

A spreading problem

Changes in the distribution of medical specialists between public and private work - 2022 to 2024



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Contents

| | |
|------------------------------------------------------------------------|-----------|
| Executive Summary | 4 |
| <i>Key points</i> | 4 |
| Introduction | 5 |
| <i>Methodology</i> | 5 |
| <i>Definitions</i> | 5 |
| <i>Limitations of the MCNZ workforce survey</i> | 6 |
| Medical specialist workforce movement | 6 |
| <i>Public hospital losses</i> | 6 |
| <i>Public hospital workforce gains</i> | 7 |
| <i>Public-private/other movement</i> | 8 |
| Notable changes in specialties | 9 |
| <i>Psychiatry</i> | 9 |
| <i>Public health medicine</i> | 10 |
| <i>Anaesthesia</i> | 10 |
| <i>Surgical specialties</i> | 10 |
| <i>Diagnostic and interventional radiology</i> | 10 |
| <i>Dermatology</i> | 11 |
| <i>Orthopaedic surgery and ophthalmology</i> | 11 |
| <i>Palliative care</i> | 12 |
| <i>The workforce split in the context of workforce shortages</i> | 12 |
| Specialist workforce trends: the warning signs | 12 |
| <i>The private gate to the public system</i> | 13 |
| Endnotes | 14 |
| Appendix 1: Net FTE changes by specialty and sector | 16 |
| Appendix 2: Net FTE changes internal medicine subspecialties | 17 |
| Appendix 3: FTE changes population adjusted | 18 |

Executive Summary

Public hospital medical specialists are leaving or reducing their hours in favour of private or other employment, according to data provided to ASMS by the Medical Council of New Zealand (MCNZ).

Key points

- The total medical workforce employed across the public, private and other sectors grew by 5.7 per cent from June 2022 to June 2024.
- The workforce is divided approximately 70/30 percent public/private & other. However, the net full-time equivalent (FTE) growth in the private/other sectors (225.1 FTEs) was greater than in the public sector (194.7 FTEs).
- The public hospital specialist workforce increased by 4.0 per cent from June 2022 to June 2024. This is less than the population growth, adjusted for ageing (estimated to be 5%), and significantly less than public hospital case weighted inpatient discharges, which grew by 11.4 per cent over the same period.
- In the same period the private/other medical specialist workforce grew by 9.6 per cent.
- Ten medical specialities saw a net loss of FTE employed in the public system in from June 2022 to June 2024. A further five specialities experienced net FTE growth lower than what is needed to keep pace with population growth and ageing.
- The largest net FTE losses from the publicly employed, hospital-based medical workforce from June 2022 to June 2024 were in Psychiatry (19.6 FTE loss) and Anaesthesia (6.6 FTE loss). Over the same time period, FTE employed in the private/other sectors grew by net 33.3 FTE for Psychiatry and net 38.7 FTE for Anaesthesia.
- New Zealand is short of approximately 1,800 FTE doctors currently, and increasing drift towards private practice reduces capacity for care to be delivered in the public system.
- Previous research by ASMS indicates low job satisfaction and poor working conditions influence SMO decisions to work outside the public system, with remuneration; the ability to manage one's own time and workload; and clinical satisfaction as the most common factors.

Introduction

There is a shortage of senior doctors and dentists in our public hospitals. This is in the context of an international health workforce shortage. New Zealand relies heavily on overseas trained doctors, and is vulnerable to international health workforce shortages. This report analyses another trend impacting workforce shortages in public hospitals - evidence showing senior doctors reducing their work in public hospitals to take up work in private practice. As Te Whatu Ora's Health Workforce Plan 2023/24 acknowledges, "FTE flight to the private sector in some areas ...can limit public capacity."¹

This report updates data published in ASMS' earlier report, *Creeping Privatisation*.²

It uses data obtained by the Medical Council of New Zealand (MCNZ), from its Medical Workforce Surveys of 2022, 2023 and 2024.^{3 4}

While this report concerns the senior medical workforce, we acknowledge the issues identified are common across the whole health workforce.

Methodology

The MCNZ surveys doctors when they are renewing their practising certificate at one of four dates during the June year (September, December, March, June).

The survey includes questions about the hours a doctor works across all work sites during a typical working week by work type (specialty) and employer type (see definitions below).

The full-time equivalent (FTE) calculation is based on a 40-hour week (eg, 60 hours = 1.5 FTE). On-call time is only included in FTE for time the doctor is actually called.

The survey findings exclude doctors who work less than four hours a week, short-term registrants, and new registrants during the period of the survey.

The response rates for the 2022, 2023 and 2024 surveys were 98.1, 97.9 and 98.3 per cent respectively. The high response rates follow MCNZ's decision to require doctors to complete the survey. Earlier surveys had lower response rates and are not included in this report.

Changes in public and private sector have been analysed by specialty.

