

# Health Minister Brown wants to “fix” the system—but risks breaking it further

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In March, the new Health Minister, Simeon Brown, declared in a speech to the BusinessNZ health forum that it is “*time to fix this system*,” and announced a raft of measures.<sup>1</sup> For secondary care this included a continued focus on health targets; Te Whatu Ora – Health New Zealand allocating NZ\$50 million to carry out 10,579 elective procedures by June 2025 (in-house and outsourced); and an expectation that as much planned care as possible should be outsourced to private hospitals—not as a stop gap, but for the long term.

The health minister’s plan to outsource as many elective procedures as possible to the private sector in the long term is unlikely to “fix” the public system. Rather, it is at serious risk of breaking it further, increasing health costs, decreasing productivity and further constraining the ability to provide patients with the care they need.

The challenges facing the public health system have become increasingly clear to the public, with frequent media coverage highlighting workforce shortages, infrastructure deficits, unmet need, overwhelmed emergency departments, ballooning waiting lists, major restructures and high turnover of leadership. Media reported that former Health Minister Dr Shane Reti received a briefing from Te Whatu Ora – Health New Zealand that warned of the rising number and complexity of acute public hospital cases “*in a highly resource-constrained environment*” and explained “*as demand grows for acute and urgent care, available capacity for planned [elective] care diminishes*.”<sup>2</sup> Public hospital capacity for the latter cannot easily be increased because of workforce shortages and hospital wards frequently operating at 100% occupation rates.<sup>3</sup>

The health system requires more than a superficial “fill it and fix it” approach. In the short term, the minister’s goal of 10,579 additional elective procedures by June 2025 is bold, but significant constraints stand in the way of

delivery. This includes severe workforce shortages (that impact both public and private sectors),<sup>4</sup> increasing demand for acute care<sup>5</sup> and limited funding (with the NZ\$50 million for electives being reallocated from another unknown part of the health system). It is also unclear what marginal capacity is available in the private system to pick up extra elective work, with documented difficulties establishing reliable information on private sector marginal capacity, despite attempts to do so.<sup>6</sup>

If the minister planned to “fix” the public system, such long-term plans involving private providers would not be necessary. The minister will be aware that the private sector is also going through hard times, with recent balance sheet losses. It is not that the private sector is losing customers. Southern Cross, Aotearoa New Zealand’s largest health insurer, for example, is inching towards the 1-million-member mark. It is more that the increasing costs and volumes of insurance claims are rising above revenue from premiums.<sup>7–9</sup> The minister’s announcement will no doubt be a relief to the private sector.

It is problematic when the private system becomes essential for filling the growing gaps in the public health system. Decades of underinvestment and inadequate planning have brought the public system to its knees, with reduced capacity to tackle elective waiting lists. Given this tragic reality and the urgent need to ensure patients receive treatment with as little delay as possible, it is necessary to involve the private sector in the short term. Taking that beyond a stop-gap measure, however, will contribute to the continuing demise of the public system.

Here’s why:

**One:** Outsourcing public services to private providers can lead to “cream-skimming”, where private providers choose patients with less severe conditions and who are less financially risky, leaving the complex and more expensive cases with the public system.<sup>10</sup> This can result in patients

needing more complex and costly treatment getting left behind, exacerbating inequitable health outcomes.

Indeed, the NZ\$50 million recently reallocated by the minister to fund an extra 10,579 procedures amounts to less than NZ\$5,000 per procedure on average, indicating they will be mostly minor procedures.

“Cream-skimming” is already happening in our system, with evidence private providers are able to choose which patients they will do procedures on, with little regard to patient need or the length of time patients have been waiting.<sup>11</sup> As the balance tips further towards the public system only providing care for the most complex cases (which take more time and money), it will also appear as though so-called “productivity” in the public sector is falling.

