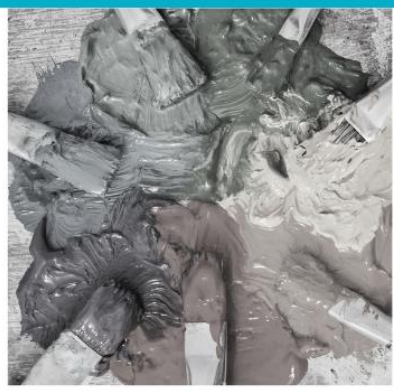
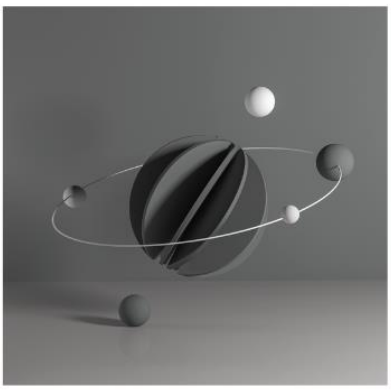
SECURING SUSTAINABLE GENERAL PRACTICE IN AOTEAROA

2024





GENERAL PRACTICE NZ

The Heart of Health Care Networks

General Practice New Zealand (GPNZ) would like to recognise the contribution of Sapere, and gratefully acknowledges the assistance freely provided by GPNZ members along with other key primary care sector experts in the creation of this document.

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Foreword

He hauora – he taonga: our health is our most precious thing.

This whakataukī guides the whakaaro presented in this document, alongside our strong commitment to Te Tiriti o Waitangi and to achieving pae ora/healthy futures through strong and sustainable primary care.

With a new coalition Government in place, and the focus of system reform now shifting to primary care, significant change is anticipated in 2024. The current challenges our sector face must be addressed with urgency if we are to avoid an increasing burden of ill health, a widening equity gap (particularly for whānau Māori) and the collapse of essential services.

In mid-2023 General Practice New Zealand (GPNZ) commissioned Sapere – well known for its work in the New Zealand health system. and specifically general practice – to undertake an independent analysis of the current general practice environment. The report produced by Sapere is published here at Section B. It was used as the basis for discussion within the GPNZ network and the development of a range of solutions we believe are essential to sustainable and thriving general practice and a world-leading health system that supports all people to live well in their communities. Details of the discussions, supplementing the solutions set out, are outlined in Section C.

We hope that decision-makers and funders will take the opportunity to work in partnership with primary care to act on them. Perhaps idealistically, instead of health being a political football we would also like to see an all-party approach to long-term actions that will stabilise and improve our health system for the benefit of Aotearoa.

Beyond stabilisation of core services, there is a wider goal – expanding and developing primary care to deliver fully on the promise of Pae Ora, combining timely and effective access to appropriate care when people need it with increased wellbeing and equity for all New Zealanders. Achieving this requires significant change to the current capitation model funding approaches, initiatives to expand, develop and value the primary care workforce, and support for technology as an enabler. It requires a level of sustained investment that has never been available to primary care providers under any government.

In the year ahead we need to see the emergence of a culture, operating model and funding framework that will strengthen primary and community care, with services planned around whānau and communities and a collective focus on illness prevention, health promotion and ensuring equitable access to timely, high-quality care and support.

In summary, we believe there are three critical issues that demand immediate attention:

- a continued focus on equitable health outcomes for all, in particular whānau Māori, Pacific and rural communities
- the stabilisation and recovery of general practice to play a vital role in emerging primary and community care networks, requiring substantial revision to the current capitation model along with dedicated investment in workforce and data development
- co-design of strong and stable network support functions building on the expertise and leadership in PHOs.

We look forward to working in partnership with Government, Manatū Hauora, Te Whatu Ora, Iwi Māori Partnership Boards and sector partners to support primary care to deliver its full potential for the population of Aotearoa. Now is the time for action.

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Executive summary

The biggest improvements in population health and the greatest value from health spending come from people having convenient access to high quality primary care, with international evidence indicating that for every $1 invested in primary care downstream savings of up to $13 are made.[1,2]

For context, around 2.5 million New Zealanders visit urgent care clinics each year, there are up to 20 million visits to general practices, and around 1 million visits to hospital emergency departments.[3] Ensuring that precious health resources are targeted where they can have the greatest impact for the most people, supporting affordable access to care, healthier lifestyles and reduced need for hospital services is essential for healthy whānau and a resilient system.

General practice sits at the heart of primary and community care, providing continuous, comprehensive, coordinated care that is shown to reduce the need for hospitalisations and urgent care and reduce mortality.[4] However, resourcing for general practice has simply not kept up with need and demand over successive years, leading to a desperate and growing situation in Aotearoa where people are increasingly unable to access the care they need when they need it. This impact is felt disproportionately on those people who need that support the most.

The stabilisation and recovery of general practice is essential, not only for improving equity, access and improved health outcomes for individuals and whānau, but for stability of the wider health system in Aotearoa. If general practice fails then the health system fails.[5]

The solutions for sustainable general practice – that will enable practices not just to recover, but to thrive – fall under a few key and interdependent themes: funding; complexity; models of care; rural general practice; workforce; integration; and primary care development and structures.

In essence, a long-awaited new funding model needs to recognise and address the significant and persistent issues of equity, workforce, rurality, deprivation and complexity. . Specific resourcing and support must be devoted to creating a stable, multi-disciplinary workforce that enables practices everywhere to meet the needs of the people they serve. At a system level, practices can be supported to thrive by future Primary Health Organisations, operating in an environment based on partnership and a shared focus on outcomes for whānau in partnership with Iwi Māori Partnership Boards.

[1] *We need more primary care physicians: Here's why and how*, available at https://www.brookings.edu/articles/we-need-more-primary-care-physicians-heres-why-and-how/
[2] Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory, available at https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-463
[3] *Te Pae Tata Interim New Zealand Health Plan 2022*, available at https://www.tewhatuora.govt.nz/whats-happening/what-to-expect/nz-health-plan/
[4] *Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway*, available at https://bjgp.org/content/72/715/e84
[5] *State of general practice in New Zealand*, available at https://journal.nzma.org.nz/journal-articles/state-of-general-practice-in-new-zealand

Commitment to Pae Ora and Te Tiriti o Waitangi

General Practice New Zealand and its PHO members are committed to Te Tiriti o Waitangi, and to supporting the Waitangi Tribunal Health Services and Outcomes Inquiry and all initiatives that further equity of health access and health outcomes for Māori.

Persistent inequity in health access, experience and outcomes is entrenched and persistent in Aotearoa for low-income groups, disabled persons, rural communities and, most particularly, for Māori and Pacific communities. A basic premise of the Pae Ora reforms is 'to achieve equity in health outcomes among New Zealand's population groups' yet additional funding to address disparities and prevent cost being a barrier to care has barely registered in general practice. Piecemeal and inadequate equity adjustments to funding and the current Very Low Cost Access funding model have not done nearly enough to address inequity, with consistently higher mortality rates and poorer health outcomes for Māori and Pacific people compared with people with a European background.[6]

We need an enduring commitment to funding that will address inequity based on the Wai 2575 conclusions. In line with the Te Tiriti o Waitangi principle of partnership, we need to co-design a new funding model based on the 2022 Sapere Review of capitation which includes a methodology for improving allocation of funding based on equity and need. This co-design should be done with Māori, for Māori.

We must recognise and uphold obligations to Māori as Tangata Whenua under Te Tiriti of Waitangi and ensure that partnership is embedded in every aspect of our healthcare system design, implementation and development. Every step taken towards improving the sustainability of general practice – funding, workforce development, model of care, systems, structures or technology – must be taken with equity at the forefront.

[6] *Mortality web tool*, available at *https://www.tewhatuora.govt.nz/our-health-system/data-and-statistics/mortality-web-tool/#:~:text=In%202021%2C%20there%20were%2034%2C997,times%20that%20of%20non%2DM%C4%81ori*.

SECTION A: SOLUTIONS FOR SUSTAINABLE GENERAL PRACTICE

Funding

Current analysis

Sapere's work for GPNZ and its review of capitation undertaken for Te Whatu Ora in 2022[7] set out the longstanding issues with a funding model designed around historic practice utilisation rates, alongside successive funding increases that have failed to match inflationary pressures. With 20 million general practice encounters a year, the consequences to the wider health system and to population wellbeing of continued neglect are catastrophic.

A growing number of practices are struggling to survive. In the absence of sufficient funding from Government, the alternative for many practices is to increase the fees their patients pay. This is a further barrier to access, creating a greater spiral of ill health and unmet need. Changes to general practice funding must protect against 'cost-shifting', with a robust formula that accounts for need alongside a revised approach to the annual statement of reasonable GP fee increases.

The latest New Zealand Health Survey published In December 2023 shows one in five adults – roughly one million people – can't get to see their general practice, with time taken to get an appointment as a barrier to accessing care almost doubling from 11.6 per cent to 21.2 per cent in just one year.[8] One third of practices have closed books.[9] The volume and complexity of work being undertaken in general practice continues to increase and half of GPs report that they are burnt-out – the highest number in any country surveyed.[10]

In addition, there are at least 300,000 New Zealanders unenrolled in general practice. Those unenrolled are likely missing out on vital screening and preventative care and living with unmanaged conditions.

Not only is general practice under pressure like never before, we are consistently failing to realise its potential to do more to promote wellbeing and prevent illness and hospitalisation. General practice can provide convenient and timely access to more procedures, point of care tests, and diagnostics if it is resourced and supported to do so.

[7] *A Future Capitation Funding Approach*, available at https://www.dpmc.govt.nz/sites/default/files/2022-11/HTU-future-capitation-funding-approach.pdf

[8] Annual Update of Key Results 2022/23: New Zealand Health Survey, available at https://www.health.govt.nz/publication/annual-update-key-results-2022-23-new-zealand-health-survey

[9] PHO Closed Books Stocktake Report 2022, available at https://gpnz.org.nz/publications/pho-closed-books-stocktake-report-2022/

[10] *Stressed Out and Burned Out: The Global Primary Care Crisis Findings from the 2022 International Health Policy Survey of Primary Care Physicians*, available at https://www.commonwealthfund.org/publications/issue-briefs/2022/nov/stressed-out-burned-out-2022-international-survey-primary-care-physicians

Solutions

Implement revised capitation funding model

Implementation of changes to the general practice funding model must begin without delay. A revised funding structure could be based on a core capitation contract (with appropriate recognition of complexity and allocation of funding to match need); some fee-for-service funding to drive uptake of targeted new initiatives and service improvements (flowing into the capitation formula once proven); and investment in ongoing improvement and change management.

Practice funding needs to take account of staffing, including physical space for workforce training and development and infrastructure costs such as IT development and security. Investment needs to be combined with the right incentives, flexibility and long term certainty in contracts.

Address historic underfunding

Although the inflationary trend is downwards, the next funding uplift (from July 1 2024) must address the historic underfunding and inflationary pressures on general practice (see Section B). The starting point for a significant uplift in funding should be the findings of Sapere's evidence-based review of capitation[11] which found that general practice was underfunded by 9 per cent on average, before adjustments for need.

Focus funding on equity

Recent equity adjuster allocations have been insignificant in addressing persistent and well recognised inequity, and a material shift is required in order to improve outcomes for Māori, as well as for Pacific peoples and other high needs populations.

[11] *A Future Capitation Funding Approach*, available at https://www.dpmc.govt.nz/sites/default/files/2022-11/HTU-future-capitation-funding-approach.pdf

Complexity

Current analysis

The increased complexity of illnesses, injuries and disabilities managed outside of hospital settings is a global trend, fuelled by an ageing population, increasing co-morbidities, new treatment options, and higher thresholds of acuity for access to secondary care ('unmet need'). Delays in planned hospital procedures since the COVID-19 pandemic has further exacerbated the pressure on practices.

However, that increased complexity and demand has not been matched by growth in human or financial resources, with primary care and general practice attracting proportionately less investment than the hospital sector for successive years. The situation is compounded by the outdated capitation formula which means practices with a large concentration of complexity face exponential stress on their finances and workforce.[12,13] Funding simply doesn't match need and the pressure of growing complexity and demand create a more difficult working environment that fuels burnout and attrition.[14] Consequently a growing number of practices facing an immediate threat to their viability.

While PHOs and general practices have the capability to offer a range of services outside of hospitals, including investigations, infusions and minor procedures, these are not commissioned and funded in a consistent and sustainable way around the needs of communities.

Solutions

Match funding to need

The long overdue changes to general practice funding must match resources to need, recognising inequity and all drivers of complexity. Funding should follow the patient, rather than being based around a standard 15-minute consultation, with a mechanism in place to the formula remains relevant.

The revised funding model needs to support coordinated and continuous care for people with more complex conditions, while incentivising health promotion and disease prevention initiatives. General practice teams need to be specifically resourced over and above capitation so they can respond and develop to meet local needs. This includes being supported to introduce new roles and embed multi-disciplinary teams and ways of working, such as flexible access to appointments.

[12] *A Future Capitation Funding Approach*, available at https://www.dpmc.govt.nz/sites/default/files/2022-11/HTU-future-capitation-funding-approach.pdf

[13] *Do general practice capitation fees account for concentrations of complexity? Available at* https://www.rnzcgp.org.nz/gpdocs/new-website/about-us/rec/RNZCGP_REC_Final_report.pdf

[14] *Stressed Out and Burned Out: The Global Primary Care Crisis Findings from the 2022 International Health Policy Survey of Primary Care Physicians*, available at https://www.commonwealthfund.org/publications/issue-briefs/2022/nov/stressed-out-burned-out-2022-international-survey-primary-care-physicians

Fund non-clinical time

Changes to general practice funding must take account of the increasing proportion of non-patient facing time, including administration, follow-ups, reporting, and multi-disciplinary team meetings. Technological innovation that can take reduce pressure on teams, including the role of Artificial Intelligence, needs urgent exploration, with funding for change management and safe and equitable adoption.

Invest in planned care outside hospitals

Transparent and organised development of more planned care services in primary and community settings needs to be supported with appropriate resources; that also includes consideration of patient co-payments for services now provided in general practice which historically have been provided in hospitals with no patient charge.

Models of care

Current analysis

Modern general practice is no longer served by traditional 15-minute consultations and a practice team of GPs and nurses. Models of care continue to evolve nationally and internationally and there is no one size fits all, rather broad principles of a flexible, team-based approach in an integrated primary and community environment, focused around the needs of whānau.

In Aotearoa the Health Care Home model of care is proven to improve access and outcomes through better management of urgent and unplanned care and systematic management of routine and preventative care. This makes best use of workforce and telehealth through proven methods such as triage to manage access for those who need it most. However, resourcing and support for model of care development has been piecemeal, with current initiatives mainly led by PHOs.

Solutions

Resource model of care change

Model of care development requires dedicated time and funding, including change management support and resourcing for workforce and service development, all of it guided by the needs and wants of the local community. There should be a systematic approach to iterating and improving solutions that have already been tested – such as the Health Care Home model – with consistent support and funding available to providers.

Invest in workforce development

Workforce development is an important component (see below) with investment in new roles, and development of a collaborative practice team environment where tasks can be undertaken by different health professionals. The rollout of Comprehensive Primary and Community Care Teams must be expedited, with ongoing resourcing assured in order to embed and sustain workforces that offer a wider range of care and support through general practice.

Create contracts with the right incentives

The funding and contracting environment must be flexible enough to enable providers to adapt and develop services according to need, while also having the necessary levers and outcome measures that support and encourage change and shared learning.

Support the role of PHOs

PHOs have an important role in leading and enabling model of care development at the practice level. They have a strong track record in delivering tailored and targeted services that are improving access, quality of care and outcomes for local populations, particularly for Māori and Pacific communities, and for people living with complex and long-term conditions. There are multiple examples of PHO-led and funded evidence-based programmes, including outreach services designed with the community, direct access to radiology, after hours solutions, telehealth options and integrated primary mental health services (see primary care development and structures section below).

