own health check-ups (7.1% compared to 8.6% compared 2022).

Figure 5.3: How Fellows monitored their general health in the last two years

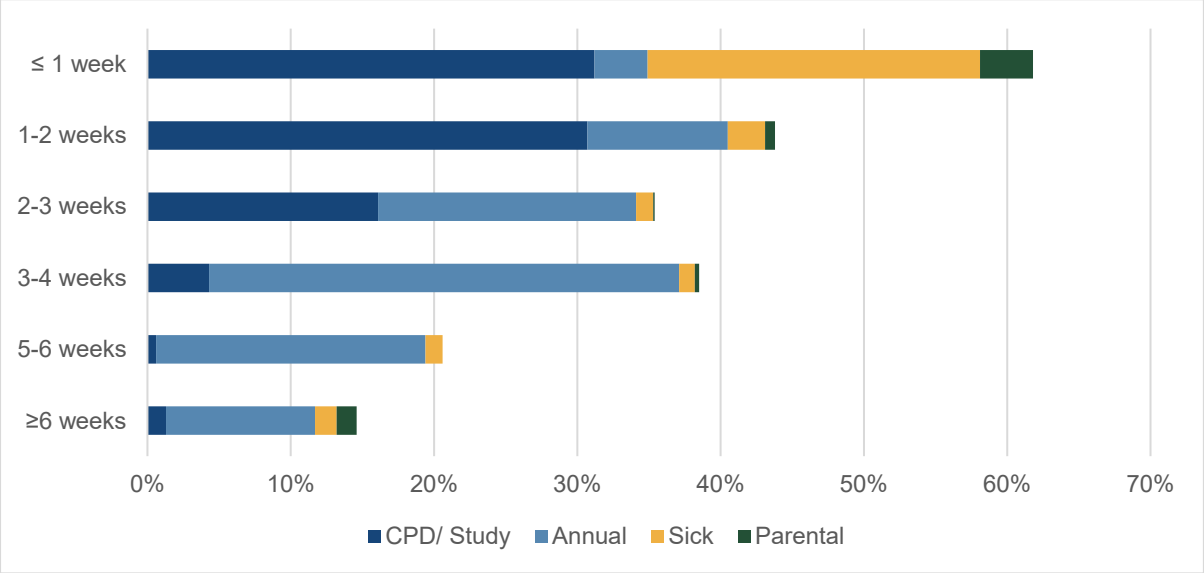


Note: Refer to Table A5.3 in Appendix A for the tabulated data

Leave

Nearly all respondents took either study leave or annual leave in the past 12 months. The most common period of leave was up to one week for CPD/ study leave and three to four weeks for annual leave (Figure 5.4). This is similar to previous Census results. Approximately 30% of Fellows reported taking sick leave during 2024, less than the 45.6% recorded in 2022.

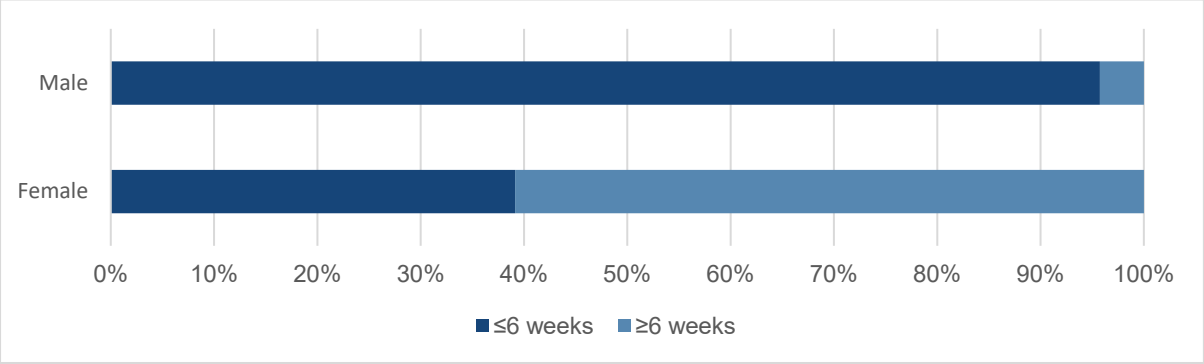
Figure 5.4: Distribution of leave Fellows took over the past 12 months



Note: Refer to Table A5.4 in Appendix A for the tabulated data

Approximately sixty percent of female Fellows (n=14) who reported taking parental leave during 2024 took six weeks leave or more compared to 96% of male Fellows (n=45). Approximately 40% of female Fellows (n=9) reported returning to work after six week or less of parental leave.

Figure 5.5: Duration of parental leave Fellows took over the past 12 months



Note: Refer to Table A5.5 in Appendix A for the tabulated data

Chapter 6 – Future Work Intentions

Summary

- Fellows across all age ranges intend on reducing their preferred weekly work hours gradually over the next 10 years.
- For Fellows aged 40 – 59 years, male Fellows have a preference to work slightly more hours in future years than female Fellows. For Fellows aged 60 years and older, male and female respondents reported similar preferences for current and future hours worked.
- Almost 62% of Fellows aged 50 years and over plan to retire from all forms of paid work within the next ten years.
- Most Fellows aged 65 years or older who intend to continue in paid employment will maintain work predominately because they are doing work that they enjoy.

