GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Have your say about the primary care workforce

Five key leadership lessons for New Zealand doctors
Dr Jonathan Hoogerbrug

Pressure cooker in rural general practice

Primary care

The heart of New Zealand's health care system
Dr Prabani Wood

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

June 2025

In this issue

Editorial

Dr Samantha Murton

A few weeks back on 19 May we celebrated one of my favourite days of the year – World Family Doctor Day. This year's theme was 'building mental resilience in a changing world,' which is a very relevant and important message for us as health professionals and the patients and communities we serve.

As the workforce that has the most engagement and interactions with our patients, we know that our jobs consist of so much more than diagnosing and treating everyday illnesses and pain. A big part of our job is identifying the unknown and what we can't physically see. We do this by listening to what is or isn't being said in a safe, supportive and non-judgemental way.

The continuity of care we provide to patients and their families – sometimes over generations – allows us to build long-lasting and trusted relationships, which means we can work with our patients to address their mental health struggles and identify a plan to work through these challenges.

But as health professionals, we also need to be aware of when we need to take our own advice. If we are to continue providing this care, we need to ensure we are prioritising our own physical, mental and emotional health and wellbeing too.

We need to have our own outlets that we utilise – professional and personal. Whether that be through peer networks, support from those who know us the best or external support organisations such as EAP. Having a hobby or extra-curricular activity is a great way to immerse yourself in something you enjoy, and to recharge and refresh. For me, that is my painting. For two hours each week I switch everything off and put paint to paper. Putting your mind to something completely different from your day job has the power to 'fill your cup' when it's feeling empty. Even when I feel at my worst at the beginning of an art class I can guarantee I will feel completely different at the end.

As I mentioned in my World Family Doctor Day message, we thought it was important to highlight and share what our members do professionally and personally to relax, refresh and recharge so that they can be at their best when they are caring for their patients.

We have created a resilience and wellbeing hub on our website for you all to visit and hopefully continue adding to. We have pulled together a bunch of stories that we've published in the past that show how you are walking the talk and taking the advice that you would give to your patients.

Dr Samantha Murton
President | Te Tumu Whakarae

> "If we are to continue providing this care, we need to ensure we are prioritising our own physical, mental and emotional health and wellbeing too.

Please visit the page and read through the stories – I hope you find some inspiration in there. If you'd like to contribute, you can email the College's communications team and they'll get in touch for more information.

This is my final editorial as President and I know I'll be saying this a lot over the coming weeks, but thank you again for all of your support and collegiality over the past six and a half years. It's been quite the journey but I've gotten to meet so many of you and hear about all the great work you are doing in your communities.

I've really enjoyed my time in the role, and I look forward to still contributing to the College's advocacy work as we continue on our journey to creating a sustainable and fit-for-purpose primary care workforce.

Enjoy this month's issue,

Goodfellow Unit podcast: **Diabetes care**

Ryan Paul is an endocrinologist at Te Whatu Ora Waikato and is an Associate Professor of Medicine at the University of Waikato. Ryan has created the Advanced Diabetes Management Course for all health professionals in Primary Care and was awarded the NZ Medical Educator of the year in 2019.

In this episode Ryan discusses disparities in diabetes care, focusing on how technology can reduce the equity gap.

The key take-home messages of this podcast are:

- Be aware of diabetes technology
- A lot has changed in the last few years
- Anyone with type 1 or Pancreatogenic diabetes should look to CGM and be aware of automated insulin delivery
- Refer those not on specialist diabetes care back into the system

Listen to the podcast

Submit your feedback

2025 College election

The results

Thank you to all the members who were nominated and who voted to elect a new College President and Board member.

College President

For the role of College President only one nomination was received so no election was held, and Dr Luke Bradford is our new President-elect.

About Dr Luke Bradford

Dr Bradford is a Tauranga-based GP working at 5th Avenue Family Practice and became a partner at the practice in 2013. He trained in Southampton in the UK and moved to New Zealand in 2008. Initially working in emergency medicine, Dr Bradford left the hospital system and worked in urgent care and hauora medicine at Ngāti Kahu Hauora before completing GPEP training and moving on to 5th Avenue.

