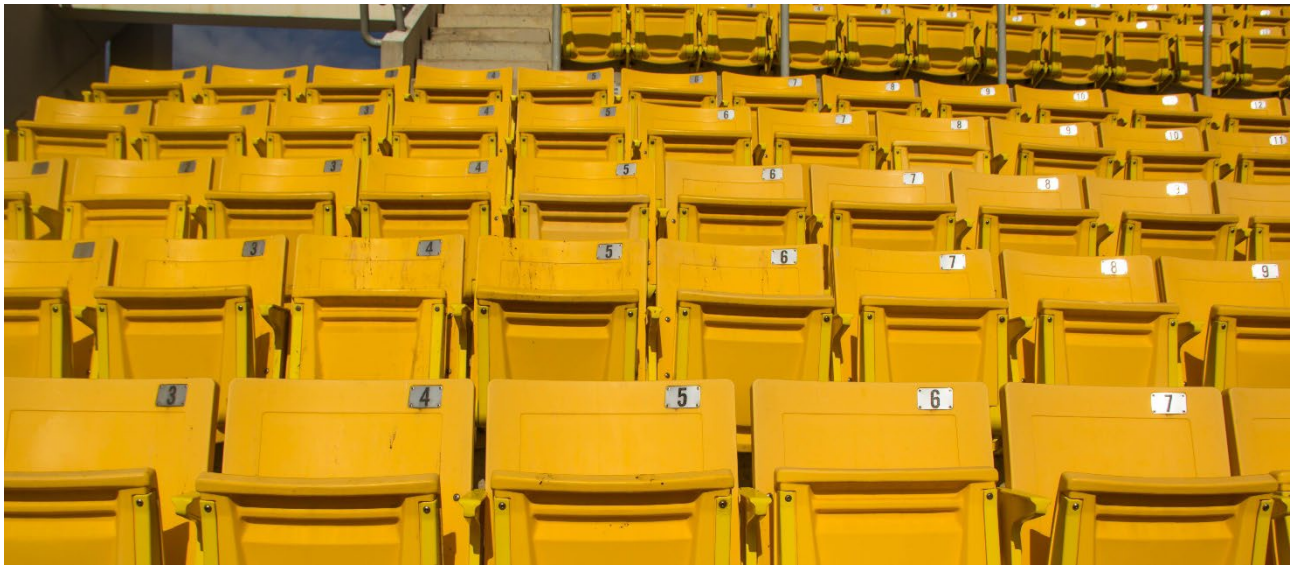


A less public place

A survey of ASMS members on reasons for working part-time outside of the public health system.

ASMS
TOI MATA HAUORA

Contents

Background

The ASMS 'exit' survey of members leaving their employment with a district health board/Te Whatu Ora during 2022 shows that, while leaving to work overseas is a major reason for leaving (20.9 per cent), those leaving to take up private practice within New Zealand is also significant (15.5 per cent). A further 4.7 per cent are leaving to take up other non-public hospital employment.[1]

Another 2022 survey of ASMS members' career intentions over the next five years finds 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.[2]

Unpublished Medical Council data shows 26 per cent of medical specialists' full-time equivalent (FTE) working hours were spent outside of the public system in 2019. In surgical specialties the figure is 36.4 per cent, including five specialties with over 40 per cent non-public FTEs. In over a quarter of specialties and sub-specialties, more than 50 per cent are non-public FTEs.[3]

The main purpose of ASMS's latest member survey, undertaken in early 2023, is to explore the reasons behind doctors' decisions to work part-time outside of the public system.

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

[2] 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

[3] Unpublished data prepared for the Ministry of Health by MCNZ from its *Medical Workforce Survey, 2019*.

Key findings

- 59 per cent of respondents indicate they do paid work outside of the public health system, and 13 per cent say they are thinking about it. Twenty-eight per cent work solely in the public system.

- Surgical specialties, anaesthesia, neurology, diagnostic and interventionalist radiology, ophthalmology, gastroenterology and cardiology have the highest proportion of respondents working outside the public system – all 70 per cent or more.

- Pathology and general medicine have the lowest proportion of respondents working outside the public system, both less than 30 per cent.

- Pathology and public health medicine have the highest proportions of respondents neither currently working in, nor considering a shift to private work (69 and 68 per cent respectively).

- Psychiatry has the highest proportion of respondents saying they are thinking about working outside the public system (34 per cent), giving a combined total of 75 per cent of respondents who are either working outside the public system or are thinking about doing so.

- Metropolitan and regional employment patterns are broadly similar.

- A vast majority of respondents who worked outside the public system are working in either private clinics (52 per cent) and/or a private hospital (40 per cent).

- Remuneration, workloads and clinical satisfaction are identified as the most important factors behind decisions to take up – or consider taking up – other non-public employment.

- Of the respondents who added comments, the most common related to under-resourcing, especially under-staffing and burnout, and feeling unvalued in a controlling management culture. ‘Frustration’ was an often-used term - at under-staffing, under resourcing, and constant delays for patients.

Research design and methodology

The survey sought to investigate the following research questions:

- What sort of other employment do members working for Te Whatu Ora have, by location and main specialty, beyond their role with Te Whatu Ora?
- What are the most important push and pull factors affecting those members' decisions to work outside Te Whatu Ora?

The survey was hosted on Survey Monkey and open for four weeks during February and March of 2023. All current members of ASMS employed by Te Whatu Ora (approximately 5,600) were invited to participate, with two follow-up reminder emails circulated. Participation was voluntary and no incentives were provided in exchange.

Members were asked to name their main specialty, their district, and whether they worked part-time for another employer other than Te Whatu Ora, or were thinking about doing so.

Other than location and main specialty of work, demographic questions were not included. The intention was to focus on a limited number of variables, manage survey fatigue in an over-stretched workforce, and offer a snapshot of public/private work trends.

Only respondents who answered 'yes' to having or considering taking up employment beyond their public work were asked to answer the remaining questions. These sought responses on:

- The amount of time spent in other employment (less than one day, one day or more than one day a week).

- The type of other employment based on employment categories used in Te Kaunihera o Rata Aotearoa Medical Council of New Zealand (MCNZ) annual Medical Workforce Surveys: private hospital, private practice, government department/agency, commercial company, university, professional body, other.

- Members were asked to rank a list of 10 push factors for working part-time in other employment. The list was based on common reasons for changing employment identified in the literature and input from ASMS industrial officers, and it included an 'other' option.

- Members were then asked to rank a list of 12 pull factors that would influence a decision to return to or stay in the public health sector. The list was based on common employment incentives identified in the literature and input from ASMS industrial officers, and it also included an 'other' option. Not all survey questions were answered by respondents. As a result, precise numbers vary according to the completeness, and are indicated throughout.

Specialties

All ASMS members employed by Te Whatu Ora (n=5,600) were invited to participate. 1,262 (22.6 per cent) responded and identified their main specialty (Table 1).