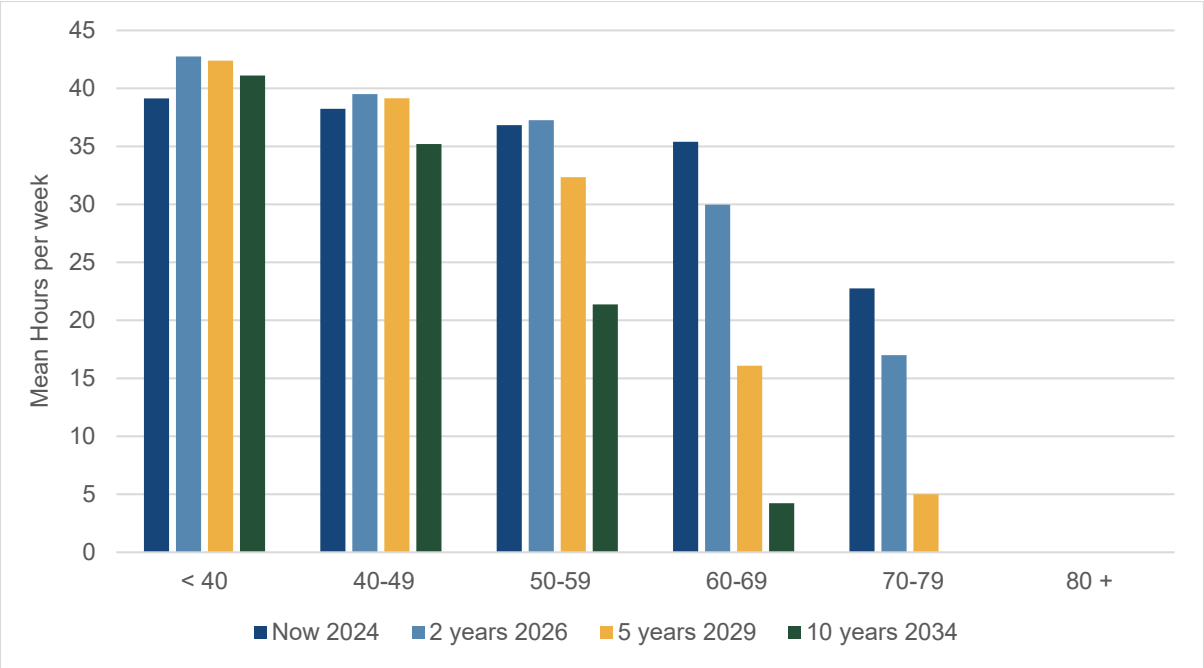
Future Work Hours

Australian and Aotearoa New Zealand Fellows were asked to nominate their preferred hours worked per week now and in the future, at two years, five years, and ten years (Figure 6.1a & b).

40 years or less

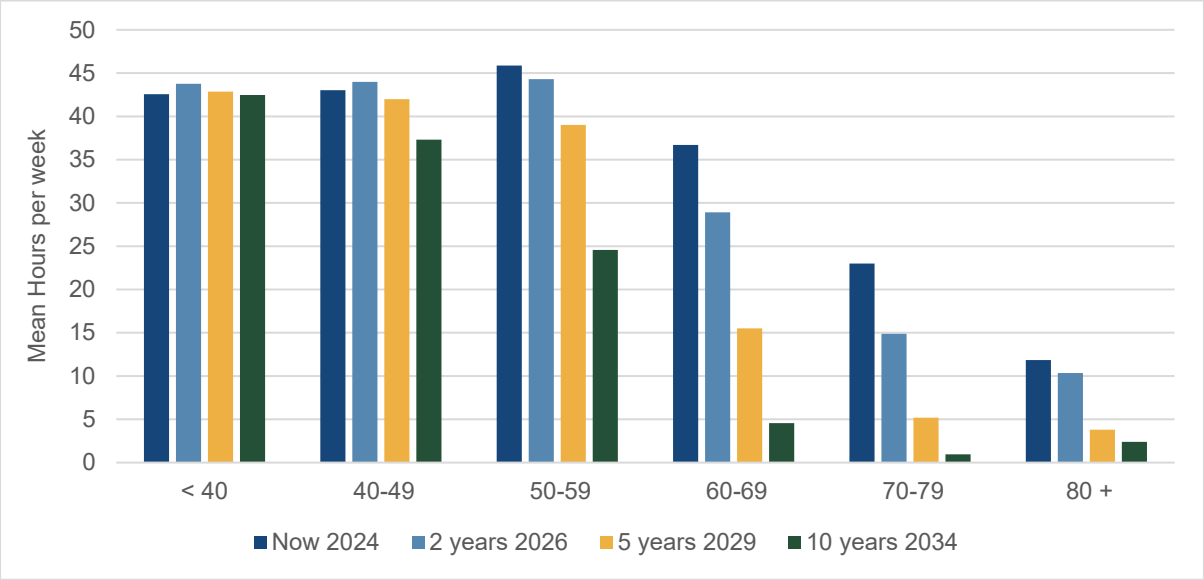
The 2024 preferred work hours for male Fellows below 40 years is slightly more than their female counterparts, with males preferring to work on average 42.6 hours per week compared to 39.1 hours per week on average for females Fellows. For male Fellows in this age range, their plan for future weekly work hours for the next 10 years remains consistent, with males planning to work on average 42.5 hours. Female Fellows plan to work on average 41.1 hours per week by 2034, an increase of 2 hours when compared to current work hours.

Figure 6.1a: Female Fellows current and future work intentions over the next 10 years



Note: Refer to Table A6.1 in Appendix A for the tabulated data

Figure 6.1b: Male Fellows current and future work intentions over the next 10 years



Note: Refer to Table A6.1 in Appendix A for the tabulated data

40 – 49 years
The current preferred work hours of Fellows aged 40-49 years is slightly higher for male Fellows compared to female Fellows (43.0 and 38.2 hours respectively). Both male and female Fellows in this age group intend on reduce their working hours gradually over the next ten years. Female Fellows reported that they have a preference to work 35.2 hours on average a week and male Fellows on average 37.3 hours per week in 2034.

50 – 59 years
For the 50 to 59 years age group, male Fellows reported higher preferred work hours per week in 2024 (on average 45.9 hours for males compared to 36.8 hours for females). Both male and female Fellows intend on reducing hours in work hours gradually over the next ten years. Specifically, male Fellows recorded a preference to work on average 39.0 hours in 2029 (reducing further to 24.5 hours a week in 2034), compared to 32.3 hours for female Fellows in 2029 (reducing further to 21.4 hours a week on average in 2034).

60 – 69 years
Male and female Fellows reported a preference to work similar hours per week in 2024 for the 60 – 69 years age range, with 35.4 hours and 36.5 hours recorded on average respectively. As reported for all other age groups, both male and female Fellows plan to reduce their weekly working hours over time.