He has chaired at PHO level and was Chief Medical Officer at Bay of Plenty DHB prior to being appointed Medical Director of the College in 2023. In his current role as Medical Director, Dr Bradford advocates for College members and the wider primary care workforce and is a regular commentator across national media providing clinical advice and updates.

College Board member

There were seven nominated candidates, and following the voting process Dr Karl Cole has been re-elected to serve a second term on the College Board.

About Dr Karl Cole

Dr Cole is a GP in Papatoetoe, South Auckland, where he co-owns and has developed a purpose-built multidisciplinary Health Hub serving a diverse community. A New Zealand–trained doctor of Ngāi Tahu descent, he gained Fellowship of the College in 2004 and has been dedicated to general practice ever since.

He is a strong advocate for independent, community-led primary care and believes that the future of general practice must be flexible, patient-centred and ready for the digital age. His experience spans both frontline medicine and health system leadership, ensuring he understands the challenges facing primary care from multiple perspectives.

Dr Bradford and Dr Cole will officially start their tenures at the conclusion of the AGM, which will be held on Saturday 26 July at *GP25: Conference for General Practice.*

Dr Luke Bradford
College President-elect

Dr Karl Cole
College Board member

Submit your feedback

Months in review

April and May

The College is a strong, constant advocate for general practice and rural hospital medicine. We use our voices and experiences to inform Government, politicians, other sector organisations, the media and the public about the importance of the work we do and the value we add to the sector and our communities. Here is a snapshot of the advocacy work from April and May.

Pre-Budget opinion editorial

Ahead of the Government's 2025 Budget, College President Dr Sam Murton and Medical Director Dr Luke Bradford wrote an opinion editorial for the *New Zealand Herald* advocating for investment into primary care as essential for thriving, healthy communities. In the op-ed they say that if we are a workforce that can provide 23 million patient contacts a year on less than six percent funding from the health budget, imagine what we could achieve if we had fair, fit-for-purpose funding that addressed the work that we do and the increasing patient need we are seeing. **Read the full opinion editorial.**

College response to Budget 2025

Read the College's response to the Budget announcement in our media statement. **Budget 2025 misses opportunity to give primary care a leading role in addressing and improving healthcare in Aotearoa.**

WONCA Asia Pacific Conference

College President Dr Sam Murton and College CE Toby Beaglehole attended this conference in Busan, South Korea. The theme was 'Primary care transformation – implementing high-value, high-quality care.' Delegates from around the world shared experiences and reflections on common issues, including rising workloads, inattentive governments and funding challenges.

National Rural Health Conference

College President Dr Sam Murton and Medical Director Dr Luke Bradford attended this conference in Christchurch in early May. Dr Murton also spoke on a panel about the opportunities and barriers in leveraging new technologies to support rural training.

Meeting with new Director-General of Health

Drs Murton and Bradford and Toby Beaglehole met with Audrey Sonerson and updated her on College advocacy, priorities and upcoming work for the College.

HiNZ Digital Health AI Summit

Dr Bradford attended this summit in Wellington with other health leaders to collaborate on how to make AI-driven change in health care and to share knowledge and experiences.

Ngā Hononga Ora: Collaborative Aotearoa Conference

The College's Quality Programmes team attended and presented at Collaborative Aotearoa's conference. The team profiled the fantastic and meaningful mahi of the general practices through the Cornerstone Equity and Continuous Quality Improvement modules. With over 200 attendees, 55 speakers and 17 stands, it was a great opportunity to advocate for the value the College's Quality Programmes provide for general practices.

Jackie Cummings, Health Services Research Centre – Closed Books Research

Meeting to discuss Dr Jackie Cummings' new research proposal to update the HSRC work on closed books in general practices.