Rural general practice

Current analysis

The pressures on services and constraints on access are even more accentuated in the rural sector and in some of our most high needs communities. Rural funding continues to underserve healthcare providers, creating barriers to delivering care in an agile and culturally safe manner and exacerbating the inequities that exist in many rural areas. To achieve equitable outcomes in our rural and isolated communities there must be recognition of the significant extra pressures faced.

It is imperative that we create comprehensive and sustainable rural primary health care solutions that incorporate access to safe and high-quality care including face to face, virtual, digital, urgent and afterhours care. Transport options must also be considered, using all options available including other providers such as St John.

Solutions

Agreed minimum set of services

All rural health providers should be brought up to an agreed minimum level, with national agreement on the core services to be provided in all rural communities, and support and resourcing to enable providers to reach that standard.

Increase digital capability

Increasing digital capability in rural communities is vital to allow timely and equitable access to healthcare, when physical services are often a considerable distance away. Investment in local digital technology and training is needed to ensure people can access care when they need it, regardless of location.

Add funding adjustment for seasonal pressures

The population of many rural communities multiplies exponentially during holiday periods, and funding for general practice and urgent care needs to be adjusted to account for the extra resource required to manage demand.

Scale successful models

There are well-established examples of integrated rural health care, notably the Aotea Health Great Barrier model and Golden Bay Health model that combine tino rangatiratanga with place-based care based around local population health needs. Evaluation of these models could provide the blueprint for services across Aotearoa.

Workforce

Current analysis

We are facing a major health workforce crisis, which has been predicted for a generation and is shared by many other health systems worldwide. Change is needed immediately and on multiple fronts to build a workforce that enables general practice to thrive. Compounded by the continuing impact of a global pandemic and wholescale system reform, with relentless pressure and too few resources, morale is low and burnout high.

Workforce shortages in general practice are exacerbated by the persistent lack of parity of pay and conditions with nurses and doctors employed in secondary care. All parts of the system are needed and should be equally valued. Higher rates of pay and advantageous terms and conditions currently available to Te Whatu Ora staff are a major disincentive to people choosing to work in primary and community care.

Solutions

Ensure parity of pay and conditions

Parity of pay and working conditions across the health sector are essential elements of a stable and thriving workforce. Expertise must be valued, irrespective of where in the system it is provided, with fair, equal and fully funded pay and conditions for people who work in primary and community care, consistently aligned with the secondary care workforce.

Parity of pay and terms and conditions for nurses employed in general practice and other primary care providers must be achieved through allocation of adequate funding in the next financial year, and then ongoing. The pay equity claim lodged by the New Zealand Nurses Organisation (NZNO) is one mechanism by which the pay differential can be addressed but resolution requires a revised funding model that adequately and fairly remunerates staff for the work they do.

Specialist General Practitioners should be valued with equivalent pay and conditions to Te Whatu Ora employed SMOs. A collaborative project should be undertaken in 2024, informed by data from The Royal New Zealand College of General Practitioners (RNZCGP), on the current gap between general practice and other specialities, with funding provided to address that gap in 2025.

Prioritise recruitment to roles in primary care

In the short term, the majority of workforce growth will need to come from internationally trained professionals. An ethical and coordinated international recruitment service needs to be available to the whole health system, with seamless pathways for suitably qualified clinicians into roles and registration in Aotearoa.

In parallel we need to focus on growing our own primary care professionals, starting with a national health workforce careers information and promotion service that encourages entry to diverse health workforce roles, through commissioning of training based on projected population health need, flexible entry points and pathways including recognition of ‘soft’ skills, greater exposure to primary and community care in all undergraduate and early

postgraduate training including PGY1/2 and NETP, and prioritisation of training placements in areas of greatest need.

Financial model that supports team development

The $102m Comprehensive Primary and Community Care (CPCT) team funding allocated in Budget 2022 needs to be rapidly distributed, and an ongoing commitment to funding for employment of a wider range of roles in general practice must be made.

Investment must be made in continued professional development of the primary care workforce through acquisition of additional skills, such as prescribing.

A revised capitation funding model for general practice needs to factor in funding for all the essential time involved in non-clinical work, including administration, professional development and team development.

PHOs have the potential to further develop their leadership and expertise in workforce development.

Make it easier to be a student

We need to maximise the support available to students in health care programmes, including reducing the financial burden, which too often means graduates leave New Zealand in search of higher salaries to help pay off student debt. Schemes like earn-as-you-learn and more bonding options need be explored.

Access to training for health careers can be made easier and more appealing through increased learning flexibility, modular pathway options, recognition of soft skills and prior learning and targeted programmes for students from rural, Māori and Pacific communities.

Integration

Current analysis

Connecting and integrating across the wider health system is vital if we are to deliver service improvement, but there is often little sense of 'one team' based around people and whānau, which is vital to underpin integrated care and support and deliver a better experience.

A perception of 'them and us' persists between hospital services and primary and community services with the relationship between Te Whatu Ora, as funder, and the funded sector typically one of master/servant rather than partner.

The disparity in pay and employment terms and conditions is an obvious example of a secondary/primary hierarchy and barrier to operating as one system.

The lack of a shared care record and persistent delays in accessing relevant patient information between different providers is a major barrier to integrated care, and at times a threat to patient safety, with transfer of patient records from one practice management system to another particularly difficult.

Solutions

Build a culture that focuses on trusted relationships and empowerment

At all levels of the system a culture must be developed that is based on trusted relationships and empowerment. That involves giving system collectives/networks the ability to identify priorities and then do the right thing in developing and delivering services, knowing that funding will follow good ideas.

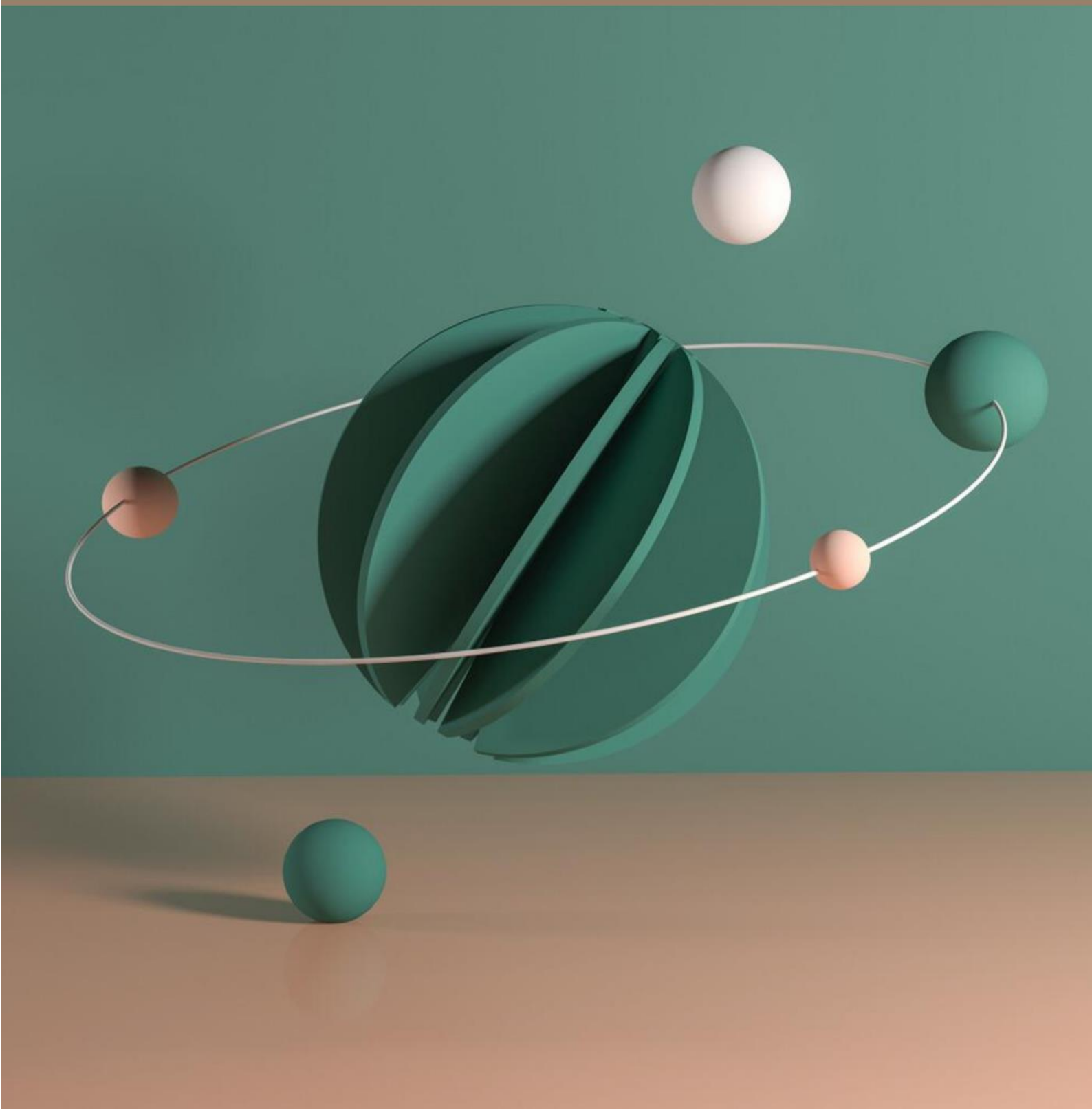
Invest in roles and mechanisms that enable connection

GP and primary care liaison roles are an important example of connector roles that should be protected and enhanced. Roles from former alliances such as neutral facilitators focusing on integration should be explored and developed.

Facilitate data and information sharing

The development of integrated IT systems must be prioritised to enable sharing of information across the system and with communities. A central information repository with appropriate oversight and access needs to be created. Access to real time data by providers across the system should be available to support delivery of care, drive change and monitor impact. Work to achieve that integrated system has been underway for many years, with specific projects such as Hira initiated by Te Whatu Ora. This work needs to be resourced with implementation/roll out of a standardised solution from 2024/25.

Primary care development and structures



Current analysis

Effective primary care is crucial for a well-functioning health system, but Aotearoa is decades behind where we could and should be. Primary care services are inequitable, underfunded and fragmented. Primary care should be embraced as an essential partner in an integrated health system – combining strong community and provider relationships and insights with innovative, solution-focused thinking and significant expertise in practical implementation.

There is a need for a clear focus on the future role of organisations that lead, develop and support effective primary and community care in the interest of local populations. Yet, four years on from the Health and Disability system review report[15] which cast doubt on the future of PHOs, that future remains uncertain.

Over those four years of reform and pandemic management, the work of PHOs and their value to the system, providers and communities has been increasingly recognised. There is now a clear acceptance there is an important role for primary and community 'meso level organisations', though their number, function and status is yet to be determined. PHOs themselves want to embrace a broader future and need to collaborate, using the best of what has been developed over past 20 years. There is a huge amount of expertise and leadership that needs to be retained, but change is required.

Solutions

Evolve and learn from current PHOs

There is a clear opportunity to build on the functions and capability of existing PHOs to create the mid-level organisations the health system needs to facilitate connection and coordination. Expectations of current PHOs need to be made clear by the Government, Manatū Hauora and commissioners. Commitment should be given to development of PHOs to provide support to local networks of primary and community providers.

Robust, honest and supportive conversations need to be progressed about variation and comparative strengths and weaknesses, followed by collective action to address inconsistencies, reduce duplication and explore consolidation and mergers.

An immediate priority is to build on existing infrastructure and expertise to co-create primary health organisations that drive population wellbeing. Regardless of future structures and accountabilities, the insights, functions, skills and leadership that sit within PHOs need to be preserved, enhanced and actively transitioned into the new system.

Codesign and embrace PHO V2.0

PHOs are ideally positioned to be the glue that binds the system horizontally and vertically - coordinating providers across primary and community care including general practice, maternity, early childhood and aged care, working taha ki te taha with Iwi Māori

[15] *Health and Disability System Review - Final Report*, available at https://www.health.govt.nz/publication/health-and-disability-system-review-final-report

Partnership Boards, iwi, hapū, and other community voices, and facilitating connection with secondary and specialist services.

These 'reimagined' PHOs, as the system glue, would work within a contractual framework that focuses on the needs and outcomes of the local population, brokering the needs of funders, providers and communities, supporting effective commissioning, and partnering in service design and delivery.

Key roles for the future primary health organisation could be:

- workforce development
- supporting the provision of consistent after hours and urgent care arrangements
- standards and performance monitoring
- clinical governance and quality
- providing data and digital leadership and support including provider capability and infrastructure development and cybersecurity; data standards
- tailoring, targeting and developing services based on data and relationships
- managing provider claims and payments
- listening and responding to whānau voice with intentional whānau and consumer engagement in decision making
- supporting and enabling innovation and change including new models of care, new workforces, service improvement
- supporting whānau-focused system integration including acting as the bridge between national and regional primary care policy, commissioning and local delivery
- holding excellent relationships with iwi and IMPBs
- supporting providers who have limited resources.

Summary of actions

WHAT	HOW	WHEN
Implement new general practice funding model	Implement findings of 2022 Sapere capitation review; complete 2024 Phase 2 review and implement changes, including significant uplift from next financial year.	From 1 July 2024
Address historic underfunding		
Focus funding on equity		
Match funding to need		
Fund non-clinical time		
Create financial model that supports team development		
Invest in planned care outside hospitals	Progress GPNZ 2023 proposals to Te Whatu Ora Extend and scale local POAC solutions	Scaled development from 1 July 2024
Resource model of care change	Build on existing expertise, with consistent national funding	From 1 July 2024
Invest in workforce development	Active involvement of primary care leaders in development of 2024/25 Te Whatu Ora workforce plan Revised capitation model for general practice	From 1 July 2024
Create contracts with the right incentives	New primary care contracting arrangements developed in partnership between Te Whatu Ora and sector representatives	From 1 July 2024 and ongoing
Agree minimum set of rural services	Te Whatu Ora/Manatū Hauora/Haoura Taiwhenua/GPNZ/PHOs	2024
Increase rural digital capability	Targeted investment in digital infrastructure and virtual health solutions	Ongoing
Rural funding adjustment for seasonal pressures	Investment plan to address seasonal changes in demand; standardised model to flex resources in times of unforeseen events	From 1 July 2024/25
Scale successful rural models	Immediate evaluation of existing initiatives with plan for wider adoption	From 2024
Ensure parity of pay and conditions	Costed and funded pay equity claim Revised capitation model for general practice	2024/25
Prioritise recruitment to roles in primary care	Implement national careers service 2024/25 Te Whatu Ora workforce plan	From 1 July 2024
Make it easier to be a student	2024/25 Te Whatu Ora workforce plan	From 1 July 2024
Build a culture focused on trusted relationships and empowerment	Application of Te Mauri o Rongo - NZ Health Charter - to whole of system	Ongoing

WHAT	HOW	WHEN
Invest in roles and mechanisms to enable connection	2024/25 Te Whatu Ora workforce plan	From 1 July 2024
Facilitate data and information sharing	Expedite progress on current initiatives, including Hira	Ongoing
Evolve and learn from current PHOs	Te Whatu Ora, Manatū Hauora, IMPBs and PHOs codesign of future meso level organisations	Phase 1 discussion paper complete April 2024
Codesign and embrace PHOs V2.0		

SECTION B: SUSTAINABLE GENERAL PRACTICE IN NEW ZEALAND - ANALYSIS

Introduction

With long-standing and growing concern about the future sustainability of general practice in Aotearoa, in early 2023 General Practice New Zealand (GPNZ) commissioned Sapere to complete a current state analysis, examining four key areas:

1. stresses on primary health care including general practitioner shortages, funding and other workforce issues
2. primary care not fulfilling its potential, and the challenges of equity and unmet need – what more could be done if settings were to change
3. risks if nothing is done to address pressures on practices
4. what is needed to increase the speed of modernisation of general practice.