Table 1: Survey respondents by main speciality or subspecialty

Specialty	Count	Specialty	Count
Addiction Medicine	5	Occupational Medicine	1
Anaesthesia	220	Ophthalmology	23
Cardiology	27	Oral and Maxillofacial Surgery	3
Cardiothoracic Surgery	4	Orthopaedic Surgery	34
Clinical Genetics	4	Otolaryngology	23
Dentistry	29	Paediatric Cardiology	2
Dermatology	6	Paediatric Oncology	2
Developmental Paediatrics	3	Paediatric Palliative Care	1
Diagnostic and Interventional Radiology	89	Paediatric Rheumatology	1
Emergency Medicine	74	Paediatrics	54
Endocrinology	17	Paediatric Surgery	4
Gastroenterology	24	Pain Medicine	10
General Medicine	49	Palliative Medicine	3
General Practice	7	Pathology	26
General Surgery	48	Plastic and Reproductive Surgery	16
Geriatric Medicine	34	Psychiatry	119
Haematology	14	Public Health Medicine	22
Immunology	1	Radiation Oncology	11
Infectious Diseases	8	Rehabilitation Medicine	3
Intensive Care	25	Respiratory Medicine	12
Medical Administration	3	Rheumatology	14
Medical Oncology	26	Rural Hospital Medicine	18
Neonatology	7	Sexual Health Medicine	6
Nephrology	19	Urgent Care	3
Neurology	19	Urology	14
Neurosurgery	3	Vascular Surgery	7
Obstetrics and Gynaecology	57	Other	8
		TOTAL	**1262**

Data was compared to the most recent MCNZ report detailing numbers of doctors in each vocational scope for representativeness using the Chi-square goodness of fit test (p= <0.001). Survey data was close to, but slightly under-representative of expected distribution when compared to the MCNZ data. Due to low numbers of respondents from general practice, family planning and reproductive medicine, and dentistry compared to overall numbers, these specialty groups were excluded from analysis.

Places of work

The survey asked respondents to state their main place of work. Almost all answered this question (n = 1,230). The small numbers of respondents employed outside Te Whatu Ora districts, including national services, non-District rural hospitals and hospice, have been grouped together under Other – National Services.

The largest group of respondents (n = 472, 38.4 per cent) are from the Northern Region (Te Toka Tumai Auckland, Waitematā, Counties Manukau and Te Tai Tokerau). Te Wai Pounamu (the region comprising of the five former South Island DHBs), accounts for 26.4 per cent (n = 342), with 17.8 per cent (n = 219) from Central and 16.8 per cent (n = 207) from Te Manawa Taki. The remaining 0.6 per cent include national services and other work sites.

Table 2: Survey respondents by place of work

Region	District	Count (n)	Per cent (%)
Northern	Te Tai Tokerau Northland	49	3.98
	Waitematā	107	8.70
	Te Toka Tumai Auckland	213	17.32
	Counties Manukau	103	8.37
Te Manawa Taki	Waikato	102	8.29
	Hauora a Toi Bay of Plenty	48	3.90
	Lakes	22	1.79
	Taranaki	29	2.36
	Tairāwhiti	6	0.49
Central	Te Matau a Maui Hawkes Bay	24	1.95
	Whanganui	10	0.81
	Te Pae o Ruahine o Tararua MidCentral	40	3.25
	Capital and Coast	95	7.72
	Hutt Valley	43	3.50
	Wairarapa	7	0.57
Te Waipounamu	Nelson Marlborough	40	3.25
	Waitaha Canterbury	158	12.85
	Te Tai o Poutini West Coast	10	0.81
	South Canterbury	13	1.06
	Southern	104	8.46
Other	National Services	7	0.57
TOTAL		**1230**	**100**

Public and private work

Of the 1,263 respondents, 59 per cent (n = 742) indicate they do paid work outside of Te Whatu Ora; 13 per cent (n = 170) say they are thinking about it; and 28 per cent (n = 351) work solely in the public system (Figure 1).

'Paid work' is defined as any remunerated employment (including contract work) in addition to work for Te Whatu Ora and is not exclusive to clinical practice. Work that SMOs may undertake for their college or professional body that is voluntary, such as serving on committees, is not included.

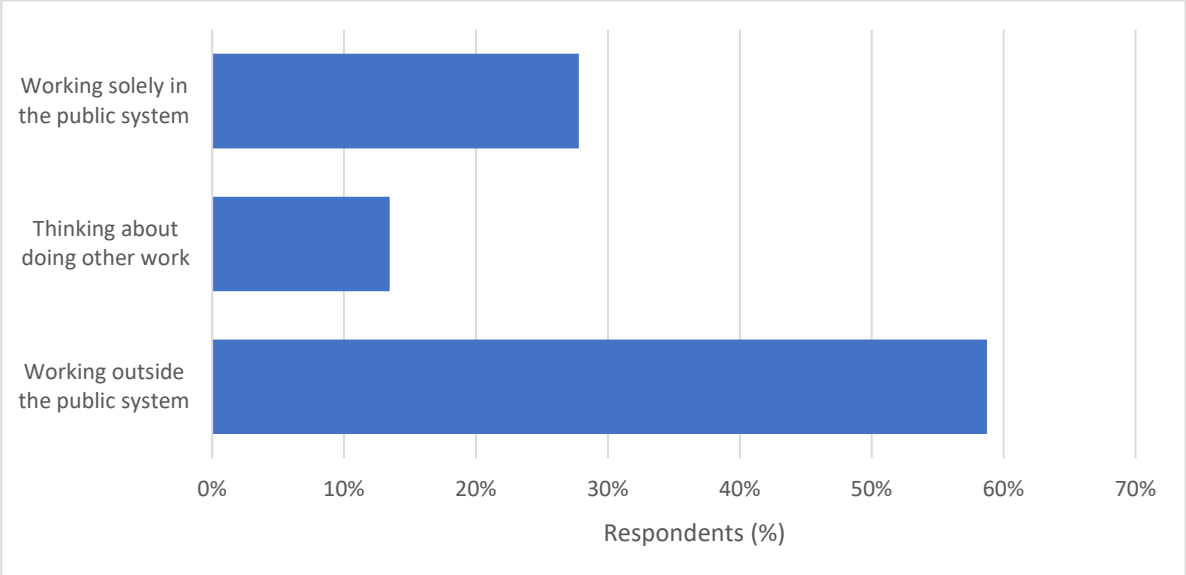


Figure 1: Proportion of respondents working outside the public system or thinking about it

Employment by specialty

Surgical specialties, anaesthesia, neurology, diagnostic and interventionalist radiology, ophthalmology, gastroenterology and cardiology have the highest proportion of respondents working in addition to the public system, all 70 per cent or more (Figure 2).