NZ Transport Agency Waka Kotahi (NZTA): Medical aspects of fitness to drive

Dr Bradford met with NZTA to provide advice on the overview of NZTA's role in medical aspects of fitness to drive (MAFTD) and position on medical assessment, cognitive testing and its relevance to fitness to drive. Greypower also attended to provide insights about the impact of current policies on older drivers and their views of changing the current model to move away from a 'one-size-fits-all' approach to cognitive testing.

NZ Police, Arms Engagement Group

The College met with the Arms Engagement Group to discuss the firearms safety engagement and education pathway, and the new Arms Act consultation.

Ministry of Health – unlocking the potential of active ageing

Dr Bradford met with the MOH to discuss the College submission and recommendations on its consultation document, 'unlocking the potential of active ageing.' The expected increase in the older population will yield benefits in their wellbeing and saved costs, but this is on the expectation that GPs can provide accessible health care for older people to live healthy and independent lives.

IMG supervision pathway

Dr Bradford participated in the MCNZ three-part workshop on an updated supervision and orientation pathway to registration for IMG doctors coming to New Zealand to work.

PGY2 Primary Care Pathway

Dr Bradford, College CE Toby Beaglehole and members of Te Akoranga a Māui were involved in this one-day workshop on the design and implementation for the new primary care pathway for New Zealand medical graduates in which junior doctors will spend their second year within general practice.

Policy submissions

- **MOH:** Putting Patients First – Modernising Health Workforce Regulation
- **MOH:** Public Health Agency – Cremations Regulations Review
- **Pharmac:** Mirena and Jaydess IUDs
- **Pharmac:** Proposing to fund two brands of Oestradiol Patches
- **Pharmaceutical Society NZ:** MedSafe – Mitigating Patient Safety Risk – Omeprazole 40mg, Flecainide 100mg
- **Pharmac:** New insulin medicine proposed (Ryzodeg)
- **Pharmac:** Proposal to support access to budesonide with eformoterol inhalers.

EVO301-AD001 CLINICAL STUDY IS LOOKING FOR PATIENTS WITH ATOPIC DERMATITIS

WE ARE INVITING CLINICIANS TO CONSIDER A NEW APPROACH FOR PATIENTS WITH ATOPIC DERMATITIS.

Atopic dermatitis (AD) is the most common chronic inflammatory skin disease and there is a need to find improved treatment options for AD patients. A 12-week, randomized, double-blind, placebo-controlled, phase II trial is recruiting AD patients to evaluate the safety and efficacy of EVO301, a novel IL-18 binding protein.

We would like to request your assistance in referring any potential AD patients that present to your clinic over the coming months.

You can learn more about the trial sites at www.AD-study.org or https://clinicaltrials.gov/study/NCT06723405

Key Inclusion Criteria:

- Are aged 18 and older
- Moderate to severe chronic AD that has been present for at least 6 months
- Body Surface Area (BSA) of AD involvement, excluding the face and intertriginous areas, of at least 10%

Approximately 60 participants will be enrolled into this trial. Participant will be randomized (2:1) to one of two study arms: EVO301 or placebo (saline). Participants will receive two doses of the study drug or placebo intravenously and will be monitored for safety and efficacy at clinical trial sites.

Medical records should not be reviewed by staff who do not have a clinical relationship with the potential participant unless that access has been previously consented. Doctors should not refer potential participants to the Study Doctor without the explicit consent of those patients.

EVO301-AD001_GP_advertisement_v1.1_NZ_dated02May2025

Submit your feedback

Having your say about the primary care workforce

The College's 2024 Workforce Survey

The College's biennial Workforce Survey took place at the end of 2024 and since closing, the College's Policy Advocacy and Insights team have been reviewing, collating and analysing responses and data from the 1374 members who completed the survey.

At GP25: Conference for General Practice College Medical Director and President-elect Dr Luke Bradford will be giving a plenary session on Saturday morning to go through the results, share comparisons and discuss how these results can be used alongside data we already have from previous surveys and the Your Work Counts study to target our advocacy towards getting the necessary changes for our workforce, and ultimately improve health outcomes.