The report (see below: *Sustainable General Practice in New Zealand*) summarised the key challenges, and concluded to successfully address the current pressures and realise general practice's potential to address inequalities and improve the health of the population a number of key elements required further exploration:

- the increased and growing complexity of the conditions that are managed in general practice, and the drivers for that
- the funding model and settings that promote or threaten financial sustainability
- the development of the primary care team
- organisational structures and business models
- workforce training and retention.

Sustainable general practice in New Zealand

Evidence for the challenges facing general practice and the opportunities for addressing sustainability

David Moore, Tom Love, Tammy Hambling, Rohan Trill

4 September 2023

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Appendices

Foreword

GPNZ has commissioned this work as a current state review of general practice. This review seeks to identify some of the key challenges that are having an impact across the current general practice and wider care landscape, and sets out some context from other parts of the world.

This report aims to be a resource in planning and development in the months ahead. As always, some of the findings here suggest that there is a need for further information and analysis, but they also summarise a number of key challenges that we know will have to be addressed if general practice in Aotearoa is to continue, and if general practice is to achieve the potential of primary health care to address inequalities and improve the health of the whole population.

This report is therefore a starting point for GPNZ and others to work towards a preferred approach to addressing these issues. We envisage that there will be subsequent work and analysis to support recommendations about how to address the issues we identify here.

Executive summary

This report provides a rapid analysis that addresses the case for the importance of sustainable general practice in New Zealand. We examine four key areas:

1. Stresses on primary health care including general practitioner shortages, funding and other workforce issues.
2. Primary care not fulfilling its potential and the challenges of equity and unmet need.
3. Risks if nothing is done to address pressures.
4. What is needed to achieve sustainable and effective primary care.

We conducted a wide range of interviews with stakeholders, as well as collecting data on general practice financial viability and workforce. We have reviewed an extensive amount of literature and set our findings in that context.

Summary: the overall picture is very challenging

Primary health care is facing serious challenges internationally, and New Zealand is clearly part of this broader trend. Primary care in many countries faces a combination of increasing complexity in demand for care, and a grave workforce shortage. These two key factors have a number of complex causes that underlie them but represent two significant challenges to the sustainability of primary care services in many jurisdictions.

The symptoms of these challenges manifest in several ways:

- **Increased inequity.** Pressures are greatest in general practices that serve high-need populations, which see the biggest challenges in recruitment and struggle most to respond to the need of their population. Practices with enrolled populations that have limited income, in the context of a cost-of-living crisis, have no option to increase patient co-payments, and limited other revenue options to enable them to meet demand. The decline in sustainability does not fall evenly across the system but has the greatest effect on those who have the most need and the fewest resources.
- **There is an increase in unmet need.** As greater complexity of need combines with an increasing population and static workforce numbers, the ability of general practice to respond to the level of need for its services in the community diminishes. This then has flow-on effects in terms of increased volumes of demand elsewhere in the health system, particularly for acute care in the forms of telehealth or emergency department services. Inability to respond to need on the part of general practice also has flow-on effects to other parts of the health system when general practice does not have the capacity to manage long-term conditions, or to manage conditions in the community while awaiting secondary care intervention.
- **Declining patient experience.** Measures of patient experience around access to care appear to be declining. This is consistent with the increased demand and lack of capacity

to respond to it. The ability to enrol with a practice, to see the clinicians of your choice, and to have an appointment in a timely manner are all declining.

- **Burnt-out workforce.** The impact of increased demand with limited capacity to respond is clearly resulting in a burnt-out workforce. This results in departures from primary care, and in turn redoubles the challenge of meeting demand for those who remain, resulting in a vicious circle of collapse.
- **Increased pressure on the whole system.** Primary care, of which general practice is a key component in Aotearoa, is a core part of health care. It has been clearly established both locally and internationally that primary care is an essential element of a well-functioning, effective health system. If primary care is not able to fulfil its promise, and meet the population need for its services, then the health system as a whole is in jeopardy and will struggle to be sustainable more generally. This is seen in a number of places around the world, perhaps most starkly in the United Kingdom, where a rapid decline in general practice capability is having severe knock-on effects across the UK NHS.

A key issue with the mismatch between need and general practice capacity to meet it is that it risks becoming a self-perpetuating spiral. Workforce pressure redoubles when parts of the workforce have to reduce hours or leave in order to cope with burnout. Change in staff can have significant costs in direct financial terms, with recruitment costs at high levels, especially for staff coming from overseas. As individual practices struggle to manage staff shortages, they also struggle financially, and these two effects risk a dangerous feedback loop. Losing sustainability in terms of the workforce is likely to be followed rapidly by losing sustainability in terms of financial viability, and a vicious circle then ensues.

The COVID-19 pandemic has been a source of strain for the health system overall, but the underlying challenges of increased complexity and a fragile workforce existed before COVID-19. Pandemic effects may have exacerbated pre-existing trends, and brought the acute phase of the challenge forward, but are not part of the fundamental problem. In some respects, the pandemic experience has been positive. It has accelerated the exploration of telehealth and alternative modes of service delivery, and it has demonstrated the ability of providers in some circumstances to reach out and engage with high-need populations, when suitably resourced and supported.

In order to address the challenge of sustainability in general practice, and to guide effective investment in order to increase capacity and respond to need, there are a number of key areas that we need to understand better. These are:

- **Drivers of complexity.** Ageing population is clearly an important issue, but there are other aspects that need to be understood if general practice is to be appropriately resourced to respond, including rapidly increasing need for mental health care, and rising prevalence of a number of diseases such as diabetes, as well as the pressures arising from technology, changing practice, and the increased ability to provide care for many conditions.
- **Financial sustainability drivers.** The sustainability of front-line general practice services in financial terms is often unclear, and a wider understanding of the drivers of financial sustainability will be needed in order to inform both the fair and reasonable allocation of

resources, but also debates about the organisational forms and business models that are best suited to managing these challenges.

- **The wider primary care team.** While there has been progress in developing broader primary care teams, there is a need to understand better the specific policy settings, including funding and business model settings, that are needed to support a more systematic development of the wider primary care team.
- **Organisational structures and business models.** The landscape of general practice ownership is changing and there is a need for a systematic review to inform debate about the future shape of general practice. Partnership still offers a career progression for some general practitioners but is not desired by others. Are there particular policy settings that should be adopted to recognise diverse business models, or to make models responsive to need?
- **Workforce training and retention.** There is existing work, but this could be built upon to improve our workforce training and retention. There are questions about the resources needed and the logistical elements of training, including the facility and supervision needs, that could be understood better. The factors that might improve retention and reduce burnout need to be explored, and factored into a discussion about funding and need.

Maintaining the sustainability of general practice is essential for the wider stability of the health system in Aotearoa. But beyond the goal of stabilising the current primary care sector, there lies the bigger goal of developing the sector so that it can deliver fully on its promise of providing effective, equitable care for all New Zealanders. A future-focussed approach will require progress to support general practice to engage more directly with determinants of health, to provide more planned care, and to enhance its capabilities on several fronts. Meeting this challenge is a complex task, but an urgent one, that will require clear focus and persistence if we are to address it successfully.

1. Purpose and approach

The purpose of this work is to provide a rapid analysis that addresses the case for the importance of sustainable general practice in New Zealand. We examine four key areas:

1. Stresses on primary health care including general practitioner shortages, funding and other workforce issues.
2. Primary care not fulfilling its potential, and the challenges of equity and unmet need – what more could be done if settings change.
3. Risks if nothing is done to address pressures.
4. What is needed to increase the speed of modernisation of general practice.

We undertook a desk-top review of existing material and information to produce a rapid, high-level picture of the issues in each of the four key areas above, including prior GPNZ analysis and including work that we have previously contributed to.

We then interviewed a purposeful sample of key stakeholders to identify the current state, key issues and possible solutions. Twenty-one interviews were conducted with 22 people. Informants included general practitioners, nurses and Physiotherapy New Zealand. Informants from the United Kingdom and Australia were interviewed to provide wider context to the issues being faced in New Zealand.

We asked for and received some summary financials from some general practices and, although this falls short of a full analysis, these results indicate some important issues for further exploration.

We received primary care workforce information from Te Whatu Ora.

2. Primary care is important for the health system, but faces issues

Primary health care is concerned with promoting an environment and society that supports good health. It is the first point of contact for most health services and includes general practitioners, nurse practitioners, dentists, pharmacists, midwives and other services based in the community. Individuals can directly access these services.

The fundamental premise of primary health care is that all people, everywhere, have the right to achieve the highest attainable level of health. Primary health care is a whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities. It has three components:

- Integrated health services to meet people's health needs throughout their lives.
- Addressing the broader determinants of health through multisectoral policy and action.
- Empowering individuals, families and communities to take charge of their own health.

Primary health care enables health systems to support a person's health needs – from health promotion to disease prevention, treatment, rehabilitation, palliative care and more. This ensures that health care is delivered in a way that is centred on people's needs and respects their preferences.

Primary health care is widely regarded as the most inclusive, equitable and cost-effective way to achieve universal health coverage. It is also key to strengthening the resilience of health systems to prepare for, respond to and recover from shocks and crises.

Primary health care in New Zealand is complex, and includes many different components, but has traditionally been founded in a strong general practice team with medical and nursing professionals (Kljakovic, 1998; Raymont et al., 2004).

It has been established for some decades that strong primary care can contribute to a more efficient, effective and equitable health system (Friedberg et al., 2010; Hochman & Asch, 2017; Starfield, 2009; Starfield et al., 2005). In effect, this body of evidence argues that effective primary care is key to achieving value-based health care – an approach that argues for the importance of thinking clearly about the nature of value in health services, and improving value in a way that delivers for patients by focussing upon team-based approaches and patient outcomes (Porter, 2010; White, 2015).

Equity

While New Zealand has traditionally had a strong primary care service in terms of core general practice, inequities in health outcomes persist. Researchers have documented inequities in the use of and access to primary care in New Zealand (Crengle et al., 2004; HURA, 2006; Raymont et al., 2004; Sheridan et al., 2023), and addressing the inequity in patient outcomes that can be addressed by primary health care has been a significant policy goal for many years. The Primary Health Care Strategy of 2001 was a substantial attempt to set a new direction for primary health care based upon the introduction of enrolment, the development of Primary Health Organisations (PHOs), team-based care and bulk capitation funding of government subsidies (King, 2001). Early evaluations of the impact

of the strategy found that while government investment had successfully reduced general practice patient co-payments for many patients (Cumming et al., 2008), there had been generally modest increases in utilisation, although some patients in Access practices with lower co-payments had seen greater increases in general practice utilisation (Cumming & Gribben, 2007). A more recent study of inequity in patient outcomes across a number of different practice models found that the underlying distribution of health need was more important than the specifics of particular models of care in terms of outcomes and equity (Sheridan et al., 2023).

Funding

There are a number of problems with Aotearoa's funding for primary care and general practice. Some of these issues were inherent in the original capitation formula that was implemented as part of the Primary Health Care Strategy, while others reflect alterations and adjustments over two subsequent decades.

To a large degree, policymakers have tended to view capitation funding as an averaged fee for service subsidy, and investment in capitation in funding takes the form of a buyout for patient co-payments. This has meant that new funding going to primary health care has often been a zero-sum game for a general practice, since reduced patient co-payments are expected to balance new government funding. If patient utilisation increases markedly, then this can potentially mean that new capitation funding will reduce practice income on a per patient basis. The consequence of this has been that while funding for general practice has increased over the two decades since capitation was introduced, there has been little investment in new services or workforces – capitation funding has largely been used to manage patient co-payment levels.

Since the original capitation formula was implemented in 2003 several changes have been made, while retaining the original basic formula for first contact general practice services. This has resulted in many ad hoc additions to the formula, resulting in an opaque, complex set of funding arrangements. The Ministry of Health website lists 12 different components and options for general practice core capitation funding. An individual PHO or (formerly) DHB will add further revenue lines, making for a complex and fragmented funding approach.

The current funding approach systematically underfunds services for Māori, by not recognising patterns of higher need and historical underutilisation by Māori (Love et al., 2021). Addressing the funding and responsiveness of general practice services to Māori health need will be an important (but far from the only) element of the Crown's response to the Waitangi Tribunal's recommendations for WAI 2575.

Overall, funding for general practice care is problematic for a number of reasons, but the core issue is that funding does not align with patient need. An obvious example is the use of a 65+ age-band for capitation purposes within which there is large variation in the impact of ageing and level of health need. This means that services that have a higher than average proportion of people with high health need are not funded adequately to deliver care to their patients. This is a serious deficiency in a core part of New Zealand's health system. Moreover, this builds inequity into the heart of general practice funding – those practices that serve the populations with the greatest health need are precisely those that will have the least funding in proportion to that need. The British GP Julian Tudor Hart coined the phrase "inverse-care law" in 1971 to describe the circumstance in which the availability of care is

inversely proportional to the need of the population being served (Hart, 1971). This effect has been observed in the underlying distribution of general practice funding in other jurisdictions (McLean et al., 2015), and is clearly the case in Aotearoa.

3. Current state of general practice in New Zealand

This section outlines the current state of general practice in New Zealand and the health, social and systemic determinants that have exacerbated the crisis. Our interviewees pointed to various factors contributing to the crisis, including the ageing population, greater patient complexity, increased administrative time, COVID-19, workforce constraints, pay disparities, funding and policy settings.

3.1 An ageing population is having a marked impact

An ageing population has consequences to health systems through increased complexity and utilisation of services. According to Statistics NZ, 16.4% of New Zealanders were over 65 in 2022 comparing to 13.7% in 2012 (Statistics NZ, 2022). This proportion is expected to reach 20.4% in 2032. This change in demographics highlights the importance of efficiently allocating healthcare resources and was consistently raised in our interviews.

> There is significant value of primary care to the aged sector. Older patients have higher need, dependency and utilisation of doctors and nurses. We need to provide sensible, low-cost care and rationalise the need for secondary services.

> General practice is not serving equally regionally. There is also a lack of consistency and understanding around what is needed for older people. Unless there is significant change to the workforce, our hospitals will become more and more overwhelmed.

Furthermore, a geriatrician argued that short consultation times are now insufficient in dealing with multiple diseases and cognitive impairment for older patients.

> A main issue in healthcare is that it is single diseased based. 15 minute consultations are not sufficient to manage multiple diseases. The model also relies on patients initiating care themselves, which is troublesome for older patients with undetected cognitive impairment. We need a more comprehensive model for older patients who are typically unaware of underlying conditions.

3.2 Complexity is relentlessly increasing

The issues around complexity were commonly discussed in interviews. A report from the New Zealand Infrastructure Commission (2021) found increasing rates of complexity for illnesses, injuries and disabilities. The key finding was a need to implement new standards and better long-term planning to allow modern care practices to handle future demand. The relationship between poverty and adverse health outcomes also means that low-income localities experience disproportionate complexity in primary care. The Workforce Crisis Survey (2022) identified the following issues for clinicians:

- Clinical risk arising from high clinical load and insufficient time to safely manage complex problems.
- Pressure on staff from increased patient complexity and a rise in demand for appointments (from deferred care at both primary and secondary level). This includes repeated

appointments for unresolved issues after referred patients have been declined by secondary care.

- Clinical paperwork and administration demands are increasing exponentially; this typically does not generate income and is therefore done unpaid and in a clinician's own time.
- New activity and expectations are created that place a burden on primary care, for example test follow-up or other activity generated from a secondary care setting.

