ASMS
TOI MATA HAUORA

Creeping Privatisation

Analysis of trends in planned care provision in Aotearoa New Zealand

September 2023

Contents

This paper has been researched and written by Lyndon Keene, Research Advisor, Association of Salaried Medical Specialists.

Introduction: “Invest in health workforce, or risk collapse”

Globally, health workforces are under immense strain. The quote above is a call to action from the World Health Organization (WHO), drawn from a recent article from the *British Medical Journal*. Although the WHO’s warning is directed at European governments, the message rings just as loudly in Aotearoa New Zealand, and the alarm ought to resonate with health policymakers here.

The international health workforce crisis is doubly significant for this country, being so heavily dependent on overseas recruits to provide its health services, owing to ongoing under-investment in training our own. It is in this context that this report examines the results of our already-short supply of senior public hospital doctors and dentists leaving to take up private practice, as indicated in a recent survey of our members on their career intentions.

The private system has a role in providing services for those who want fast-tracked ‘non-acute’ care, the extra comfort and trimmings, and are willing and able to pay for it. But lack of investment in the public hospital workforce and infrastructure is rapidly increasing dependency on private services to provide what public services can’t. As private services expand, so must their staff. In a world desperately short of health workers, Aotearoa New Zealand’s private health sector is inevitably poaching from an already over-stretched public hospital workforce - and its easy pickings, given the poorer working conditions.

This report uses previously unpublished data obtained from New Zealand Health Surveys, Te Whatu Ora Health New Zealand and the Accident Compensation Corporation (ACC), as well as recent survey results of ASMS members to examine the implications of this creeping privatisation for access to public health services. Its findings reinforce the WHO’s message: invest in the workforce or risk a public health system meltdown.

While it concerns mostly the senior medical workforce, we acknowledge the issues identified here are common across the whole health workforce. We also recognise that the trends towards more private health care raise many other issues, including the implications for additional costs, access to training for health workers, potential conflicts of interest for medical specialists, deteriorating health inequalities, and maldistribution of health professionals. All of which deserve urgent scrutiny.

At a glance

Creeping privatisation: The trends

- Estimated elective private hospital discharges increased by 38 per cent between 2013/14 and 2019/20 while public hospital non-acute discharges dropped by 4 per cent.
- Broad indicators suggest most elective surgery is performed in private facilities, although accurate comparisons between privately and publicly provided elective surgery are stymied by private data shortcomings.
- There was an estimated 32 per cent jump in the number of adults who saw a specialist at a private hospital (other than as an inpatient) between 2014 and 2020. A similar increase is reported for the estimated number of adults who saw a specialist (excluding GPs) at a private clinic.
- Southern Cross Medical Society, Aotearoa New Zealand's largest health insurer with 62 per cent of the health insurance market, reports over half-a-million specialist consultations in 2021/22.
- The number of adults with private health insurance grew by 13.5 per cent from 2014 to 2020, which is similar to the growth in the adult population, suggesting the real growth in the use of private hospitals and specialist clinics has been due to an increase in insured people needing treatment and an increase in self-funded care, the latter for which no data is available.
- The take-up of health insurance varies widely across the socioeconomic groups, with the least deprived adults (Quintile 1) three times more likely to hold health insurance than the most deprived (Quintile 5).
- About 46 per cent of private hospital discharges are funded from the public purse, in part from overloaded public hospitals outsourcing their workload to private services, but mostly from the Accident Compensation Corporation (ACC).
- Te Whatu Ora Health New Zealand's Planned Care Taskforce has recommended greater use of private facilities to help cope with the Covid backlog for non-urgent treatments. In addition, ACC's use of private health services is trending upwards, with 89 per cent of electives provided in private facilities in 2022 compared with 83 per cent in 2012/13.
- New Zealand Health Survey estimates show that by mid-2022, nearly 140,000 more adults were holding private health insurance than in the previous year.

Losing doctors to the private sector

- Thirty per cent of the total hours worked by the medical specialist workforce were spent in 'Private/Other' services in 2022 - mostly in private hospitals or private clinical practice.
- For surgical specialties, more than a third (35 per cent) of worked hours were spent mostly in the private sector, and a further 3 per cent were spent in other employment.
- Specialists in dermatology are employed more in private services than in the public system (dermatologists are unavailable in many parts of Aotearoa NZ), while the orthopaedic and ophthalmology workforces are split 50-50 between the two.
- Surveys of senior public hospital doctors and dentists show low job satisfaction and poor working conditions, as well as an ageing workforce, are key drivers behind decisions to either move away from the public health system or leave medicine entirely.
    - A 2022 survey on members' career intentions within the next five years found 42 per cent intended to reduce their hours in the public system, with many indicating a move to the private sector. Thirty-six per cent of respondents aged 55 and over were either likely or extremely likely to leave medicine entirely.
    - A 2022 'exit' survey of members leaving their district health board/Te Whatu Ora employment during that year found 15.5 per cent of respondents were leaving to increase their private practice. This does include members who decided to work more hours in private practice but retain part-time employment in the public sector.
    - In a 2023 survey 59 per cent of respondents said they worked part-time outside of the public health system and a further 13.5 per cent said they were thinking about it. Most work in the private health sector.
    - Remuneration, the ability to manage one's own time and workload, and clinical satisfaction were the most common factors influencing decisions to work outside the public system. Conversely, remuneration, staffing levels and resourcing were the most common factors that would influence a decision to return or stay in the public system.
- As a consequence of the above trends, timely access to non-acute health care, as well as some urgent time-critical care, is becoming increasingly dependent on an individual's ability to pay for it.

The private gate to the public system

The shift towards greater dependency on the private secondary health services creates a double disadvantage for those who cannot afford health insurance, or to self-fund their care. People unable to access private services are more likely to be Māori, Pasifika and lower-income whānau, who already experience multiple barriers to access private primary health services – required to receive a referral to secondary hospital and specialist services.

Access to primary care is likely to become worse for many communities as GP practices are taken over by local and overseas corporations.

The solutions

- The common policy response to private services 'crowding out' public services advocated in the international literature is to increase public sector salaries or increase the total supply of doctors, or both. (Ways to close the gap between health needs of our whānau and health workforce capacity are covered fully in *Workforce: The make or break of the health reform*).
- To achieve this, a radically different approach to public health and social spending is urgently needed. Unmet health need and delays in treatment are a substantial drain on the economy while, conversely, good health and timely treatment are important contributors to stronger economic growth.