Definitions

Specialist: This is generally understood to require membership of a relevant specialist college (and registration within a vocational scope of practice). However, the data are self-reported and doctors may apply the term more broadly.

The data used in this report excludes the specialties of general practice, urgent care, and other primary care disciplines.

Public employment: Specifically refers to public *hospital* employment

Private employment: Includes private practice, working for a private hospital or commercial companies.

Other employment: Includes government agencies, other professional bodies, universities and NGOs.

Limitations of the MCNZ workforce survey

FTE numbers are based on a doctor’s self-reported estimate of a “typical working week” or their most recent week.

Specialists complete the workforce survey annually when they renew their practising certificate at one of four dates during the year (September, December, March, June), based on their birth date.

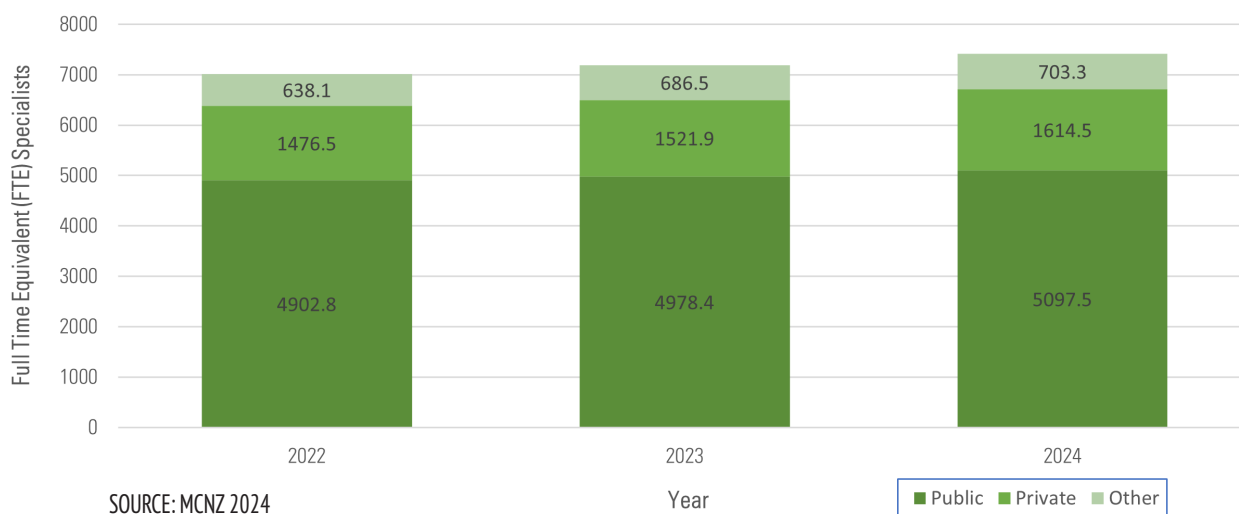
The survey excludes new registrants in the year of the survey. Nor does it capture possible exits from the workforce between the times of the first three survey dates and the end of the year. Therefore, the results of each survey are more reflective of the previous year’s workforce and should be considered indicative. The data does not distinguish who is employed as a locum versus an employee.

Covid pandemic lockdowns and border closures are likely to have affected the FTE volumes in the 2021/22 surveys and may have affected FTE volumes in 2022/23 surveys.

Medical specialist workforce movement

The medical specialist workforce is gradually shifting away from the public sector towards private/other employment. While the former grew by 4.0 per cent from June 2022 to June 2024 (less than population growth), the private/other sectors grew by 9.6 per cent. (Figure 1).

FIGURE 1: FTE GROWTH IN MEDICAL SPECIALIST WORKFORCE 2022-24



Public hospital losses

Ten of 36 specialties in public hospitals saw a drop in medical specialist FTEs from June 2022 to June 2024. A further five specialties saw FTE growth less than needed to keep up with estimated population growth and ageing (Table 1).

In some cases, the numerical loss is small, but it must be considered relative to the size of the specialty. For example, paediatric surgery lost 1.7 FTEs between June 2022 and June 2024, but that represents a 9.1 percent reduction. Similarly, the loss of 3.1 FTEs in cardiothoracic surgery amounts to a 12.6 percent loss of cardiothoracic surgeons working in public hospitals.