Interviews with clinicians have demonstrated how health services are under capacity and unable to cope with the increasing prevalence of multimorbidity:

> When [General Practice] is allowed to do what it does well, it does it very well, but it's grossly under capacity. Its mindset is still lagging behind the reality of what the world's like. Particularly in terms of the complexity of medical care, and the complexity of multimorbidity.
>
> South Auckland has a lot of low-income migrants. The workforce can't handle the complexity of needs of those of lower socioeconomic status.
>
> Closed books are an issue for our community as we take the complex patients that people don't want. Quality of care is a risk and there are times where we as clinicians don't feel safe. We are constantly burnt out and there is stress to our own mental wellbeing.

The COVID-19 pandemic has worsened mental health across the population. A 2021 study found abnormal rates of depressions and anxiety during its peak in 2020 (Gasteiger et al., 2021), and the lasting effects of poor mental health have not been adequately managed by our health services.

> Complexity has increased following the pandemic. We are observing significantly more mental health issues, longer waiting lists, and the cost of living has driven adverse health outcomes.
>
> We are observing a lack of meaningful mental health support. We have enough people to prescribe, but need more people to talk.

3.3 Non-clinical/administrative time is increasing

There is consensus among practitioners that the proportion of administrative work in relation to direct patient time is increasing. There is an increasing workload of emails and paperwork that GPs are having to undertake in their own time in the evenings, weekends and holidays (McGinn, 2023). Many of our interviewees highlighted this issue in their own experience:

> They say you need 3.5 hours for clinical and 0.5 hours for paperwork, but we looked and it is more 50/50. There is 8 hours' worth of mundane paperwork for every 1,000 patients. This could easily be outsourced.
>
> Pressure is accelerating. I did GP training in 2007 and I have counted hours and it was increasing by 1–1.5 hours a day each year. So that is why people drop sessions… Paperwork should be done within the job like in a DHB it is allowed for but not a for a GP.
>
> There is significant non-patient contact time (admin) which contributes to burnout of GPs and makes the career appear less attractive if administration work is a large expectation.

3.4 COVID-19 has exacerbated the challenges

As well as affecting patients and the wider community, COVID-19 has exacerbated workforce issues. According to the 2022 International Health Policy Survey of Primary Care Physicians (Gunja et al., 2022), 85% of primary care physicians said their workload had "increased somewhat" or "increased a lot" since the pandemic. Similar themes were found in our interviews.

> COVID funding highlighted discomfort for many people. It created different permissions and imperatives. Lots of colleagues do not want to go back to in-person consultations. More money has been put into this virtual system.

> We do stuff and no one recognises the value. COVID took a lot out of people and there are factors such as stress that are hard to quantify. Part of the crisis is that the workforce is not in good shape to take on what it is challenged to do.

3.5 There are serious workforce shortages

A report commissioned by The Royal New Zealand College of General Practitioners (Foley et al., 2021) projected that the number of GPs per 100,000 New Zealanders will fall from 74 in 2021 to 71 in 2031. Furthermore, the Workforce Crisis (McGinn, 2022) identified the following issues arising from workforce shortages in primary care:

- Long-term vacancies for all practice roles (GPs, practice nurses, reception staff).
- Difficulty for small practices of managing cover for sickness and leave, especially rural practices.
- Currently a job seekers market; the rates required for staff retention are not sustainable from a business continuity point of view (as it is impossible to raise fees to generate enough income).
- Difficulties attracting new graduates to general practice (lack of pay parity, devaluing of role, unsustainable model).
- Restrictions and rules from Immigration and the Medical Council of New Zealand (MCNZ) are impacting on the ability to have international medical graduates fill the vacancies.
- Unacceptably long waits for GP appointments with up to six weeks being common.
- General practitioners are retiring early as they are burned out from excessive workload or are restricting their practice to existing patients, not new patients.
- General practitioners leaving their practices to retrain in other specialties or leaving medicine altogether long before retirement age.

Many of the clinicians in our interviews identified these issues and reiterated that workforce shortages are continually affecting general practice and the wider community.

> The workforce is a disaster. The number of doctors … has dropped and is continuing to drop. Workforce capacity has diminished at the same time patient utilisation and complexity has increased. There are too many expectations of GPs without the appropriate resources.

> We have been in dire straits because of workforce shortages. One of our GPs died working incredibly hard and passed in his 50s. He was going to be our clinical leader,

> managing our clinical community. The person who has recently come in doesn't really get the context.
>
> The workforce is the biggest current challenge in general practice. Although the UK government emphasize that thousands of GPs are in training, the net amount is continually decreasing.

The survey also highlights an ageing workforce and states that 55% of current GPs will retire by 2032. In addition, workforce preferences are changing as people prefer flexibility from working part-time.

> A large portion of our GPs will retire in the next few years. The retiring workforce is also not helped by the fact that working preferences are changing. Many GPs prefer to work part-time which creates significant access problems.

Rural areas have been disproportionately affected by workforce shortages.

> Rural practices are continually relying on locums, and a lot of locum GPs are medical graduates coming and going. This turnover is quite prevalent, and a lack of access in rural communities hurts those of lower socioeconomic status the most.

3.6 Pay disparities are an issue for many

Our interviews highlighted issues around pay disparities in general practice for both general practitioners and nurses.

> Pay discrepancies between medical professions highly disincentivises entry into general practice. Another issue is that principals in general practices are earning less than employees as they need their employees to provide the service. Principals are accepting less just to keep employees onboard.
>
> Nurses are underpaid in primary care. Aged residential care is most affected, and hospitals have struggled to get nurses back into wards. This is also not helped by vaccination work as it pays too high and disincentivises other areas.
>
> There is no pay parity [for practice nurses] we are getting at least $10/hour less [than other nurses].

The 2021 GP Future Workforce Requirements Report (Grimmond, D. et al., 2021) found pay equity issues relating to the 25% pay penalty registrars experience when choosing to train in general practice. There is a significant disparity in remuneration between GP registrars and other specialty registrars in hospital-based training settings. The difference is between $90,000 versus $120,000, causing a significant disincentive in attracting registrars to choose general practice as a career path.

The responsibilities of nurses in primary care have increased in the last decade to address the workforce constraints in general practice. Pay increases have not followed, meaning primary care nurses are earning approximately 10% less than their hospital counterparts (Meier, 2023). When increases to the practice nurse MECA were finally negotiated in 2023, further rincreases were provided for hospital nurses, so disparities remain substantial.

The New Zealand Nurses Organisation Survey (2023) found the following.

- One third of registered nurses in general practice were currently paid minimum rates between 22% and 27% ($5.77 and $9.68 per hour) less than their Te Whatu Ora colleagues.
- On average, general practice nurses were paid 14–21% (between $5.14 and $7.88) less per hour than their Te Whatu Ora counterparts.
- 3% were paid higher than their Te Whatu Ora counterparts (noting that Te What Ora salary increases have since been agreed).
- Registered nurses were paid up to $9.68 (27%) less per hour and enrolled nurses up to $6.75 (26%) less per hour.
- Nurse prescribers and nurse managers were also paid less than an equivalent Te Whatu Ora nurse on average.
- While increases have been negotiated to the practice nurse MECA, there remain substantial disparities with hospital nurse income (Garcia, 2022).

3.7 Fragmented funding isn't working

A fragmented wider health system and a shift to more complex care in the community has changed policy initiatives and funding settings. Access to surgery has worsened, with an additional 2,500 people waiting longer than four months for surgery in October of last year compared to May (Gauld, 2023). Furthermore, there has been increasing pressure on emergency departments and demand for ambulances. The amount of 'ramping' time (the extra time ambulance crew spend waiting for patients to be admitted) has more than tripled since 2019 (Hill, 2023). Reduced access to hospital services has resulted in an increase in primary care activity, as the government has enabled more care to be provided in primary settings to free up inpatient hospital beds (Pearse, 2023). This relieves pressure in hospitals but simultaneously increases pressure on primary care.

Our interviewees reiterated the importance of cost-effectiveness in general practice, and a system that is ineffective in responding to data that highlights areas to fund and prioritise.

> General practice is the heart of primary care. International evidence demonstrates sustainability of health and care systems. Cost-effectiveness is determined by the strength of the primary care component. There is a clear relationship between cost-effectiveness and health outcomes related to primary care staff and the availability of services.
>
> There is a fundamental disconnect in primary care where we don't respect analysis. We have observed a catastrophic drop in immunisation rates and the PHOs don't respond to data.

Previous analysis of general practice funding has relied heavily on counting the volume of consultations with a general practitioner. This tends to emphasise the role of the GP at the expense of the wider practice team, and to underestimate the time needed for high-need patients at the complex end of the range (Love et al., 2021). Dr James Peckett, a clinical adviser for the Western Bay of Plenty Public Health Organisation, outlined the current funding constraints in a recent interview (Garcia, 2022):

> General practices are pretty much private businesses that are subsidised through the Ministry of Health. Because of that, we are constrained as to how much we can charge, and we still need to pay our staff at market rates. A really hard thing for us is we are

competing with Te Whatu Ora and the nurses in the hospital who get paid more, and we find that's very unfair because primary care nurses are of the same value. The Government only allowed general practices to increase fees by 2.38% in 2022, a number which did not cover increasing costs due to inflation. We can't run at a loss. We've had to close our books. We reduce the number of hours we are open. We no longer provide after-hours services and we have increased pay to retain our employees.

4. Financial and workforce current state

Having addressed issues of complexity, and consequences of not getting general practice right, we now turn to issues of financial and workforce sustainability.

4.1 Financial surplus and service stability

It is fundamental that a general practice, as an independent entity, should have a net financial operating surplus unless it is supported by additional external sources, e.g. as part of an NGO service network. Most independent general practices are not in a position to sustain a financial loss for more than a short period of time, which means that a decreasing surplus is highly likely to lead to a reduced service offering, as staff salaries and other expenses are cut back.

Where a practice is independently owned by clinicians, owner operators will need to be able both to pay themselves for their clinical work, and to see a return on any capital investment they have made in the practice. Where owner operators are unable to achieve these goals, the incentives for ownership become weakened, and the consequence may be that services close, they are propped up by an external support (such as a Primary Health Organisation, community trust or, historically, District Health Board), or a corporate owner may purchase the practice and try to achieve operational efficiencies.

The range and degree of profitability across privately owned general practices is not generally known – public figures are not typically available – but the ability to make an operational surplus is an important prerequisite for a viable practice. Anecdotally there exists a wide range of profitability, although the ability to make a surplus is likely to be heavily influenced by fundamentals such as the ability to charge co-payments from the enrolled population. Increasing complexity, if it results in increased demand on clinical time resources, may affect the ability to make a surplus if more staff time is needed to meet patient needs. Other pressures may also reduce a surplus, for example recruitment costs if there is staff turnover.

This project does not aim to achieve a general understanding of the financial viability of general practice across Aotearoa, which would be a substantial piece of work. However, we aim to provide a starting point for a more in-depth analysis of this issue, which is central to the sustainable provision of general practice services in the future.

4.2 Downward trends in financial performance post COVID-19

We have not attempted to conduct a detailed analysis of practice financial pressures and sustainability. We have, however, been provided with information on profitability from a small number of general practices. The findings from this information are only intended to be indicative, but tend to underline the need for a comprehensive analysis in order to understand current financial sustainability trends.

We were provided with information from four practices. The graph below shows a rolling average in monthly profitability per enrolled patient for four practices over a 14-month period. Profitability was high, and likely artificially high, in early 2022 as practices were funded for COVID-19 related activity. As that activity dropped markedly over 2022, the practice profitability has declined. For the practices described in Series 3 and Series 4 there has been a general decline from the early 2022 level, but this appears to be approximately stable at the level of around $8 or $9 per patient. Series 1 is a little volatile but appears to be stabilising around the level of around $5 per patient, while the practice depicted in Series 2 has seen negative surpluses, but appears to be trending back towards break even.

These practices report that they have faced an increase in computer support fees as well as advertising costs due to job vacancies, which have driven up costs and therefore lowered net income. Furthermore, practices are facing additional recruitment costs and reduced income due to GP turnover inefficiencies. While anecdotal, this illustrates how the wider workforce shortage can be a cause of direct cost to practices, and how workforce instability can reduce financial sustainability as well as clinical sustainability.

Figure 1: Surplus per patient – recent trends

While this data is based on a small number of practices, and can only be indicative, it suggests several important points:

- COVID-19 funding did bring higher profitability, at least for some practices, but the impact of that waned over the course of 2022. It is likely that practices have returned to their underlying financial sustainability levels.
- While a small sample, this group of practices illustrates the range of surplus seen across practices – these four practices work as part of an organisation managing a number of practices and have the same access to management support. The underlying profitability clearly varies substantially across them. This underlines the point that it is important to be

careful about generalising about practice profitability – there is clearly a range, and some practices are much closer to the edge than others.

- The overall financial sustainability of general practice services is related, in complex ways, to the challenges faced in maintaining the clinical workforce.

This data clearly doesn't provide a comprehensive answer to the many questions that can be asked about the underlying financial viability of New Zealand's general practices. But it is a starting point for considering a comprehensive analysis that identifies and addresses key questions about the factors that support or imperil the basic financial viability of general practice services.

4.3 Trends in workforce data

The government has recently released a Health Workforce Plan for 2023/24. This is a short-term focus upon the immediate challenges in the health workforce, that sits within a longer-term view of workforce development. The six action areas of the plan are:

- Growing pathways for Māori in health.
- Growing pathways for Pacific peoples in health.
- Driving local led innovation in training.
- Bolstering priority workforce groups.
- Supporting and retaining our valued workforce.
- Growing our future leaders.

The plan explicitly proposes scaled up training for rural generalists and general practice.

Workforce data illustrating current key trends on flow into and out of the primary care workforce were provided by Te Whatu Ora.

4.3.1 General practitioners

Table 1 describes the annual profile of new GPs in New Zealand in terms of place of training. This is sorted into NZ-trained and International Medical Graduates (IMGs) that have entered the workforce in the last five years. The self-sufficiency rate is the proportion of new GPs that have been trained in NZ, and Lawrenson (2023) highlights that New Zealand has the highest dependency on overseas-trained doctors in the OECD.

Table 1: Annual number of new NZ-trained and International Medical Graduate GPs

Year	Total GPs	NZ-trained	IMG	Self-sufficiency rate
2018	160	93	62	58%
2019	149	77	62	52%
2020	161	90	71	56%
2021	176	114	72	65%
2022	154	92	67	60%

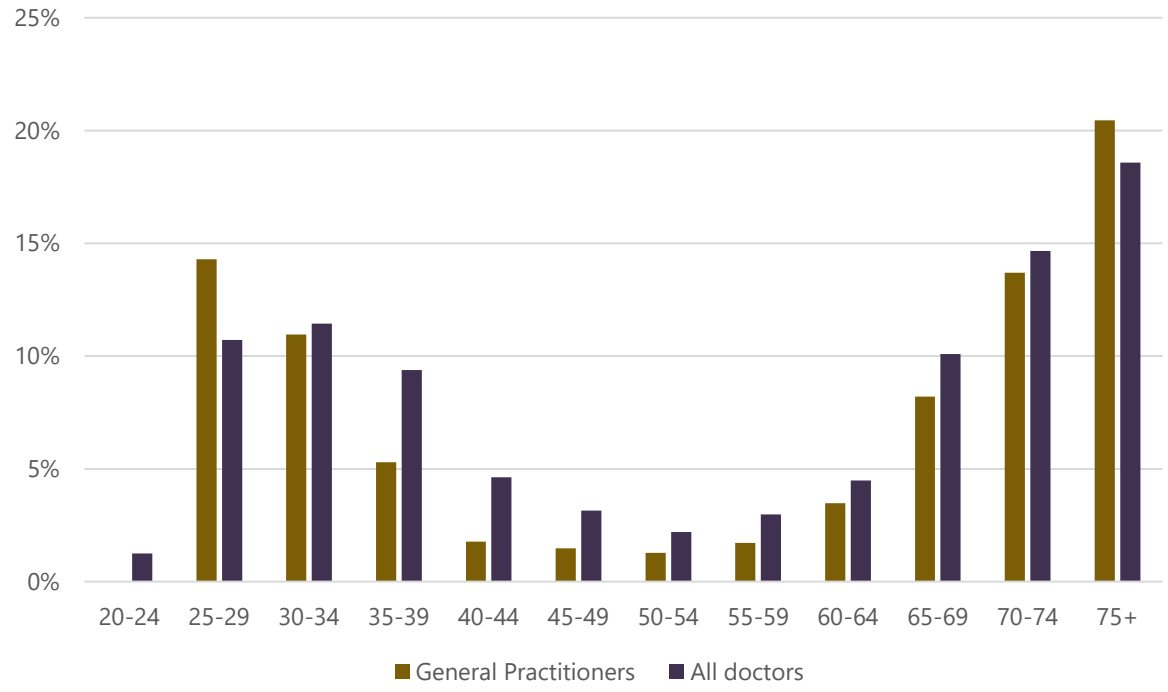
The increasing self-sufficiency rate in 2021 and 2022 may seem to be a good thing, but in the context of an overall workforce shortage, it reflects a falling number of international graduates coming to support the domestic workforce. The overall number of new GPs is a little volatile from year to year, but doesn't seem to be showing a trend.