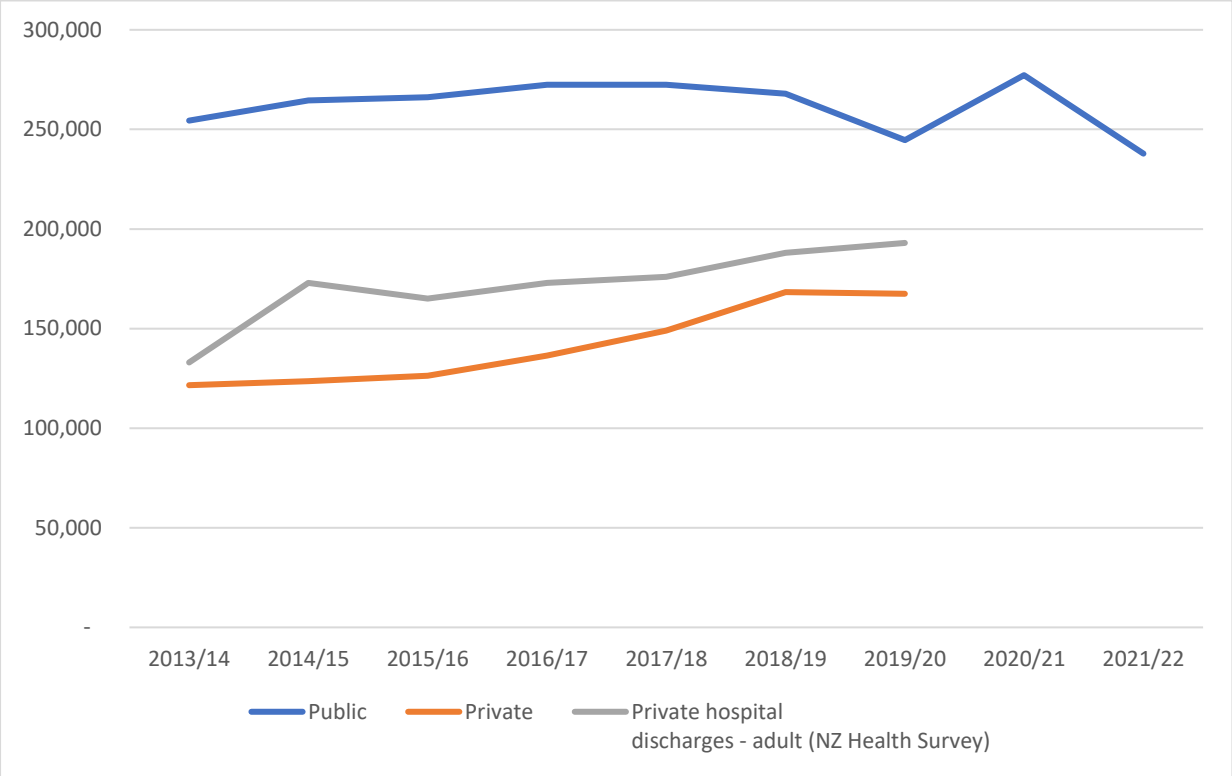
The mostly private primary health care system urgently needs reform to be more compatible with the public hospital system, including eliminating user charges, improving the distribution of services, and addressing access inequalities.

Glossary

Non-acute	Elective treatment or "arranged" admissions. The latter is a planned admission that occurs within seven days of a decision to admit; or uncomplicated maternity cases.
Non-acute admission	Elective treatment or "arranged" admissions.
Elective treatment	Admitted from the waiting list (restricted to patients deemed as needing treatment within four months)
Arranged admission	A planned admission that occurs within seven days of a decision to admit; or uncomplicated maternity cases.

Trends in the provision of private medical specialist care

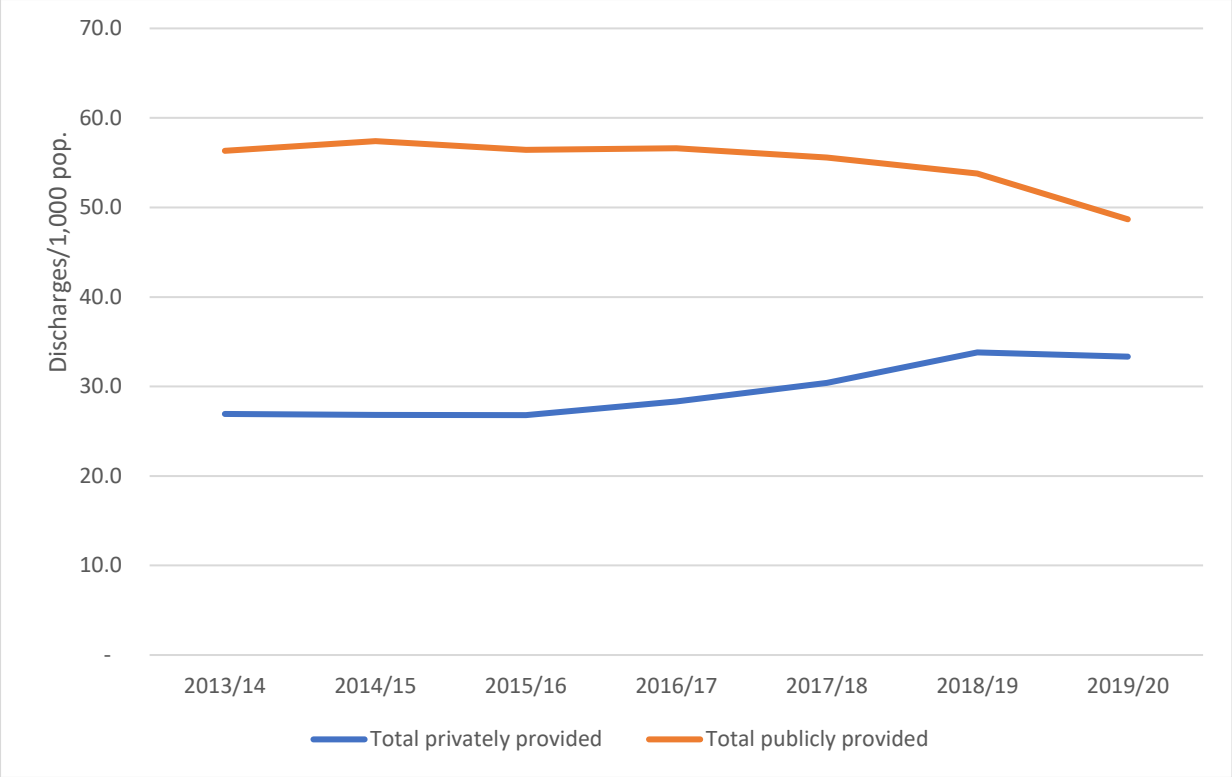
According to figures obtained from Manatū Hauora Ministry of Health, estimated elective private hospital discharges increased by 38 per cent between 2013/14 and 2019/20 while public hospital non-acute discharges dropped by 4 per cent (Figure 1). While the extent of private hospital reporting is incomplete and variable over that period, the general trend is confirmed by data from New Zealand Health Surveys. Private hospital data is not yet available beyond 2019/20. Discharges from 2019/20 to 2021/22 will have been affected by Covid-related lockdowns and periods of restricted activity.



Source: National Minimum Data Set (Ministry of Health), New Zealand Health Survey and ACC

Figure 1: Elective discharges in private and public facilities, 2013/14 to 2019/20

When population growth is taken into account, private hospital elective discharges increased by 23.8 per cent between 2013/14 and 2019/20 while public hospital discharges decreased by 13.5 per cent (Figure 2). When the two are combined, total electives increased by 5.3 per cent per capita over that same period. While more elective procedures are being performed in the public health system, the trends show a shifting away from public provision towards private provision.