70 – 79 years
Among this age group, male and female Fellows reported similar average weekly work hours preference in 2024 (on average 23.0 hours and 22.8 hours respectively). Male and female Fellows in this age group also reported similar preferred weekly working hours in five years.

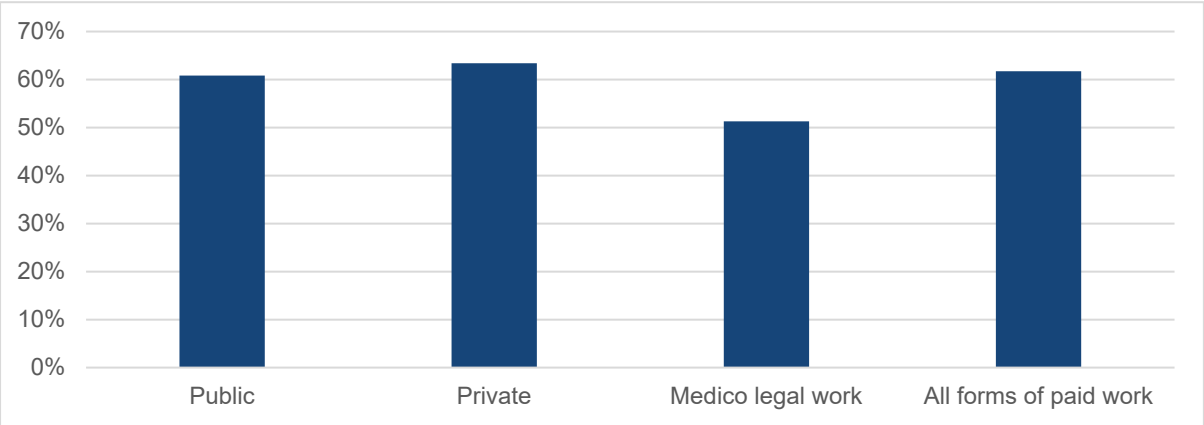
Retirement

Fellows were asked to indicate when they intend to retire from a surgical work within the next ten years, specifically for public work, private work, medico legal work and all forms of paid employment.

Approximately 3.6% of Fellows aged less than 50 years reported that they intend to retire from all forms of paid work within the next ten years. Almost 13.5% of Fellows in this age group plan to retire from clinical practice in the public sector within the next 10 years (refer to Appendix A6.2).

For respondents aged 50 and over, approximately 60.8% of Fellows reported that they intend to retire from public practice within the next ten years, with 63.4% intending to retire from private practice within the next ten years. In total, almost 62% of Fellows aged over 50 years (n=1365) plan to retire from all forms of paid work within the next ten years (Figure 6.2).

Figure 6.2: Proportion of Fellows aged 50 years or older who intend to retire within the next 10 years from clinical practice and all forms of paid work



Note: Refer to Table A6.2 in Appendix A for the tabulated data

Respondents who reported that they plan to retire within the next two years were asked to comment on why they plan to retire. Over 200 responses were received.

The most frequently raised reasons for retirement were:

- age and normal timing for retirement
- lifestyle, family and work life balance
- work exhaustion/ burnout
- recognition of health and physical limitations.

There was also a small group of respondence who indicated that they wish to continue engaging in non-operative roles.

RACS Support for Retirement

Respondents who reported that they plan to retire within the next two years were also asked about how RACS can further support Fellows leading up to retirement. Over 170 responses were received.

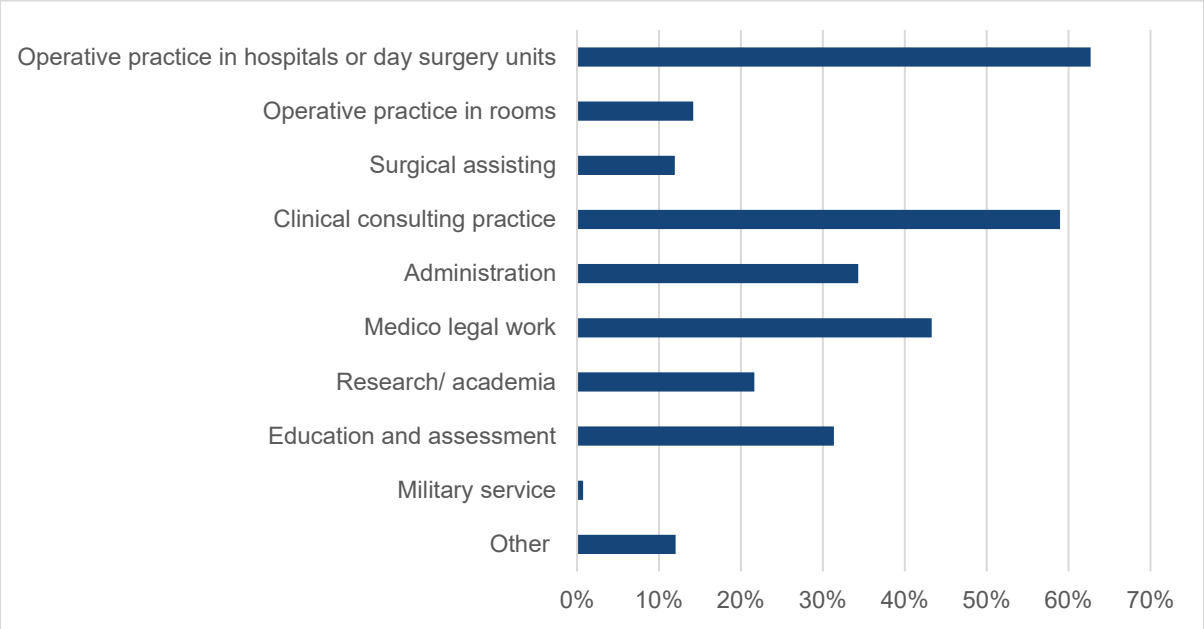
A range of support options were identified including:

- increasing the flexibility of CPD Program requirements for semi- retired Fellows
- reducing subscription and conferences fees
- promoting opportunities for non-operative, teaching and advisory roles
- retirement planning guidance and resources, including events
- providing educational resources and support for transitioning to non-operative roles.
- better recognition of the value of senior surgeons, contributions and experience.