TABLE 1: PUBLIC HOSPITAL FTE LOSSES FROM 2022 TO 2024

| Speciality | Change in FTE | Population Adjusted Loss in FTE | Population Adjusted Percentage Loss |
|-------------------------------------------------------------------------------------------------|---------------|---------------------------------|-------------------------------------|
| Specialties with an actual loss in the number of FTE | | | |
| Anaesthesia | -6.6 | -43.5 | -5.8% |
| Clinical Forensic Medicine | -0.7 | -0.7 | -71.6% |
| Diagnostic & Interventional Radiology | -5.7 | -19.2 | -7.0% |
| Occupational Medicine* | -1.5 | -1.7 | -30.3% |
| Pathology | -1.5 | -8.1 | -6.0% |
| Psychiatry | -19.6 | -43.2 | -9.0% |
| Public Health Medicine* | -13.3 | -15.1 | -39.2% |
| Rural Hospital Medicine | -1.9 | -5.0 | -7.9% |
| Surgery: Cardiothoracic | -3.1 | -5.0 | -12.6% |
| Surgery: Paediatric | -1.7 | -2.3 | -9.1% |
| Specialties with a gain in the number of FTE not sufficient to keep pace with population growth | | | |
| Other Specialties | 4.4 | -0.1 | -0.5% |
| Ophthalmology | 2.3 | -2.1 | -2.4% |
| Radiation Oncology | 1.6 | -1.5 | -2.4% |
| Surgery: Vascular | 1.1 | -0.5 | -1.7% |
| Surgery: Other Subspecialties | 3.1 | -0.1 | -0.2% |

SOURCE: MCNZ 2024

*Most specialists in these specialties are employed in the private/other sectors

** Population growth adjusted for ageing. Calculations are subject to rounding. See Appendix 3.

Public hospital workforce gains

Twenty-one out of 36 specialties saw public hospital workforce increases above estimated population growth (Table 2).

In many cases the increases are from a relatively low numerical base. For example, dermatology and rehabilitation medicine are not available publicly in many parts of the country.

While the increases in emergency medicine are relatively large, that workforce would need an additional 105 specialists to be proportionate with the Australian emergency medicine specialist workforce on a per capita basis in 2023.

Furthermore, emergency department presentations in the June 2024 quarter were 15.5 per cent higher than in June 2022,⁵ and emergency medicine case-weighted 'inpatient' discharges (including day patients) grew by 16.7 per cent.⁶

At the same time recent media reports show all hospital emergency departments failing to assess patients with imminently or potentially life threatening conditions within clinically acceptable timeframes⁷.

TABLE 2: PUBLIC HOSPITAL FTE GAINS FROM 2022 TO 2024

| Specialty | Change in FTE | Population Adjusted Ga in FTE* | Population Adjusted Percentage Loss* |
|-------------------------------------------|---------------|--------------------------------|--------------------------------------|
| Basic Medical Science | 1.1 | 0.2 | 1.4 |
| Clinical Genetics | 0.8 | 0.3 | 3.3 |
| Dermatology | 3.6 | 2.7 | 14.7 |
| Emergency Medicine | 38.4 | 22.1 | 6.9 |
| Family Planning & Reproductive Health | 0.6 | 0.6 | 93.7 |
| Intensive Care Medicine | 10.5 | 4.9 | 4.5 |
| Internal Medicine | 90.9 | 35.7 | 3.3 |
| Medical Administration | 3.9 | 2.7 | 12 |
| Musculoskeletal Medicine | 1 | 0.9 | 112.3 |
| Obstetrics & Gynaecology | 13.2 | 0.9 | 0.4 |
| Surgery: Otolaryngology Head & Neck | 5.7 | 1.7 | 2.1 |
| Paediatrics | 20 | 12 | 3.5 |
| Palliative Medicine | 5.9 | 4.8 | 23.6 |
| Surgery: Plastic & Reconstructive Surgery | 2.7 | 0.3 | 0.6 |
| Rehabilitation Medicine | 3.4 | 2.8 | 24.9 |
| Sexual Health Medicine | 1.1 | 0.6 | 5.8 |
| Surgery: General | 13.4 | 4.2 | 2.3 |
| Surgery: Neurosurgery | 2.9 | 1.5 | 5.7 |
| Surgery: Oral & Maxillofacial | 4.4 | 3.8 | 38.1 |
| Surgery: Orthopaedic | 17.3 | 7.9 | 4.2 |
| Surgery: Urology | 8.7 | 6.1 | 12.4 |

SOURCE: MCNZ 2024

* Calculations are subject to rounding. Population growth adjusted for ageing - see Appendix 3.

