



The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

An equitable, accessible health-positive model

A MANIFESTO FOR GENERAL PRACTICE

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Te Whare Tohu Rata o Aotearoa

26 MAY 2020

COVID-19 has been an extraordinary event for general practice in New Zealand – one that highlighted inequity and showcased the role of technology in medicine like never before. Before we took the frontline defence against this global pandemic, GPs had been awaiting the final report of The Health and Disability System Review, a government-contracted, wide-ranging assessment designed to future-proof our health and disability sector.

Ahead of the report's release, I want to take this opportunity to share GPs' lessons from our COVID-19 experience. This tragic and significant health crisis has helped identify how general practice needs to transform if we are to serve our patients well in future. This document outlines the issues and challenges our College confronted and details our hopes for the future.



How did general practice pivot?

On 21 March, with just over 48 hours' notice, The Royal New Zealand College of General Practitioners (the College) asked our 5,500 general practitioners (GPs) across New Zealand to begin remote consultations – seeing patients by phone and video – with a target of 70 percent of consultations happening this way. We made the decision having taken advice from overseas that showed sick patients sitting in waiting rooms had fuelled the rampant spread of COVID-19.

At the time there was no thought of how this change would affect the business model of general practice; our move was solely based on saving lives while continuing to provide care. Concurrently many hospital services were suspended and presentations at emergency departments dropped by 50 percent.

Our shift to remote consults has had many implications for community-based health services, which consistently deal with 90 percent of New Zealand's health needs, COVID-19 or no-COVID-19.

The change, although dramatic, shows the nimbleness and flexibility within community medicine. While there are hooks in the new system that we need to consider, they do not necessarily make it worth reverting to the old 'normal'. We have an opportunity to do things differently now and a chance to focus on areas – like equity – that need to be transformed. Having made enormous changes to cater to the wellness of our patients, why would we change back to something that had not been providing adequate or equitable service for many? The short answer is, we shouldn't.

E-health and access

The traditional GP–patient interaction is built upon relationships, *whakawhanaungatanga*. This is how we're able to listen and partner with our patients to define a diagnosis or a problem and come up with an effective management plan. These relationships and continuity of care are an essential part of the management of long-term conditions and



encompass both physical and mental health. There are some groups of people that this relationship-based model of care is particularly important to: those with long-term conditions, isolated rural people, and Māori and Pasifika peoples.

However, the special relationship between a patient and their doctor has, for some years, been threatened by time and technology. The likes of Dr Google, mobile apps like the UK's Babylon, or now New Zealand startups Well Revolution and TEND, offer convenience medicine and quick answers but lack the history, continuity, personalised care and follow-up that GPs deliver. However, now that we've seen GPs' response to COVID-19, it is clear GPs can – indeed must – own this e-health space.

When GPs pivoted to doing remote consultations, we coupled the benefits of technology with the relationship-focused, holistic care delivered by seeing a doctor in person. We learnt telehealth can remove some barriers and can offer a new way forward.

For some people, the cost of accessing health care is very real. According to the latest [NZ Health Survey](#), 13.4 percent of adults do not visit a GP due to the cost. The reasons for this are many; a 15-minute appointment at a GP clinic could mean half a day off work (which may be unpaid), while for others their work hours extend into times when GPs aren't open.

The unbudgeted extra petrol required to travel to the GP means some people will put off appointments, while others who may work on zero-hour contracts or in precarious jobs simply don't have the flexibility to get their health care needs seen to. It is no accident that hardship is a huge predictor of health outcomes. A further barrier can be mistrust of the health system itself because, despite our best attempts to remove them, inequities and racism do still exist.

However, by attending to patients via phone or video, we've found patients are able to fit their appointments into their day and with more time certainty. There is no more sitting in waiting rooms and no more travelling across town and country. Appointments can occur remotely in a meeting room at work, or in a car on the side of the road, or while baby naps in the next room.



