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A case against the increased use of the private health sector

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As pressure continues for public health services to meet increasing health needs on tighter budgets, business is booming in the private sector. There are two reasons for this:

- increasing levels of public funds are going to the private sector to provide services, and
- lack of resources, and cuts, in the public sector are driving more people to use private insurance.

The rationale behind the Government's policy to make greater use of private health service providers – especially for elective surgery – is that the public sector lacks the capacity to address our growing health service needs.

Health Minister Tony Ryall told the New Zealand Private Surgical Hospitals Association in March 2009 that he wanted "improved flexibility" for District Health Boards (DHBs) in their contracting with private hospitals. He also indicated a removal of some of the boundaries between the public and private systems, which he wanted to see "working together rather than [as] two separate parallel systems".[1]

For now, that means using private facilities to provide some publicly funded services. Whether in the future it also means using public facilities for privately funded services has not been made clear.

The volume of publicly funded elective surgery provided in private hospitals (excluding ACC) has increased from 1245 cases in 2005/06 to over 11,000 in 2008/09 and it is still rising.[2]

According to media reports, the three Auckland DHBs, which contracted virtually no elective services to private providers in 1999/2000, had contracted out 11% of their elective surgery in the year to March 2010.[3,4,5]

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[1] T Ryall. Address to NZ Private Surgical Hospitals Association, 6 March 2009.

[2] T Ashton. "The benefits and risks of DHBs contracting out elective procedures to private providers," *NZ Medical Journal Digest*, Vol 123, No 1314, 12 May 2010.

[3] M Johnston, "Elite hospitals do 10% of public ops", *NZ Herald*, 4 November 2008

[4] T Ryall. Address to NZ Private Surgical Hospitals Association, 6 March 2009.

[5] P Gower, M Johnston. "Private hospitals get greater public role", NZ Herald, 27 May 2010

On the face of it, contracting private services seems a commonsense measure to boost the number of publicly funded operations performed and cut waiting times. However, closer scrutiny shows the glossy paintwork of this policy to be highly corrosive.

First, greater use of the private sector is occurring even though theatre use of 10 out of 26 public hospitals in New Zealand have been used at less than 60% capacity and only four have been used at full capacity.[6] The Ministry of Health has advised the Minister that some DHBs are faced with capacity restraints “that are often due to shortages of specialist staff”.[7]

Those shortages are compounded when public funds that could be used to build the workforce and service capacity in public hospitals are instead channelled into private hospitals. Where funding goes, staff follow, and they are not easily replaced because there are international shortages of nurses, medical specialists and some allied health professions.

This shift is being driven further by growing numbers of people using private insurance. The cost of health insurance claims increased by 10.1% in the year to June 2010. While some of that is attributed to increased service costs, the Health Funds Association of New Zealand (an industry body representing health insurers) says it is also due to increased demand and expansion of services funded.[8]

Southern Cross, New Zealand’s biggest health insurer has seen significant increases in surgical volumes, especially in general surgery and orthopaedic surgery.[9]

In 2009, a total 145,000 elective surgery patients were discharged from private hospitals, compared with just under 135,000 procedures funded (with some privately provided) by DHBs.[10,11] (Note: Statistics vary across a range of sources but they all indicate greater volumes undertaken in the private sector.)

A key factor in the increased demand for private services is ACC’s introduction of stricter guidelines for funding elective surgery, which has recently seen a doubling of cases rejected. “Those with private health insurance were lucky and typically had their surgery funded by their insurer,” says the HFANZ. “Others were simply referred to public hospital waiting lists.”[12]

The HFANZ is anticipating more “cost-shifting” from ACC to the private sector in the future.[13] In fact any moves by government to open up ACC to private competition would almost certainly lead to further business for private health service providers from private injury insurance companies.

The *expansion* of services for which private insurance is now available includes private radiotherapy treatment in Auckland, and more recently in Christchurch. The growth of private services in Auckland and the poaching of staff from the public sector over a number of years have had a significant impact on Auckland DHB’s ability to provide timely access to public radiotherapy services. The Ministry of Health has advised the Minister that for Auckland DHBs

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[6] J Coleman. Parliamentary questions for oral answer (to K Hague), 29 July 2009.