Future Work Plans for Fellows Aged 65 or Older

Just over 55% of Fellows (n=134) aged 65 years or older reported an intention to be engaged in paid employment for the next two years (refer to Table A6.3a in Appendix A). The most common types of employment these Fellows plan to be engaged in are operative practice in hospitals or day surgery units, clinical consulting practice, and medico legal work (Figure 6.3). This is a similar result to the 2022 Census.

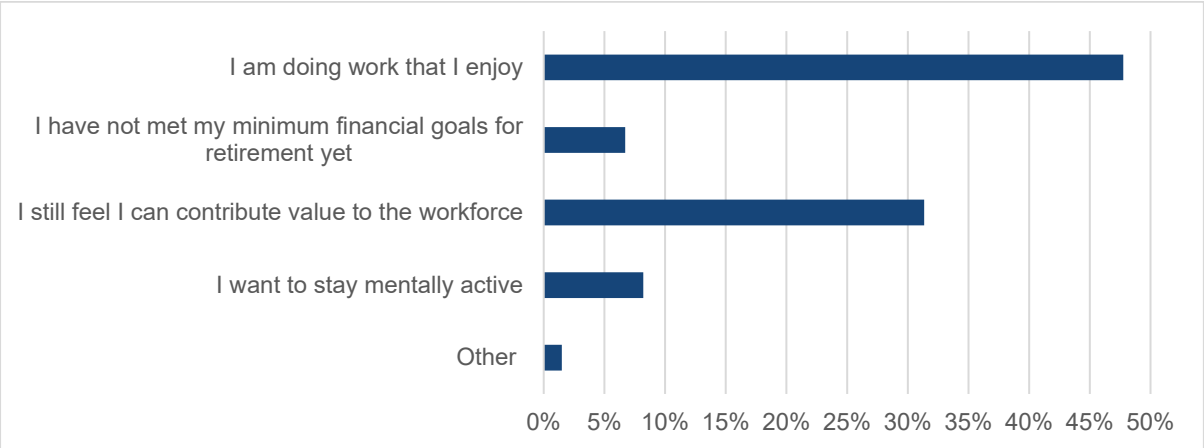
Figure 6.3: Type of work Fellows aged 65 years or older plan to do in the next two years



Note: Refer to Table A6.3b in Appendix A for the tabulated data

Of the Fellows aged 65 years and older who plan to continue in paid employment for the next two years, the main reason given for continuing in paid employment was because they are doing work that they enjoy (47.8%) and approximately 31.3% reported their main reason was because they believed that they could still contribute value to the workforce (Figure 6.4).

Figure 6.4: Main reason why Fellows aged 65 years or older continue to be engaged in paid employment for next 2 years



Note: Refer to Table A6.4 in Appendix A for the tabulated data.

RACS would like to acknowledge and thank the Fellows who gave their time to participate in the 2024 Surgical Workforce Census.

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APPENDIX A

Note: *The 2024 Census results exclude Fellows of the Royal Australasian College of Surgeons who do not currently living in Australia or Aotearoa New Zealand.*

Chapter 1 Supplementary data

Appendix A1.1 Sex profile of Active Census respondents and Active RACS Fellows, 2024

	2024 Census Active Respondents	2024 Activities Report
Female	240	1154
Male	986	5538
Unspecified	0	2
Total	1226	6694

Exclusions: Retired Fellows.
This total is derived from the Fellowship status recorded by RACS. The 2024 data includes Fellows who have reported that they are semi-retired in the analysis.

Appendix A1.2: Age profile of Active Census respondents and Active RACS Fellows, 2024

	2024 Census Active Respondents	2024 Activities Report
<40	86	815
40-49	320	2230
50-59	345	1906
60-69	306	1151
70+	169	592
Total	1226	6694

Exclusions: Retired Fellows.

Appendix A1.3: Location profile of Active Census respondents and Active RACS Fellows, 2024

	2024 Census Active Respondents	2024 Activities Report
ACT	19	98
NSW	272	1842
NT	6	32
QLD	188	1180
SA	79	460
TAS	22	106
VIC	278	1536
WA	101	530
AoNZ	261	910
Total	1226	6694

Exclusions: Retired Fellows.

Appendix A1.4: Surgical specialty profile of Active Census respondents and Active RACS Fellows, 2024

	2024 Census Respondents N	2024 Activities Report N
CAR	44	276
GEN	460	2980
NEU	54	351
ORT	246	1933
OTO	151	762
PAE	31	162
PLA	102	686
URO	86	657
VAS	52	311
Total	1226	8118

Exclusions: Retired Fellows.

Appendix A1.5: Fellowship status of Census respondents, 2024

	N	%
Active Fellow	1061	73.7
Semi-retired Fellow	231	16.0
Retired Fellow	148	10.3
Total	1440	100.0

Note: Active, Semi-retired and Retired are self reported by respondents.

Appendix A1.6: Age distribution and Fellowship status of Census respondents, 2024

Age Group	Active Fellow	Semi-retired Fellow	Retired Fellow	N	%
<40	86	0	0	86	6.0
40-49	320	0	0	320	22.2
50-59	343	2	2	347	24.1
60-69	258	44	27	329	22.8
70-79	52	73	115	240	16.7
80+	2	29	87	118	8.2
Total	1061	148	231	1440	100.0

Note: Active, Semi-retired and Retired are self reported by respondents.