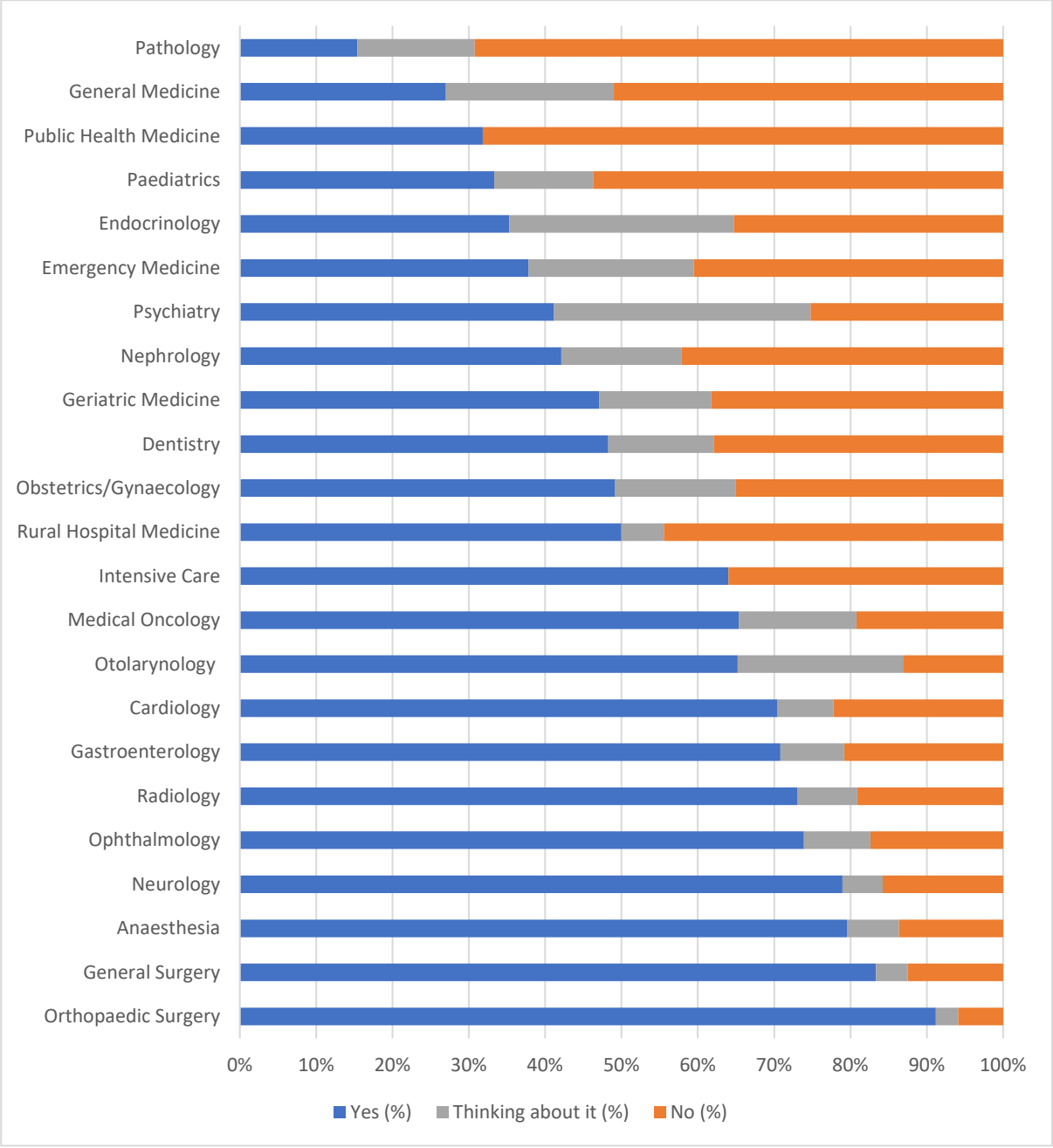


Figure 2: Do you work for another employer, or yourself, outside your work for Te Whatu Ora? Employment in specialties with 15 or more respondents

Pathology and geriatric medicine have the lowest proportion of respondents working outside the public system, both less than 30 per cent.

Pathology and public health medicine have the highest proportions of respondents neither currently working in, nor considering a shift to private work. SMOs in these specialties are more likely to work solely in the public system (69 and 68 per cent respectively).

Psychiatry has the highest proportion of respondents saying they were thinking about working outside the public system (34 per cent), giving a combined total of 75 per cent of respondents who are either working outside the public system or are thing about doing so. Orthopaedic surgery had the smallest proportion of respondents considering private work at 3 per cent; however, combined with those already working in addition to their public sector work, 94 per cent of orthopaedic surgeons are already working privately or thinking about it.

Employment by major metropolitan and regional areas

Whether working in a major metropolitan centre (Tāmaki Makaurau Auckland, Te Whanganui-a-Tara Wellington or Ōtautahi Christchurch) or in the regions, the proportions of respondents who work solely in the public sector are equal (28 per cent) (Figure 3). Slightly more respondents in the metropolitan centres work outside the public system – 61 per cent, compared with 56 per cent in the regions. Further, slightly more respondents in the regions (15 per cent) are thinking about doing other, non-public work than those in the main centres (12 per cent).

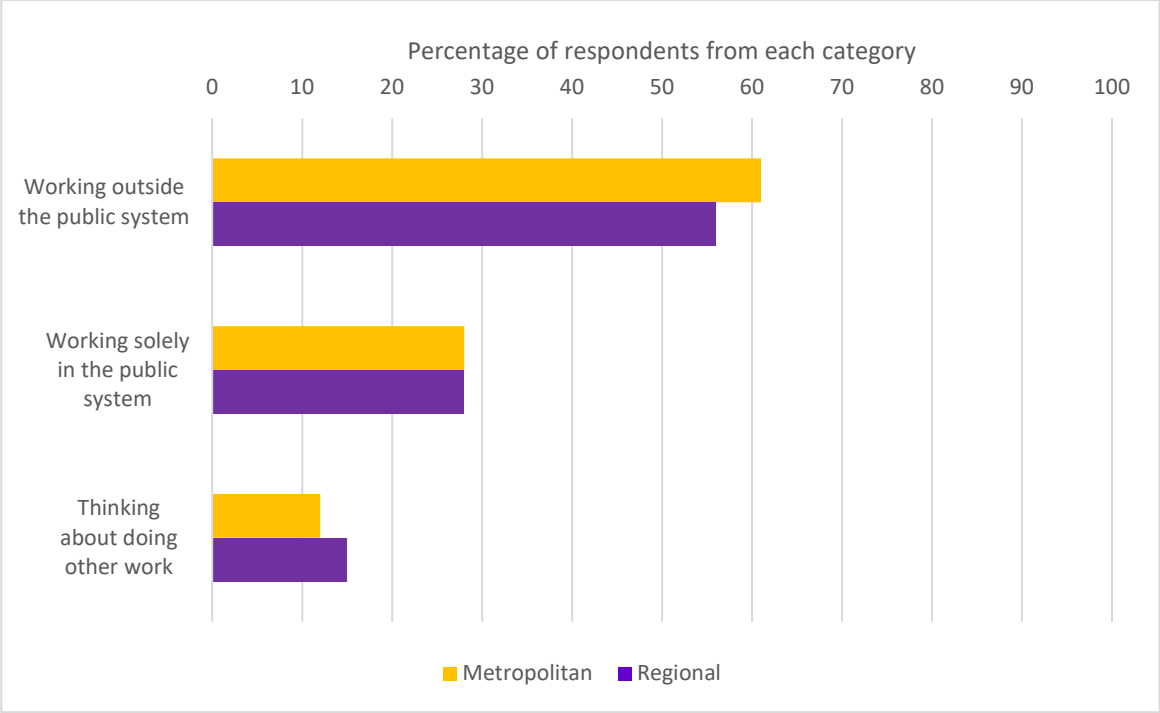


Figure 3: Responses from major metropolitan versus regional members

Respondents working in surgical specialties, ophthalmology, anaesthesia, intensive care and radiology have significantly higher proportions of respondents working outside the public system in the main centres.

On the other hand, of the specialty areas with 15 or more responses from the main centres, only dentistry, paediatrics and pathology have more than 50 per cent working solely in the public system. Nearly a third of psychiatry respondents in the main centres are thinking about working outside the public system, leading to a total of 76% per cent who are either working outside the public system or thinking of doing so.

In the regions, of the specialty areas with 15 or more responses, surgical specialties, anaesthesia, ophthalmology and radiology specialties have significantly higher proportions of respondents working outside the public system (Figure 5). Only paediatrics has more than 50 per cent working solely in the public system.

Psychiatry respondents again have the highest proportion of respondents (36 per cent) indicating they are thinking about working outside the public system, leading to a total of 66 per cent who are either working outside the public system or thinking of doing so.

Time spent in non-public health sector employment

Of the total survey respondents, 59 per cent (n = 745) answered the question asking how much time they spent working outside the public system (Figure 2). 40 per cent (n = 296) said they worked less than one day per week outside the public system; 20 per cent (n = 148) worked one day; and 40 per cent (n = 301) worked more than one day per week (Figure 6).