[7] Ministry of Health. *Elective Services: “Opening the books on waiting lists”.* Health Report No 20082448. 1 December 2008.

[8] Health Funds Association of New Zealand. “Elective surgery boosts health insurance claims by 10”. Media release, 9 August 2010.

[9] Southern Cross Healthcare Group. “Use of private health sector increasing”. Media release, 20 June 2010.

[10] Health Funds Association of New Zealand. “Growth in elective surgery demand to 2030”. Summary Paper. March 2010. (Note, HFNZ claims 171,000 elective surgery discharges from the public sector in 2009. The Minister’s statements indicate 135,000 publicly funded procedures in that year.)

[11] T Ryall. “Elective surgery numbers jump 10%”. Media release 28 March 2010.

[12] Health Funds Association of New Zealand. *Annual Review 2010*.

[13] ibid

to meet the Government's waiting times requirements for radiation treatment they will need to contract with private providers. The Canterbury DHB is in a similar situation.[14]

Expansion of private services is also occurring through a government programme to integrate hospital and primary care services. The programme enables some primary care services to contract directly with private providers, such as those in Auckland, which may now contract with private radiology providers for diagnostic tests, and to "commission" a range of specialist hospital services, including those in the private sector.[15,16]

Further, Southern Cross is currently in discussion with primary care services in various parts of the country to develop service partnerships and to develop "new business and ownership models".[17]

Employment trends of medical specialists are key indicators of staff movements from public to private services because, when they move, teams of other health professionals move with them. Medical Council data show most medical specialists work in both private and public sectors. Policies favouring more private provision in the 1990s meant that by the end of that decade specialist staff spent only half their time, on average, in the public sector. Policies favouring more public provision in the 2000s led to that portion increasing to around 73% by 2006/07. There are now signs of a reversal of that trend.[18]

Medical Council data show a steady increase in the number of practising medical specialists in New Zealand over recent years but that growth appears to be confined to the private sector: DHB workforce data show a drop of nearly 60 specialists working in DHBs over the three years to March 2010.[19],[20]

Southern Cross reports that its "affiliated provider programme has undergone significant expansion with many new specialists added in the areas of cardiac, imaging, radiotherapy, general surgery, orthopaedics and more".[21]

This drawing away of staff from the public sector will not only impact on access to public services but will also threaten the very viability of some services, especially in provincial areas. A Ministry of Health report points out: "In a number of DHBs, a critical mass with respect to volume of work is required to ensure clinical and financial viability. This includes the ability to provide both elective and acute services. The removal of services (in most cases lower acuity services) to alternative providers, may potentially compromise the viability of the DHBs…"[22]

There are also negative implications for medical training and safety, with fewer medical specialists being available in the public sector to supervise and train junior doctors. This is

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[14] Ministry of Health 2010. *Radiation Oncology Capacity Modelling for 'shorter waits for cancer treatment' health targets.* Health Report No 20100747, 1 June 2010.

[15] Greater Auckland Integrated Health Network. *Newsletter* 28 June 2010.

[16] NZ Doctor Online. www.nzdoctor.co.nz

[17] Southern Cross Healthcare Group. "Southern Cross in partnership talks with general practices". Media release, 13 August 2010

[18] Medical Council of New Zealand. Unpublished data extracted from Annual Workforce Surveys, 2010.

[19] Medical Council of New Zealand. Annual Workforce Surveys and unpublished registration data, 2010.