General practitioner exit rate – getting older and leaving early

Figure 2 compares the age distribution of general practitioners and all doctors exiting the vocation from 2013 to 2021. This shows an interesting relationship between age and workforce exit, since the rate is high for younger GPs with a gradual decline until the middle age groups, and then an increasing rate throughout the older ages.

High exit rates are expected for older GPs due to retirement, but exit rates for younger GPs could be due to several factors. Many young GPs head overseas due to the financial incentives (Mcilraith, 2022), while younger GPs are more likely to face parenthood effects and thus more likely to exit the workforce during child-raising years. The exit rate for all doctors is higher for all age groups except the youngest and oldest categories.

Figure 2: Medical exit rate



General practitioner age profile

Table 2 presents the age distribution of GPs in New Zealand over the last five years, sorted into younger (30-44), middle-aged (45-59) and older (60+) age groups. While the total number of GPs has increased, there have been significant shifts in the age distribution. The proportion of younger and older GPs has strictly increased over the last five years, while the proportion of middle-aged GPs has strictly decreased. As outlined in section 5.2.3, a higher proportion of GPs in the younger and older age groups has implications for capacity. Younger GPs are more likely to work part-time due to

parenthood effects, therefore a higher number of GPs overall does not necessarily mean greater workforce capacity and greater nationwide access to primary care.

Table 2: Annual age profile of GPs

Year	Younger (30-44)	Middle-aged (45-59)	Older (60+)	Total
2018	19.8%	48.4%	31.7%	3,610
2019	20.6%	45%	34.4%	3,671
2020	21.5%	42.6%	35.9%	3,746
2021	23.1%	39.6%	37.2%	3,835
2022	23.7%	38.5%	37.8%	3,843

4.3.2 Primary care nurses

Table 3: Annual number of new NZ-trained and IMG primary care nurses

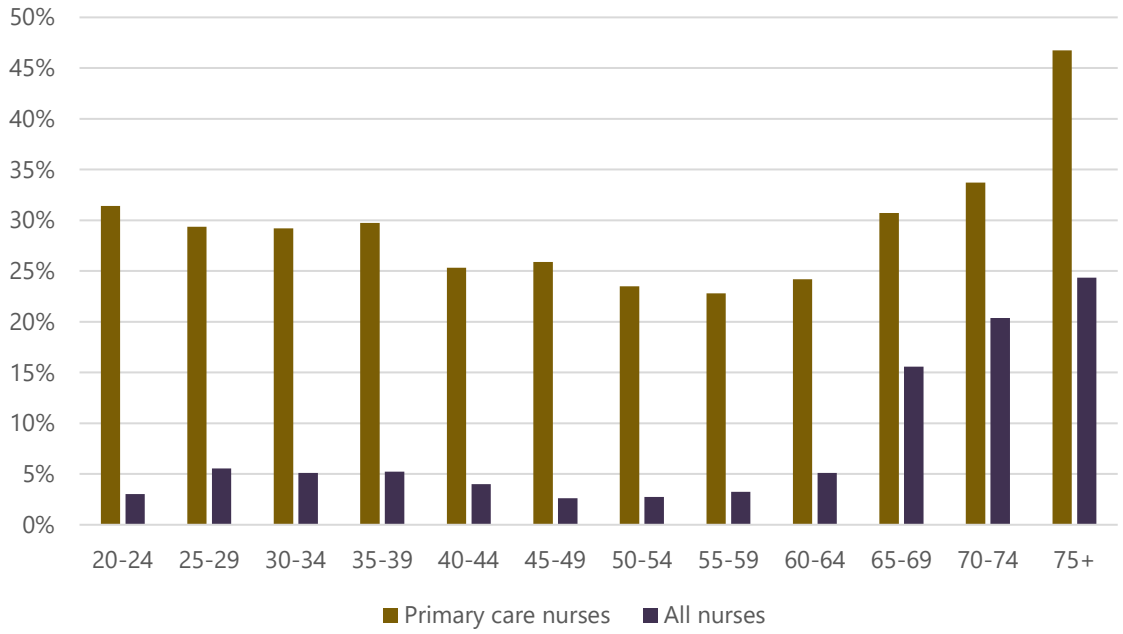
Year	Total nurses	NZ-trained	IMG	Self-sufficiency rate
2018	299	209	90	70%
2019	340	221	119	65%
2020	383	250	133	65%
2021	369	249	120	67%
2022	520	298	222	57%

Table 3 describes the annual profile of new primary care nurses in New Zealand. The self-sufficiency rate has declined in the last five years, implying that we are increasingly relying on international primary care nurses to cater for workforce shortages. This suggests that while domestically trained nurses have increased, there is a still a need for further increases in training numbers.

Primary care nurse exit rate

Figure 3 compares the age distribution of primary care nurses and all nurses exiting the vocation from 2013 to 2021.

Figure 3: Nurse exit rate



The extreme difference in the exit rate reflects the proportion of primary care nurses who leave primary care, and nursing overall, compared to overall rates of departure from the nursing profession. Nursing exit rates in primary care are much higher than medical exit rates.

5. Risks and consequences of not addressing the pressures

This section describes the risk and consequences of not addressing the pressures in general practice identified above. The risks include barriers to access, unmet need, inequities not being addressed, a lack of continuity of care compromising health outcomes, reduced quality of care and poorer patient experience, workforce stress and dissatisfaction, and increasing burden on secondary care.

Themes from the interviews indicate that these consequences are real and significant. These views are supported by wider literature.

> There are many consequences associated with a deteriorating primary health care system. Quality of care will reduce, patients will take longer to recover, and we will experience overall poorer health outcomes, especially for older populations and those of lower socioeconomic status.

In a 2022 Workforce Crisis Survey (McGinn, 2022) respondents identified multiple risks because of the workforce crisis including delayed diagnoses, medical errors, inability to staff workplaces, deferred care leading to patient health declines and poorer outcomes, loss of continuity of care, patient dissatisfaction, poor job satisfaction.

5.1 Barriers to access are creating unmet need

Barriers to access such as practices with closed books, waiting times for appointments and costs (e.g. appointment, prescription, transport) are creating unmet need, with this particularly evident in some regions and for some population groups.

Data published by Te Whatu Ora (2023) show that the percentage of Māori estimated to be enrolled with a PHO (83%) is lower compared to other ethnicities (Pacific peoples 94% and other ethnicities 98%), though still a significant majority of the overall Māori population.

Table 4: Estimated percentage of the total population enrolled with a PHO by ethnicity, at April 2023

	Māori	Pacific peoples	Other	Total
Number	747,738	350,035	3,773,984	4,871,757
Percentage	83%	94%	98%	95%

A stocktake of 853 general practices by General Practice New Zealand (2022) in 2022 found that :

- 34% of general practices were closed to new enrolments, an increase of 25% from June 2021. Areas most affected were Marlborough, Northland and Taranaki, with PHOs in those areas reporting more than 50% of practices having closed books.
- 220 practices reported information on strategies being implemented to maximise patient access, including widespread use of telehealth, GP and nurse phone triage and remote computer access for offsite virtual health care, as well as some practices extending opening hours and offering set times for walk-in clinics.

Interviewees also reflected on the increase in barriers to patients accessing care.

> Patients are being recommended to stay with their current doctor in Auckland even if they have moved elsewhere in the North Island and they have to travel back for an appointment.
>
> We are still seeing a growing divide in rural and provincial issues. In Ashburton it is one GP to 3,000 patients and they also have a large unenrolled population…we will see a big shift in inequity with those with means being able to access care while others will struggle.

New Zealand's level of health loss from all causes (adjusted for population size and age structure) is similar to that of most peer group countries (Te Tahu Hauora, 2021) (see page 34 for the list of peer group countries).

5.2 Inequities are not being addressed

A study by Jeffreys et al. (2022) evaluated inequities in the prevalence and consequences of barriers that children can in seeing a general practitioner in New Zealand. Factors associated with barriers included cost, inability to get an appointment, being after hours, no transport, unable to spare the time, and unable to get in touch with the GP. Overall, 4.7% of children experienced barriers to seeing a GP at age 12–24 months and 5.5% at age 42–54 months. Barriers were higher for Māori (OR: 2.92, 95%CI: 1.60 to 5.30) and Pacific (OR 2.01, 95%CI: 0.92 to 4.37) children compared to European children. Facing barriers at age 12–24 months for Māori and Pacific children was associated with a higher hospitalisation rate from various illness at 42–54 months.

> Rural inequities are aligned to the Māori population. Our current model of care works okay for those who are wealthy.
>
> Māori providers and PHOs cannot service the needs of all Māori people. They do not have the infrastructure or breadth. We need to develop partnerships.
>
> There are issues of power dynamics in primary care. We need to address institutional issues as well as racism and bias from frontline providers.

A very recent comprehensive literature review identifies five principles for developing primary care services that will be effective in addressing equity issues (Gkiouleka et al., 2023):

- Involving coordinated services across the system (i.e., connected).
- Accounting for differences within patient groups (i.e., intersectional).
- Making allowances for different patient needs and preferences (i.e., flexible).
- Integrating patient worldviews and cultural references (i.e., inclusive).
- Engaging communities with service design and delivery (i.e., community-centred).

5.3 A lack of continuity of care is compromising health outcomes for complex patients

Common themes from the interviews were the demand for more complex care in the community, the growing number of patients with multiple diagnoses and the impact that a lack of continuity of care has, particularly for these complex patients.

> Continuity is compromised under corporatisation. We had a receptionist who was randomly putting patients with any doctor, and by the end of two weeks all our doctors were crying after they had figured out what was happening. So we thought what would happen if we did it the other way around so only acute could see any doctor and others all to go to own doctor even if they had to wait a few days. In 3 months there was a big improvement in doctors mental state and it took 3–4 years to get into that properly. Think it has also helped with frequent flyers but they are ageing at the same time so hard to tell.

> Capitation needs to reward continuity as it is king. There should be a bonus for seeing your own patient and that would take a lot of complexity out. It would also be better for reducing the number of appointment and better than using a Nurse Practitioner.

> There is a need for greater governance in local communities. We can achieve better outcomes through increased efficiency rather than increasing numbers. The strength of general practice is continuity and family care. Without them the premise of general practice is lost.

> We're in danger of specialising and fragmenting when we know generalist practice is the go and we need people to move and morph to the role. Making sure have range and don't fragment and have too many bodies involved. We need to keep eye on generalism. As a patient you don't want more than say six people involved in care—district nurse, GP, care worker…etc. don't need more than a handful.

There is an extensive body of literature supporting this. For instance a 17-year prospective cohort study conducted in the Netherlands (Maarsingh et al., 2016) found that low continuity of care in general practice is associated with a higher risk of mortality. Similarly, a Canadian longitudinal cohort study (Smithman et al., 2022) found that attachment to a family physician through centralised waiting lists improved access to continuity of primary care, leading to increased primary care utilisation and concentration of care at the physician and practice level. A recent analysis of outcomes in New Zealand general practice found that, after controlling for other variables, new enrolment with a general practice within the previous 12 months was associated with poorer health outcomes (Sheridan et al., 2023).

In a systematic review and thematic synthesis of qualitative studies by Damarell et al., (2020), which explored experiences of GPs managing patients with multimorbidity, several challenges were identified. These included practising without supportive evidence, a fragmented health care system focused on single condition care and specialisation, and the clinical uncertainty associated with multimorbidity complexity and GP perceptions of decisional risk. To address these challenges, GPs employed strategies such as prioritising patient-centredness, individualising care based on patient preferences, and structuring consultations to minimise risk.

5.4 Patient experience is impacted

The Adult Primary Care Experience survey for November 2022, a quarterly survey of 30,000 people by the Health Quality & Safety Commission (HQSC, n.d.), showed that patient experience is being affected by various factors, including limited access to care and long wait times for appointments.

- 18% reported a time when they wanted healthcare and couldn't get it, in August 2020. This increased to 24% (30% for Māori) in November 2022.
- 11% reported the waiting time to get an appointment was too long, in August 2020. This increased to 18% (21% for Māori) in November 2022.

In addition, respondents reported the following financial implications, in November 2022.

- 3% (4% for Māori) of respondents reported that the cost of an appointment was too expensive, or they owed money to the general practice.
- 4% (6% for Māori) felt that GP or afterhours was too expensive.
- 9% (18% for Māori) had not picked up a prescription because of the cost.

5.5 The workforce are getting burnt out and are leaving

As noted in Section 3, pay disparities and an increasing workload are having an impact on the general practice workforce including burnout and a desire to leave general practice.

Findings from the 2022 International Health Policy Survey of Primary Care Physicians (Gunja et al., 2022) show that since the start of the COVID-19 pandemic, New Zealand GPs have exhibited high rates of emotional distress (74% for those under age 55 and 45% for those over 55). Also, younger GPs were more likely to report burnout than older GPs (57% for those under 55 compared to 44% for those over 55).

The College's survey also showed a rise in burnout levels. The 2022 Workforce Survey (The Royal New Zealand College of General Practitioners, 2022) showed 48% of the workforce were burnt out and 31% were somewhat burnt out. Another survey of 1,495 GPs found three core themes contributing to burnout increased patient need and complexity, structure of the funding formula and administrative burden.

Similar themes were reflected in our interviews.

> The amount of administrative, non-patient contact time has significantly increased in general practice. This has led to a burnout of GPs and has made the career less attractive for medical school graduates.

> GPs get a bad reputation, yet they are under so much stress. Accessibility of care is declining which is not due to issues of individual GPs. The system can't handle the demand.

> The workforce is burning out. GPs are working in high-needs areas and trying to drive change with minimal support. We need to pay more attention to workforce in these areas.

> I want to go within a year as I've had a gutsful…I will sell my practice probably to the GPs in the practice but at the moment it is running at a loss so they probably won't want it.

As described in Section 3, the NZNO report on their pay disparity survey showed that general practice nurses were paid less than their Te Whatu Ora counterparts (New Zealand Nurses Organisation, 2023b).

There have also been media articles about the number of nurses leaving New Zealand to work in Australia (*Thousands of Nurses Are Jumping across the Ditch*, 2023) and Australian nurses not wanting to work in New Zealand (*Australian Nurses Not Keen to Work in New Zealand, Data Shows*, 2023).

In interviews we heard about understaffing, burnout, pay disparities, lack of job satisfaction, and the ongoing education requirements for practice nurses.

> Nurses are leaving as the workload is high and there is no pay parity, we are getting at least $10/hour less for doing lots of work. Burnout is also an issue and some nurses would like a better work life balance as it's not good for their general health. 15 mins appointments, where is the satisfaction that you are providing good care or the patient receiving good care.