Source: National Minimum Data Set, ACC and Statistics NZ

Figure 2: Elective discharges per 1,000 population in private and public facilities, 2013/14 to 2019/20

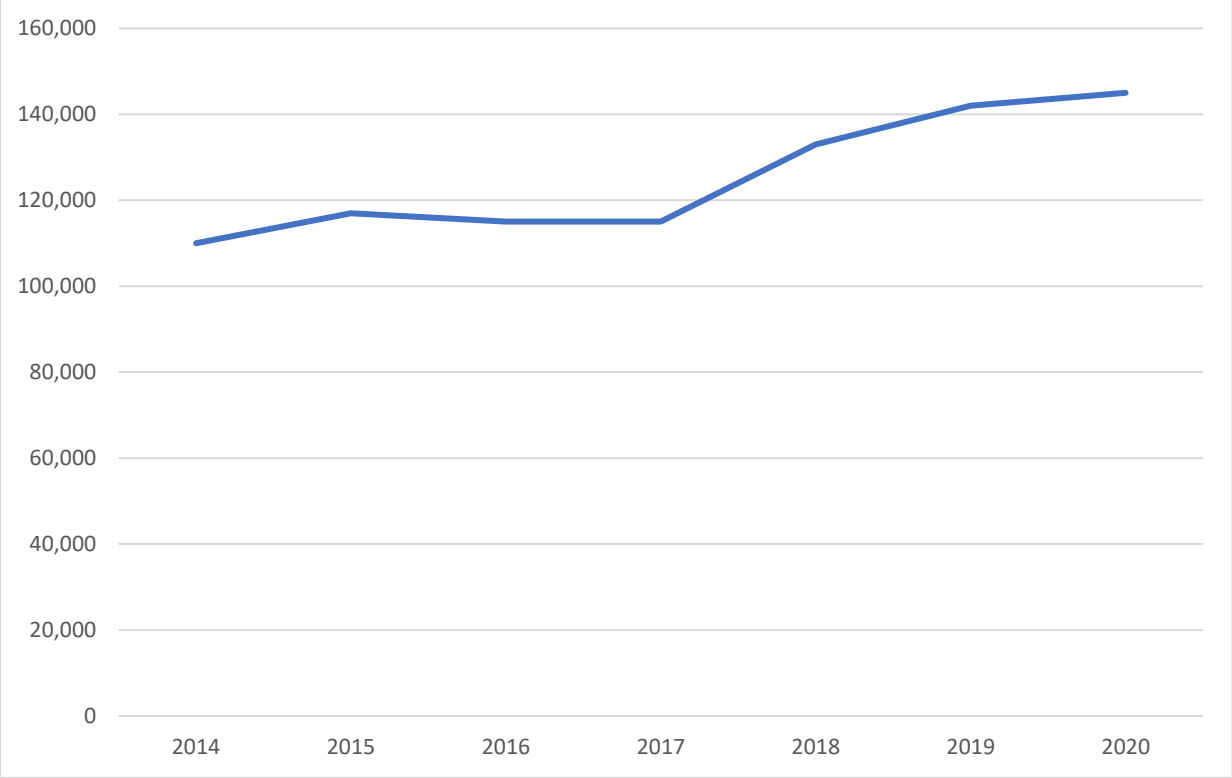
The Private Surgical Hospitals Association claims its hospitals perform approximately 206,165 surgical discharges per year, "representing around 66 per cent of all elective surgery performed in New Zealand".[1] According to one Ministry source, this figure sounds too high, considering how private hospital discharges are tracking, and that not all are surgical cases. However, some private providers are still not providing discharge numbers to the Ministry. The New Zealand Health Survey estimates of adult day patient and inpatient admissions to private hospitals was approaching the 200,000 mark in 2020, including non-surgical cases, plus about 12,000 children (though the latter is deemed not robust by the Ministry).[2] Ministry data show there were just 174,665 publicly provided elective surgical discharges 2021/22. While accurate comparisons between privately and publicly provided elective surgery are stymied by private data shortcomings, the broad indicators suggest a growing majority of elective surgery is performed in private facilities.

The growth in the use of private medical specialist services is reinforced in unpublished annual New Zealand Health Survey data showing a 32 per cent jump in the estimated number of adults who saw a specialist at a private hospital (other than as an inpatient) between 2014 and 2020 (Figure 3). A

[1] NZ Private Surgical Hospitals Association. NZPSHA home page. https://www.nzpsha.org.nz/

[2] NZ Health Survey. Unpublished data from 2014-20 surveys, compiled for ASMS by Manatū Hauora Ministry of Health, March 2023.

similar percentage increase is reported for the estimated number of adults who saw a specialist (excluding GPs) at a private clinic, increasing from 320,000 in 2014 to 427,000 in 2020.



Source: NZ Health Surveys (unpublished), 2023

Figure 3: Estimated number of adults who saw a specialist at a private hospital

No data is available on the average number of times that patients see specialists at private hospitals in any given year. As an indicator however, Southern Cross, Aotearoa New Zealand's largest health insurer with 62 per cent of the health insurance market, reported over half-a-million specialist consultations in 2021/22.[3]

[3] Southern Cross Medical Care Society. *2022 Annual Report Summary*. https://www.southerncross.co.nz/about-southern-cross/society.

The drivers of private health care growth

Significant unmet health need has been a hallmark of the health system long before Covid-19. As a result, many patients over decades have been unable to get timely health care for elective and other 'non-acute' care in the public system. [4] [5] [6]

This has been pushing those who can afford it to privately fund their care, either through private insurance or out-of-pocket. From 2014 to 2020 the number of adults with private health insurance grew by 13.5 per cent, which is similar to the growth in the adult population, suggesting the real growth in the use of private hospitals and specialist clinics has been due to an increase in insured people needing treatment and an increase in self-funded care, the latter for which no data is available.

In addition, publicly funded private hospital discharges increased by 19 per cent over the same period, broadly in line with the growth in privately funded discharges (21 per cent). About 46 per cent of private hospital discharges are funded from the public purse, in part from overloaded public hospitals outsourcing their workload to private services, but mostly from the Accident Compensation Corporation (ACC).[7] [8]

While data on private hospital use during the years affected by Covid lockdowns is not yet available, the early indicators are pointing to a steeper rise in the trends. In 2022, Te Whatu Ora Health New Zealand's Planned Care Taskforce recommended greater use of private facilities to help cope with the Covid backlog for non-urgent treatments.[9] In addition, ACC's use of private health services is trending upwards, with 89 per cent of electives provided in private facilities in 2022 compared with 83 per cent in 2012/13.

Perhaps more significantly, the effects of the Covid pandemic and growing waiting lists for elective treatments and first specialist assessments[10] are seeing a surge in private insurance membership. As consultants KPMG put it in 2022:

"We've seen other nations' demand for healthcare insurance and self-funded treatment increase off the back of high rises in waiting times (largely due to the Covid-19 pandemic and global workforce

[4] Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. N Z Med J. 2017; 130(1452):23-38. https://pubmed.ncbi.nlm.nih.gov/28337038/.

[5] Inglis T, Armour P, Inglis G, Hooper G. Rationing of Hip and Knee Referrals in the Public Hospital: The True Unmet Need, N Z Med J, 2017; 130(1452):39-48. https://pubmed.ncbi.nlm.nih.gov/28337039/.

[6] Matheson A, Ellison-Loschmann L. Addressing the complex challenge of unmet need: a moral and equity imperative? N Z Med J 2017, 130 (1452):6-8. https://pubmed.ncbi.nlm.nih.gov/28337035/.