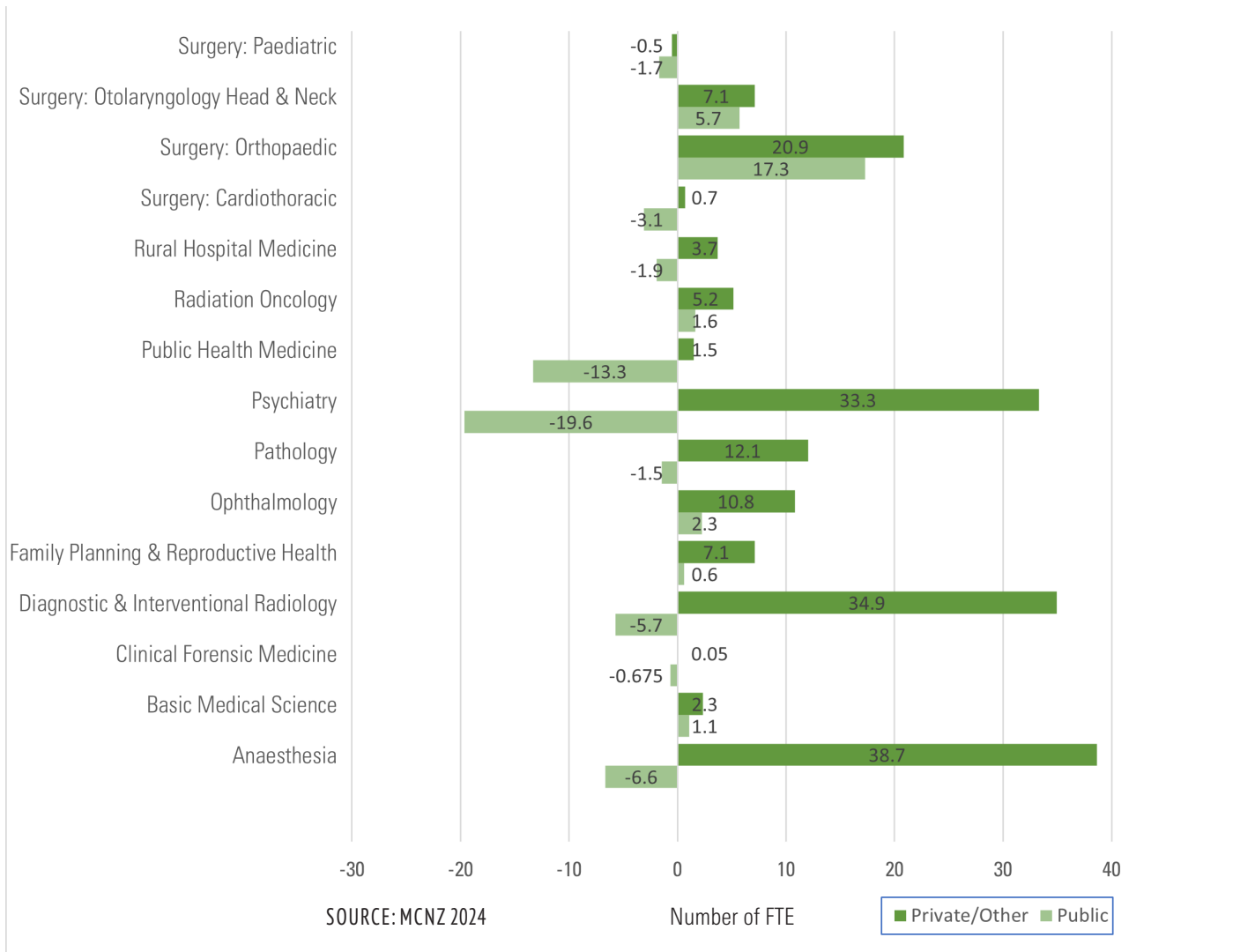
Similarly, intensive care medicine would have needed an additional 57 specialists to be proportionate with Australia; obstetrics and gynaecology would have needed 31 specialists.⁸

The lack of parity with \ Australia is reinforced in the results of an ASMS survey of clinical directors across 15 DHBs in early 2022, which found an average 22 per cent shortfall of senior medical officers across all departments.⁹

Public-private/other movement

Fifteen of 36 specialties saw a shift in FTEs from June 2022 to June 2024 which favoured private/ other employment. This includes specialties that saw losses in public hospitals but gains in private/ other employment; specialties that saw a drop in both public and private/other employment but where the former was greater than the latter and specialties that saw gains in both public and private/other employment but where the former was less than the latter (Figure 2).

FIGURE 2: SPECIALTIES WITH A SHIFT IN FTE FROM PUBLIC HOSPITALS TO PRIVATE/OTHER EMPLOYMENT FROM 2022 TO 2024



Collectively those 15 specialties saw a net loss of 25.6 FTEs in public hospitals, while the private/other sectors saw a net gain 177.9 FTEs.

Notable changes in specialties

Psychiatry, public health medicine and anaesthesia incurred the largest numerical losses in public hospital FTE (19.6, 13.3, and 6.6 respectively).

Psychiatry

For psychiatry, the 19.6 FTE losses in the public sector were more than equalled by gains (33.3 FTEs) in the private/other sectors - 18.1 FTEs and 15.2 FTEs respectively. This shift comes as in the year to June 2024 an estimated 428,000 adults and 45,000 children had an unmet need for Mental Health and Addiction (MHA) services – an increase of 153 per cent and 45 per cent respectively since 2016/17. Vacancy rates for psychiatrists working in the public system hit 18 per cent in the year to March 2022. More psychiatrists are now leaving the public sector workforce than are entering it.¹⁰

Public health medicine

While most specialists are employed by Te Whatu Ora, the MCNZ surveys record most specialists in the “Other” category which made a small gain. However, the FTE employed in public hospitals dropped by 13.3 FTEs, resulting in an overall loss of 6.8 percent of this workforce. Note that the MCNZ Medical Workforce Survey identifies “employer types” as “public hospital”, various categories of private employment, and “all other” employment types. At the time of writing, further significant cuts were proposed to the National Public Health Services – a key service for preventing illness, promoting health, and ensuring New Zealand is better prepared for the next pandemic.