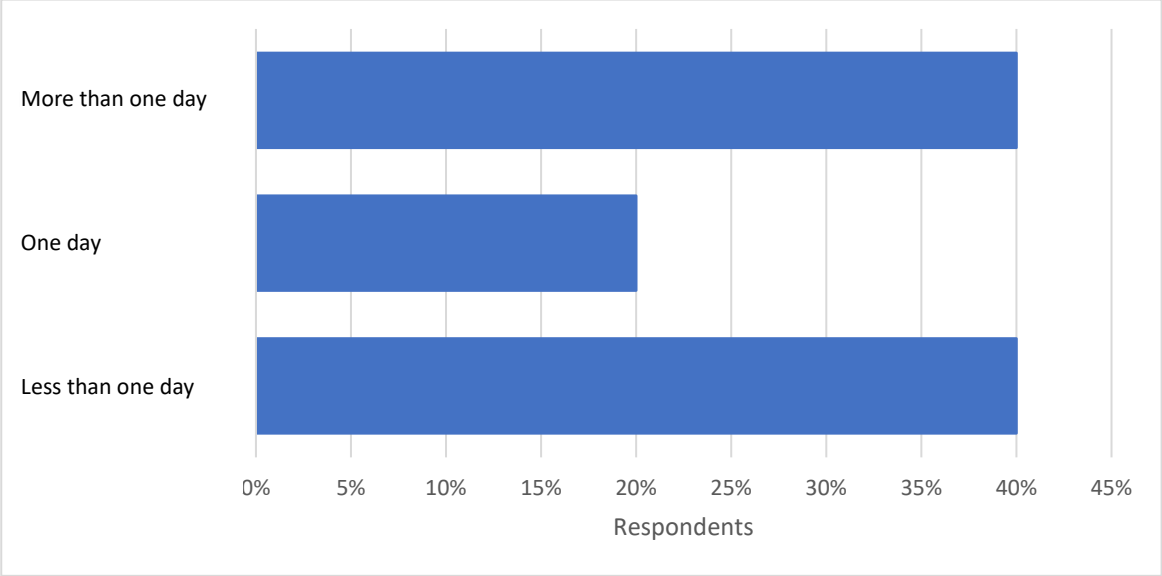


Figure 6: Time spent working outside the public system

Type of non-public health sector employment

Of the total survey respondents, 59 per cent (n = 739) answered the question: “Where is your other employment?” from a list of eight employment areas based on categories used by MCNZ in its annual Medical Workforce Survey. Respondents were asked to check all employment areas that applied to them,

so the total is more than 100 per cent. The large majority work in a private clinic or private hospital (Table 3, Figure 7).

Table 3: Respondents' areas of non-public sector employment

Employment area	Count (n)	Per cent (%)
Private practice/clinic	384	52
Private hospital	296	40
University or research entity	99	13
Other (please specify)	94	13
Government department	58	8
Commercial company	29	4
Non-government organisation	30	4
Professional body or association	28	4

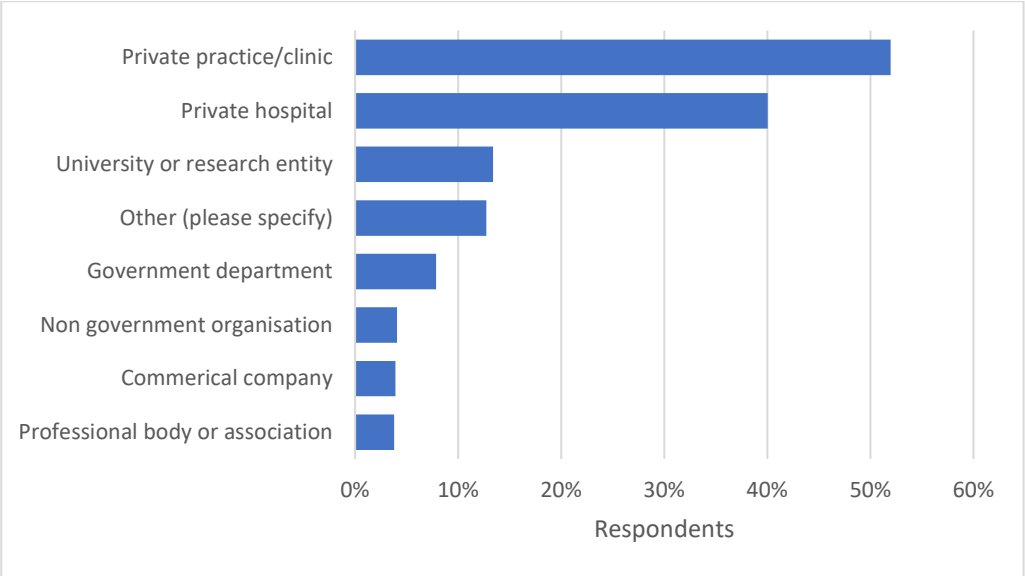


Figure 7: Respondents' areas of non-public sector employment

Respondents who stated 'Other' have a variety of other employment arrangements including locum work in Aotearoa New Zealand and overseas; mobile medical, surgical, or dental clinics; and providing medicolegal expert opinions.

Reasons for taking up non-public health sector employment

The 61 per cent of respondents (n = 767) who answered they are currently working, or thinking about working, for another employer, were asked to rank a list of 10 "push factors" that affected their decision from most important (1) to the least important (10) and to note any other reasons not included in the list.

Remuneration, workloads, and clinical satisfaction were the factors most commonly ranked as important (ranked 1-3).

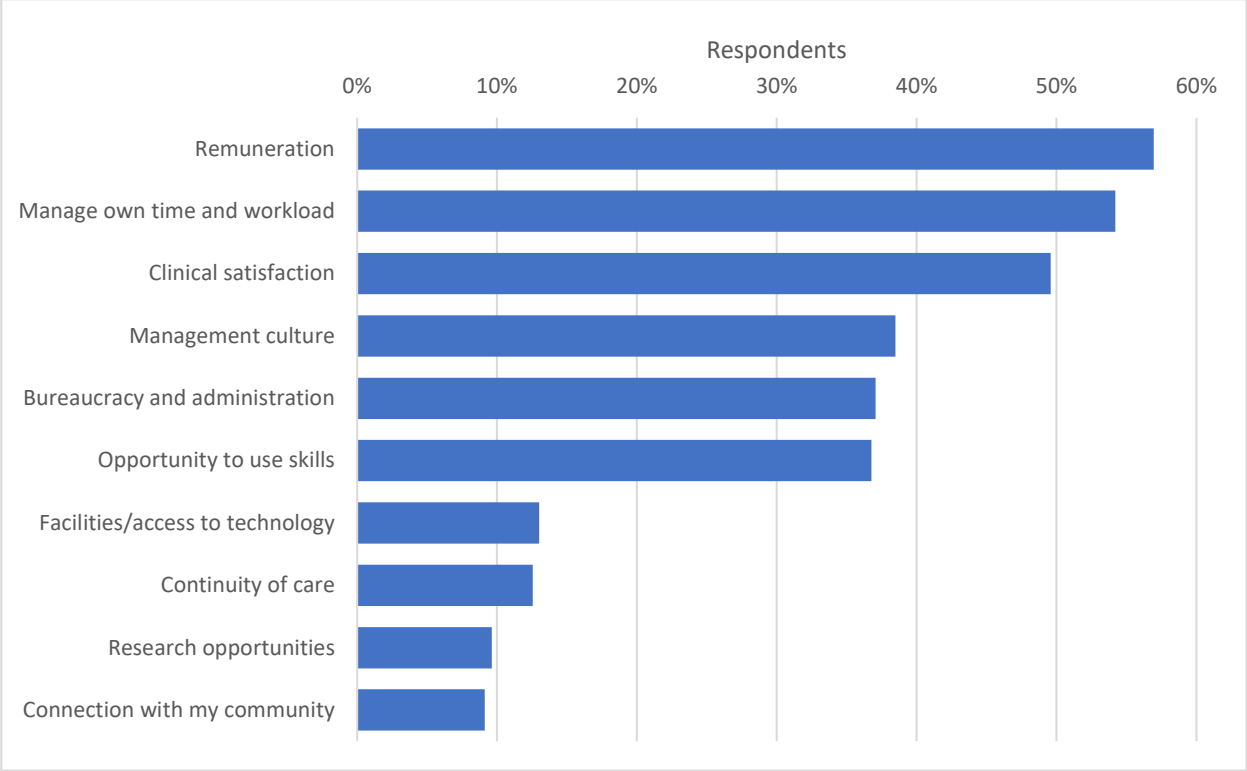


Figure 8: Factors ranked as most important (ranked 1-3) behind decisions to take up – or consider taking up – other employment

