The Value of General Practice

27 May 2025 Webinar – Q & A

Q. Has this evidence been presented to politicians? Is anyone taking the responsibility to ensure they are bombarded with this information which completely contradicts the direction they are taking such as the national telehealth service? They need to see this presentation!

A. This has been presented to the Ministry in general, to the Ministry Policy Group, GPNZ and some Te Whatu Ora groups. Many are trying very hard to present this information in as many fora as possible. The aim is to have us all understand the evidence as policymakers and politicians have not necessarily been exposed to this.

Q. I'm interested in where and how you see allied health roles in primary care being helpful in Aotearoa, to support our essential GP and nurse practitioner workforce?

A. We don't have a common understanding of what team-based care looks like, when it is most effective and when it is not so effective, except to understand that very big teams are probably not that effective in terms of continuity. I think where it doesn't work, and hopefully you will have seen from the evidence, is fragmenting the general practice role to out to other people, is not effective and potentially harmful.

I worked in Canada for 10 years and in Canada there are family health teams. A family health team means the team members are co-located. I worked in a clinic that had 12 doctors, and we had an occupational therapist, a physiotherapist, two pharmacists, a social worker, an assistant navigator, a mental health team, and a dietician. I can't even remember the number of people that were there; we had a list size of 50,000 patients. What we did realise though, that with 12 doctors it wasn't actually going to give good continuity. So we divided into four smaller teams, our patients were essentially enrolled with the smaller team, but the allied health providers were located and wrapped round all of those teams. So, that's my description of the way that I think it works best for allied health providers to support general practice. Using a team-based model that supports continuity of care, I see is the is the best way, and I have to say it was the dream to work in this Family Health Team model.

Q. As an emergency physician, many of my patients tell me they don't see the same doctor, they don't know “their” doctor but only know the practice. How do we get back to the nirvana of continuity of care? Is it a numbers game or something else?

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A. I think there is probably a complex solution to that.

Number one, primary care in New Zealand is inadequately funded – there are no substitutes for appropriate funding.

The model of seeing one GP in a practice is not the modern model of care, I think team-based care is the modern model of care but within that model there can be high and low continuity approaches and ways of organising.

It is a bit about measuring what we value and valuing what we measure. For example, I think there there's a lot of data around about HbA1C levels and what diabetes care is like. There are no measures of the things which are far more valuable, and if we measure these and make them visible, (which says that we value them), then I think that that will help to support care and moving back to the continuity of care model. It's the care that we know is the best general practice care, but we just need to be supported to be able to provide it.

At the moment, there's inadequate resource to support General Practice and nothing can replace fixing the longstanding erosion of funding a model we know is extremely effective. Care has become fragmented by the necessity of the strain on general practice. I think as well as providing adequate resourcing for primary care that reflects its value in the health system and for population health, if policy, resources, and money were aligned with things like continuity, then that would support excellent care because we (patients and clinicians) all know, the best care that we can provide, is continuity of care. Again, it's much more satisfying to see patients who you're familiar with than patients who you haven't seen before.

Q. I have been doing a small study of the impact of telehealth on rural primary care. I think there are some really salient lessons to be learned that reflect much of what you say. Do you think that hybrid clinics where the same clinician provides virtual and in person care to the same cohort would overcome some of these virtual care disadvantages?

A. Yes. The Canadian study provides a really good example of the model of care that best works when it's supported by telehealth or virtual care: it is when it’s provided by your continuity provider and we saw that in this study in the data on hospital attendance rates and need for follow up care. Care is much more effective provided by your continuity provider than if it's provided a person not known to you.

Whatever innovative models or disruptive models of care we use, we do have to look at access, but continuity has to be one of our markers and we have to incentivise that equally. In telehealth we know that some conditions could be managed virtually, but we also know there are some conditions that just can't, and so we have to think about using data to create evidence to understand what is suitable for that kind of care and what's unsuitable.