[7] National Minimum Dataset, Manatū Hauora Ministry of Health, 2023.

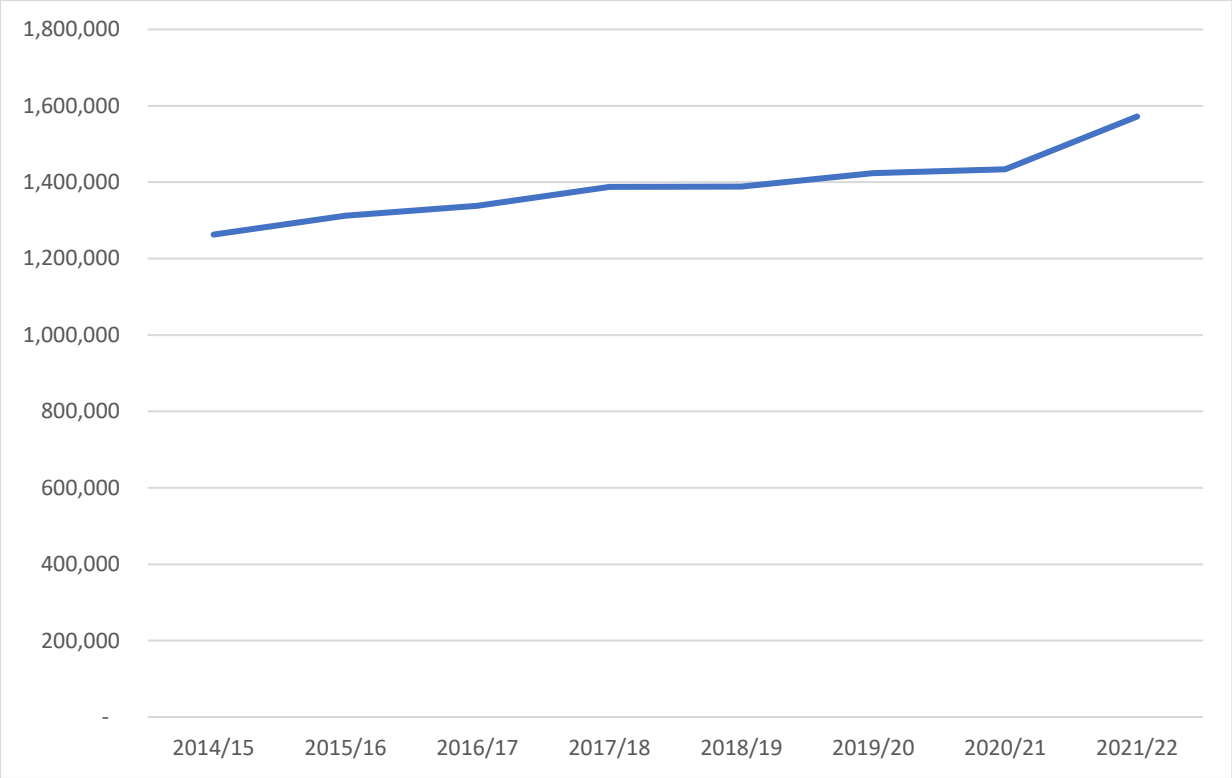
[8] ACC. Request for data under the Official Information Act, March 2023.

[9] Te Whatu Ora. Reset and Restore Plan. Planned Care Taskforce, September 2022. https://www.tewhatuora.govt.nz/publications/planned-care-taskforce-reset-and-restore-plan/.

[10] Quinn R. Elective surgery waiting lists continuing to grow, latest figures show. Radio NZ, 27 January 2023. https://www.rnz.co.nz/news/national/483180/elective-surgery-waiting-lists-continuing-to-grow-latest-figures-show.

crisis) and in New Zealand, the Southern Cross Medical Care Society has reported its highest membership numbers in 30 years."[11]

According to New Zealand Health Survey estimates, by mid-2022, nearly 140,000 more adults were holding health insurance than in the previous year (Figure 4)[12]



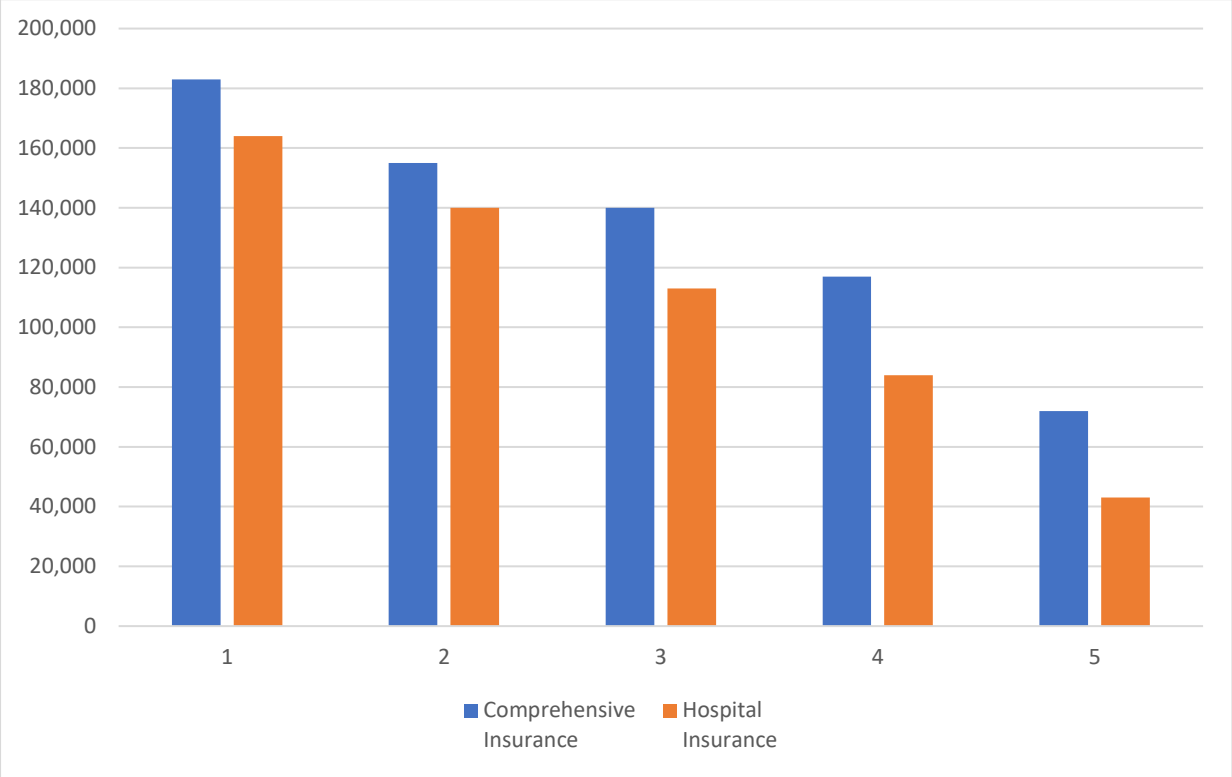
Source: NZ Health Survey, 2021/22.

Figure 4: Number of adults with health insurance 2014/15 to 2021/22

[11] KPMG NZ 2022 Insurance Update. https://assets.kpmg.com/content/dam/kpmg/nz/pdf/2022/11/2022-new-zealand-Insurance-update-v2.pdf.