**Two:** We have a finite pool of doctors. Many medical specialists who staff public hospitals also work in the private system. Given the entrenched workforce shortages both here and internationally, outsourcing to the private sector will almost certainly mean pulling more specialists away from the public system. Association of Salaried Medical Specialists (ASMS) analysis shows this is already happening, and the key reasons for specialists leaving the public system to work in private are remuneration, the ability to manage one’s own time and workload, and clinical satisfaction.<sup>12</sup> Losing staff from the public sector places additional burden on those left behind, as fewer specialists are available to be on-call and public capacity to cover acute presentations reduces, with negative impacts on patient care. Due to “cream-skimming”, the work in public is also increasingly complex, and the pull towards private where specialists can earn more money, take more straightforward cases and not have to participate in call rosters will become more and more enticing.

**Three:** Outsourcing to the private sector limits medical trainees’ exposure to a range of procedures, since they are mostly trained in public hospitals. The more elective procedures go to the private sector, the more difficult it becomes for resident doctors to successfully meet training requirements and the more difficult it becomes to develop skilled and experienced medical specialists. Loss of senior medical officers to the private system will also mean that those who remain in public are stretched even thinner, impacting their ability to train and mentor junior colleagues.

**Four:** The private system is not subject to the same level of scrutiny and accountability as the public system.<sup>13</sup> Anyone who has attempted to obtain basic data from private providers will know this. International evidence suggests that higher rates of privatisation and outsourcing correspond with poorer health outcomes for patients.<sup>14</sup> In Aotearoa New Zealand, it is an unknown.

**Five:** Commercial barriers also mean there is scant information about the cost effectiveness of the private system compared with public provision. This raises a fifth issue: that of cost to the taxpayer. One rare study, by the Health Funds Association, compared the average cost of five elective surgical procedures in the two sectors during 2004/2005. It did not account for the likelihood of public hospitals undertaking more complex (and therefore more costly) procedures. Despite this, of the five procedures, all except one was more costly in the private sector than in the public sector.<sup>15</sup>

Today, media reports suggest the costs of outsourcing elective operations are growing,<sup>16</sup> and the Planned Care Taskforce found private providers were seeking “*significant uplifts to historic prices – in some cases ... in excess of 20%*.”<sup>16</sup>

Private hospitals also do not carry the same overheads as public hospitals. Public hospitals maintain essential services such as intensive care units and blood banks. When patients treated in private facilities need such services, the public sector picks up the bill.<sup>17</sup>

**Six:** Private hospitals are not evenly distributed,<sup>18</sup> raising issues of unequal access, especially for regional communities and those in poorer areas. Private hospitals have little incentive to service rural communities where smaller populations mean it is difficult to generate profits or break even.

**Seven:** As more elective treatment is provided in the private sector, drawing staff away from the public sector, the public capacity to cope with the growing and more complex acute hospital admissions will deteriorate further. The minister appears to have not understood this when he says he wants to see more outsourcing of electives, thereby “*freeing public hospitals for acute needs.*”

Genuinely fixing the public health system is imperative if we are to ensure Aotearoa New Zealand is able to deliver on the universal health coverage that was intended in the 1938 *Social Security Act*. This will require real, substantial investment well beyond the funding needed to simply tread water.

We need:

- a comprehensive health workforce plan, including increasing our domestic supply of medical practitioners, and implementing extensive recruitment and retention strategies across the board.
- strong clinical leadership to turn Te Whatu Ora – Health New Zealand into an organisation that prioritises patient care and excellent clinical outcomes, and in which staff are thriving rather than surviving.
- significant investment in hospital infrastructure and equipment, to recover from decades of deferred maintenance and ensure we have facilities fit for future generations and the tools for health practitioners to provide excellent patient care.
- adequate funding to increase access to primary care, so people can receive care early in the community and stay well for longer.

Making such investments will require a shift in mindset. Rather than seeing health spending as a short-term cost, it needs to be understood as a long-term investment to support a healthy society. How we value health is fundamental to the economic success and resilience of Aotearoa New Zealand.<sup>19</sup>

**COMPETING INTERESTS**

The authors are employed by Toi Mata Hauora, the Association of Salaried Medical Specialists.

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