> We are understaffed. To be an experience practice nurse takes many years and you are learning constantly. For example, when vaccines are added to the schedule we need to be educated and be able to educate and do the learning in own time…we have to get good at it quickly so we can share that and be able to explain a new vaccine to parents etc. The value of experience is fundamental we are kind of the anchor, and we mop up all the other stuff as patients only have a short time with a GP.

5.6 There is increased burden from secondary care

Several interviewees identified that the current limitations of general practice mean an increasing burden on secondary care. The follow up required after transfer from secondary care to primary care is also increasing in complexity.

> More is pushed into primary care from secondary and we are meant to provide the services but there is nowhere near the funding needed to provide them. People have lots of brief hospital visits and then they are discharged back to their GP they are in and out so quickly and they are complex patients with needs to be sorted still so you need a lot more follow up time. For example, in hospital a prescription change is made, they are a complex patient that needs follow up for this, but they also need wellbeing and more holistic review when they get home and more after care. NZCPHN

Interviewees felt that secondary care services were not well equipped to deliver primary care, and that patients fall through the gaps when relying on other avenues for care such as emergency departments.

> There will be more burden on secondary care as immunisation rates drop, there's more diabetes in urgent care. The trend in immunisations is a big red light on what will happen. Northland for example are more at risk for low immunisation rates and ED nurses probably don't know the immunisation schedule so they won't give a vaccination when someone is in ED in for an accident.

General practice in Australia and the UK

There are big problems in New Zealand, but not just in New Zealand. The UK story is, in part, a cautionary tale for New Zealand.

Based on the literature and qualitative interviews, the issues we face in general practice are encountered elsewhere, particularly with respect to workforce, funding and regional variation. Australia and the UK are experiencing similar issues in their primary care systems.

Australia faces workforce and funding challenges

The Australian Medical Association forecasts a nationwide shortage of about 10,600 GPs within 10 years. Although Australia has produced more than 4,000 medical graduates in recent years, less than one sixth have pursued general practice, which reflects the specialty being undervalued and underfunded (Rachael Ward, 2022).

A survey of 3,200 GPs conducted by the Royal Australian College of General Practitioners suggests that one quarter will retire in the next five years. The insufficient flow of recruits and retiring workforce have exacerbated the crisis, and the college has highlighted that inflation has significantly outpaced the amount GPs receive for a typical consultation. Medicare payments to doctors have risen by only 18.5% in 14 years, and the government is yet to indicate whether it will address this issue (Tahlia Roy & Markus Mannheim, 2022). This was reiterated in our interviews:

> Medicare rebates haven't kept pace with the CPI and froze in 2012. They only recently unfroze and GPs have stopped bulk billing as it has become unsustainable for the last two years.

Rural communities have been especially affected by the GP crisis. Workforce shortages have been worsened by the COVID-19 pandemic and a continued reliance on international medical graduates. Approximately half the country's rural GP workforce comprises of overseas-trained doctors, and visa restrictions, remuneration issues and restricted travel from the pandemic has led to a continued fall in numbers. Furthermore, there is little incentive for GPs with families to practice in rural areas due to the lack of general job opportunities and schooling. There are considerable discrepancies in pay between general practice and other medical specialties, and although more locums are expected to fill the gaps, there is concern that this could have a direct impact on the quality of care and doctor-patient relationships. To address the national workforce shortages, the Australian Medical Association (AMA) and the Rural Doctors Association of Rural Australia (RDARA) have put forward reforms to:

- reduce bureaucratic costs by transitioning from a service fee model to a basic hourly rate
- improve pathways to increase GP involvement in hospital patient care decisions
- support GPs in providing training for medical students and registrars.

These recommendations are intended to highlight the importance and contribution of GPs within communities and increase the appeal of general practice (Morgan Liotta & The Royal Australian College of General Practitioner, 2021). In 2022, the Minister for Health and Aged Care established the Strengthening Medicare Taskforce with aims to recommend high priority improvements to primary care (Australian Government, 2022). The taskforce focuses on:

- improving patient access to general practice, including after hours
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health

- making primary care more affordable for patients
- improving prevention and management of ongoing and chronic conditions
- reducing pressure on hospitals.

According to a recent national survey of Australia's primary health care nursing workforce (APNA, 2022), 34% of nurses working in residential or community aged care settings are underutilised despite workforce shortages. Additionally, 51% of nurses requested to use more of their skills and experience in their role, but many were denied because there was no financial benefit to their employer.

The United Kingdom

The number of permanently qualified GPs in the UK has gradually decreased in the last few years, and the Health Foundation predicts that the shortfall will increase to approximately 8,800 GPs by 2030–31. The UK has fewer GPs per capita than many developed countries, but differences in the scope of care provided make it difficult to make international comparisons. The average number of patients per GP has increased almost 17% since 2015 to 2,260, and there are now only 0.44 GPs per 1,000 patients, down from 0.52 in 2015 (BMA, 2023). British GPs are having to care for more patients with complex conditions due to an ageing population and an increasing prevalence of chronic diseases which were previously handled by hospital specialists. GPs are expected to feel increased pressures as demand outpaces supply, and long hours as well as job dissatisfaction are said to be key reasons for the reduction in nationwide GP numbers. To fix the UK's recruitment and retention crisis, initiatives have been suggested to improve support, reduce administrative workload and allow physiotherapists, paramedics and pharmacists to undertake certain tasks that can be easily shifted from general practice (Lee, 2023).

A report by the House of Commons Committee (2022) revealed the increasing pressures on general practice through several statistics. In June 2019, the estimated total number of general practice appointments was 23,800,000, and in June 2022, this number had risen to 25,910,000—an increase of 8.9%. Furthermore, the number of patients registered with a GP had increased 3.2% from around 59,900,000 to 61,800,000. Although the government stated its commitment to recruit 6,000 additional GPs by 2024, it has since admitted that this target is unfeasible. Workforce issues were also expressed in our interviews:

> The workforce is the biggest current challenge in general practice. Although the UK government emphasize that thousands of GPs are in training, the net amount is continually decreasing.
>
> GPs coming out of training do not find the career attractive. There is general discomfort around the bureaucratic environment and workload expectations. Young people don't want a full-time, permanent role as a GP. They want a portfolio career with a range of experience and training.

Another issue is that practices are continually relying on locum GPs to fill staff shortages. Rates of pay for locum GPs are typically higher than for salaried GPs, meaning a higher proportion of care being undertaken by locum GPs results in an increased cost of healthcare. Moreover, locum GPs are unlikely to retain the same patients over time, which undermines the continuity of care. In 2022, the proportion of patients who saw their preferred GP for the majority of appointments declined to 38.2% from 45.2% in 2021. A reduction in the continuity of care results in several complications, as a 2022 study in the British Journal of General Practice reported that continuity for patients with dementia improved prescribing effectiveness and reduced the risk of emergency department admissions (Maarsingh et al., 2016). Manchester University's GP Worklife Survey found that 33.4% of GPs intend to leave the profession within five years in 2021, comparing to 21.9% in 2008 (Odebiyi et al., 2022).

6. What is needed to achieve sustainable and effective general practice?

This section outlines the opportunities to modernise general practice through systemic changes in funding and workforce.

6.1 System change/new model

The current general practice models have been scrutinised in recent years, and there has been increasing discussion and exploration of new structures to improve primary care services and sustainability. General practitioners have outwardly expressed the need to incentivise more effective business models to improve the access and quality of care (Johnstone, 2023), and our interviews highlighted the structural issues within the health sector:

> We need to focus on system changes nationally, but also focus locally. We need to ask communities and people who provide service across all sectors what to prioritise.

> Within the current structure, we cannot adequately advocate for contracted providers because of the nature of PHOs. The contract system has created restrictions.

> There is a need to create change systemically. The sector has been calling out for shared service agreements and business mentoring. GPs want autonomy from small practices but do not embrace the business side of running a practice.

The structures of healthcare systems have consequences for equity, as issues within traditional models disproportionally affect those who are worse off. Individuals of lower socioeconomic status cannot rely on private healthcare and are stuck with bearing the consequences of unsustainable public models.

> If we don't change, we will see more private healthcare. People will look for where the money is. I used to have doctors who would swear they would not sell, but now they have sold because the cheque is quite big. There will be a growing divide, not just with Māori and Pacific, but all in the lower income quintiles. Those who are wealthy will always have access to health.

> Many of the business models in primary care suit those who are well off. It is easier to advocate and support analysis that benefits the easiest models that benefit middle-income individuals.

6.2 Funding

General practice owners have expressed their concern that recent government funding increases are insufficient in handling higher workloads and costs (Forbes, 2022). This was also apparent in our interviews:

> Funding needs to be weighted towards providing a service and continuity of care. It needs to account for age, gender, rurality, as we get the same funding for a 65 year old as a 95 year old.

> Enrolments and the incentives around enrolments are about money. Maximising enrolment base drives the funding model of primary care.

A Sapere report (Love et al., 2021) proposed that capitation funding should be based on age, ethnicity, deprivation and morbidity. Under this structure, high-need general practices would need funding increases of between 34% and 231% to function sustainably and to fund the additional capacity required to respond to unmet need.

6.3 Investment in primary care workforce

The workforce challenges in primary care are partly attributable to the preferences of medical graduates and financial incentives to practice overseas after training. Furthermore, we have a high dependency on overseas recruitment when there are also international shortages. As noted above, out of the OECD, New Zealand has the highest reliance on overseas-trained doctors, as 42% of the workforce are international medical graduates (Lawrenson, 2023). The 2021 GP Future Workforce Report (Foley et al., 2021) highlighted the following barriers to attracting more medical graduates into general practice:

- Insufficient medical graduates.
- Lack of general practice exposure in undergraduate training programmes.
- Lack of access to general practice, and financial support for training in the community during post graduate tenures.
- Large disparity of remuneration for GP registrars entering training, compared to other medical specialist registrars in a hospital setting.
- The perceived unattractiveness of general practice as a viable career option, in comparison to other medical specialties.
- The widening and large disparity in financial remuneration and benefits for Specialist GPs, in comparison to other medical specialties.
- Lack of proactive and timely interventions to address the acknowledged workload and workforce issues.

Our interviewees elaborated on these points:

> General practice has not been admired as something to aspire to by younger colleagues. Medical schools insist on General Practice exposure during training, however this does not translate into young people wanting to be GPs in reality.

> The number of entries into medical schools is determined by cabinet as it is very expensive to train. However, we need to train more and incentivise nursing to fill the gaps in the workforce.

To address the lack of New Zealand trained doctors, the government has recently announced an increase in the number of funded medical students from 2024 (Verrall, 2023). This will increase the number of medical school enrolments from 539 to 589 annually across the University of Auckland and University of Otago. However, this will have no effect for at least seven years until the first cohort under this funding increase has graduated, and there is no guarantee that the extra doctors will choose general practice as their vocation.

6.4 An expanded workforce

A common point of discussion in our interviews was the potential to expand the primary team to allow for a broader scope of care. Many GPs highlighted the wider benefits of sub-specialisation and increased utilisation of nurses.

> We need to move to a multidisciplinary approach in primary health care. There is a lot of talk of integrated settings and opportunities to sub-specialise where practices are large enough.
>
> We need a different type of GP system that can cope for demand, especially in rural communities. The answer is integrated health teams working in and around communities. GPs don't have instant access to support people with multiple chronic conditions.
>
> We need better models and services to allow for a broader scope of care. Better utilisation of nurses leads to better patient outcomes. We should impose more of a team model and multidisciplinary approach to primary care.
>
> We need to improve the status of general practice. The workforce should be expanded, and we should support a collaborative environment rather than a competitive one.
>
> We need a new model with less singularity in primary care. We need a wider primary care team in which we can benefit from economies of scale from the workforce.

An NZIER report on allied health professions (Hogan, 2021) summarises evidence that collaborative, interdisciplinary teams are optimal in delivering equity, quality and value particularly for complex patients. Physiotherapy New Zealand recently released a media statement suggesting it has the workforce and capability to help ease the GP crisis (Physiotherapy New Zealand, 2022). It indicates that physiotherapists have the skillset to treat musculoskeletal conditions which would alleviate the overwhelming workload in general practice. President Mark Quinn says that the government should increase the funding for physiotherapists in primary care, and advocates for the removal of legislative barriers that don't allow physiotherapists to sign off-work patient certificates.

> Another action the government can implement now is getting ACC to allow physios to sign off-work certificates for patients. We can currently do medical certificates but not for ACC income related payments. This would help ease the bottleneck and clear the backlog and wait times. – Mark Quinn

Our interviewees also responded with similar points:

> For better health outcomes we should focus on the whole scope of registered practitioners. The physio workforce tends to be younger and is a growing workforce. They are trained and regulated and don't have the same concerns about early retirement as GPs.
>
> Small changes to laws could make things easier. For example, physios can issue medical certificates but not worker compensation certificates. Legislative barriers are causing inefficiencies.

Budget 2023 provided for a degree of investment in Comprehensive Primary and Community Teams, and PHOs have been working with front-line general practices to develop these roles in a number of

locations. Similarly, PHOs have been important in implementing mental health practitioners, health improvement practitioners, clinical pharmacists and other members of the primary care team. However, communities' access to these enhanced teams is highly variable.

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Appendix A Survey evidence

RNZCGP Survey

Royal New Zealand College of General Practitioners had 5,728 members in 2022. Survey results are provided at: https://www.rnzcgp.org.nz/our-voice/data-and-statistics/

Key statistics

- 58% female
- 69% European, 20% Asian, 5% Māori, 3% MELAA, 2% Pacific peoples
- 51% work full time
- 64% work in GP-owned practices
- 62% had first medical degree in NZ,
- 48% of rural doctors had first medical degree overseas.

New Zealand Women in Medicine

Identified workforce issues in primary care (McGinn, 2022):

- Long-term vacancies for all practice roles (GP, practice nurses, reception staff).
- Clinical risk arising from high clinical load and insufficient time to safely manage complex problems.
- Very difficult for small practices to manage cover for sickness and leave, especially rural practices.
- Currently a job seekers' market; the rates required for staff retention are not sustainable from business continuity point of view (as it is impossible to raise fees to generate enough income).
- Difficulties attracting new graduates to general practice (lack of pay parity, devaluing of role, unsustainable model).
- Restrictions and rules from Immigration and Medical Council of New Zealand (MCNZ) are impacting on the ability to have international medical graduates fill the vacancies.
- Increased patient complexity and a rise demand for appointments (from deferred care at both primary and secondary level) is putting huge pressure on available staff. This includes repeated appointments for unresolved issues after referred patients have been declined by secondary care.
- Chronic secondary service deficits in particular specialties such as mental health is escalating the volume and severity of unmet need. High acuity patients are being managed in primary care – e.g. complex mental health, eating disorders. Lack of access to psychology or other support services adds to the burden of care in general practice.
- Unacceptably long waits for GP appointments, with up to six weeks being common.
- Clinical paperwork and administration are increasing exponentially; this typically does not generate income, therefore is done unpaid and in a clinician's own time.

- Debt write-offs (sometimes tens of thousands of dollars per year) for those who cannot afford the care that is provided are common. This impacts on the financial security of the general practice business.
- Practice financial insecurity due to rising infrastructure costs, particularly with COVID-19 (PPE, extra staff to manage streaming, enabling telemedicine etc).
- Devaluing of the role of the general practitioner suggesting equivalence with nurse practitioners – these roles need clearly defining, as the skill sets are different, and they are not interchangeable.
- General practitioners are retiring early as they are burnt out from excessive workload.
- General practitioners leaving their practices to retrain in other specialties or leaving medicine altogether long before retirement age.