I say using data to create evidence as in the Canadian study on threats to capacity in primary care, we looked we looked at telehealth and we looked at the evidence for the kinds of conditions that are suitable for managing by telehealth and those that aren't. So, we know that mental health care can be effectively provided using telehealth, especially if it's with a continuity of care provider. We don't have the evidence for other conditions, and that is where there is this opportunity to trial things, to pilot them. We need to know if they are as good as the gold standard or, are there things that are really best to be in-person care, and where someone's in a rural location, how do we enable that?

I was working in Canada during COVID and I felt I could provide some care by telephone, which we often did anyway, it’s just that it became more visible during COVID. But what enabled me to safely provide that care was that I knew that patient really well. So, because I was their

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continuity provider, I could make judgments, and we could make plans together, both feeling safe with that plan because we knew each other. I knew whether this was an anxious person, whether this was a stoic person, I knew what other medical conditions we had to keep an eye on and I knew whether they would recognise deterioration and be able to get transport if they needed to – whether they had adequate support, all of those complex things.

Lapointe-Shaw, L., et al. (2023). "Virtual Visits With Own Family Physician vs Outside Family Physician and Emergency Department Use." JAMA Netw Open **6**(12): e2349452.

Q. Digital exclusion disproportionately affects Māori, Pacific peoples and Kaumātua/older adults in Aotearoa. What specific policy mechanisms or funding models for equitable access do we need?

A. There are 2 aspects to this: one is what can policy support to reduce structural (e.g. context, privacy, cultural) and financial barriers to digital exclusion. The second consideration is the dual access to both face to face and virtual. Patient preference and outcomes data suggest policy must ensure virtual and face to face options are provided. One study in the UK using large datasets shows patients' satisfaction and the likelihood of their needs being met is associated with a higher ratio of face to face to virtual care appointments. There is evidence from Canada around the time of the pandemic that patients who reported difficulty making ends meet, those new to Canada, and those with fair or poor health reported lower comfort with virtual care and were less likely to want virtual care options to continue, and 5% of all patients didn't not want to receive any virtual care.

Q. The challenge is propagating this information to the decision makers and ensuring they see the value in this. Many decisions about solutions are being made in a hospital centric manner because waiting lists win votes. How can this kōrero be expanded at the ministerial and Te Whatu Ora level?

A. There is data and there are economic figures, those dollar values must speak to politicians at this time of budgetary pressure in general and on the health system. It is clear adequately resourcing primary care saves the health system money. These figures are not well known, so it's making them well known in as many fora as we possibly can. While waiting lists are important one of the other questions tonight raised the issue about the number of patients seen in ED who don't have a regular continuity provider, patients are experiencing this pressure and are not happy about it. Patients are voters and so as the pressure increases in primary care, I hope that there will be more pressure put onto politicians by voters.

Q. Do any of the studies referenced include outcomes for Indigenous populations?

A. The effects persist across studies in different countries and there is clear evidence these mechanisms are health equity – enhancing. I am not aware of any that looked specifically at an "indigenous / non-indigenous" framework in analyses. There is evidence for access and ethnicity (greater benefit in equity of referral with greater supply) for African Americans and Hispanics in a US study) as well as a comprehensive review of evidence between clinical care and health disparities in this summary:

Starfield B, Gérvas J, Mangin D. Clinical care and health disparities. Annu Rev Public Health. 2012;33:89-106.

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Basu J, Clancy C. Racial disparity, primary care, and specialty referral. Health Serv Res. 2001;36(6 Pt 2):64-77.

There is an opportunity to understand this in the Aotearoa NZ context if we start to use these measures of value.

Q. Does everyone in the population benefit equally from this or could we prioritise those people most likely to benefit in some way?

A. I wish I could give you answer, it seems on the face of it there may be groups who could benefit more, however there is a danger in "shortcut thinking" without evidence and there is not data to be able to answer this question, but I think if we started measuring this and looking at changes over time in New Zealand, we could start to answer that question for our population and particular groups.