A snapshot report of the key findings will also be released at this time, with more in-depth analysis to come after the conference.

As a reminder the Workforce Survey questions were grouped into seven overarching themes:

1. Training
2. Technology and Tools
3. 'Team GP'
4. Models of Care
5. Positives and Wellbeing
6. Workforce
7. Gender Pay

Commonwealth Fund International Health Policy Survey of Primary Care Physicians

The Commonwealth Fund, a New York–based organisation, is running its eighth International Health Policy survey for primary care physicians collecting data across 10 countries: New Zealand, Australia, Canada, France, Germany, the Netherlands, Sweden, Switzerland, the United Kingdom and the United States.

Topics covered in the survey include GPs' views on access to care, use of telehealth, care management for patients, care coordination with other providers, AI/technology use and perspectives on the health care system.

Over 220 New Zealand–based GPs have completed the survey so far and early data (to date) tells us:

Submit your feedback

Having a robust international dataset means we can get a better understanding about how our overseas counterparts practise medicine and learn from one another about how improvements can be made in health care.

Our vocationally registered GPs who are eligible to complete the survey were sent an email from medical director Luke Bradford on 19 March with the link to the survey (which you can access by entering your MCNZ number as the passcode).

If you need the link to be re-sent, please email simon.wright@rnzcgp.org.nz. If you've started but not yet completed the survey, this is a friendly reminder to complete your responses too.

The survey is open until Monday 30 June and will take 15–20 minutes to complete.

Research funding applications open now

Did you know that the College provides funding for research and education that benefits general practice, rural general practice and rural hospital medicine? There are three funding rounds each year, and the second funding round is now open for applications until **Wednesday 25 June**.

Applications are welcomed from anyone who is undertaking research in this field. You do not have to be a doctor or a member of the College to apply – so please share this with your colleagues.

Funding

Grants are typically in the range of $5,000 – $20,000 for individual applications.

Previous successful applications have included research into exploring inequity of access to medications for type 2 diabetes, rural placements of health professionals, capitation fees, a clinician survey of STI management methods and the impact of HDC complaints and investigations.

Applications close on Wednesday 25 June and will be considered by the College's Research and Education Committee (REC).

Find out more and apply on the College website.

If you need more time to prepare your application, the final funding round for 2025 will be from Wednesday 20 August to Wednesday 1 October.

Submit your feedback

Celebrating connection, purpose and progress at GP25: Conference for General Practice

At the heart of health care is people. Not just the patients we serve, but the professionals who dedicate their lives to care, connection and their communities.

This year's whakataukī, *Mā te kotahitanga e whai kaha ai tātau* (In unity, we have strength) resonates deeply as we face challenges in health care across Aotearoa New Zealand. Primary care and rural hospital medicine face workforce shortages and the need to attract more doctors into training remains a critical issue. Now more than ever, our strength lies in coming together with a shared purpose.

The *Conference for General Practice* has always been a place where this unity is nurtured.

It began in Christchurch in February 1974 when the inaugural Conference for General Practice welcomed 299 attendees. A third of those participants travelled from overseas, reflecting the growing global interest in general practice and rural health in Aotearoa. The conference was organised by the Canterbury Faculty committee led by Dr Cleve Sheppard. From the outset, it served as a space for members to connect, engage in professional development and celebrate the achievements of the College, including the welcoming of new Fellows. The aim was to create a sense of belonging or collegiality within the College.

More than 50 years later, we continue to honour that legacy. This year's conference remains committed to creating an environment that brings people together to share knowledge, build relationships and support each other both personally and professionally.

The 2025 programme has been carefully designed to reflect the interests, scopes and realities of our profession. It will offer practical and forward-thinking sessions, hands-on workshops and keynotes from Sir Ian Taylor, Olympian Emma Twigg, Kiwibank New Zealander of the Year Prof Bev Lawton and Minister of Health Hon. Simeon Brown who will challenge and inspire. But beyond the professional development, the conference is also a place of connection where attendees can take part in our GP25 quiz night, network at our welcome reception and form new relationships with colleagues from across the motu.