Anaesthesia

Public hospitals saw a net loss of 6.6 FTE in this specialty from June 2022 to June 2024, with private increasing by 31.1 FTE (15.4 per cent) and the ‘Other’ category increasing 7.6 FTE (32.1 per cent). In order to keep abreast of estimated population growth (including adjustments for ageing), there needed to be an increase of more than 40 FTE in the public workforce. This may be a conservative estimate as case-weighted public hospital inpatient discharges in surgical specialties increased by 10 per cent over that time¹¹.

Surgical specialties

Public cardiothoracic surgery and paediatric surgery saw net FTE losses between June 2022 and June 2024, while the net growth in two other public surgical specialties was less than estimated demographic growth (Table 1). While the total public surgical specialty FTEs grew by 7.3 percent, the private sector grew by 8.9 per cent and the ‘Other’ category grew by 37.5 percent.

Diagnostic and interventional radiology

In this specialty, public hospitals saw a net loss of 5.7 FTEs while Te Whatu Ora estimates a current radiologist shortage of 90 FTEs.¹² The private/other sectors picked up 35 FTEs - 18.7 FTEs and 16.3 FTEs respectively.

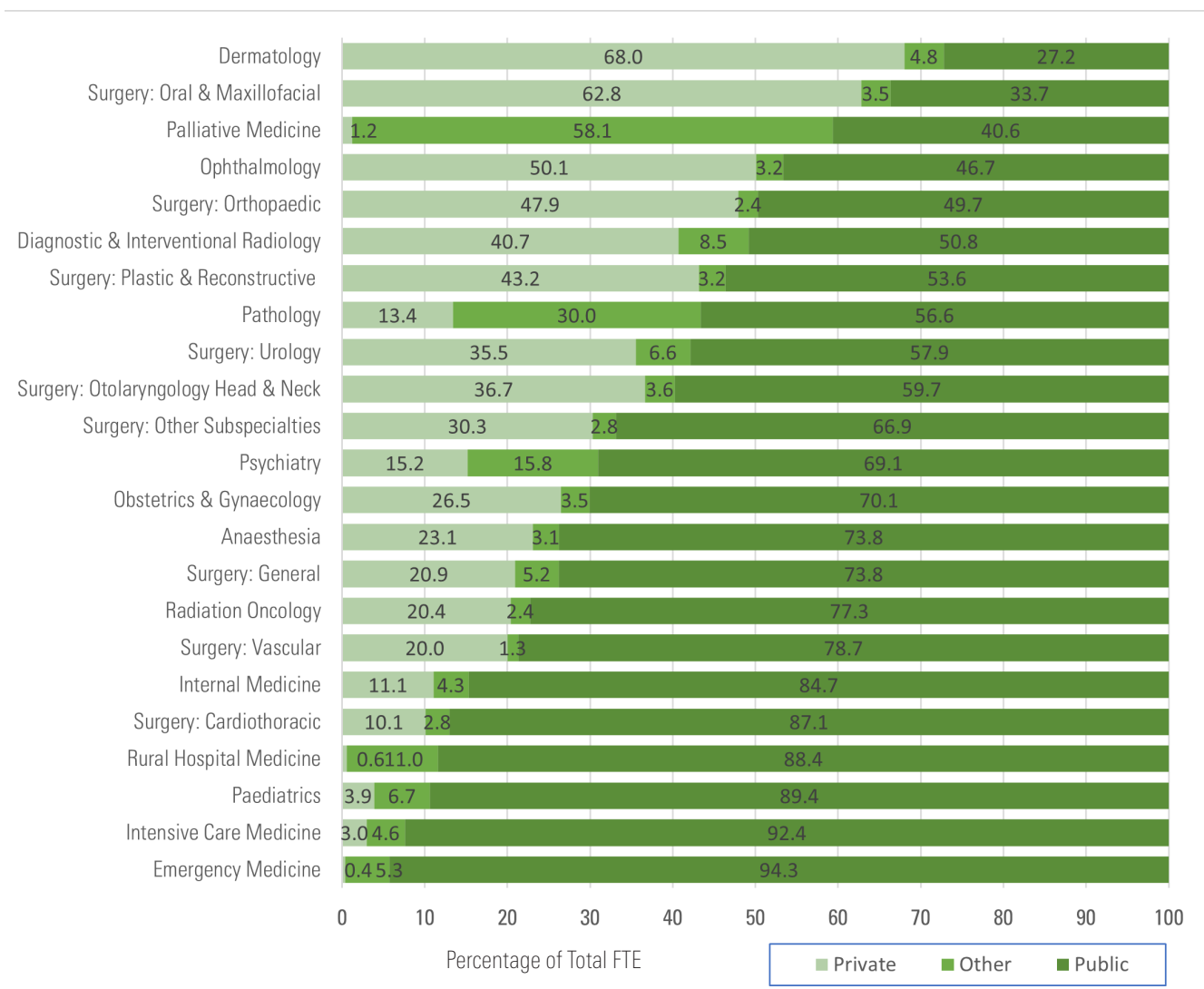
The public-private division

Just over 31 per cent of the total hours worked by medical specialists was spent in ‘Private/Other’ services in 2024 - mostly in private hospitals or private clinical practice: 21.8 per cent of specialist workforce hours were spent in private practice, with 9.5 per cent spent in other employment (eg university, NGOs, other government departments etc. For surgical specialties), more than a third (35.3 per cent) of worked hours were spent in the private sector, and a further 3.5 per cent were spent in other employment.

In hospital specialties with more than 40 FTE and more than 15 per cent working in private/other employment, dermatology, oral and maxillofacial surgery, palliative medicine and ophthalmology employ more in private/other employment than in the public hospital system. Orthopaedic surgeons and radiologists are split virtually 50-50 between the two (Figure 3).

The division of the specialist workforce across the public-private/other sectors would not necessarily be an issue if there was sufficient specialist workforce capacity to meet health need in the public system. The effects of the workforce split have to be seen in the context of workforce shortages in each specialty, where every specialist moving to the private sector can exacerbate the shortage in the public sector.¹³

FIGURE 3: PROPORTION OF SPECIALISTS WORKING IN PRIVATE, 'OTHER' AND PUBLIC EMPLOYMENT



SOURCE: COMPILED BY ASMS FROM UNPUBLISHED DATA PROVIDED BY THE MEDICAL COUNCIL OF NEW ZEALAND FROM ITS MEDICAL WORKFORCE SURVEY, 2024. Notes: Excludes the largely non-hospital-employed specialties of occupational medicine and public health medicine. Comprises hospital specialties with more than 40 FTEs and more than 15% working in private/other employment

Dermatology