Q. Is there is any other current research on the safe GP to enrolled population ratios to support clinical safety and maintain continuity of care?

A. No, there isn't, and often the question is asked in the other direction, when talking about that per 100,000, when do you reach the ceiling. Certainly, in the studies it's not clear where the ceiling is. We don't have data on an unsafe ratio, but I think you probably could look at those measures of system strain to understand that. Where there is intense system strain, there is not accessibility and availability and continuity, and when those measure are low, then you're probably not at a safe ratio. There's been some suggestion around continuity that if continuity scale usually of 0 to 1 and that the benchmark may be around 0.7, if you can achieve it, that's reasonable. If you're getting a continuity measure around 0.7, then probably you have safe levels of access or quality, but we don't fully understand where the sweet spots are in the trade-offs. We just know there's a continuum, the higher the ratio is, the better the outcomes are.

Q. AI in primary care, is it likely to affect patient outcomes and is it also likely to impact on critical thinking ability of clinicians?

A. We don't know.

AI is not my area of expertise, but I've been keeping an eye on it.

I know there is interest in AI software, and we know that there are issues with AI and health just as there is with AI generally, you will be familiar with the kinds of errors that AI can make with hallucinations or errors of omission and those kinds of things. It probably depends, a bit like virtual care, on how we use it and how much clinical oversight we have. If we get something to write notes for us, as we carefully review those notes, that's safer than if we, we get AI to write them and we don't carefully review those. One of the things I think I think will be interesting, and that people have recorded anecdotally, is how using AI might change our clinical encounter and we just don't know that, we certainly know it changes, you have to speak out loud, which has an immediate impact on that relationship between clinician and patient. I agree it may have significant implications for clinicians critical thinking skills and ability to synthesize and use clinical judgement. We have seen the tension that exists between following guidelines (measurably "good" care but often meaningfully worse) and exercising good judgement in not following them so that is likely to be amplified with AI, so there's lots to understand about that and lots we don't know about that.

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Q. Primary care is so important, yet many are unenrolled, in particular those often mentioned to be of high risk, Māori, Pasifika and some Asian populations. There is a big risk of urgent care taking these on and as mentioned in another question, what if going back to your GP team is not an option? Where does their care sit?

A. At the moment it sits nowhere and that's our huge problem and the answer is adequate resource. Primary care desperately needs resource, it's been chronically underfunded for years, and we are seeing the outcomes of that. There is no magic wand to wave, nor the disruptive innovation that will solve it - it needs resourcing, and the resources need to be focused on those most deserving of the best quality care.

Q. The wait times are out to two weeks to see a GP and so they pop into the emergency department, or the 24-hour surgery and the wait times blow out at those clinics. Do you think urgent care needs to pick up a bit more of the burden of non-urgent care?

A. It's a bit like the traffic light metaphor. Developing new models of care rather than funding what we know is the best care is not the best solution, and it could lead us to further fragmentation of primary care. I don't think it's good for people to go and be getting their chronic care at the emergency department or in urgent care.

The question that has been asked before is perhaps we should set up some regular primary care clinics in urgent care centres, but that is going to be non-continuity care, it's going to be fragmented care and I think it's a dangerous path because we could see it as a solution, and it will result in poorer care for our population. It will also cost more. Better to use the funding where it works best.

One approach that could help, is to look at the resource that we have and decide how we best use it. There're tonnes of stuff that's done in primary care that does not need to be, there is these huge administrative burdens which are just so unnecessary. The national kōrero needs to be, as a nation, what care is important for our general practice teams to provide and how can we get the capacity for those who need enrolment to be enrolled and for GPs and general practice team's not to be burnt out and stressed.

Q. I very much like your term declutter of general practice, having just moved house and done the big declutter and I feel so much better without all that junk. So how can we get rid of the stuff that we don't enjoy in general practice?

A. It's a conversation for individual GPs and for GP organisations to come together collaboratively with patients to talk about what we see, with the data such as the example that I gave you around exercise; but also to talk about what New Zealand values about high quality care and what they don't.