The most frequently cited 'Other' factors related to under-resourcing, especially under-staffing and burnout. Many respondents used the 'Other' category to add comments. 'Frustration' – at under-staffing, under resourcing, constant delays for patients – came up often, as did feeling unvalued in a controlling the 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."*

Others noted:

> *"Poor levels of staffing leading to public lists being cancelled. Frustration at a public system that seems more focused on saving money than providing adequate patient care."*

> *"The repeated cancellations of elective surgery (even cancer cases!) and the inability to provide care for deserving patients with benign conditions is causing excessive stress/moral trauma/burnout."*

A surgeon spoke of not being able to treat people who needed it:

"I do not want to see people in clinic and tell them an operation would help but they can't have one."

Others commented on the impact of nurse and RMO shortages:

> *"I work a shift with no registrar and the stress of having 20 people a day leave without being seen is wearing me down. I'm thinking of just doing locums in Australia myself."*

> *"The RMO shortages are a nightmare and then all the work is left to us, and they argue about paying additional duties. All the joy has gone, there is nothing nice about coming to work anymore. I am actively looking for alternatives."*

Yet others cited the impact on their own health and welfare:

> *"I stopped full time clinical work ... because of the intensity of on-call together with my own medical and mental health."*

> *"Have stopped believing I can change the system and now realise I need to protect myself with healthier boundaries."*

Another put it simply:

> *"I'm really bloody tired. I'm really stressed."*

Others noted the impact on family life:

> *"Public would not allow reduced hours with a young family. I had to work my old job hours or not at all."*

One respondent raised the difficulty in getting annual leave:

> *"This affects quality of family life and is a main reason my department may lose staff in the near future, based on conversations with colleagues."*

Many spoke of feeling under-valued in the public sector, and perceived better appreciation in the private sector:

> *"Specialists are more valued in private. There is more recognition and appreciation of your skill, years of training and expertise and this is reflected in how you are treated and dealt with ... Being disrespected* [in the public sector] *while working hard, and to the detriment of yourself and your family, wears thin in the end."*

> *"I don't feel valued or respected by Te Whatu Ora and the pay difference is so huge. I considered the value of my time with my family and can get paid more for working less ... I am still committed to public health care but reduced my hours."*

Another summed up the common attraction to working in the private sector compared to the public sector:

> *"Better staffed, lighter workload. Less burnout."*

More detailed charts on the reasons identified by respondents for taking up non-public health employment are provided in Appendix 1.

Pull factors that would influence a return to – or decision to stay in – the public health sector

The survey asked those who are currently working for another employer or themselves, or thinking about doing so, what pull factors would influence them to return to or stay in the public health sector. Respondents were asked to rank a list of 12 common pull factors from the most important (1) to the least important (12) and to note any other reasons not included in the list. Fifty-nine per cent of respondents answered this question (n = 745).

The main factors that would help to keep or attract respondents back reflected the push factors: better remuneration and better staffing and resourcing, which impact on workloads and clinical satisfaction (Figure 9).

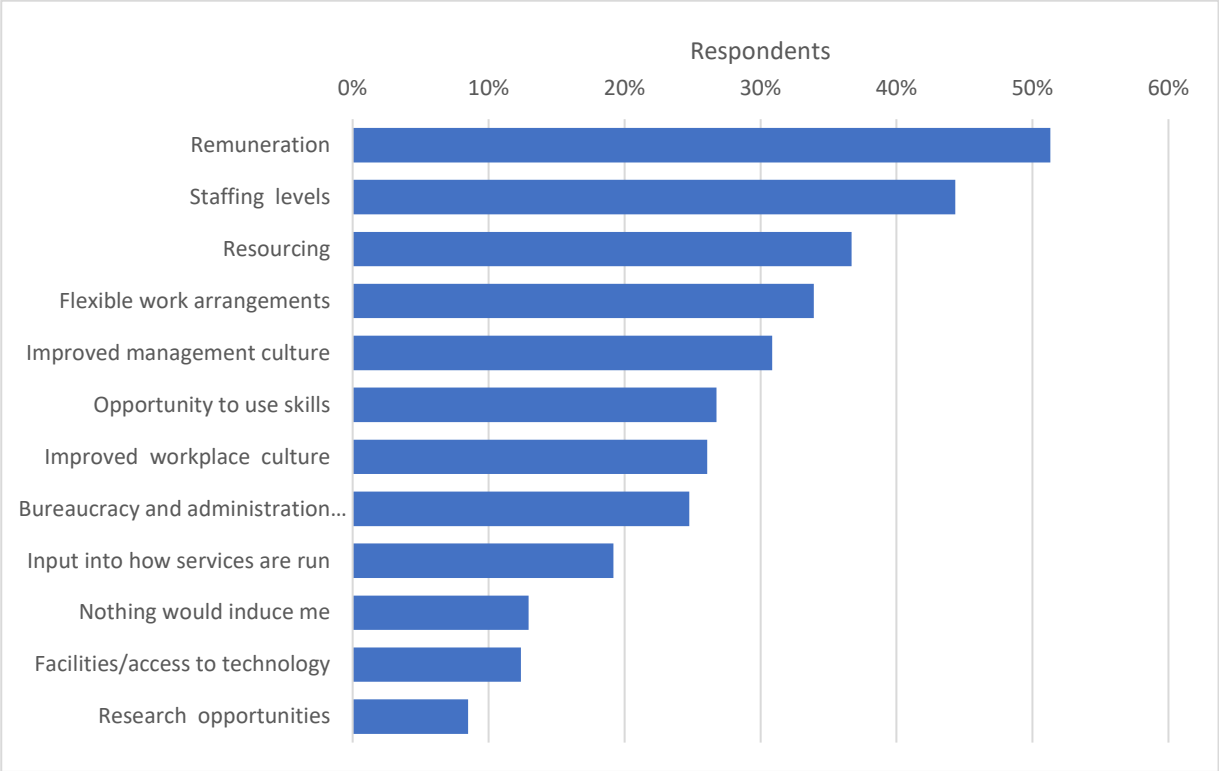


Figure 9: Factors ranked as most important (ranked 1-3) behind decisions to return to or stay in the public health sector

As with the question on push factor, many respondents used the 'Other' category to add comments. Remuneration, resourcing to match the workloads, and the need for a more respectful and collaborative management culture were common themes.

> *"Definitely need to work on better remuneration in public. Currently considering doing more in private or moving to Australia, as are others I know."*
>
> *"Remuneration is a fraction of that across the ditch and fails to keep pace with inflation."*
>
> *"Valuing staff would be highest on my priority list."*

The need for the government and management to acknowledge the workforce crisis was also seen as a critical issue.

> "*Management* [needs to] *acknowledge the current state of affairs (e.g., stop pretending that the health system isn't in crisis). Until they acknowledge there is a problem, it's not going to get better."*
>
> *"There would need to be a gargantuan shift in management culture, the way SMOs are valued*, [and] *resourcing ... The system is broken and being held together with band-aids and the sweat of the staff working in it ... The worst part is the government fails to acknowledge any issue."*

Concluding comment

There is no shortage of comments from politicians on how highly they value our health workforce. Yet this survey indicates senior doctors and dentists have a strong sense of being under-valued and pessimism about the prospects for improvement.