Dermatology is unavailable in the public system in many parts of the country. Long-standing shortages of dermatologists are well recorded. 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.¹⁴ In December 2024 there were 839 patients (34 percent of the dermatology waiting list) waiting longer than four months for an FSA.¹⁵

Orthopaedic surgery and ophthalmology

In the year to June 2024, the number of orthopaedic patients waiting longer than four months for an FSA grew by 30 per cent. By December 2024, 8,001 patients were waiting longer than four months for treatment while 16,638 were waiting more than four months for a first specialist assessment (FSA). The number of ophthalmology patients waiting longer than four months for an FSA and for elective treatment grew by 14 per cent and 29 per cent respectively in the year to June 2024.¹⁶

Palliative care

While difficulty in accessing 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.¹⁷ While the World Health Organisation considers palliative care a fundamental component of universal health coverage, a large part of the palliative medicine specialist workforce is employed in hospices, which are only part-funded by government and rely heavily on donations, op shop income and volunteers.¹⁸

The workforce split in the context of workforce shortages

Evidence gathered by ASMS over many years shows long-standing shortages in the specialist workforce across the board and little or no sign of them being addressed.¹⁹ Only recently has the government formally acknowledged medical shortages. However, its assessment of those shortages is largely based on vacancy rates (which are largely determined by budgets rather than service needs). The numbers fall well short of the estimates by clinical leaders identified by ASMS in surveys.²⁰

Even where FTE growth has kept pace with or exceeded population growth and ageing in 2024, it still falls short of remediating shortages that have accumulated over years. Nor does it address the experiences of services under extreme pressure, such as the country's emergency departments, where the shortages are exacerbated by shortages of general practitioners and shortages in the hospital wards.^{21 22}

The latest data shows the workloads of public hospital senior doctors (specialists and medical officers) is growing. Between June 2022 and June 2024, total case-weighted public hospital inpatient discharges increased by 11.4 per cent while the senior doctor FTE workforce grew by 6 per cent (5.1 per cent headcount).²³

Te Whatu Ora has estimated a current medical workforce shortage of 1,810 FTEs (including 1,140 Senior Medical Officers - SMOs) and a projected shortage of 3,440 by 2033.²⁴ Current plans for training medical graduates would only cover only about 40 per cent of their projected workforce need.²⁵

Specialist workforce trends: the warning signs

Surveys of Toi Mata Hauora ASMS members have found low job satisfaction and poor working conditions, as well as an ageing workforce, are key drivers for medical specialists moving away from the public health system or leaving medicine entirely.