Chapter 2 Supplementary data

Appendix A2.1: Employment status of Fellows by country, 2024

Country	Full time	Part time	Locum	Parental leave	Unemployed	Retired	N
Australia	709	214	18	6	4	1	952
Aotearoa New Zealand	205	48	4	1	0	230	488
Total	914	262	22	7	4	231	1440

Appendix A2.2: Employment status of Fellows by age group, 2024

Age group	Full time	Part time	Locum	Parental leave	Unemployed	Retired	N
<40	67	13	3	3	0	0	86
40-49	273	38	4	4	1	0	320
50-59	316	27	2	0	0	2	347
60-69	221	75	4	0	2	27	329
70-79	36	79	9	0	1	115	240
80+	1	30	0	0	0	87	118
Total	914	262	22	7	4	231	1440

Appendix A2.3: Mean hours worked per week and preferred weekly work hours by workforce status, 2024

Status	Hours worked per week			Preferred weekly work hours		
	N	Mean	SD	N	Mean	SD
Full time	914	45.6	18.1	862	43.8	16.1
Locum	22	26.9	23.7	17	23.2	17.1
Part time	262	19.9	16.7	234	21.5	13.4
Total	1198	39.7	20.9	1113	38.8	18.1

Exclusions: Retired Fellows; unemployed or parental leave.

Appendix 2.4: Mean hours worked per week by age group, 2024

Age Range	Mean			Standard Deviation			
	M	F	Total	M	F	Total	N
<40	45.7	40.7	43.9	13.5	8.8	12.2	82
40-49	44.7	41.3	43.7	10.8	11.6	11.1	315
50-59	47.6	40.9	46.2	9.3	13.7	10.7	345
60-69	40.4	42.6	40.6	15.9	15.1	15.8	292
70-79	26.4	30.0	26.5	16.3	14.7	16.2	112
80+	14.0	0.0	14.0	11.0	0.0	11.0	22
Total	41.1	41.6	41.5	12.6	15.0	14.5	1168

Exclusions: Retired Fellows; unemployed or parental leave.

Appendix A2.5: Mean hours worked per week and preferred weekly work hours by surgical specialty, 2024

	Current hours worked per week			Preferred hours to work per week		
	Mean	SD	N	Mean	SD	N
CAR	39.1	20.1	41	41.1	18.7	40
GEN	37.7	17.1	447	37.6	14.1	417
NEU	41.2	17.2	53	43.3	17.0	50
ORT	39.8	17.0	241	40.9	28.3	223
OTO	40.0	14.9	147	36.9	13.7	139
PAE	37.6	19.0	30	34.8	15.5	30
PLA	41.4	13.9	102	39.0	11.7	91
URO	42.1	16.7	85	40.8	16.5	78
VAS	39.1	13.5	51	37.9	12.1	45
Total	39.3	16.6	1197	38.8	18.1	1113

Exclusions: Retired Fellows.

Appendix A2.6: Fellows working in public or private practice by surgical specialty, 2024

		%			
	N	Public practice only	Private practice only	Mixed practice	Neither public nor private
CAR	42	35.7	7.1	52.4	4.8
GEN	447	32.0	13.0	52.6	2.5
NEU	53	7.5	28.3	62.3	1.9
ORT	241	14.1	32.0	51.9	2.1
OTO	147	10.2	21.1	66.0	2.7
PAE	30	46.7	3.3	46.7	3.3
PLA	102	13.7	41.2	44.1	1.0
URO	85	18.8	17.6	61.2	2.4
VAS	51	29.4	9.8	58.8	2.0
Total	1198	22.5	20.6	54.5	2.3

Exclusions: Retired Fellows.

Appendix A2.7: Number of Fellows working in public or private practice by surgical specialty, 2024

	Public practice only	Private practice only	Mixed practice	Neither public nor private	N
CAR	15	3	22	2	42
GEN	143	58	235	11	447
NEU	4	15	33	1	53
ORT	34	77	125	5	241
OTO	15	31	97	4	147
PAE	14	1	14	1	30
PLA	14	42	45	1	102
URO	16	15	52	2	85
VAS	15	5	30	1	51
Total	270	247	653	28	1198

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; Retired Fellows.

Appendix A2.8: Frequency of emergency on-call Fellows undertook by work sector, 2024

	Public sector		Private sector	
Frequency	N	%	N	%
1:1	13	1.1	72	6.6
1:2	58	5.1	14	1.3
1:3	30	2.6	21	1.9
1:4	66	5.8	22	2.0
1:5	97	8.5	27	2.5
1:6	85	7.5	16	1.5
1:7	87	7.6	17	1.6
1:8	74	6.5	24	2.2
1:9	101	8.9	22	2.0
1:10	18	1.6	7	0.6
≥1:10	111	9.7	43	4.0
No emergency on-call	399	35.0	802	73.8
Total	1139		1087	

Exclusions: Retired Fellows; unemployed or on parental leave.

Appendix A2.9: Method used to obtain private billing income, considering total private procedural income, Australia 2024

	N	%
Only "no gap" (no other additional fees)	222	25.1
>50% "no gap" or "known gap"	98	11.1
"No gap" but "known gap" when available or charge a co-payment	180	20.3
<50% "no gap" or "known gap"	140	15.8
Hardly ever use "no gap" or "known gap"	126	14.2
No response	119	13.4
Total	885	100.0

Exclusions: Aotearoa New Zealand Fellows; Retired Fellows; unemployed or on parental leave.

Appendix A2.10: Consideration of a fair professional fee, ignoring current private billing practices, Australia 2024

	N	%
AMA is about right	395	42.0
Higher than private health insurance amount but less than AMA	143	15.2
More than AMA rate	90	9.6
The "schedule fee"	6	0.6
The private health insurance "known gap" amount (when available)	45	4.8
The private health insurance "no gap" amount	39	4.1
No response	222	23.6
Total	940	100.0

Exclusions: Aotearoa New Zealand Fellows; Retired Fellows; unemployed or on parental leave.