Many feel let down by the lack of recognition of how long-standing under-resourcing is affecting their patients' and their own health and wellbeing. Taking a real pay cut in relation to inflation has added insult to injury and many are voting with their feet.

This survey suggests that there has been an increase in the proportion of FTE spent working outside the public system. MCNZ data from 2019 indicated that around 26 per cent of FTE was spent outside the public system, with several specialities and sub-specialities over 50 per cent.

In 2023, after the immense strain of the Covid-19 pandemic's emergency phase, critical workforce shortages and a public health system creaking under the load, the push factors for SMOs to seek additional employment continue to appeal.

Qualitative comments left by respondents reveal a palpable sense of lack of support at every level. Relationships with managers are often described as tense, though there is also acknowledgement that managers are in the same boat, being expected to deliver more with less, and that responsibility for the health workforce crisis lies with those who deny its existence further up the chain.

In short, neglecting the health workforce is neglecting the public health system and is leading to increasing privatisation by default.

This is reinforced in the absence, until very recently, of basic information about the medical workforce. While it is recognised globally that the workforce is the most important asset of any health system, successive governments in Aotearoa New Zealand have lacked interest in monitoring and assessing its state of health. This can be taken as an indicator of how much they have valued the health workforce.

In July 2023, Te Whatu Ora and Te Aka Whai Ora published a workforce plan which attempted to quantify the shortfalls in health professions, including medicine. The plan is Te Whatu Ora's first to identify both immediate workforce need, and project the FTE shortfall by 2032.

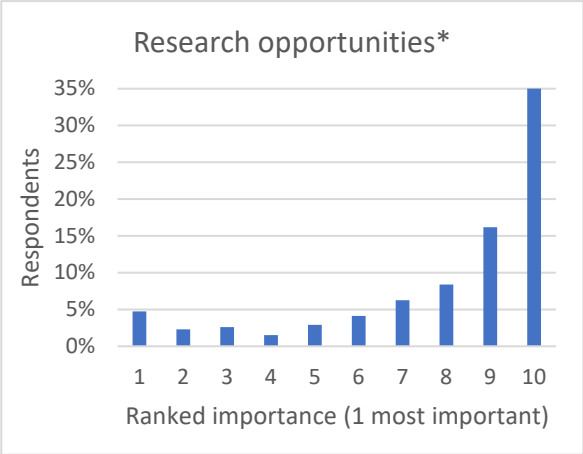
The plan notes recruitment and retention as critical to addressing medical workforce shortages. It also acknowledges "FTE flight to the private sector" as a challenge, which impacts capacity in the public system particularly in areas like orthopaedics.

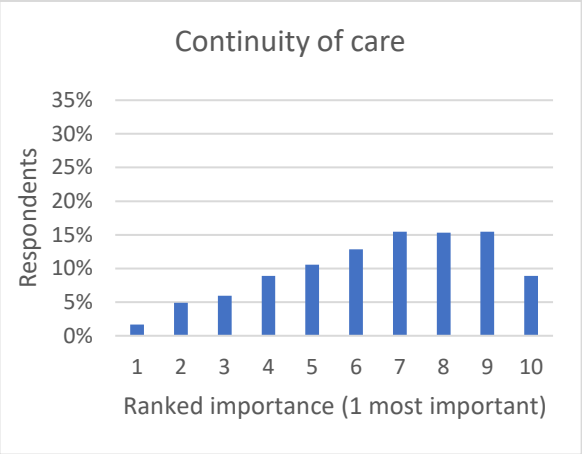
ASMS has conducted surveys of clinical directors to quantify the capacity of the public health system's senior medical workforce to meet the health need of communities. ASMS continues to advocate for a medical workforce census to establish national data on headcount, FTE, distribution and vacancies, combined with an assessment of unmet need for hospital and specialist services to gain a comprehensive understanding of the medical workforce shortage, and the impacts of persistent underinvestment in the public health system.

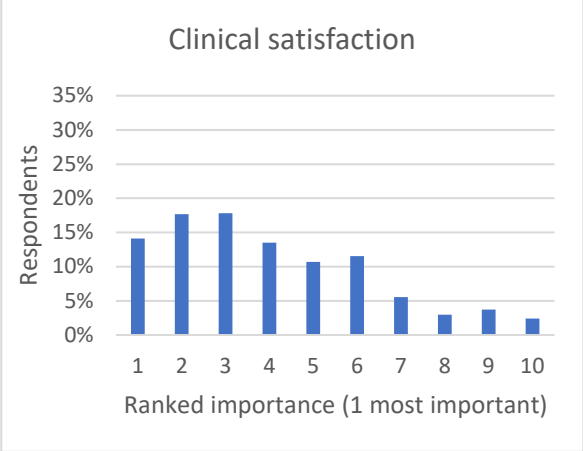
This survey is the latest in a series done by ASMS to build information on the current state of the medical workforce. Its findings, along with ASMS's recent exit survey of SMOs leaving their district health board/Te Whatu Ora employment, surveys of SMO career intentions, surveys of clinical heads of department on staffing capacity, and a recent examination of how under-resourcing of the public health sector is driving increased use of the private sector, all show how far the government has to go to begin showing it genuinely values the health workforce – and the public health system.

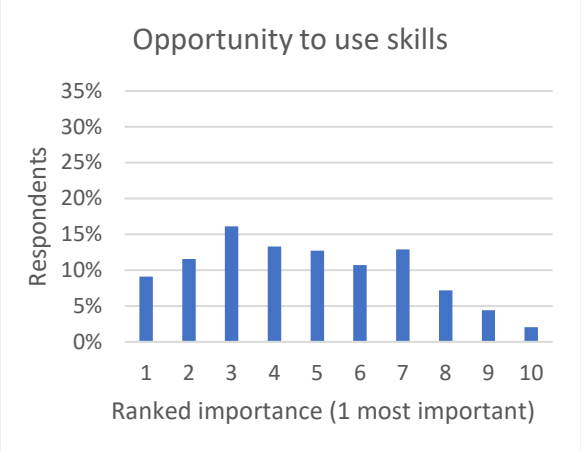
Appendix 1

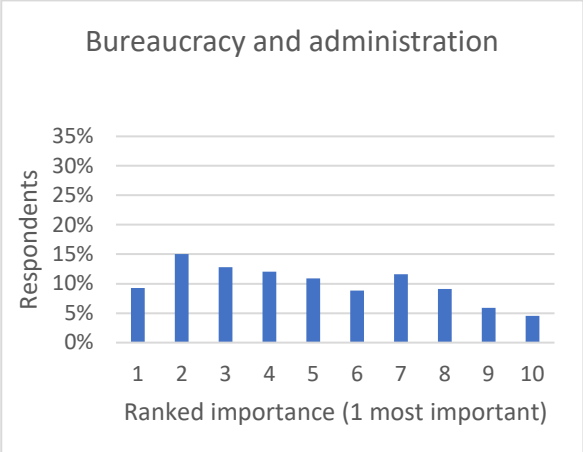
Factors behind decisions to take up, or consider taking up, other non-public health sector employment, ranked by importance