[12] Financial Service Council. 2021 – Health insurers make a significant contribution to Kiwi's health, March 2022. https://blog.healthcareplus.org.nz/hcp/health-insurers-make-contribution-to-kiwi-health

The insurance take-up, however, varies widely across the socioeconomic groups, with the least deprived (Quintile 1) three times more likely to hold health insurance than the most deprived (Figure 5).



Source: NZ Health Survey, 2021/22.

Figure 5: Number of adults with health insurance by quintile averaged over the 3 years 2018/19 to 2020/21

As well as noting the rise in health insurance uptake, KPMG also stressed the importance of the private sector's competitiveness in attracting staff: "As workforce shifts cause gaps in capacity and backlogs in treatment ... insurers will need to be assured approaches to national workforce shortages and skills gaps are being addressed adequately by providers in the private sector."

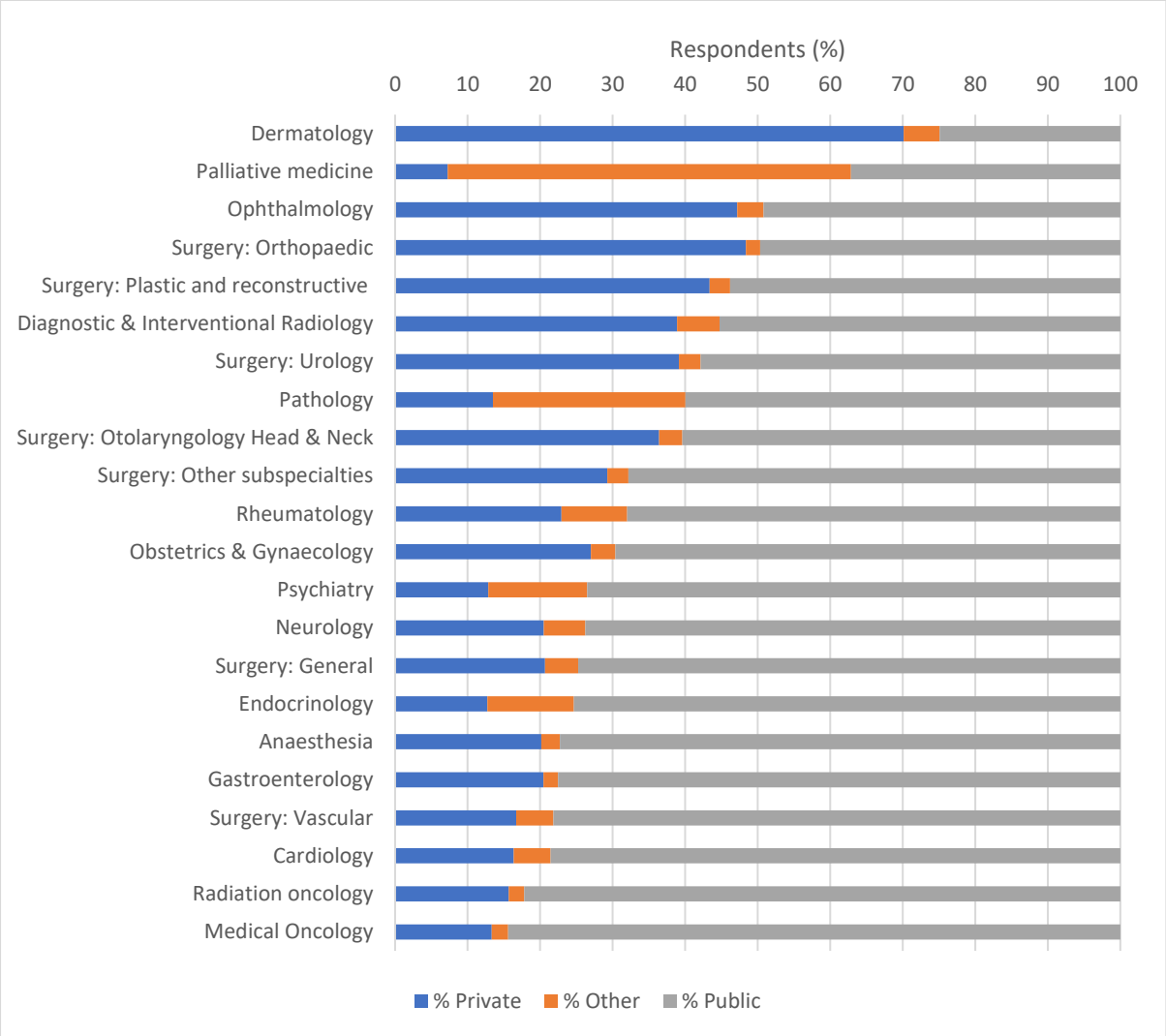
Private providers need little prompting. "Caring for our staff is our first step in caring for our patients," says Southern Cross, which offers an environment where staff "feel supported, equipped for personal and professional success, and able to be their best".[13]

For medical specialists, the "workforce shift" from the public to private system risks further reducing the capacity of the public system to meet Aotearoa New Zealand's health needs, as discussed in the following sections.

[13] Southern Cross Healthcare and Hospitals. https://healthcare.southerncross.co.nz/.

The medical specialist workforce: the public-private divide

Thirty per cent of the total hours worked by the medical specialist workforce was spent in 'Private/Other' services in 2022 - mostly in private hospitals or private clinical practice (see footnote). For surgical specialties, more than a third (35 per cent) of worked hours were spent in the private sector, and a further 3 per cent were spent on other employment.



Source: Compiled by ASMS from unpublished data provided by the Medical Council of New Zealand from its Medical Workforce Survey, 2022.

Figure 6: Specialties with more than 40 full-time-equivalent (FTE) specialists and more than 15 per cent working in private/other employment, 2022[14]

[14] 21 per cent of specialist workforce hours were spent in private practice, with 9 per cent spent in other employment (e.g. university, NGOs, other government departments etc).

These figures are likely to be higher today as more patients opt for private treatment to bypass the Covid-related waiting list back-log in the public system, and as private facilities are contracted by Te Whatu Ora Health New Zealand to attempt to address that backlog.

In specialties with more than 40 full-time-equivalent (FTE) specialists and more than 15 per cent working in private/other employment, specialists in dermatology and palliative medicine are employed more in private/other employment than in the public system. Ophthalmologists and orthopaedic surgeons are split virtually 50-50 between the two (Figure 6).

The public/private split in the context of workforce shortages

The division of the specialist workforce across the public-private/other sectors would not necessarily be an issue if there were sufficient specialist workforce capacity to meet health need in the public system. In contrast, the evidence gathered by ASMS over many years show long-standing shortages across the board with little or no sign of them being addressed.[15] Only recently has the Government formally acknowledged medical shortages, though its assessment, largely based on vacancy rates (which are largely determined by budgets rather than service needs) falls well short of the estimates of clinical leaders surveyed nationally by ASMS.[16] The effects of the workforce split therefore has to be seen in the light of workforce shortages in each specialty, where every specialist moving to the private sector can exacerbate the shortage in the public sector.

The Government's Planned Care Taskforce report, *Reset and Restore Plan,* recognises this risk: "It should be noted that … any increase in use of private sector capacity may lead to a reduction in public workforce availability to deliver existing and additional levels of planned care within the public system."