Commonwealth Fund – Stressed and burned out: the global primary care crisis

Available at: https://www.commonwealthfund.org/publications/issue-briefs/2022/nov/stressed-out-burned-out-2022-international-survey-primary-care-physicians

- More than half of primary care physicians in all countries said their workload has increased since the pandemic began.
- Younger primary care physicians in nearly all high-income countries were more likely than their older peers to have stressful jobs.
- More than half of younger primary care physicians in most countries have experienced emotional distress since the start of the pandemic.
- Younger primary care physicians were generally more likely to report burnout than older physicians; physicians in the Netherlands and Switzerland were least likely to report burnout.
- Younger primary care physicians with emotional distress were more likely to seek professional help for mental health needs in nearly all countries, but most physicians, regardless of age, did not seek help.
- Primary care physicians experiencing stress, emotional distress, or burnout were more likely to report the quality of care they provided declined during the pandemic.
- Nearly half of older primary care physicians in most countries say they intend to stop seeing patients in the near future.

HQSC Adult Primary Care Experience survey

		All Aug 2020	All Nov 2022	Māori Nov 2022
Time they wanted healthcare but couldn't get it		18%	24%	30%
Waiting time to get an appointment too long		11%	18%	21%
Difficult to take time off work		2%	3%	5%
Time to get an appointment	Same day	45%	31%	35%
	Within a week	45%	44%	42%
	Over a week	11%	25%	23%

		All Aug 2020	All Nov 2022	Māori Nov 2022
How they felt about the wait for next available appointment	Didn't mind	83%	72%	74%
	A bit too long	13%	19%	17%
	Far too long	4%	9%	9%
Time to wait for pre-booked appointment to begin	≤15 mins	80%	79%	78%
	16–30 mins	12%	13%	14%
	>30 mins	7%	8%	9%
How they felt about wait for pre-booked appointment to begin	Didn't mind	87%	85%	86%
	A bit too long	10%	12%	10%
	Far too long	3%	4%	4%
Time to wait for walk-in appointment	≤1 hour	83%	74%	77%
	1–<2 hours	9%	11%	10%
	2–<3 hours	5%	7%	7%
	3–<4 hours	2%	4%	3%
	>4 hours	1%	4%	3%
Appointment too expensive or owed money to general practice/medical centre		2%	3%	4%
Cost stopped them picking up a prescription		9%	9%	18%
GP or afterhours was too expensive		4%	4%	6%

About Sapere

Sapere is one of the largest expert consulting firms in Australasia, and a leader in the provision of independent economic, forensic accounting and public policy services. We provide independent expert testimony, strategic advisory services, data analytics and other advice to Australasia's private sector corporate clients, major law firms, government agencies, and regulatory bodies.

'Sapere' comes from Latin (to be wise) and the phrase 'sapere aude' (dare to be wise). The phrase is associated with German philosopher Immanuel Kant, who promoted the use of reason as a tool of thought; an approach that underpins all Sapere's practice groups.

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SECTION C: PROCESS AND OUTPUTS FROM GPNZ DISCUSSION

Introduction

With the current state analysis completed (see Section B), GPNZ engaged in discussions to identify solutions that would contribute to sustainable general practice. That included a workshop, facilitated by Sapere and attended by the GPNZ Executive together with a small group of primary care sector representatives in early November, discussions at regular GPNZ member hui and at the GPNZ national member forum on 1 December 2023.

The November workshop focused on key themes set out in the current state analysis, adding an additional rural theme. Participants identified potential solutions, barriers, actions and priorities relating to

1. dealing with increasing complexity in primary care settings
2. models of care changes and addressing equity
3. workforce sustainability
4. connecting with the wider health system
5. role of primary care network organisations
6. rural general practice.

The outputs of the November workshop were then synthesised and presented at the December member forum, with attendees prioritising actions.

This second phase of work also reinforced a number of key principles:

- importance of equity and the need for solutions to explicitly acknowledge commitment to Te Tiriti o Waitangi and to Wai 2575
- crucial role of general practice within a strengthened primary care system, and the importance of investment in primary care to realise its value and potential – given more resources, general practice and primary care can do more
- primary care voice must be central and valued in decision making
- need to preserve the good things, learn, and scale innovation alongside variation and tailoring that adds significant value
- potential to leverage the collaborative and collegial support that already exists, pushing further with integration and connection
- need for the right incentives and model to support proactive and preventive care and address need
- potential for greater flexibility of contracts, alongside connected IT infrastructure and access to real time data, as key enablers.

The following section provides additional detail on those discussions in addition to the solutions set out in Section B.

Complexity

Barriers

Unmet need

When need for a hospital procedure or investigation cannot be met, the consequence is growing waiting times and waiting lists or declined referrals for hospital care because of higher acuity thresholds. The ongoing management of the (potentially deteriorating) problem remains with the general practice, with no additional funding. Early evidence shows patients waiting for first specialist appointments (FSA) use general practice at higher rates (averaging at least double the rates of those not on waiting lists).

System issues

General practice is picking up more and more work that used to be undertaken in secondary care but without the funding or the workforce to manage it. While there are capacity restraints in all parts of Aotearoa's health system, the secondary care system has responded largely through increasing the thresholds for access to care, which has had the knock-on effect of increasing complexity and utilisation in general practice.

In turn this has contributed to longer waits for general practice appointments, as well as a growing number of practices with closed books. The constant 'see more, do more' mentality for general practice teams without access to additional resources can contribute to workforce burnout and attrition, contributing further to the vicious cycle of capacity being unable to match need and demand.

The inbox burden is a major and growing problem, with multiple notifications and administrative time that is not funded and is making a significant contribution to the current pressure on general practice.

Integration with secondary care is a major issue, with primary care clinicians too often unable to access information about care of their patients in the hospital system. The lack of communication and information is a great source of inefficiency for the entire system, and places unnecessary stress on patients.

Potential solutions

Data

Measures of complexity, including co-morbidities and utilisation of general practice, need to be appropriately captured to enable funding to match need.

Data sharing arrangements need to be in place to ensure data is used to monitor population health trends and better understand and manage complexities in communities. This in turn must underpin the design of new services and interventions. Sharing between primary and secondary care is also essential so clinicians are always able to access appropriate information on the patient's care history, tests and treatments.

Model of care

The model of care needs to support the primary care team to work across disciplines and manage people with highly complex needs, optimising top of scope working with tailored appointments to reflect complexity.

Research has documented better outcomes over time from continuity of care.[16] Strong, trusted relationships between patients and providers help providers to build a fuller knowledge of the patient, the wider whānau and the factors that may be influencing outcomes. Team-based continuity of care, combined with shared care plans and enhanced methods of communication, are the way forward.

Integration

Integration across primary, community and secondary/hospital care is essential. We need more integration that allows people to access care at multiple places in the system. Knitting the system closer together in this way will support best outcomes through best use of interventions and resources.

Referral

The creation of Te Whatu Ora as a single system should enable a broader range of referral options, allowing people to be seen further from home if it means better or sooner treatment. This will benefit rural and remote communities in particular and will help to ensure the workforce is utilised to its potential.

Better technology is needed to support referrals, so at a minimum the referring primary care clinician can see and track the referral, and ideally a similar level of information is available to the patient.

Whānau engagement

An honest conversation with the public about rationing is needed to raise awareness and set appropriate expectations of all parts of the health system.

It is important we find new ways to reach, engage and build trust with people to keep them well.

Role of the Primary Health Organisation

To maximise support to general practices, Primary Health Organisations (PHOs) need to be resourced to improve models of care, to grow workforce capacity and capability and the use of integrated data for equity and quality of care.

PHOs need to play a key integration role throughout the care continuum, acting as the 'glue' in the system. PHOs should create their own broad networks to facilitate access to a wider range of services with efficiency and clarity. This will enable a broader range of care

[16] *Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway*, available at https://bjgp.org/content/72/715/e84

pathways for effective management of complex conditions that leverage resources and capabilities across health and social care providers.

PHOs should also be empowered to lead population health, focusing on a range of prevention, health promotion and health literacy programmes and supporting the work of multiple agencies and organisations in working towards addressing the wider determinants of ill health, to improve health outcomes, especially the more vulnerable groups within society.

Model of care

The role of general practice in the primary care eco-system needs to be addressed, drawing on the evidence of the importance of access to first level services, alongside population expectations and realistic workforce modelling.

Barriers

Restrictive and single-focused contracts

Existing contracts can reinforce silos and create artificial barriers. Some can result in services being funded in an environment or provider where they don't fit well, or haven't been designed well with the priorities of the community in mind. Too often contracts are focused on inputs rather than outcomes, many are too short term to offer service or workforce stability or enable learning and development.

Workforce development

Regulatory bodies continue to have a tendency to limit rather than enable teamwork. Professional protectionism is still evident in behaviours in some organisations and workplaces, and Aotearoa's embracing of new roles and extended scopes has been comparatively slow.

Physical environments

Though outreach services are a proven way to improve equity and access, too often these services are ad hoc and temporary and support and resources aren't made available to sustain and scale up. It is difficult to quickly stand up a service in the event of short term need e.g. following a natural disaster.

Physical space constraints make it hard to co-locate services and infrastructure funding is not available to offer wide and varied services across a community.

Workforce 'headspace'

The primary care workforce currently is worn down by the daily grind, with high levels of fatigue, and a feeling of being unseen and undervalued. Despite several years of health reform, the future of primary care and specifically general practice, remains unclear and uncertain. Clinical demands mean it is hard for general practice teams to find time to meet to plan for the future, so are operating without a clear vision of what it is they want or where they are heading as a practice.

Patient expectations

Practices are mindful of patient complaints which can be a barrier to trying new ways of delivering services. There is still an expectation among some patients that they need to see a doctor, even when another health professional is available, potentially with more appropriate skills or experience for the condition.

There is much more potential to provide convenient access to more procedures, undertake more point of care tests, have greater access to diagnostics, and be able to manage more complex conditions with more complex interventions in the community. A community-based (not hospital outreach) hospital in the home model has operated in Canterbury for more than 10 years[17] and could easily be replicated elsewhere.

Over the past few months GPNZ has coordinated a national proposal to deliver more planned care in primary and community settings. As well as tackling the current lengthy waits for planned care there is an important opportunity to promote access, engagement and efficiency by creating additional capacity close to home.

Expansion of community-based services requires resources and training, working with medical colleges, regulatory bodies and education providers. The skills, interest and potential are there subject to the appropriate investment, including infrastructure development.

Potential solutions

Practice development

At a macro level, a clear national vision is required to help create new mindsets for how primary and community care is delivered, and the place of the general practice team within that local ecosystem.

Practices serve different populations, each with important nuances, and each practice needs to plan and evolve according to those local demographics, optimising interactions and outcomes through being connected to other providers in the community. Where and how a general practice fits into the community should be locally tailored, guided by the impact and outcomes sought, and the local whānau voice. While some design principles can be standardised for scale and efficiency, such as planned care, routine and preventative care, models of care must be flexible enough to be tailored to the local environment, including the available workforce and other providers as well as the needs of the population.

At the practice level, change must be intentional, which means first creating time for planning. Alongside the national vision, there needs to be a clear vision for the practice and associated networked community providers of how services can be sustained, enhanced and developed.

Change of this nature needs time, effort, investment and ongoing support, from supporting new models in the workplace, to facilitating peer support across disciplines, to educating patients through resetting of expectations and acceptance of new ways of working.

[17] *Pegasus Health Acute Demand Service*, see https://www.pegasus.health.nz/2022/06/15/pegasus-health-acute-demand-service/

Teams that inspire

There needs to be more support for new roles and tasks being performed by different health professionals to what may have been done in the past, including maximising the potential of the unregulated workforce. Risks need to be weighed appropriately, particularly in the context of significant workforce shortages.

Patient interactions need to be maximised through deep understanding of tasks and skill sets. This requires individuals understanding more about the roles of others and being willing to approach decision-making and access solutions on a team basis.

Clever funding

There needs to be dedicated funding for model of care change management at a community level, combined with clarity on what is being purchased – that means knowing the outcomes that are sought and working backwards from there.

Future contracts must be more enabling, and co-designed with communities and the providers who know those communities best to ensure they deliver the outcomes that matter.

Technology – data and digital enablers

Good data and reporting can let the past guide better future interventions, through a clear methodology such as PDSA cycles. It is important to measure the right things, in the right way and to be mindful of the local context in drawing conclusions and making recommendations. Learning from overseas research and data also needs to be consistently considered for the Aotearoa context.

Digital technologies should be used to automate the things that don't require human interventions, and to ensure good connections between providers to improve work and information flows. Personal health information should be available to patients who should also be in charge of how it is shared.

Create joy

Workplaces need to be places people want to stay, where they see growth and potential and reward. A valued and happy team is an important outcome, and one that also contributes to better patient satisfaction and outcomes. A key question in designing models of care is not just who does what, but who enjoys what? Top of scope is not simply about task shifting but also about considering the impact on others. Investing in a happy workforce will help change the narrative from "why would I want to work there?" to "where else could I feel so supported and happy?"

Support

The innovation and adoption curve should be used to apply effort where it is most likely to get results, then use positive storytelling to move people through change – "if nothing changes, nothing changes" conversations. A 'small wins' approach will be beneficial to reinforce change – solve a pain point, create a 'win' and move forward to the next pain point.

Regulatory and professional bodies, contracts and funding models need to enable rather than inhibit change.

Technology needs to make work more efficient, ease clinical burden and empower the patient. People need to be able to work in ways that help them to love what they do.

Rural general practice

Barriers

Definition

The Otago University definition of rurality was never established to be used in a contracting context. Largely based off drive times, rural health is poorly defined in Aotearoa. Drive times do not adequately account for people who don't have a vehicle and live in areas with no public transport, some with no road access at all. There is a need to work with communities to identify what constitutes rural and rural remote areas, creating a common definition to be used for commissioning and funding purposes.

Resourcing

Lack of resourcing is a major threat to the sustainability of many of the 150 existing rural general practices and consequently the wellbeing of rural populations, who rely on those services. If a rural general practice has to cease operating, or simply close its books, the impact on a local community, which may rely exclusively on that provider, is significant.

It is generally more difficult to attract staff to work in rural communities and programmes to locally train, recruit and develop the primary care workforce are essential to ensure services are maintained and thrive.

Environmental vulnerability

Being more exposed to climate-related events such as droughts, flooding and sea-level rise, rural communities are disproportionately affected by climate change, with direct and indirect impacts on rural health. Additionally, rural communities are more prone to being cut off from vital support networks and economic activity – as evidenced by rural communities left isolated in the wake of Cyclone Gabrielle.

Digital infrastructure

Rural communities need digital infrastructure upgrades to ensure access to vital digital communication tools. During weather events of early 2023 prolonged internet outages left some communities disconnected for weeks. Mitigation and management are urgently needed.

Population growth, seasonal fluctuation

Consistent service planning is a challenge with seasonal population fluctuation in many rural areas at holiday periods throughout the year.

Notably, one in five Māori reside in rural areas, representing around 22 per cent of the population compared to 15 per cent in urban areas. The need to address rurality inequities is directly linked to addressing ethnicity inequities.

Advocate for appropriate and enabling legislation
Legislation needs to reflect and address the unique needs of rural areas, fostering growth and wellbeing.

Potential solutions

Whānaungatanga – the art of connection

In rural health, the treasure lies in the robust relationships fostered, with whānaungatanga embodying the community's heart. Rural relationships are the cornerstone of a thriving rural health environment.

Positive 'can do' attitudes

The 'Number 8 wire' approach to healthcare and a nimble 'get it done' mentality, is a vital element in rural communities. Practice teams regularly go beyond the four walls of practice to deliver services with a 'can-do' attitude that defines rural healthcare and makes all the difference for service delivery.

Innovation and creativity

In rural healthcare necessity breeds innovation, which has led to remarkable advancements from mobile healthcare units to virtual care solutions, point-of-care testing to extended roles. Innovations, often achieved without substantial financial investment, are helping to redefine rural healthcare, with major learning for the whole of the health system.