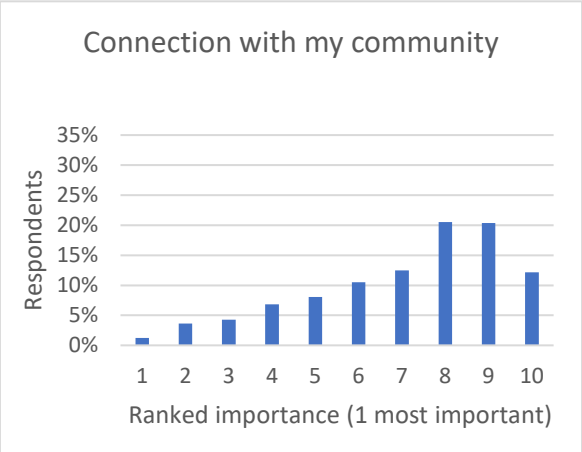


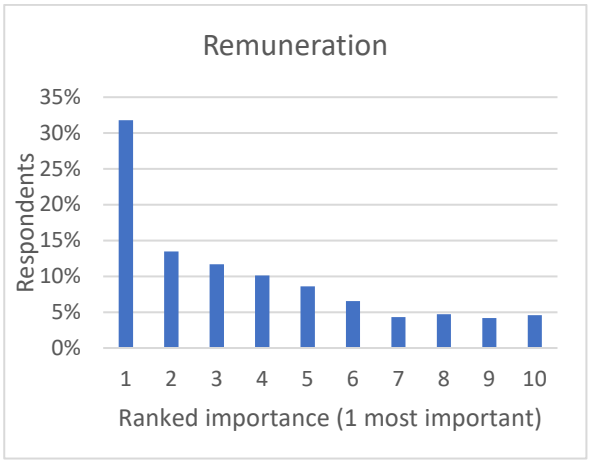


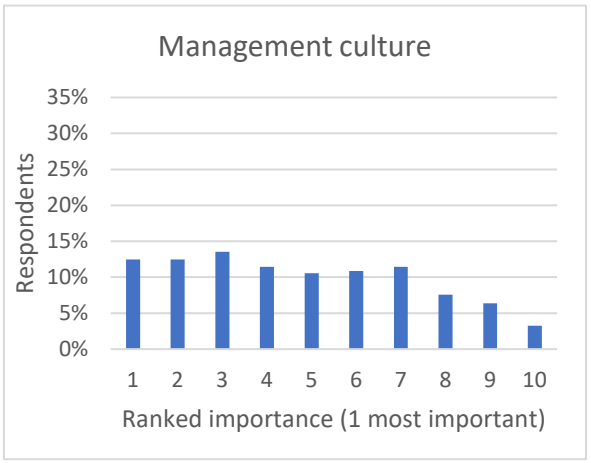


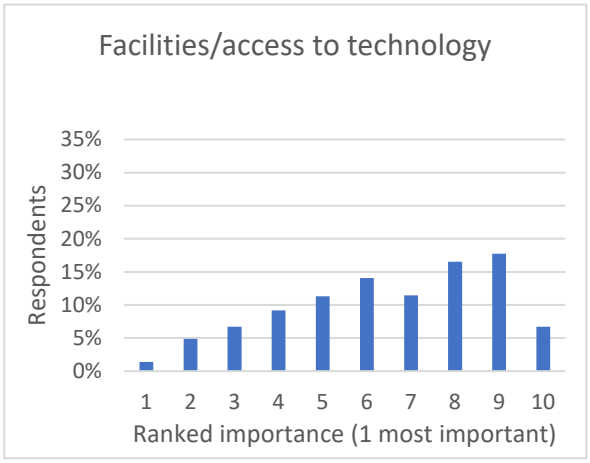


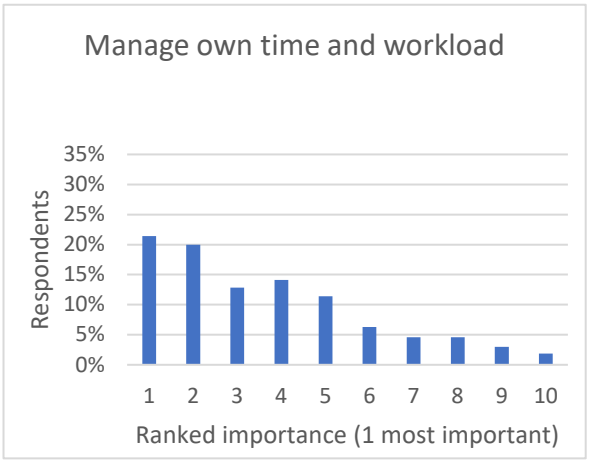








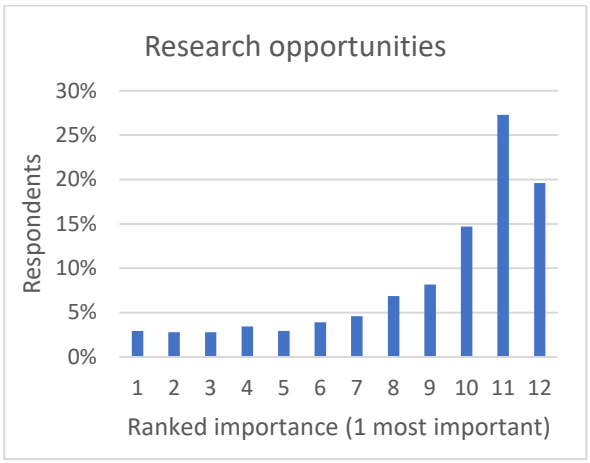


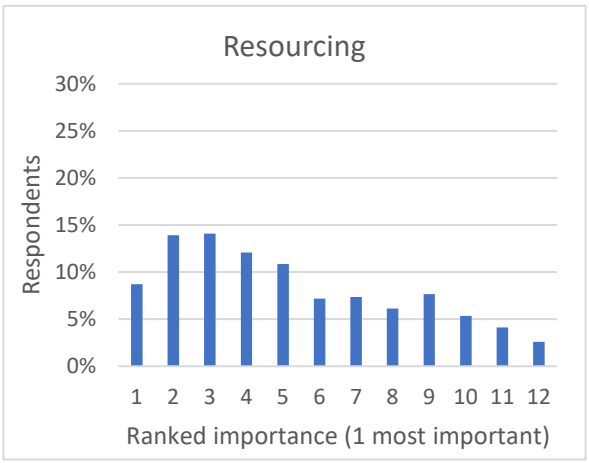


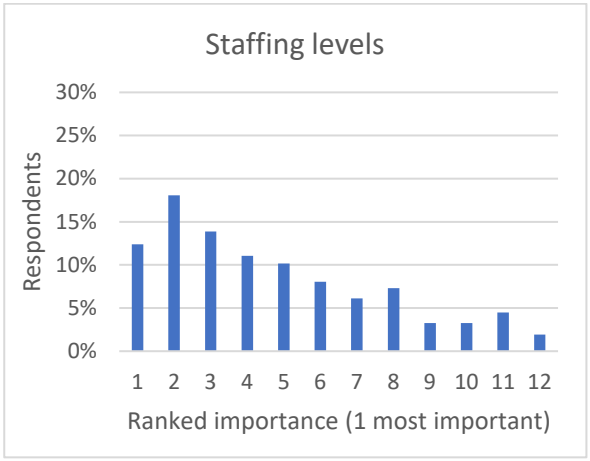
* All charts were given a maximum 35% respondent rate. ‘Research opportunities’ contained an outlier with 51% of respondents giving a ranking of 10.