The following examples which typify what is happening across many specialties.

Dermatology

Long-standing shortages of dermatologists are well recorded[17]. Aotearoa New Zealand has about a third of the number of dermatologists that international statistics suggest we should have, despite having the world's highest death rates for melanoma, and high hospitalisation rates for skin and soft tissue infections in children. [18] Dermatology is unavailable in the public system in many parts of the country. Many former district health boards had no budget to employ them (a salient example of the

[15] ASMS. *Workforce: The Make or Break of the Health Reforms*, November 2022. https://asms.org.nz/workforce-the-make-or-break-of-the-health-reform/

[16] Te Whatu Ora Health NZ. Aotearoa New Zealand Health Workforce Plan 2023/24, July 2023. https://www.tewhatuora.govt.nz/assets/Publications/Health-Workforce-Plan/FINAL-HEALTH-WORKFORCE-PLAN_3-July-2023.pdf.

[17] Gordon LG, Leung W, Johns R, McNoe B, Lindsay D et al. Estimated health care costs of melanoma and keratinocyte skin cancers in Aotearoa New Zealand and Australia in 2021. Int J Environ Res Pub Health. 2022; 19(6): 3178. https://pubmed.ncbi.nlm.nih.gov/35328865/.

[18] Arnold M, Singh D, Laversanne M, et al. Global Burden of Cutaneous Melanoma in 2020 and Projections to 2040. JAMA Dermatol. 2022;158(5):495-503. https://pubmed.ncbi.nlm.nih.gov/35353115/.

consequences of assessing shortages according to vacancy rates).[19] Dermatology is among 28 specialties with fewer trainees than there are specialists (private and public) aged 55+ (estimated ratio of 8:34), and more than 20 per cent of dermatologists are aged 65+.

Palliative care

While the number of people struggling to access palliative care services is growing rapidly, studies project the need for palliative care services to increase by half in the next 20 years, and almost double in the next 50 years.[20] Palliative medicine is another of the specialties with fewer trainees than there are specialists aged 55 or over, who comprise more than 40% of the palliative medicine workforce. Many palliative medicine specialists are employed in hospices, which are only part-funded by government and rely heavily on donations. Last year hospices had to raise $94 million from community fundraising – op-shops, cupcake stalls and strawberry fairs - to cover over half of their running costs.[21]

Orthopaedic surgery and ophthalmology

Pre-Covid pandemic, Ministry of Health modelling showed health needs for orthopaedic surgery and ophthalmology were forecast to outstrip workforce growth in both specialties over the decade 2018 to 2028.[22] In July 2022, following the emergency phase of the pandemic, the New Zealand Orthopaedic Association said there were about 6,600 people waiting for elective hip, knee, and spine surgery.[23] In ophthalmology there were 7,800 people on waiting lists in July this year. The Government announced funding for 3,500 additional eye surgeries (including outsourcing to the private sector) over 18 months from 1 July 2023, though it is unclear whether staffing will increase accordingly[24].

The 50-50 public-private split in both specialties means most of any additional funding for elective surgeries is likely to be outsourced to the private sector. Meanwhile, public hospitals will continue to cover acute admissions as well as elective admissions (including the more complex ones), in addition to grappling with the backlog of referrals from GPs, new referrals and follow-up appointments in the absence of their colleagues working in the private sector.

---

[19] Thomson L. Dermatology sector suffering 'massive unmet need' due to lack of dermatologists. Newshub, 3 September, 2022. https://www.newshub.co.nz/home/politics/2022/09/dermatology-sector-suffering-massive-unmet-need-due-to-lack-of-dermatologists.html`.

[20] Van Dalen, D. *Ending Well: The Case Urgent Case for Accessible Palliative Care*. A discussion Paper; Maxim Institute, Auckland, November 2021. https://www.maxim.org.nz/content/uploads/2021/11/WEB-Ending-Well-Nov-2021-FINAL.pdf.

[21] Hospice NZ. Hospice Welcomes Funding Boost to Address Pay Parity. Media release. Hospice NZ, 16 June 2023. https://www.hospice.org.nz/news/11-5-million-funding-boost-for-hospice/.

[22] ASMS. Forecasting New Zealand's future medical specialist workforce needs. Research Brief, Issue 15, 2019. https://asms.org.nz/wp-content/uploads/2022/05/Research-Brief-specialist-workforce-projections-_172060.2.pdf.

[23] Macintosh C. Surgical waiting list soars as patients languishing in pain say they feel like the 'living dead'. Stuff, 8 July 2022. https://www.stuff.co.nz/national/health/129209277/surgical-waiting-list-soars-as-patients-languishing-in-pain-say-they-feel-like-the-living-dead.

[24] RNZ. Government expands cataract surgery eligibility, targets waitlists. 3 July 2023. https://www.rnz.co.nz/news/political/493096/government-expands-cataract-surgery-eligibility-targets-waitlists.

In a report in April 2023 a patient with a leg injury classified as semi-urgent was told there would be a 26-week wait to see a specialist.[25] Despite first specialist appointments being an important milestone towards diagnosis, Te Whatu Ora does not uniformly collect data on the number of people waiting for a first specialist appointment; it records only those waiting for more than four months. That figure – covering all specialties – increased by 23 per cent from January 2022 to December 2022 – from 35,800 to 43,900.

Long waits for first specialist appointments have been put down in part to not only the number of specialists available but also the hours they choose to work in public hospitals. In Australia, where for example orthopaedic surgeons spend 70 per cent of their time in the private sector, it is not uncommon for people to wait several years for first specialist appointments in the public system.[26] [27]

Specialties listed above with a relatively low private/other component – such as radiation oncology and medical oncology (both 13.7 per cent) – might appear less affected by the workforce hours split. However, these are among many other specialties where the total workforce capacity is not sufficient to meet the growing workload, which will impact patient outcomes.

A global survey of the medical oncology workforce, for example, shows Aotearoa New Zealand has one of the highest rates of newly diagnosed patients with cancer per specialist in the OECD, with about 525 newly diagnosed patients per oncologist. This is almost twice the rate of Australia's, which had an estimated ratio of 272 newly diagnosed patients per oncologist.[28] Similarly, radiation oncologists work high numbers of clinical hours but have an intervention rate that is lower than in comparable countries. Workforce modelling predicts "a large mismatch between the supply of radiation oncologists in NZ and demand for radiation therapy in the coming decade, with this mismatch even more pronounced if intervention rates and retreatment rates are to increase from their current rates". [29]

Notable among the smaller specialties (less than 40 FTEs), 66 per cent of Oral & Maxillofacial FTEs are in the private/other employment, with rehabilitation medicine recording 44 per cent, rheumatology 32 per cent, and vascular surgery 28 per cent.

[25] One News. Orthopaedic surgery wait times 'devastating' for patients – surgeon. One News, 5 April 2023. https://www.1news.co.nz/2023/04/05/orthopaedic-surgery-wait-times-devastating-for-patients-surgeon/.

[26] Freed G, Turbitt E, Allen A. Public or private care: where do specialists spend their time? Aust Health Rev 41(5) 541-545; 5 September 2016. https://pubmed.ncbi.nlm.nih.gov/27592388/.

