State of general practice in New Zealand

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If general practice fails then the health system fails.[1]

We are not alone in understanding the vital role general practice plays in successful health systems. Internationally, and over time, the evidence is clear.[2,3]

However, we clearly have a problem.

The system has not delivered equitable outcomes to sectors of the Aotearoa New Zealand community, especially for Māori and Pasifika communities,[4] the system is not providing population health outcomes that meet expectations[5] and the system is not providing its workforce with working conditions that are attractive or sustainable.[6]

The latest Commonwealth survey[7] showed younger general practitioners (GPs) have the highest rates of burnout. We also know that the proportion of GPs is falling in the Aotearoa New Zealand health workforce. Not nearly enough young doctors are choosing a career specialising in general practice.

The effect of this mismatch is that a growing and ageing population is being cared for by an ageing, diminishing and dispirited health workforce, large numbers of whom are contemplating relocation or retirement at or before the normal retirement age, citing stress, burnout and feeling unsupported.[6] As the population ages so does complexity of care, with Māori and Pasifika suffering higher levels of multi-morbidity at a younger age.

How do we move forwards to a sustainable, affordable health system the public trusts, which delivers high-quality equitable outcomes and satisfying working conditions?

Why is this not happening already in Aotearoa New Zealand, when we have known what success looks like for such a long time? Much as politicians find it hard to admit in public, why is it the Aotearoa New Zealand health system has moved into crisis mode over recent years?

Many of the reasons for our current situation stem from an insufficient, poorly distributed, under-valued and under-resourced workforce—one that does not reflect the ethnic and sociocultural diversity of the population it serves.

The current inadequate and worsening workforce demographics were both predictable and repeatedly predicted decades ago. The folly of Aotearoa New Zealand's historic reliance on shoring up the health workforce with overseas-trained health workers came home to roost when the pandemic closed our borders.

Investment by successive governments has failed to provide and maintain adequate facilities, nor to train the workforce needed to service rapid population growth and the associated increased demand. Now the borders are reopened, many other developed countries find themselves with the same workforce shortages and the global market for skilled health workers has become highly competitive.

For general practice, the way forward to a sustainable, equitable system involves regaining adequate staffing levels, with an interdisciplinary workforce—the makeup of which better reflects Aotearoa New Zealand society, and which has the capacity, capability and connections to deliver accessible, high-quality care in partnership both with communities and with the wider health and social care systems.

While there are encouraging examples of great teamwork throughout the country, there are many systemwide changes that will be necessary to turn the ship around and achieve this worthy goal across the motu.

The traditional model of 15-minute consultations is no longer adequate for caring for the growing number suffering multi-morbidity and associated polypharmacy, many with additional social problems linked to ageing, living alone and experiencing economic hardship.

In 2001, when the primary healthcare strategy and enrolment were first introduced, the average number of GP visits per year used for modelling the base capitation funding formula was only 2.5 per year. The model is poorly targeted to those most in need and urgently requires a major overhaul. Although there have been incremental increases over time, these do not reflect the increased costs of running a medical practice. Full-time GPs (or equivalent part-timers) now see more patients, more often and for more complex needs than when the formula was introduced 20 years ago. In the face of rising costs, this is increasingly financially unsustainable.

In addition, general practice has long been seen and used by other parts of the health system as

the universal backstop, with assumed uncapped ability to mop up lack of capacity elsewhere. This is no longer possible and, consequently, emergency departments are increasingly required to manage chronic conditions or the consequences of inadequately managed long-term problems. This results in a vicious cycle of further poor management that directly impacts equitable health outcomes, as the people with the least capacity to access the system find themselves in the greatest need.

As public hospital capacity has diminished relative to increased demand, and as they have been faced with their own workforce shortages, secondary care has had to raise thresholds for referral both for first specialist appointments (FSAs) and for planned care. Similarly, waiting lists for those accepted for FSAs and subsequent care grow longer and longer. While people are waiting for hospital and specialist interventions, we know they use general practice at a higher rate, further adding to capacity pressure in the system.

The administrative burden of trying to meet inconsistent, changing and ever more restrictive referral criteria has fallen back onto general practice, as has the explicit expectation to provide additional and unfunded ongoing clinical care for those on the growing waiting lists, those whose referral has been rejected on grounds of "insufficient capacity", and those who need follow-up care after increasingly early discharge.

The increasing complexity of care and associated administrative burden, unsolicited work resulting from a lack of capacity elsewhere in the system, funding formula long since unfit for purpose and workforce shortages represent a perfect storm.

In response to this additional work and in striving to provide the best care possible for existing patients, general practices in many areas have been forced to close their books to new patients and waiting times for routine appointments in many areas have ballooned from days to weeks.[8] These are, in effect, the same rationing methods long used in planned secondary care.

As these rationing methods cannot be applied to acute and emergency care, unmeetable demand in general practice leads to longer and longer waiting times for stressed patients and staff in urgent care clinics and emergency departments. In rural areas, where there are no alternatives, urgent care has to replace capacity for routine and planned care.

As we move forward with the *Pae Ora (Healthy Futures)* legislation, focus hopefully will once again fall on the numbers and makeup of the workforce and the skills that are needed to deliver a future high-performing health system. Te Whatu Ora – Health New Zealand's recently released *Health Workforce Plan 2023/24* has six key targets that appear to be a move in the right direction—whether it turns the tide in time remains to be seen.

As the scopes of practice of both existing and new staff evolve and are (re)defined, some discomfort can be expected. The future role and best use of specialist physicians working as generalists in the community (aka GPs) could usefully be re-examined from community, practitioner and system perspectives.

The evidence of patient benefit and positive health outcomes from generalist healthcare teams providing comprehensive and continuity of care in the community is both strong and substantial.[2,3] The best use of generalist physicians should include managing the most complex medical situations.

A funding and business model that allows sufficient time for these physicians to carry out that work should be a high priority. Working with the complex will require reallocation of some of their existing workload to other team members. This will no doubt be embraced by some and resisted by others. It will also require widening the scope of postgraduate training and education programmes.

We need a framework through which high-quality sustainable general practice can deliver to all New Zealanders, and which addresses long-standing inequitable health outcomes. This is the core challenge for the government and central health agencies as we implement the *Pae Ora* legislation.

If we want to achieve more equitable health outcomes, we clearly need to do some important things differently. However, the system must also recognise, celebrate and continue to support the many innovations driven by the sector over the last 20 years.[9]

The need for cross-party accord on long-term workforce and health system planning has never been more necessary, nor, as it seems from recent pronouncements, more distant.

The Aotearoa New Zealand public and health workforce deserve better.

COMPETING INTERESTS
Nil.

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