Workforce development

The value of a diverse comprehensive care team has been recognised in rural primary care for many years, and the ability to incorporate new skill sets into a care team typically happens with ease. Practices have employed physician associates, extended care paramedics, clinical pharmacists and more to effectively deliver services, both in-hours and after-hours. More workforce investment, targeted training programmes, including 'earn as you learn' upskilling of current staff, scaling of telehealth services, and emphasis on building cultural safety will contribute to a thriving rural health workforce.

Tackling rural inequities

Targeted investment is needed in social initiatives for iwi and hapū, including enhancing local capabilities, improving rural infrastructure, and redesigning access to local services and support to ensure they work for Māori and other priority populations.

Empowered local design

Place-based planning and service development starts with giving communities access to their population health data and growing the capability and leadership within rural

communities. The work that PHOs have been doing to enable and empower communities needs to be scaled and supported, working alongside Iwi Māori Partnership Boards.

Rural health providers need to be connected and enabled through purposeful integration.

Workforce

Barriers

Lack of workforce growth and development

Our health workforce has not been planned, trained or recruited based on projected need, contributing to unrelenting shortages in many workforces and geographical areas.

The current health workforce shortage was reliably and repeatedly predicted a generation ago. Workforce development and sustainability has not been a priority for successive governments and can no longer be ignored. We are facing a major health workforce crisis, which is shared by many other health systems, and which will take many years to resolve, even if we start immediately. At 57 per cent, New Zealand had the highest rate of burnout in GPs under the age of 55 across the 10 countries surveyed.[18]

Reluctance and 'patch protectionism' still remain which hamper true uptake of working differently across roles and settings.

A growing amount of time is also spent on administration, much of which is not funded.

A vicious cycle now exists where overwhelmed staff leave, contributing to greater pressure for remaining staff.

Student experiences

The dropout rate for many clinical training programmes is extremely high, indicating that the system is both wasteful and failing to set students up for success. Barriers to training remain for rural, Māori and Pacific students and medical training is out of reach for many.

Student selection criteria is out of step with what is really needed in the workforce, and it is time to examine soft skills – people skills, team skills, relationships, and leadership qualities – rather than high school academic performance as a predictor of who will be a great health professional.

Clinical placements come with financial hardship for many students, and students are entering placements where staff can be stressed and too busy to offer adequate teaching.

Potential solutions

Parity

Parity of pay and working conditions across the health sector are essential elements of a stable and thriving workforce. All parts of the system are needed and should be equally

[18] *Stressed Out and Burned Out: The Global Primary Care Crisis Findings from the 2022 International Health Policy Survey of Primary Care Physicians*, available at https://www.commonwealthfund.org/publications/issue-briefs/2022/nov/stressed-out-burned-out-2022-international-survey-primary-care-physicians

valued. Higher rates of pay and advantageous terms and conditions available to Te Whatu Ora staff are a major disincentive to people choosing to work in primary and community care.

There must be fair, equal and fully funded pay and conditions for people who work in primary and community care with remuneration consistently aligned with the secondary care workforce. In parallel, the new general practice funding model needs to recognise and resource non-clinical work which is a major and unfunded time commitment for many clinicians.

A clear remuneration pathway and supported professional development should be available to all health professionals, wherever they are employed.

Ongoing central funding must be made available for more primary care roles, including allied health, mental health and kaiāwhina.

Recruitment and training

The team of the future will be dealing with even more complex situations and using more complex tools. We need to consciously makes choices now to develop programmes at all levels that will produce the sustainable teams we need.

Teaching and training require resources, including time, physical infrastructure and space for students and learning and teaching expertise. This resourcing needs to be intentional and ongoing.

We need to grow a more diverse workforce – specifically training and recruiting more Māori, Pasifika, and rural people in health. That entails building on successful initiatives such as MAPAS and rural health workforce pathways and placements.

A key planning principle should be that the primary care workforce is anchored in primary care – district nursing, for example, should be integrated with other primary and community providers to enable better integration and smoother pathways of care for patients.

PHOs are well placed to further develop innovative solutions to build the primary and community workforce, including development of common protocols, training and evaluation, management of placements, co-ordination of information and support on role development and the potential to create workforce ‘hubs’ that combine local needs with national planning and coordination.

To address acute primary care workforce shortages equivalent subsidies and supports for international recruitment provided to Te Whatu Ora services need to be made available to primary care. This includes coverage of recruitment costs and relocation expenses.

However, a full solution doesn’t lie in international recruitment. We need to see more New Zealanders trained to enter the primary care workforce, including a dedicated effort to increase the Māori and Pacific primary care workforce. This could include working collaboratively with the sector on a direct to GP medical training pathway.

To assist with recruitment the NZREX primary care pathway should be extended, based on the outcomes of the successful pilot in the Waikato region.

There is a need for regionally coordinated and appropriately funded PGY1 and PGY2 community placements, in collaboration with PHOs and contracted providers, with practices fairly reimbursed to cover costs.

NETP placements for nursing needs to be regionally coordinated and funded in collaboration with PHOs and contracted providers. In 2024 year 20% of these should occur in general practice settings.

Funding should be available for as many practice based 2-year pharmacist prescriber internship roles as can be filled by practices from 1 July 2024 to 30 June 2026 including a 60% salary subsidy (80% in Māori / Pacific or 50%+ high need practices) and education and training cost.

Pathways

Flexible career pathways need to be available across primary and community providers, enabling people to move employers or even switch disciplines taking account of past skills and experience.

We need to create flexibility in the system, acknowledging the value of 'portfolio careers' offering people the ability to dip in and dip out. More supports for flexible working will enable more people to contribute to the workforce.

Support

Recruitment and training schemes need to be matched with initiatives that ensure people remain in health careers. Parity of pay and terms and conditions across the system will help, but more needs to be done to provide wellbeing support for primary and community care staff. This could entail professional advice, for example, by health improvement practitioners and self-care programmes, staff surveys to benchmark and track staff satisfaction and wellbeing and paid professional development time.

Effective leadership is essential to developing a positive workforce culture. This is likely to require training with a focus on team outcomes alongside patient care.

Bring joy back to the workplace

Creating a positive team culture and paying attention to workplace wellbeing pay dividends. This could involve using tools such as the 'wellbeing wheel'[19] and staff surveys to systematise approaches and track progress. PHOs could have a role in supporting and coordinating the efforts of individual employers.

Tell more positive stories

[19] *Collaborative Aotearoa Wellbeing Wheel*, available at https://healthcarehome.org.nz/resources/library/collaborative-aotearoa-wellbeing-wheel/

The current negative narratives do little to encourage people to choose health careers so telling more positive stories is imperative to attracting people into primary care. Stories of the diverse, challenging and rewarding work in primary care work need to be told from across the range of professions and diverse backgrounds. Stories need to reflect opportunity at all stages of careers and the value of holding a treasured role in communities.

System integration

Barriers

Silos

There is significant concern about the interface between primary and secondary care, with fears that the health system has become more siloed than ever. There needs to be an intentional focus on shifting services that do not need to be carried out in the hospital into primary and community settings, but progress has been extremely slow and inconsistent.

GP liaison roles, which have been a bridge between primary and secondary care are no longer in place in many areas.

Understand the wider picture

Despite the recognition that 80 per cent of a person's health and wellbeing relates to wider determinants of health, there is still a tendency to function in silos, with funding, contracting and employment arrangements (across multiple agencies and funders) reinforcing separate objectives and ways of working rather than whānau-centred approaches. The emerging localities has focused on bringing stakeholders together around the needs of communities, a principle that must not be lost with any shift in policies.

Information sharing

The lack of a single electronic health record in Aotearoa remains a major barrier to effective, efficient and safe care and more targeted delivery of funding and services to where they are needed most.

Navigation support

General practice can be seen as the gatekeeper to other care and support, without necessarily having the time, capacity or knowledge to provide connection with other services. Care coordination requires funding to enable specific roles and systems to be put in place.

Potential solutions

It’s about ‘we’

Connection across a system is underpinned by trust, relationships and confidence between different parts of the system. This requires investing in building a culture that focuses on meaningful partnership – a commitment to one system.

To create a more connected system a shift must be made to peer/partner model across primary and secondary care, based on shared problems and collective solutions, valuing of different perspectives and understanding of community and provider needs.

The key design principle is putting the needs and aspirations of people, whānau and community at the very centre of everything – he tangata, he tangata, he tangata.

Build on what works

There are examples where system connection and integration has worked well, including 'bright spot' alliances in MidCentral and Canterbury. It is important to retain the learnings and insights from these alliances into our new system as the final stages bed in, particularly creating a neutral shared space for change and improvement, having influence, permissions and delegations to make change, having access to data to drive and monitor change and shaping the role of funders as system enablers which means ceding control into a collective.

System leadership

System leaders and champions are key in integrating and connecting a system, so general practices and primary care must be engaged at a system level. Investment may be required to support primary care's capacity to contribute and provide such leadership, with adequate time put into creating relationships and building influence.

Great innovation at the local level

Within the context of a system, there is the need for local tailoring around the needs of communities. We need mechanisms that enable proactive sharing, learning and collaboration between PHOs and local systems.

Any door is the right door

We need to create a system with multiple entry points, meaning we prioritise the needs, interests and aspirations of communities in system design. This also means providing clarity on where the responsibility for connecting a system sits, the mechanism to do so (priorities, delegations) and embedding this way of working. This needs to be in the structure of the system, and not person dependent.

This problem could be eased through development of community-based navigation/coordination services that assist whānau to access the right service or part of the system, alongside increased resourcing for ongoing development of health pathways to support healthcare staff to connect to the most effective and relevant specialist support.

Trusted community relationships

Trusted relationships and stronger links between general practice, midwives and other primary and community providers must be developed. PHOs should be considered first and foremost in the role of coordinating and supporting other care providers.

A key success of the emerging localities has been in bringing communities and stakeholders together around the needs of communities. Cross sector and community partners working collectively in a collective impact model is vital.

Shared health information and IT systems

We need connected and adequately resourced IT infrastructure and clear information sharing agreements. Hira[20] is a good concept, but it is vital that there is urgency in implementation of a shared solution.

Primary care development and structures

Barriers

The aspirations of the Primary Care Strategy of 2001[21] remain valid but unfulfilled. Despite the flawed and outdated general practice funding model being the initial driver for the health reform process, and the Pae Ora solutions subsequently proposed, there has been no progress towards an alternative. The emergence of the locality model, a core plank of the Pae Ora reforms, has been slow and piecemeal, with doubts over its future under the new Government. Workforce planning and investment have been marginal, and pay parity remains a critical factor.

Lack of data and digital capabilities

Across the system, we are lacking data and digital capabilities, with little historical investment in general practice and community provider data and digital capacity and capability. PHOs have supported, innovated and made some gains in this space, but much more is needed.

Focus on wider determinants and wellbeing

Although the 2022 Pae Ora legislation sets an expectation that behavioural, social and economic factors are essential considerations, primary care in Aotearoa remains predominantly focused and funded around a reactive, treatment-based 'health care' model.

Potential solutions

Model of care for Aotearoa

Derived from the seminal work of Barbara Starfield and adapted with relevance to twenty first century Aotearoa, the core principles of primary care are: first contact (access), continuity of care, comprehensiveness, coordination, family orientation, cultural competency, community orientation and planetary health care.[22]

Basing a future model of care around these domains, grounded in Te Tiriti o Waitangi, has the potential to transform services and outcomes and bring the joy the primary care workforce seeks. PHOs, and their national partners and representative bodies (GPNZ, Collaborative Aotearoa) have demonstrated skills in this area.

Funding and equity

[20] *Hira – connecting health information*, see https://www.tewhatuora.govt.nz/our-health-system/digital-health/hira-connecting-health-information/
[21] *Primary Care Strategy 2001*, available at https://www.health.govt.nz/system/files/documents/publications/phcstrat_0.pdf
[22] Planetary health care and Barbara Starfield´s legacy, available at https://blogs.bmj.com/bmjgh/2021/06/10/planetary-health-care/

Typical contracts include packages of funding with prioritisation of distribution for the most vulnerable according to set criteria, allowing flexibility for local implementation to achieve desired outcomes (tight-loose-tight). PHOs are familiar with contracting and accountability arrangements that achieve the best outcomes, together with service design and delivery in partnership with providers and communities.

Workforce

Increasing the capacity and capability of the primary care workforce is a top priority. PHOs are already leading a range of workforce solutions, with PHO initiatives forming the basis of the current development of CPCTs. PHOs should have the opportunity to build on their existing knowledge and expertise, including implementation of CPCTs without delay or barriers, coordination of training placements, and development of tailored and integrated recruitment initiatives.

Network development

PHOs are already deeply connected with local primary and community providers, operating far beyond general practice. Properly resourced, PHOs could achieve more as 'system connectors'. PHOs would bring together the interests of funders, providers and the communities they serve, with a focus on equity, access and outcomes, while prioritising and maximising use of resources.

With that combination of relationships across funder, provider and community, PHOs would support and facilitate whānau-led commissioning in partnership with Te Whatu Ora and Iwi Māori Partnership Boards. Sitting alongside IMPBs, they would provide support, capability development and co-ordination for provider networks, so that primary and community services meet local needs based on robust data, strong relationships and collective responsibility.

Given the opportunity and the resources, PHOs will further enhance the planning, coordination and delivery of primary care services that improve population wellbeing and drive equity. Operating at the population health level, there would be a much greater potential to make inroads towards the wider social determinants of health and wellbeing, including enabling horizontal integration with the full range of community services and agencies.

We are not advocating for the status quo in terms of existing entities; rather we want to see the vital functions, transformational thinking and expertise that are not found anywhere else in the system protected and enhanced.

Embrace learnings from Māori PHOs

Our persistently poor Māori health statistics must be turned around. The work of Māori PHOs and their experience in whānau-centred models of care, use of broad workforces, and focus on wider determinants of health must be supported and enhanced as a key driver of improved access and outcomes.

GENERAL PRACTICE NZ

The Heart of Health Care Networks

GPNZ is a national membership organisation providing leadership, advocacy and voice for primary care.

O mātou moemoeā - Our mission

Connecting primary and community care to shape the future of hauora and achieve health equity.

O mātou whakakitenga - Our vision

A health and care system that supports all people to live well in their communities, delivers best possible care where and when people need it, and will be there for future generations.

He aha o mātou mahi - What we do

We actively promote strong, sustainable and well-resourced primary care in an integrated system. We are constructive and collegial in our approach, striving to support general practice and primary care leadership and seeking opportunities for shared mahi in the interests of equity, better outcomes, and pae ora for all New Zealanders.

Ko wai mātou - Who we are

GPNZ represents 24 of Aotearoa's 30 PHOs, covering an enrolled population of more than 4.4m New Zealanders, including more than 80 per cent of the enrolled Māori population.

Ko mātou me ngā amokura - Our groups and leadership

GPNZ has five member rōpu - PHO CEOs group; primary care clinical leaders; nursing leads group; data and digital leads group; and Ngā Matapihi o te Wairua (Māori leadership from PHOs) meet regularly, providing collegial support, shared learning and a conduit for advice and information-sharing between primary care and national agencies.

The work of GPNZ is overseen by an Executive Committee that draws on the expertise of our member organisations. The Executive is supported by the CEO and a small management team.

We are taking active steps to become a Te Tiriti o Waitangi partner organisation, ensuring the work we do gives effect to Te Tiriti o Waitangi and demonstrates the Te Tiriti principles of active protection, tino rangatiratanga, equity, options and partnership.

Introducing Primary Care New Zealand

To align with our organisational goals General Practice New Zealand will soon become Primary Care New Zealand. Our new name better reflects who and what we are about. It gives us room to grow and support a wider range of health and care professionals providing comprehensive primary and community care services that ultimately will deliver pae ora for all New Zealanders.