[27] Duckett S. Getting an initial specialists' appointment is the hidden waitlist. Grattan Institute. The Conversation, July 16, 2018. https://theconversation.com/getting-an-initial-specialists-appointment-is-the-hidden-waitlist-99507.

[28] Mathew, A. Global Survey of Clinical Oncology Workforce. *Internal Medicine Faculty Publications*. 169, 2018. https://uknowledge.uky.edu/internalmedicine_facpub/169

[29] Dunn A, Costello S, Imlach F, et el. Using national data to model the New Zealand radiation oncology workforce, J Med Imaging Radiat Oncol 66 (2022) 708–716. https://pubmed.ncbi.nlm.nih.gov/35768935/.

Definitions

Specialist: Doctors reporting their work role as 'specialist' in the Medical Council's Medical Workforce Survey. Excludes general practitioners and urgent care specialists.

Private/Other: The categories covered in the MCNZ's Medical Workforce Surveys, comprising: private practice, private hospital, commercial company, government agency, professional body, other.

Specialist workforce trends: the warning signs for coming years

Low job satisfaction and poor working conditions, as well as an ageing workforce, are key drivers behind medical specialists either moving away from the public health system or leaving medicine entirely. These have been highlighted in several recent Toi Mata Hauora ASMS surveys of its 5,600+ members.

A 2022 survey on members' career intentions within the next five years found 42 per cent of over 1,600 respondents intend to reduce their hours in the public system, with many indicating a move to the private sector. 36 per cent of respondents aged 55 and over were either likely or extremely likely to leave medicine entirely.[30]

A 2022 'exit' survey of members leaving their district health board/Te Whatu Ora employment during that year found 15.5 per cent of 129 respondents were taking up private practice and many others were intending to do a mix of casual/contract, locum and/or private work.[31]

The greater rate of employment exit in psychiatry, emergency medicine and anaesthesia are significant, and will have consequences for remaining clinical staff and provision of patient and whānau care. All three specialties have exit rates of more than 10 per cent, though psychiatry is overrepresented among exiting doctors at 27 per cent.

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

Emergency Medicine Specialist[1]

The findings in these surveys were reinforced in a further survey of members in early 2023. Fifty-nine per cent of 1,263 respondents said they worked part-time outside of the public health system and a further 13.5 per cent said they were thinking about it. Most work in the private health sector:

[30] ASMS. Over the Edge: Findings of the 2022 survey of the future intentions of senior doctors and dentists, 2023. https://asms.org.nz/wp-content/uploads/2023/03/Over-the-Edge-Future-Intentions-of-the-SMO-Workforce-March-2023.pdf

[31] ASMS. Exit Survey 2022: Findings from the annual survey of doctors and dentists exiting employment in Aotearoa New Zealand's public hospital system, 2023.

40 per cent worked in private hospitals, 52 per cent worked in private clinics and 4 per cent worked for commercial companies (some of these overlap).[32]

Remuneration, the ability to manage one's own time and workload, and clinical satisfaction were the most common factors influencing decisions to work outside the public system. Conversely, remuneration, staffing levels and resourcing were the most common factors that would influence a decision to return or stay in the public system (Table 1).

Survey respondents working part-time outside the public system – or were thinking about it – were asked to rank the factors influencing their decision to go on a scale of 1-10 (1 being the most important), and the factors that would influence a decision to stay or return on a scale of 1-12.

Should I stay or should I go?	
Top 5 reasons for going	**Top 5 factors for staying/returning**
Remuneration (57%)*	Remuneration (51%)
Managing time and workload (54%)	Staffing levels (44%)
Clinical satisfaction (50%)	Resourcing (37%)
Management culture (39%)	Flexibility in work arrangements (34%)
Bureaucracy/administration (37%)	Improved management culture (31%)

***Percentage of respondents indicating 1-3 in the scale of importance**

Table 1: Ranked reasons for leaving/reducing public hospital employment and factors for staying/returning

'Frustration' comes up often in respondents' comments about why they are drawn to working outside of the public system. Frustration at under-staffing, under resourcing, constant delays for patients, and feeling unvalued in a controlling management culture. As one respondent put it:

"At the end of a day in private I'm not tired/frustrated/saddened/disheartened/undervalued. I'm all of those after a day in public."

Another summed up the common attraction to working in the private sector: "Better staffed, lighter workload. Less burnout."

[32] ASMS. A less public place: A survey of ASMS members on reasons for working part time outside the public health system. August 2023. https://asms.org.nz/wp-content/uploads/2023/08/A-Less-Public-Place-FINAL-1.0.pdf.

The private gate to the public system

The shift towards greater dependency on the private secondary health services creates a double disadvantage for those who can't afford health insurance or to self-fund their care as they are the same sections of the community – mostly Māori, Pasifika and lower-income groups – who miss out in accessing private primary health services due to the costs and consequently have higher preventable hospitalisation rates.

The cost barriers to primary care and the uneven distribution of general practices has prompted calls from health professionals and researchers for reform of primary health care services. This action would remove user charges and to employ GPs like every other specialist working in a public hospital: on a salary, with regular benefits and paid continuing medical education, the right to collective bargaining, and most importantly, the ability to take care of all patients, regardless of income.[33] [34] [35]

Despite the government giving high priority to addressing health inequities, it has so far shown no signs of committing to such reform. In the meantime, primary care practices, which have mostly been run as small GP-owned business, are rapidly being bought up by local and overseas corporations – a move which is likely to see further barriers to accessing primary care as for-profit health care tends to cluster around the most profitable patients in the urban centres.[23]

Concluding comment

There's a fine balancing act to having private and public health systems existing together without the former destabilising the latter. On the one hand it can be argued the opportunities for working part-time private hospital or private clinic work may make part-time work in the crisis-ridden public sector more tenable. Part-time private work can therefore help retain staff in the public system, especially if the alternative were to move overseas, change careers or retire early. Further, outsourcing more non-acute public services to the private sector has the potential to provide more timely services to patients, as is one of the strategies to cope with the Covid-lockdown-related backlog of electives.

However, contracting out more services to the private sector will put even greater pressure on public hospitals if health workers simply shift from the public to the private sector in response to the

[33] Payinda G. For-profit healthcare will lead to increasing neglect of Kiwis on the margins. Stuff, 15 April 2023. https://www.stuff.co.nz/opinion/131777189/forprofit-healthcare-will-lead-to-increasing-neglect-of-kiwis-on-the-margins.

[34] Rashbrooke M. Lightening the Load: The Case for a Fully Free Public Healthcare System. ASMS, 2023. https://asms.org.nz/lightening-the-load/.

[35] Gauld R, Atmore R, et al. The 'elephants in the room' for New Zealand's health system in its 80th anniversary year: general practice charges and ownership models. N Z Med J. 1 February 2019. Vol 132(1489):8-14. https://pubmed.ncbi.nlm.nih.gov/30703775/.

increased demand, especially when there are significant national and international staff shortages.[36] [37]

This risk was acknowledged by Andrew Connolly, who led the Health Minister's planned care taskforce to advise on how to deal with the electives backlog.[38]

The findings in this paper show not only that this is happening but is being intensified in a vicious cycle with lengthening public waiting lists (as well as the hidden waiting lists to get onto a waiting list) leading to a surge in the use of private services, exacerbating long-standing staff shortages in public hospitals, and contributing to worsening access to services and to staff morale.