Appendix A2.10a: Crosstabulation of Fellows' method of private billing and what they considered to be a fair professional fee, Australia 2024

	What Fellows consider to be a fair professional fee (N)							
Method used to obtain private billing income	AMA is about right	Higher than private health insurance amount but less than AMA	More than AMA rate	The "schedule fee"	The private health insurance "known gap" amount (when available)	The private health insurance "No gap" amount	Did not answer	Total
"No gap" but "known gap" when available or charge a co-payment	75	37	6	1	18	3	0	140
>50% "No gap" or "known gap"	104	49	13	2	12	0	0	180
Hardly ever use "No gap" or "known gap"	64	8	47	0	0	0	0	119
<50% "No gap" or "known gap"	88	21	14	0	3	0	0	126
Only "No gap" (no other additional fees)	38	18	1	2	6	33	0	98
Did not answer	0	0	0	0	0	0	287	287
Total	369	133	81	5	39	36	287	950

Exclusions: Retired Fellows

Appendix A2.11: Consideration of a fair professional fee, ignoring current private billing practices, by surgical specialty, Australia 2024

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
AMA is about right	10	122	32	88	58	6	31	37	11	395
Higher than private health insurance amount but less than AMA	7	59	6	30	13	4	9	8	7	143
More than AMA rate	2	20	1	17	21	0	20	7	2	90
The "schedule fee"	1	2	0	0	2	0	0	0	1	6
The private health insurance "known gap" amount (when avail)	1	19	3	6	6	0	4	2	4	45
The private health insurance "no gap" amount	4	18	1	5	1	2	2	0	6	39
Did not answer	11	121	4	33	15	13	11	15	9	232
Total	36	361	47	179	116	25	77	69	40	950

Exclusions: Retired Fellows.

Appendix A2.12: Fellows who are involved in other forms of paid employment by age group, 2024

	Yes	%	Total
<40	13	4.5	81
40-49	69	23.6	313
50-59	80	27.4	343
60-69	82	28.1	299
70-79	41	14.0	124
80+	7	2.4	31
Total	292	24.5	1191

Exclusions: Retired Fellows.

Appendix A2.13: Other forms of paid employment for Active Fellows, 2024

	N
Surgical assisting	26
Medico legal work	107
Research/ academia	113
Clinical education/ assessment	100
Administration	76
Military service	14
Other paid work	92

Multiple responses given. Exclusions: Retired Fellows.

Chapter 3 Supplementary data

Appendix A3.1: Location of work for Active Fellows in Australia and Aotearoa New Zealand, 2024

	N	%
AUS Exclusively working in a regional, rural or remote location	133	14.7
AUS Mainly working in a regional, rural or remote location with outreach to other regional, rural/ or remote area(s)	35	3.9
AUS Mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s)	20	2.2
AUS Mainly working in a metropolitan location with outreach to regional, rural or remote location(s)	203	22.5
AUS Does not work in regional/ rural areas	512	56.7
AoNZ Exclusively working in a regional, rural or remote location	38	15.6
AoNZ Mainly working in a regional, rural or remote location with outreach to other regional, rural or remote area(s)	6	2.5
AoNZ Mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s)	11	4.5
AoNZ Mainly working in a metropolitan location with outreach to regional, rural or remote location(s)	48	19.7
AoNZ Does not work in regional, rural or remote areas	141	57.8
Total	1147	

Exclusions: Retired Fellows.

Appendix A3.2a: Fellows working in a regional, rural or remote location by surgical specialty, Australia 2024

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Does not work in regional, rural or remote area(s)	27	194	26	90	64	20	42	27	22	512
Exclusively working in regional, rural or remote location	4	60	2	34	12	1	6	12	2	133
Mainly working in a metropolitan location with outreach to regional, rural or remote location(s)	3	61	16	38	30	2	25	18	10	203
Mainly working in regional, rural or remote location with outreach to other regional, rural or remote area(s)	0	21	2	2	3	1	0	4	2	35
Mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s)	1	6	0	6	4	0	0	3	0	20
Total	35	342	46	170	113	24	73	64	36	903

Exclusions: Aotearoa New Zealand Fellows, Retired Fellows.

Appendix A3.2b: Fellows working in a regional, rural or remote location by surgical specialty, Aotearoa New Zealand, 2024

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Does not work in regional, rural or remote area(s)	5	57	3	32	16	2	13	6	7	141
Exclusively working in regional, rural or remote location	0	15	0	13	4	0	1	5	0	38
Mainly working in a metropolitan location with outreach to regional, rural or remote location(s)	1	9	2	10	7	4	8	3	4	48
Mainly working in regional, rural or remote location with outreach to other regional, rural, remote area(s)	0	2	0	1	2	0	0	1	0	6
Mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s)	0	5	0	4	1	0	0	1	0	11
Total	6	88	5	60	30	6	22	16	11	244

Exclusions: Australian Fellows, Retired Fellows.

Appendix A3.3a: Location of work using Monash Modified Model classification for Fellows in Australia, 2024

	Main practice	%	Other practice 1	%	Other practice 2	%	Other practice 3	%	Other practice 4	%	Other practice 5	%
MM 1	201	52.3	143	37.2	81	21.1	44	11.5	23	6.0	17	4.4
MM 2	88	22.9	75	19.5	28	7.3	16	4.2	18	4.7	14	3.6
MM 3	43	11.2	49	12.8	17	4.4	13	3.4	6	1.6	4	1.0
MM 4	6	1.6	11	2.9	19	4.9	5	1.3	2	0.5	0	0.0
MM 5	39	10.2	69	18.0	40	10.4	21	5.5	12	3.1	10	2.6
MM 6	4	1.0	5	1.3	6	1.6	3	0.8	2	0.5	1	0.3
MM 7	3	0.8	13	3.4	5	1.3	5	1.3	2	0.5	2	0.5
Total	384		365		196		107		65		48	

Exclusions: Aotearoa New Zealand Fellows, Retired Fellows.

Appendix A3.3b: Location of work using Functional Urban Areas (FUA) classification for Fellows in Aotearoa New Zealand, 2024

	Main practice	%	Other practice 1	%	Other practice 2	%	Other practice 3	%	Other practice 4	%	Other practice 5	%
Metropolitan area	51	49.5	34	33.0	9	8.7	3	2.9	2	1.9	2	1.9
Large regional centre	35	34.0	35	34.0	10	9.7	7	6.8	6	5.8	5	4.9
Medium regional centre	8	7.8	16	15.5	5	4.9	5	4.9	4	3.9	3	2.9
Small regional centre	3	2.9	7	6.8	5	4.9	2	1.9	3	2.9	0	0.0
Land area outside FUA	6	5.8	6	5.8	3	2.9	2	1.9	1	1.0	0	0.0
Total	103		98		32		19		16		10	

Exclusions: Australian Fellows, Retired Fellows.