Although there are many advantages to remote consults, we cannot forget telehealth does create barriers for people who do not have English as their first language and for those who are deaf. Children, young people and adults with cognitive differences or more acute mental and emotional wellbeing needs are also likely to prefer an in-person consult. Additionally, there are barriers for those who don't have smartphones or access to data or the internet.

The 'COVID-19 world' has seen a rapid change to many health services, including requirements for WINZ and ACC medical certificates, online allied health appointments, and e-prescriptions. These were all strongly advocated for by the College and offer great advantages in terms of time and efficiency.

Equity and access

With the potential for long-term change now a reality, we must ask ourselves: How can we proactively care for patients to ensure equity? We need to learn from and enact the [Wai 2575 claim](#) (opens to PDF) when looking at new models for primary care because, despite issues around rural access and the working poor, the biggest predictor of poor health outcomes continues to be ethnicity.

The recent quietness in our waiting rooms created an opportunity to triage and see patients more quickly, to spend time dealing with complex issues, and to reach out to patients who do not have access to care due to financial, transport or childcare challenges.

Many practices focused on flu vaccinations for Māori, some went out to homes to vaccinate, deliver medication and hygiene packages, and to check on their patients' general health, embracing the Whānau Ora model of care that works so well for whānau.

We found there were patients who missed the 'kanohi ki te kanohi' contact with their practice team. Queries about how people are getting on might be answered with

“fine” – but this may not truly reflect the chronic health conditions they are struggling with. Not all patients were able to be contacted either – again, access to phone and internet can be a barrier to care. Thanks to this new virus, we also discovered a fear of coming to the clinic or hospital, which resulted in late presentations and unwell patients.

We have begun a transformational journey and we will need to continually adapt, develop, and reassess what we are doing to ensure we are getting the equitable outcomes that we are aiming for. This work needs to be done in partnership with Māori. The College is lucky to have its own Māori representative group Te Akoranga a Māui, but it's important that we continue to foster relationships with others such as Te ORA (Māori Medical Practitioners Association) and Te Rōpū Whakakaupapa Urutā (National Māori Pandemic Group); at a local level, community doctors must be encouraged to work with whānau, hapū, iwi and Māori communities.

E-hospital and access

During Alert Level 4, my colleague Dr Garry Nixon told me that he'd seen base hospitals seriously question the need for rural patients to travel for brief outpatient appointments or be transferred for specialist investigations and treatments.

As a rural hospital doctor who has researched and documented this issue for some time, his city colleagues' 'lightbulb' moment was a relief. Perhaps COVID-19 will be the catalyst for introducing sensible, practical changes for rural people, who often incur inequitable levels of cost and inconvenience to access health care.

If we continue to successfully triage and maximise e-health regularly, ask our patients to travel only when necessary, decentralise our health system as much as possible, and make videoconferencing the norm for meetings, we can make major inroads into reducing rural–urban health inequities in New Zealand (not to mention the potential climate change benefits of reduced travel).

Having transformed general practice to a more virtual system, we should now ask ourselves: Can we create the same virtual process for hospital referrals? GPs are experts when it comes to uncertainty and differential diagnosis. We rarely send a patient to hospital saying, “I don't know what this person has, can you work it out?” Diagnosing is what we do extremely well. If we can arrange tests in the community to confirm our diagnosis, then there may be much less need for patients to be seen in hospitals. Keep in mind, though, that such a change would need to be funded adequately, and we're **still waiting on community medicine to be adequately considered**.

Across the country there are generalists (GPs and rural hospital medicine doctors) providing levels of care and procedures that in some regions are the preserve of a secondary or tertiary hospital. If more services were provided in our communities, then access to care would be transformed. Making rural people travel for hours to attend a five-minute appointment that could have been done easily via videoconference is nonsense. It would serve us well if testing was completed in the community, so that only those who need to go to hospital do so.