In the fast-paced, often isolated work of health care, a sense of belonging can be transformative. It's what helps us navigate challenges, reduce burnout and maintain our passion for the work we do. When we come together, not just in proximity but in purpose, we strengthen each other and, in turn, the communities we serve.

Health care isn't delivered in isolation. It relies on strong relationships and collaboration. Whether we are working with colleagues, whānau or communities, it's our unity that strengthens the care we provide.

This year's whakataukī is both a reflection and a call to action. It reminds us that we are stronger when we come together and that the future of health care in Aotearoa depends on our ability to support and uplift one another.

Join us from Thursday 24 to Saturday 26 July at Te Pae Christchurch Convention Centre. In unity, we have strength.

Find out more about and register to attend GP25: Conference for General Practice on the conference website.

Journal
OF PRIMARY HEALTH CARE

The *JPHC* is a peer-reviewed quarterly journal that is supported by the College. *JPHC* publishes original research that is relevant to New Zealand, Australia, and Pacific nations, with a strong focus on Māori and Pasifika health issues.

For between issue reading, visit the 'online early' section.

Trending articles:

1. Horny Goat Weed/Epimedium
2. Protecting primary healthcare funding in Aotearoa New Zealand: a cross-sectional analysis of funding data 2009–2023
3. Rural Māori experiences of accessing heart health care: a Kaupapa Māori qualitative analysis
4. Interprofessional collaboration in general practice
5. Technology-enhanced, culturally-informed primary care results in sustained improvements in biomarkers for Indigenous patients with type 2 diabetes – a pilot study

Submit your feedback

MIND THIS

Watch out for important adverse effects that can occur with hyaluronic lip fillers

Dr Peter Moodie

A recent decision by the HDC has highlighted some of the possible risks associated with cosmetic procedures that are routinely performed in the community setting. In this case, there was a delay in acting on an adverse event that occurred in a cosmetic clinic following the injection of hyaluronic acid lip filler.

It is apparently a well-recognised but rare (1:1000) event where the filler is injected into an artery and can embolise from there. As the HDC's expert witness commented:

- 'Vascular occlusion' occurs when dermal filler is inadvertently injected into an artery. The filler immediately moves (embolises) into very small vessels (microcirculation), compromising the blood supply to the skin which may result in scarring and tissue loss. Conversely, it may continue as an embolus into the vessels supplying the eye with catastrophic consequences (blindness or stroke) [sic].
- Due to the devastating sequelae of failing to quickly recognise and reverse this complication, a low threshold for administering hyaluronidase (to dissolve the filler) should always be followed.

It appears that these procedures can be performed by suitably trained nurses and there is no requirement for a doctor to be on site. The actual filler is regarded as a 'medical device' and therefore does not need to be a written 'standing order'; however, to administer the hyaluronidase, a standing order is required and the overseeing doctor must take responsibility for it.

In this case, the nurse did contact the overseeing doctor as she was suspicious about what was happening; however, there was a delay in managing the situation and the patient suffered an injury as a result.

Although this case was managed by the clinic and their doctor, it is always possible that the initial presentation may be to a general practitioner or an emergency department. Both should be alert to this complication and treat it with the urgency it deserves.

Peter Moodie is the College's Clinical Advisor

Primary Care:

The heart of New Zealand's health care system

An interview with Dr Prabani Wood, New Zealand Initiative Research Fellow and FRNZCGP

Dr Prabani Wood

New Zealand Initiative Research Fellow and FRNZCGP

Recently, the New Zealand Initiative published a research report that College Fellow and New Zealand Initiative Research Fellow Dr Prabani Wood undertook around reviewing the critical role and challenges facing general practice in New Zealand with a particular focus on the importance of continuity of care and systemic health care issues. '*The Heart of Healthcare: Renewing New Zealand's Primary Care System*' report looks at the economic case for strengthening GP services, with personal touches to the analysis that Dr Wood adds from her 15 years of experience as a GP in New Zealand.