Appendix A3.3c: Monash Modified Model main practice location by surgical specialty, Australia 2024

Surgical Speciality	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6	MM 7	Total
CAR	4	4	0	0	0	0	0	8
GEN	58	36	22	2	20	2	3	143
NEU	17	3	0	0	0	0	0	20
ORT	46	16	9	1	7	1	0	80
OTO	30	8	4	1	4	1	0	48
PAE	2	2	0	0	0	0	0	4
PLA	22	5	0	0	4	0	0	31
URO	14	13	6	1	3	0	0	37
VAS	8	1	2	1	1	0	0	13
Total	201	88	43	6	39	4	3	384

Exclusions: Aotearoa New Zealand Fellows, Retired Fellows.

Appendix A3.3d: Functional Urban Areas main practice location by surgical specialty, Aotearoa New Zealand 2024

Surgical Speciality	Metropolitan area	Large regional centre	Medium regional centre	Small regional centre	Outside Functional Urban Area	Total
CAR	1	0	0	0	0	1
GEN	12	12	4	1	2	31
NEU	2	0	0	0	0	2
ORT	10	13	4	0	1	28
OTO	8	5	0	0	1	14
PAE	3	0	0	1	0	4
PLA	8	0	0	1	0	9
URO	3	5	0	0	2	10
VAS	4	0	0	0	0	4
Total	51	35	8	3	6	103

Exclusions: Aotearoa New Zealand Fellows, Retired Fellows.

Appendix A3.4a: Workforce status of Fellows who work in a regional, rural or remote area only, 2024

		Full time	Locum	Part time	N
Regional, rural or remote only	Australia	137	8	23	168
	Aotearoa New Zealand	34	2	8	44
	Total	171	10	31	212

Exclusions: Retired Fellows; Fellows mainly working in metropolitan location with outreach to regional, rural or remote location(s); Fellows mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s).

Appendix A3.4b: Mean weekly hours worked for Fellows who work in a regional, rural or remote location only by employment status, 2024

		Full time	Locum	Part time	N
Regional, rural or remote only	Australia	39.3	18.1	19.5	167
	Aotearoa New Zealand	39.8	3.5	27.1	43
	Total	39.4	15.2	21.5	210

Exclusions: Retired Fellows; Fellows mainly working in metropolitan location with outreach to regional, rural or remote location(s); Fellows mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s).

Appendix A3.5a: Outreach services for Fellows who work in regional, rural or remote only and rural and metropolitan locations, 2024

	N	%	Mean hours
No outreach services	369	74.0	
Yes, monthly outreach	106	21.4	9.3 per month
Yes, weekly outreach	21	4.6	9.4 per week
Total	496	100	

Exclusions: Retired Fellows; Active Fellows do not work in regional, rural or area(s).

Appendix A3.5b: Frequency of outreach surgery for Fellows who work in regional, rural or remote only or rural and metropolitan centres by work location, 2024

	Per month	Per week	No outreach	Total
Exclusively working in regional, rural or remote location	23	74	74	171
Mainly working in regional, rural or remote location with outreach to other regional, rural or remote area(s)	86	52	115	253
Mainly working in a regional, rural or remote location with outreach/ inreach to major metropolitan centre(s)	19	13	9	41
Mainly working in a metropolitan location with outreach to regional, rural or remote location(s)	10	8	13	31
Total	138	147	211	496

Exclusions: Retired Fellows; Active Fellows do not work in regional, rural or remote area(s).

Appendix A3.6: Regional, rural or remote area future work intentions over the next five years, Australia and Aotearoa New Zealand, 2024

	Australia	Aotearoa New Zealand	N	%
Continue working in city/ metropolitan area (or considering locating to a city/ metropolitan area)	444	132	576	55.5
No plans to change current regional, rural or remote work pattern	194	40	234	22.6
Decrease work hours in regional, rural or remote area	64	17	81	7.8
Increase work hours in regional, rural or remote area	31	6	37	3.6
Uncertain	95	14	109	10.5
Total	828	219	1037	100

Exclusions: Retired Fellows; missing work location responses

Chapter 4 Supplementary data

Appendix A4.1: Proportion of Fellows who undertake volunteer or pro bono work by surgical specialty, 2024

	Pro bono work	%	N
CAR	35	76.1	46
GEN	341	65.0	525
NEU	37	59.7	62
ORT	168	62.0	271
OTO	99	63.1	157
PAE	29	69.0	42
PLA	73	67.6	108
URO	61	67.0	91
VAS	42	73.7	57
Total	885	65.1	1359

Appendix A4.2: Types of pro bono or volunteer activities Fellows participate in, 2024

N=885	N	%
Domestic clinical work	196	22.1
Domestic aid work	36	4.1
International aid work	110	12.4
RACS (incl. SET Program training and supervision)	654	73.9
Specialty Society/ Association	290	32.8
Clinical education not related to SET Program	499	56.4
Non-clinical work (e.g. administration, charity, committee appointments)	432	48.8
Other volunteer work	130	14.7

Note: those participating in multiple areas may be counted more than once.

Appendix A4.3: Mean hours worked per month on pro bono or volunteer activities, 2024

N=885, Avg hours per month = 11.0	Mean hours per month
Domestic clinical work	12.3
Domestic aid work	10.3
International aid work	7.7
RACS (incl. SET Program training and supervision)	18.3
Specialty Society/ Association	6.3
Clinical education not related to SET Program	8.9
Non-clinical work (e.g. administration, charity, committee appointments)	12.1
Other volunteer work	12.2

Note: those participating in multiple areas may be counted more than once.