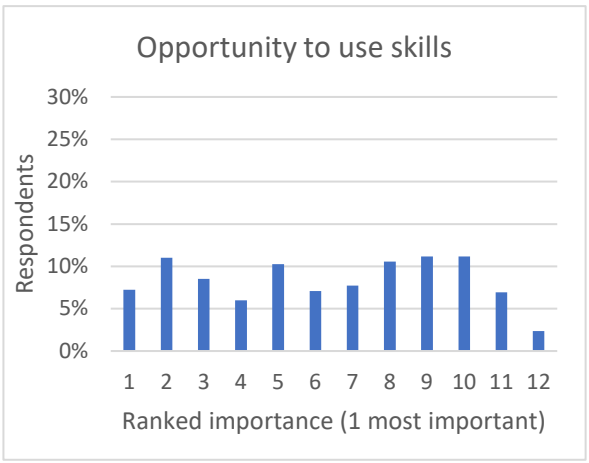
Appendix 2

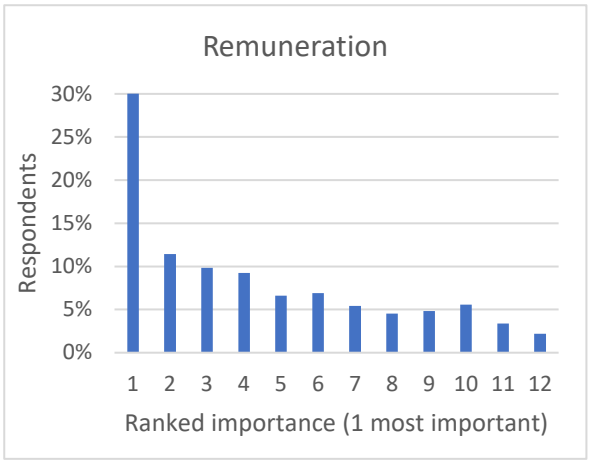
Pull factors that would influence a return to – or decision to stay in stay in – the public health sector, ranked by importance

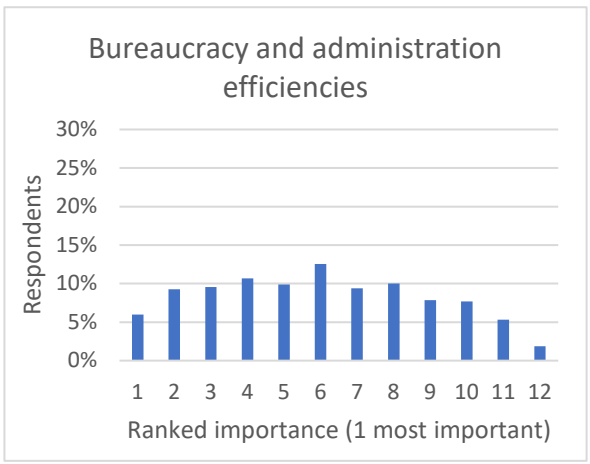


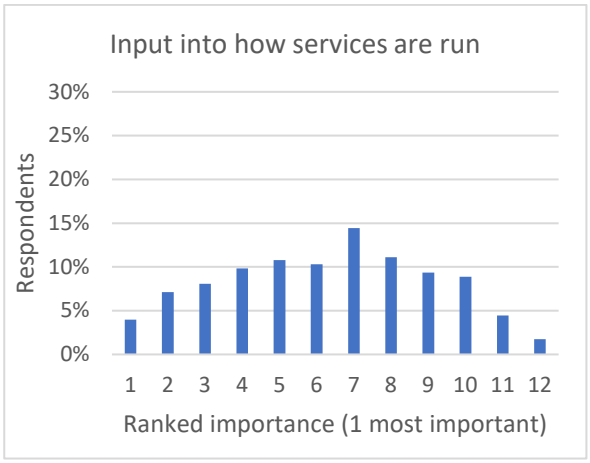


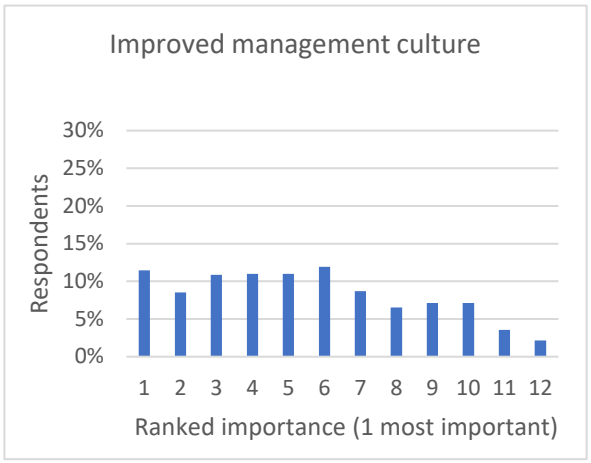


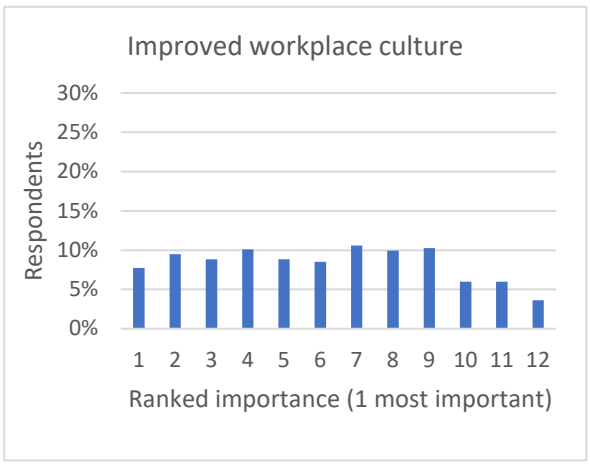


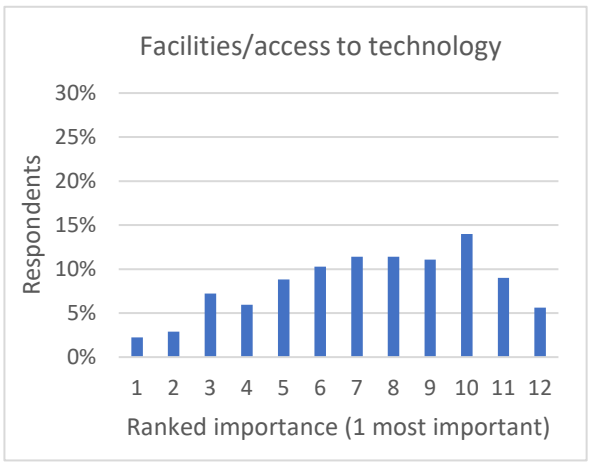


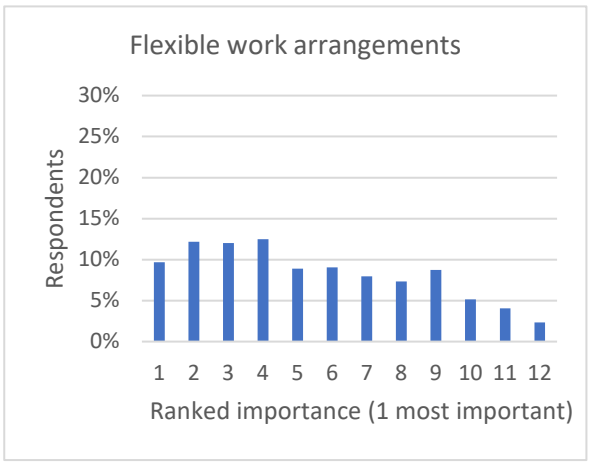


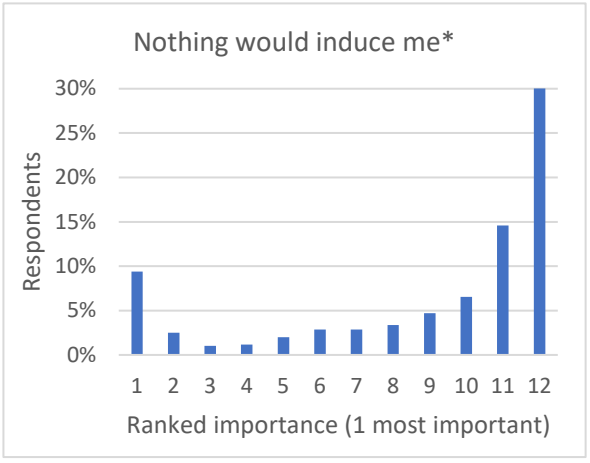












* All charts were given a maximum 30% respondent rate. 'Nothing would induce me' contained an outlier with 49% of respondents giving a ranking of 12