A 2022 survey of members' career intentions within the next five years found 42 per cent of over 1,600 respondents 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.²⁶

A 2024 'exit survey' of members leaving their Te Whatu Ora employment during that year found 10 per cent of 120 respondents were taking up or increasing private practice and many others were intending to do a mix of casual/contract, locum and/or private work. Nineteen per cent were leaving medical or dental practice completely, while 27 per cent were leaving the country. Exit surveys in the previous two years showed similar results.

Psychiatry and emergency medicine were over-represented in these surveys. MCNZ's data indicating a net gain for the latter specialty in 2024 suggests a high 'churn rate'.

The findings in these surveys were reinforced in a further survey of members in early 2023.²⁷ 59 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. Of those working outside the public health system, most work in the private health sector: 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).

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 3).

‘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 undervalued 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.”

TABLE 3: SHOULD I STAY OR SHOULD I GO?

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.

| 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%) |

The private gate to the public system

The shift towards greater dependency on 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, Pacific Peoples 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 have prompted calls from health professionals and researchers for reform of primary health care services. This action would remove user charges and 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.^{28 29 30}

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.^{31 32}

Endnotes

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Appendix 1:

Net FTE changes by specialty and sector for 3 years to June 2024

| Specialty | FTE Change 2022-24 | | | Percentage change 2022-24 | | |
|---------------------------------------------|--------------------|--------------|-------------|---------------------------|------------|-------------|
| | Public | Private | Other | Public | Private | Other |
| Anaesthesia | -6.6 | 31.1 | 7.6 | -0.9 | 15.4 | 32.1 |
| Basic Medical Science | 1.1 | -0.5 | 2.8 | 6.5 | -9.6 | 24.4 |
| Clinical Forensic Medicine | -0.68 | 0.0 | 0.0 | -68.0 | | -5.1 |
| Clinical Genetics | 0.8 | -0.1 | -1.5 | 8.4 | -16.7 | |
| Dermatology | 3.6 | 2.8 | 0.2 | 19.9 | 5.3 | 4.1 |
| Diagnostic & Interventional Radiology | -5.7 | 18.7 | 16.3 | -2.1 | 9.5 | 56.6 |
| Emergency Medicine | 38.4 | -1.0 | 4.6 | 12.0 | -40.4 | 29.0 |
| Family planning & reproductive health | 0.6 | 9.3 | -2.2 | 97.9 | | -32.7 |
| Intensive Care Medicine | 10.5 | -1.4 | 2.6 | 9.5 | -26.5 | 73.4 |
| Internal Medicine | 90.9 | 19.3 | -6.9 | 8.3 | 14.2 | -10.4 |
| Medical administration | 3.9 | 1.1 | -5.8 | 17.2 | 55.3 | -29.9 |
| Musculoskeletal medicine | 1.0 | 0.2 | 0.3 | 118.8 | 1.2 | 24.4 |
| Obstetrics & Gynaecology | 13.2 | -0.1 | 1.5 | 5.4 | -0.1 | 13.0 |
| Occupational Medicine | -1.5 | -1.5 | -4.1 | -26.2 | -4.0 | -19.6 |
| Ophthalmology | 2.3 | 11.4 | -0.5 | 2.6 | 13.5 | -8.2 |
| Paediatrics | 20.0 | 5.9 | 5.0 | 5.8 | 58.7 | 22.2 |
| Palliative medicine | 5.9 | -3.1 | 7.0 | 28.9 | -79.2 | 22.7 |
| Pathology | -1.5 | 1.2 | 10.9 | -1.1 | 3.9 | 18.1 |
| Psychiatry | -19.6 | 18.1 | 15.2 | -4.1 | 21.6 | 16.8 |
| Public Health Medicine | -13.3 | -0.6 | 2.1 | -34.7 | -16.1 | 1.7 |
| Radiation Oncology | 1.6 | 4.9 | 0.3 | 2.6 | 40.4 | 20.0 |
| Rehabilitation medicine | 3.4 | 1.6 | -0.8 | 30.2 | 24.6 | -32.3 |
| Rural Hospital Medicine | -1.9 | 0.2 | 3.6 | -3.0 | 60.0 | 87.7 |
| Sexual health medicine | 1.1 | 0.8 | 0.3 | 10.9 | 52.5 | 10.9 |
| Sports Medicine | 0.0 | 5.2 | -0.7 | | 17.9 | -12.9 |
| Surgery: Cardiothoracic | -3.1 | -0.5 | 1.2 | -7.8 | -10.1 | |
| Surgery: General | 13.4 | 4.9 | 3.6 | 7.4 | 9.7 | 34.7 |
| Surgery: Neurosurgery | 2.9 | 1.2 | 1.0 | 10.8 | 21.7 | |
| Surgery: Oral & Maxillofacial | 4.4 | 1.3 | -0.6 | 43.6 | 5.0 | -26.8 |
| Surgery: Orthopaedic | 17.3 | 17.7 | 3.1 | 9.3 | 9.9 | 46.9 |
| Surgery: Other subspecialties | 3.1 | 1.5 | 0.8 | 4.8 | 5.2 | 41.8 |
| Surgery: Otolaryngology Head & Neck | 5.7 | 5.6 | 1.6 | 7.1 | 11.8 | 42.8 |
| Surgery: Paediatric | -1.7 | -0.3 | -0.3 | -6.8 | -14.9 | -100.0 |
| Surgery: Plastic and reconstructive surgery | 2.7 | 2.0 | 0.0 | 5.7 | 5.1 | -1.6 |
| Surgery: Urology | 8.7 | 2.0 | 3.3 | 17.6 | 5.8 | 101.5 |
| Surgery: Vascular | 1.1 | 2.4 | -1.3 | 3.3 | 39.9 | -70.7 |
| TOTAL | 201.8 | 161.0 | 69.9 | 4.0 | 9.3 | 10.2 |