Appendix A4.4: Types of RACS pro bono roles Active Fellows participate in, 2024

N=654	N	%
Council/ board/ committee member	130	19.9
SET Program supervisor	225	34.4
Educational instructor/ presenter	240	36.7
Examiner/ interviewer	179	27.4
International aid	20	3.1
Surgical mortality audit assessor	180	27.5
Other	86	13.1

Note: those participating in multiple RACS activities may be counted more than once

Appendix A4.5: Proportion of Fellows involved in RACS pro bono activities by surgical specialty, 2024

	RACS pro bono activities	N	%
CAR	22	46	47.8
GEN	263	525	50.1
NEU	24	62	38.7
ORT	114	271	42.1
OTO	76	157	48.4
PAE	23	42	54.8
PLA	51	108	47.2
URO	46	91	50.5
VAS	35	57	61.4
Total	654	1359	48.1

Chapter 5 Supplementary data

Appendix A5.1: Workplace sources of Fellows' self-rated stress levels, 2024

	N	No stress	Little stress	Moderate stress	High stress	Extreme stress
Administrative regulation	1240	197	367	365	222	89
Administrative processes	1257	175	371	407	214	90
Threat of litigation	1224	444	420	196	100	64
Workplace culture	1231	378	369	263	138	83
Adopting new technologies	1206	511	503	154	33	5
Maintaining and updating knowledge base	1242	563	485	163	23	8
Maintain skill set	1223	511	484	189	30	9
COVID-19	1270	607	427	160	49	27

Exclusions: Retired Fellows and Fellows who selected 'not applicable to me' responses.

Appendix A5.2: Proportion of Fellows who have sought professional assistance to deal with stress or a mental health issue in the last 2 years, 2024

	N	%
Yes, I sought professional assistance	150	10.4
No, I had not sought professional assistance	530	36.8
I have not experienced any mental health issues in the last 2 years	658	45.7
I'd rather not say	22	1.5
Fellows who skipped the question	80	5.6
Total	1440	100

Exclusions: Retired Fellows

Appendix A5.3: How Fellows monitored their general health in the last 2 years, 2024

	N	%
I did my own health check-ups	97	7.1
I visited a medical doctor for a health check-up	532	39.1
I see a GP/medical doctor at regular intervals as dictated by my existing medical condition requirements	530	39.0
It has been more than 2 years since I've had a general health check-up	201	14.8
Total	1360	100.0

Exclusions: Retired Fellows; missing responses.

Appendix A5.4: Distribution of leave Fellows took over the past 12 months, 2024

	N				%			
Leave	CPD/ Study	Annual	Sick	Parental	CPD/ Study	Annual	Sick	Parental
1 week	350	42	261	42	31.2	3.7	23.2	3.7
2 weeks	345	110	29	8	30.7	9.8	2.6	0.7
3 weeks	181	202	14	1	16.1	18.0	1.2	0.1
4 weeks	48	368	12	3	4.3	32.8	1.1	0.3
6 weeks	7	211	13	0	0.6	18.8	1.2	0.0
>6 weeks	15	117	17	16	1.3	10.4	1.5	1.4
Yes	946	1050	346	70	84.2	93.5	30.8	6.2
No leave	177	73	777	1053	15.8	6.5	69.2	93.8
Total	1123	1123	1123	1123	100	100	100	100

Exclusions: Missing responses.

Appendix A5.5: Duration of parental leave Fellows took over the past 12 months, 2024

		N		%	
	N	<6 weeks	>6 weeks	<6 weeks	>6 weeks
Female	23	9	14	39. 1	60.9
Male	47	45	2	95.7	4.3
Total	70	54	16		

Exclusions: Retired Fellows; missing responses.

Chapter 6 Supplementary data

Appendix A6.1: Fellows current and future work intentions over the next 10 years, 2024

		Mean work hours per week				
N = 1299		Now 2024	2 years 2026	5 years 2029	10 years 2034	N
Female	<40	39.1	42.8	42.4	41.1	32
	40-49	38.2	39.5	39.2	35.2	96
	50-59	36.8	37.3	32.3	21.4	71
	60-69	35.4	30.0	16.1	4.2	37
	70-79	22.8	17.0	5.0	0.0	4
	80+	0.0	0.0	0.0	0.0	0
Male	<40	42.6	43.8	42.8	42.5	54
	40-49	43.0	44.0	42.0	37.3	224
	50-59	45.9	44.3	39.0	24.6	274
	60-69	36.7	28.9	15.5	4.6	269
	70-79	23.0	14.9	5.2	1.0	129
	80+	11.9	10.4	3.8	2.4	36

Exclusions: Retired Fellows; missing responses.

Appendix A6.2: Proportion of Fellows aged less than 50 years and 50 years and over who intend to retire within the next 10 years from clinical practice and all forms of paid work, 2024

Age ≤50 years	Public	Private	Medico legal work	All forms of paid work
In ≤10 years	49	29	6	12
Total	366	330	67	332
%	13.4	8.8	9.0	3.6
Age ≥50 years	**Public**	**Private**	**Medico legal work**	**All forms of paid work**
In ≤10 years	404	409	160	392
Total	664	645	312	635
%	60.8	63.4	51.3	61.7

Exclusions: Retired Fellows; missing responses.

Appendix A6.3a: Proportion of Fellows aged 65 years or older who intend to be engaged in paid employment for the next two years, 2024

N=242	N	%
No	108	44.6
Yes	134	55.4
Total	242	100

Exclusions: Retired Fellows; missing responses.

Appendix A6.3b: Type of work Fellows aged 65 years or older plan to do in the next two years, 2024

N=134	N	%
Operative practice in hospitals or day surgery units	84	62.7
Operative practice in rooms	19	14.2
Surgical assisting	16	11.9
Clinical consulting practice	79	59.0
Administration	46	34.3
Medico legal work	58	43.3
Research/ academia	29	21.6
Education and assessment	42	31. 3
Military service	1	0.7
Other	13	9.7

Exclusions: Retired Fellows; missing responses.

Appendix A6.4: Main reasons why Fellows aged 65 years or older continue to be engaged in paid employment for the next 2 years, 2024

N=134	N	%
I am doing work that I enjoy	64	47.8
I have not met my minimum financial goals for retirement yet	9	6.7
I still feel I can contribute value to the workforce	42	31.3
I want to stay mentally active	11	8.2
Other	2	1.5

Exclusions: Retired Fellows; missing responses.