[20] District Health Boards New Zealand. Unpublished data extracted from the Health Workforce Information Programme, 2010

[21] Southern Cross Healthcare Group, Southern Cross Medical Society *Annual Report 2009.*

[22] Ministry of Health 2006. *Addressing Disincentives – Working Party Report*, Ministry of Health June 2006. Available: www.moh.govt.nz/publications

becoming an increasingly significant issue identified in recent reports by the Medical Training Board and the Resident Medical Officers' Commission.[23,24]

A further consequence of increased use of the private sector is decreased public accountability. Private service providers are not subject to the Official Information Act or regular parliamentary scrutiny, as is the case with public providers. At a time when the Government has been squeezing DHBs to find evermore "cost efficiencies", the same constraints have not applied to private providers when they are spending public funds to provide elective services. The Minister's response to a parliamentary question in 2009 indicates the policy of increasing private provision of publicly funded surgery has not been assessed for its relative cost-effectiveness. [25]

In fact an analysis undertaken by the Health Funds Association comparing the costs of five common elective procedures performed in the public and private sectors shows in all but one procedure the surgery was cheaper when done in a public hospital. (Total knee replacements, total hip replacements, cataracts and angioplasties were cheaper in the public sector; coronary artery bypass graphs were cheaper done privately. Across the five procedures, private service costs were nearly 8% higher than for public services.)[26]

The higher costs of private health services have also been acknowledged by Treasury, which states in a 2002 report:

- *privately-financed health care is generally more expensive than publicly-financed care*
- *private insurers are likely to have higher overhead and administrative costs*[27]

International studies consistently show that administration costs of private health care are not only higher but *much* higher than in single-payer public systems, so the Government's policy of more private sector involvement undermines its aim to reduce administration costs.[28,29,30]

Additional administration costs are also incurred by DHBs, including the tasks of selecting appropriate providers, negotiating contracts, monitoring the contracts, and possibly settling any disputes between the contracting parties.[31]

The Minister points to increased elective surgery rates as a sign of the effectiveness of government policy. Around 8600 more procedures were performed in the 2009/10 financial year than in the previous year.[32] However, sizeable increases were actually forecast from 2007, when Labour Health Minister Pete Hodgson announced the roll-out of an additional

[23] Medical Training Board. *Foundations of Excellence: Building infrastructure for medical education and training*, Report of the Medical Training Board, Wellington, June 2009.

[24] Commission on the Resident Medical Officer Workforce. 2009. *Treating People Well: Report of the Director-General of Health's Commission on the Resident Medical Officer Workforce*. Wellington: Ministry of Health.

[25] Parliamentary question for written answer, No 4706 (2009)

[26] NZ Health Funds Association. *Elective procedures, performance and costs*. June 2003

[27] Treasury Report: Costs of Subsidising Private Health Insurance, 28 February 2002. Available at: www.treasury.govt.nz

[28] S Woolhandleret et al, "Costs of Health Care Administration in the United States and Canada" *New England Journal of Medicine*, Vol 349:768-775, 21 August 2003.

[29] I McCauley, "Private health insurance: still muddling through". *Agenda*, Vol 12, Number 2, 2005, pages 159-178

[30] S Ducket, T Jackson. "The new health insurance rebate: an inefficient way of assisting public hospitals. *Medical Journal of Australia*. 2000:172:439-444.

[31] T Ashton. "The benefits and risks of DHBs contracting out elective procedures to private providers," *NZ Medical Journal Digest*, Vol 123, No 1314, 12 May 2010.

[32] T Ryall, "Elective surgery numbers continue to rise". Media release, 30 August 2010.

$200 million funding package for elective services. They were expected to benefit an additional 10,000 patients a year up to the end of this year.[33]

Logically, more additional procedures would have been performed had there been greater commitment to providing them in the more cost-effective public sector.

To sum up, the growth of the private health sector is at the expense of the public sector and that growth is forming a vicious spiral. It will not only lead to further deterioration of the public sector but could also have dire consequences for the broader economy. As one commentator put it:

If we are concerned about the sustainability of health spending, we need to consider the level of total health spending in the economy. Rather than making the health system more sustainable as the population ages, increasing the share of private funding would open the lid to ever-increasing health expenditure because governments have little or no control over private spending. In the United States, where private funding accounts for more than 50 per cent of health expenditure, total health expenditure now accounts for 15 per cent of GDP compared with the OECD average of 8.8 per cent.[34]

[33] P Hodgson. “Roll out of extra money for elective procedures”. Media release, 29 January 2007.

[34] T. Ashton. “More debate needed on private provision”. *NZ Herald*, 10 May 2006.