Appendix 2:

Net FTE changes by specialty and sector, Internal Medicine subspecialties June 2022 to June 2024

| Work type | FTE Change 2022-24 | | | Percentage change 2022-24 | | |
|-------------------------------------------|--------------------|-------------|-------------|---------------------------|-------------|--------------|
| | Public | Private | Other | Public | Private | Other |
| Cardiology | 21.8 | 3.5 | -2.5 | 14.5 | 10.3 | -27.7 |
| Clinical Pharmacology (Internal Medicine) | 2.0 | 0.0 | 0.8 | 127.4 | | 76.9 |
| Diabetology | 0.9 | 0.4 | -0.8 | 12.3 | | -65.2 |
| Endocrinology | 4.9 | 1.7 | -2.0 | 13.8 | 21.0 | -34.1 |
| Gastroenterology | 9.1 | 8.1 | 0.0 | 9.1 | 29.9 | |
| Geriatric Medicine | 2.5 | 0.5 | -1.1 | 2.6 | 20.4 | -32.6 |
| Haematology (Internal Medicine) | 2.7 | 0.4 | 2.8 | 4.3 | 14.5 | 150.0 |
| Immunology (Internal Medicine) | 0.1 | -0.3 | 0.2 | 1.0 | -14.7 | 300.0 |
| Infectious diseases | -2.8 | -0.7 | -0.9 | -8.8 | -44.8 | -22.8 |
| Internal Medicine | 13.7 | -3.0 | 2.3 | 5.0 | -38.5 | 16.6 |
| Medical Genetics | -1.2 | 0.0 | 0.0 | -100.0 | | |
| Medical Oncology | 8.8 | 2.1 | -0.3 | 10.3 | | -14.9 |
| Nephrology | 5.2 | 0.2 | -2.9 | 7.4 | 6.5 | -40.8 |
| Neurology | 3.4 | -0.1 | 1.1 | 6.3 | -0.9 | 25.7 |
| Nuclear Medicine | -0.2 | 1.2 | -1.7 | -5.7 | | -100.0 |
| Obstetric medicine | 6.5 | | | 537.5 | | |
| Physical medicine | -2.2 | 0.2 | 0.0 | -100.0 | | |
| Respiratory medicine | 10.8 | 0.8 | -1.8 | 14.3 | 13.2 | -41.7 |
| Rheumatology | 3.3 | 3.4 | -0.5 | 10.3 | 30.0 | -10.9 |
| Sleep medicine | 1.6 | 1.0 | 0.3 | | | |
| Grand Total | 90.9 | 19.3 | -6.9 | 8.3 | 14.2 | -10.4 |

SOURCE: MCNZ 2024
Totals are subject to rounding

Appendix 3:

Public FTE changes by specialty, population adjusted

The population adjustment, taking into account factors such as ageing, deprivation levels and ethnicity, as well as population growth, is assumed to be 5% from June 2022 to June 2024. This is based on a Treasury document showing the weighted demographic growth component of Core Crown Health expenditure ranged from approximately 2% to 3% per year in the five years to June 2020. (Treasury: The 'Residual' in Healthcare Expenditure Modelling: Summary, released under an OIA request, 2 December 2024.)

The validity of this assumption is supported by Ministry data (from the National Minimum Dataset) showing public hospital caseweight inpatient discharges grew by 11.4 per cent between June 2022 and June 2024. This suggests the assumption may be conservative (as the population has aged since 2020) or 'productivity' has increased, or both.

The net gains/losses in FTEs between 2022 and 2024 were estimated by comparing the changes in actual FTEs recorded in the MCNZ surveys against the FTEs needed to take account of the demographic adjustments, based on FTEs per 100,000 population across those years. The calculations for paediatric specialties were based on the under-16 population estimates; family planning and sexual health specialties were based on aged 13+ population estimates; obstetrics and gynaecology estimates were based on the female population aged 13 and over. Assuming the ageing factor is the main population adjustment, the paediatric specialties and the family planning specialty were not adjusted.