Having to seriously weigh the actual benefits of interventions has been good for us and our hospital peers. COVID-19 has forced us to assess what can be done in the safer and more cost-effective community environment, what can be done virtually, what can be done without travel, and what doesn't have to be done at all.

Another revelation of the 'COVID-19 world' has been the many layers of bureaucracy that lie between the Ministry of Health and patients. The College worked hard to ensure the voice of community medicine was heard during the national planning and managing of COVID-19.

What we've seen though during the COVID-19 response is that accessing local information has been fraught, variations in delivery of service have been inequitable, and pre-COVID-19 patient hospital referrals have been returned to the GP for 're-referral later' – effectively just delaying health care.

Our Medical Director Dr Bryan Betty has been actively involved in the national COVID-19 response as a member of the Ministry of Health's Technical Advisory Group and chair of its Primary Healthcare Sub-Committee. Having community-based health care embedded in the decision making has made an enormous difference for patients and those who deliver most of their care.

Essential services and access

One of the main reasons GPs were able to change the way they deliver services 'overnight' is that we didn't have to wait for bureaucracy to 'approve' the move. As independent service providers we were able to change quickly in a way that was safe and practical. And while we were nimble and adaptable, that has left us at risk.

Discussions around funding are always difficult. How do we rationalise seeking greater funding when foodbanks have increasing numbers of people lining up outside them? Health care is critically important – but is it more important than having food on the table? Governments, the health system, practitioners, and patients have relied on a successful public-private partnership to deliver medicine in the community. However the way funding is allocated and distributed has eroded general practice over many years, creating a service that is financially fragile.

Across the globe, governments grapple with how to fund health services and not one is perfect. Fee for services encourages over servicing. Capitation incentivises corporate primary care and risks high-needs patients being seen as liabilities. Much

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of the care we provide is at the instigation of the patient and often at the discretion of their bank balance. In some regions general practices are provided with discretionary funds to provide proactive care, but this is not nationally consistent. There are many changes that could be made to funding, but overall, community medicine needs to be funded equitably.

What now?

Of course, now and in the future, there will still be patients that need to be seen in person. There will be patients who need hospital services, there will be funding niggles, and any future system may not be perfect. But as Winston Churchill once said, “never waste a good crisis”.

We welcomed the Health and Disability System Review because we knew we couldn't keep doing things the way we have been. Nowhere is that clearer than in general practice. We are ready for change. We have proven change is possible. And we've seen that it is needed.

During the COVID-19 response, GP leaders have worked collectively (albeit remotely) so we could provide valuable advice to the Ministry of Health. At the same time, we saw failings with the localised autonomy of DHBs, which resulted in patchy delivery of health care equipment and services (think PPE and flu vaccine). I acknowledge some DHBs have been very forward thinking and responsive, but we need consistency so that all New Zealanders – regardless of their postcode – have proper access to health care.

As community-based health care evolves it will become even more important for us to collaborate with our hospital colleagues to ensure changes support new ways of working. Being answerable to DHBs run by urban-based Boards who don't really understand the communities they are responsible for (particularly with regard to Māori and rural populations) is not the way of the future. The DHB specialist-centric view is at odds with generalism and community care.

The changes we made during the lockdown were centred around patient safety. Let's continue to build momentum and keep patients at the centre of all health care decisions. Where do patients spend most of their health care time? In the community with 'their' doctor. That's why I believe community medicine is the key to achieving superior health outcomes for all.

The Health and Disability Systems Review recommendations will almost certainly generate some interesting debate. Let's accept that nothing about 2020 and beyond is going to be business as usual. We need a new, sustainable and patient-centred 'normal'. Major structural change of our health care system is both needed and wanted. Let's get on with it.

Acknowledgement

I acknowledge the work and collaboration on this article from College members in Te Akoranga a Māui, Rural General Practice, Rural Hospital Medicine, the Board and College staff.

Read the [Wai 2575 Waitangi Tribunal Report 2019](#) (opens to PDF)