Add to the mix the fact that ACC uses the private sector to do 80-90 per cent of its electives and it all points to an expanding private sector in the years ahead, so long as it can keep attracting the staff.[39]

Judging from the ASMS surveys of members discussed above, and reports from other public health sector workforces, the public sector is ripe for poaching.

New Zealand is not alone in seeing demand for healthcare insurance and self-funded treatment increase off the back of long waiting times largely due to the Covid-19 pandemic and the global workforce crisis. Nor are we alone in seeing many doctors working in dual public-private systems favouring the latter. International studies on the motivations and effects of dual public-private practice show relatively lower pay in public systems, along with poorer working conditions and heavier workloads were generally the main push factors for working privately, echoing ASMS survey findings. And in most cases, there is an overall detrimental effect on public services. [40] [41] [42] [43]

In Aotearoa New Zealand, it means among other things that timely access to non-acute health care, as well as some urgent time-critical care, is becoming increasingly dependent on the ability to pay for it (unless you happen to have an accident and meet ACC's claimant tests enabling you to access more timely treatment). There are also, if indirectly, negative consequences for acute care, as can be witnessed in any public hospital Emergency Department.

Despite the arguments against dual public/private practice, remedies proposed in the literature hardly ever include its ban. The most frequent justification for not forbidding dual practice is that it

---

[36] Ashton T. The benefits and risks of DHBs contracting out elective procedures to private providers. N Z Med J. 14 May 2010, Vol 123(1314):84-91. https://pubmed.ncbi.nlm.nih.gov/20581916/.

[37] Duckett S. Private care and public waiting. Aust Health Rev. 2005;29(1):87–93. https://pubmed.ncbi.nlm.nih.gov/15683360/.

[38] Jones N. Revealed: Hospital waiting lists ae getting worse – and a fix could be three years away. NZ Herald. 18 March 2023. https://www.nzherald.co.nz/nz/hospital-wait-lists-the-long-fight-to-see-a-doctor/HLAX5BJ4FNDUZG6OQVRRJIF3JA/

[39] ACC. Data of elective surgery, 2012/13 to 2021/22. Obtained under the Official Information Act, March 2023.

[40] Hoogland R, Hoogland L, Handayani K, et al. Global Problem of Physician Dual Practices: A Literature Review. Iran J Public Health. Jul 2022. Vol. 51(7):1444-1460. https://pubmed.ncbi.nlm.nih.gov/36248302/.

[41] Brekke K, Sorgard L. Public versus private health care in a national health service. Health Economics. 2007;16:579–601. https://pubmed.ncbi.nlm.nih.gov/17163459/.

[42] Garattini L, Padula A. Dual practice of hospital staff doctors: Hippocratic or hypocritic? Journal of the Royal Society of Medicine; 2018, Vol. 111(8):265–269. https://pubmed.ncbi.nlm.nih.gov/29905490/.

[43] Humphrey C and Russell J. Motivation and values of hospital consultants in south-east England who work in the National Health Service and do private practice. Soc Sci Med 2004; 59: 1241–1250. https://pubmed.ncbi.nlm.nih.gov/15210095/.

would reduce the appeal of public hospitals and favour the migration of more doctors to the private sector. Rather, the common policy response advocated internationally is to increase public sector salaries or increase the total supply of doctors, or both - consistent with ASMS's position for many years.

In Aotearoa New Zealand's case, there is also urgent need for the government to reverse the trend towards more for-profit primary care and reform those services to remove user charges and offer GPs salaried employment in line with hospital specialists.

For that to happen here requires governments to take a radically different approach to health and social spending. First is the need to shift from a model that frames health system delivery and health employment as a 'cost' to one in which the contribution of health to economic and societal wellbeing is more fully recognised.[44] [45] As a WHO report put it: "...there can be no viable national or global economy without effective investment in the health workforce."[46] Not investing adequately in a country's health workforce, on the other hand, leads to cumulative social and economic costs down the line.[47] [48] [49]

Invest in health workforce or risk collapse, WHO warns governments

BMJ [31]

Second is the need to address the determinants of ill health through whole-of government Wellbeing Budgets that live up to the name.

Third, in order to do the above, is the need to lift restrictive government fiscal policies. Aotearoa New Zealand has a low-tax economy matched against a dozen other comparable countries.[50] And the Government's current debt of around 20 per cent of GDP is well below its self-imposed 'net debt' ceiling of 30 per cent of GDP, and is due to fall to 14 per cent by

Under-investment, not investment, is the greatest cost.

Max Rashbrooke, Lightening the Load [32]

[44] HLC. Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. Switzerland: World Health Organisation, 2016. https://www.who.int/publications-detail-redirect/9789241511308.

[45] Rashbrooke M. Lightening the Load: The Case for a Fully Free Public Healthcare System. ASMS, 2023. https://asms.org.nz/lightening-the-load/

[46] Lauer J, Soucat A, Reinikka R, et al. Pathways: the health system, health employment, and economic growth. In: Buchan J, Dhillon I, Campbell J, editors. Health employment and economic growth: an evidence base. Geneva: World Health Organization; 2016. https://apps.who.int/iris/handle/10665/326411.

[47] Holt H. The Cost of Ill Health. New Zealand Treasury Working Paper 10/04, Wellington: NZ Treasury, November 2010. https://www.treasury.govt.nz/sites/default/files/2010-11/twp10-04.pdf.

[48] Ministry of Health. Report on New Zealand Cost-of-Illness Studies on Long-Term Conditions. Wellington: Ministry of Health, 2009. https://www.health.govt.nz/publication/report-new-zealand-cost-illness-studies-long-term-conditions.

[49] Mahase E. Invest in health workforce or risk collapse, WHO warns governments *BMJ* 2023;380:p713. https://www.bmj.com/content/380/bmj.p713.

[50] OECD. Revenue Statistics 2021, accessed April 2023. https://www.oecd.org/tax/revenue-statistics-2522770x.htm

2027. The government could borrow nearly $40bn today and still not reach its already conservative debt limit.[51]

In 2016, in response to growing unmet health need, an *NZ Medical Journal* editorial called for "an honest appraisal and public debate... to determine more appropriate levels of healthcare spending".[52] Since then the ability of the public health system to meet health need has deteriorated further. That debate, in this election year, is needed now more than ever. Do New Zealanders want governments to invest more to ensure a well-functioning public health system through reasonable borrowing and a fairer and more effective tax system? Or are they willing to let it slide and watch growing privatisation by default?

The size and nature of the health system … are likely to have profound direct implications for the performance of the economy as a whole.

Cylus et al[53]

[51] Renney C, Russell D, Foster J. Monthly Economic Bulletins. NZ Council of Trade Unions, February & June 2023. https://union.org.nz/category/economic-bulletin/.

[52] Keene L, Bagshaw P, Nichols MG, et al. Funding New Zealand's public healthcare system: time for an honest appraisal and public debate. N Z Med J. 2016; 129(1435):10-20. https://pubmed.ncbi.nlm.nih.gov/27355164/.

[53] Cylus J, Permanand G, Smith PC. Making the economic case for investing in health systems: What is the evidence that health systems advance economic and fiscal objectives? Copenhagen: WHO Regional Office for Europe, 2018. https://apps.who.int/iris/handle/10665/331982.