Thinking about what we can do without in this time of crisis might involve some radical thinking. We regard smoking cessation as core part of general practice; do you need a GP to do that? when you have policy that's permissive of tobacco products, is using individual care to try to stem the subsequent addiction the best use of that resource?

The rider is, it's not all about us agreeing and saying that general practices are no longer able to do these things because they are low value. It also needs to be a cross-party political agreement

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on the future and funding of the health system, politicians, and policymakers need to be involved in that conversation and need to take responsibility for their bit both in policy and in decluttering the burdens. A lot of the administrative burdens are requirements, and a lot of those requirements might be nice to have, but they're not need to have, they are not a core part of care.

Q. Wouldn't social determinants of health contribute to health outcomes? whānau and clinician exist in a system that has influence on both of them and the outcome of the interaction

A. Absolutely - there are multiple complex influences on health outcomes, and this webinar looks at one modifiable part - clinical primary care. See webinar recording "More effective than a Pill". This is not due to bias: Effects persist after controlling for sociodemographic measures and lifestyle factors, e.g. % older adults, urban, ethnicity; education; income; unemployment; pollution, obesity, smoking

Additional reading on the contribution of primary care to health equity can be found here: https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031811-124528 Basu J, Clancy C. Racial disparity, primary care, and specialty referral. Health Serv Res. 2001;36(6 Pt 2):64-77.

Q. Looking at patient opinion as to the quality of GP care, do you recommend that the annual patient survey we have to send to our patients to take part in each year, is truly taking the pulse of our GP system? This was set up quite a few years ago & was not designed by GP leaders & hasn't changed. It feels overly political & has a gaslighting flavour. Do you support this being re - looked at comprehensively by GPs, GP reps plus GP patients, to be more realistic & relevant?

A. Assessing quality of primary care needs to be dual: patient and clinical service delivery measures. I am not familiar with the development/ testing / validation process of the NZ survey but can make a few comments. Any surveys need to be constantly reassessed to be sure they are assessing what they intend to, that they are covering the range of important dimensions from different stakeholders' perspectives (patient / GP clinicians / health services). Updating is key as context and evidence changes but retention is also important so you can see change over time. There is a well validated (in a number of countries) patients survey developed initially by patients and primary care providers where the questions map directly onto the concepts we discussed in the webinar that could very usefully be considered in the evolution - take a look here (Table 1 has the questions) : https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_483_MIPSCQM.pdf. It would be a useful "pulse" to have service provider level and patients level assessment of the core mechanisms of GP and how they are functioning. Both are needed as some studies show that patient reports can be inaccurate – likely as they have a lot going on. For example, in the RCT of continuity I mentioned patients' report of their provider continuity did not correlate that well with the degree of continuity seen from their bookings. This is not to invalidate patients' experience but to say that recall is difficult, especially after periods of illness and multiple perspectives are needed.

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Q. How do we change the perception that technology is only the enabler to support clinicians to provide improved health care for their patients by having integrated systems?

A.

1. Making visible to as many stakeholders this strong evidence base that has repeatedly found the key enablers over decades now.
2. Asking for evidence of similar robust evidence for benefits of technology.

Q. With continuity of care measures, how does it work if you have GP Registrars rotating every 6 months? how does this affect the measures?

A. Given the small number of GP registrars in NZ it is unlikely to affect assessment at that level. At individual practices you can do "sensitivity analyses" with GP Registrars consults in and out to assess the effect on measures. It would be an interesting thing to study in more detail to see if “supervision” has an impact. If a core practitioner provides 70% of a patient’s care that will still rate as good continuity. Continuity measures at practice level would also ideally include continuity from a provider’s perspective (what proportion of the patients I see are from my enrolled group) and looking at patterns. This could add value by looking at how continuity can be optimised both for patients and for GP Regs.

Q. Do you believe there is a need for nurse practitioners and GPs from minority communities in primary care settings?

A. Yes

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