It is an extensive report in which Dr Wood highlights that specialist general practitioners (GPs) are fundamental to a functioning and effective health care system, providing a multifaceted value-add that extends far beyond initial patient contact. This value is most powerfully realised through the development of long-term, trusting relationships with patients or continuity of care. She states that we know that the current New Zealand health care system is hampered by a severe GP workforce shortage, inadequate funding models, poor IT infrastructure and a traditional view that devalues primary care, which is actively undermining the ability of GPs to provide this essential continuity of care, leading to negative consequences for patient outcomes and increasing pressure on the broader health system. The report calls for three key actions:

1. Reform the outdated GP funding model to better support care for complex patients.
2. Implement a unified national health IT system to replace fragmented technology still reliant on fax machines.
3. Develop team-based care models that preserve continuity of care – seeing the same doctor consistently.

We sat down to interview Dr Wood after the launch of this important research to learn more about what motivated her to undertake this extensive piece of work and what her fellow GPs could take from it.

Why was it so important for you to undertake this research as a GP?

I started working on it in July last year, when at the time it didn't feel that there was much media coverage about what is actually going on in our health system. I felt that people needed to be aware of what is really going on, and as a practising GP, I thought I could offer a front-line perspective. I think the perception has been that our sector advocacy work has been just about greedy doctors wanting more money, but we are starting to see this slowly changing.

One of the most important points for me is that we really are struggling – GPs do an amazing job, but they are not being properly funded and supported to do that by the health system, and it's now reached crisis point. The second key reason was that I don't think people really understand what a specialist GP is and what we do. We have such a broad scope of practice that it's very easy to break it up into component parts, such as acute, episodic care, but the whole is far greater than the sum of its parts. It's genuinely the hardest job in medicine. My report shows, however, that right from medical school onwards, it's not seen that way, and that has to change. Thirdly I wanted to show that you don't get the full value-add of specialist GPs to the health system without continuity of care.

More broadly speaking, how do you hope that your research will generate action within the health system in New Zealand?

My key point is that I am not saying anything new. What I have done with this report is build on previous research that has been undertaken by others, including the College's Your Work Counts study, whilst also utilising my experience both as a practising GP and in public health, to add a voice to the collective through a different platform that has large political influence. There is a hell of a lot to do and I don't think the current direction is going far enough to ensure the long-term sustainability of the health care system. Where the current Government is saying they will focus on change, we want to see broader action. What they are currently planning is definitely not enough, but at least it's a foot in the door.

In the report you talk about the devaluing of primary care and how this is actively undermining the ability of GPs to provide essential continuity of care within their communities. What are the actions that as a GP you would like to see the Government take to stop this?

It does come down to money unfortunately. You have to fund primary care so that GPs can actually provide the care that patients need. It needs to be appropriate funding that ensures it is an attractive profession so that we retain GPs in New Zealand. I think that doctors who choose general practice as a career do so mostly because of their sense of social justice and wanting to do good for their communities. So, the reason that so many GPs are leaving is because they are overburdened by increasing workloads and feeling unable to provide the type of care they want to give to their patients.

If you fund it appropriately though, people would stay because it's a great job. I think we all love the job – it's just the current system we are working in which is the problem. You have to address how the system is funded – in the Sapere report it shows that just by CPI alone primary care is under funded by about 9%. That doesn't factor in need, and to address unmet need practices would need funding increases of 34 – 231%, depending on the populations they serve. We need to plan the health system around primary care by building it up and funding it appropriately. This is how we can alleviate the pressures in the hospital system, save money, and keep people healthier and living longer lives.

“

You have to fund primary care so that GPs can actually provide the care that patients need. It needs to be appropriate funding that ensures it is an attractive profession...

Based on your research and experience, what do you think the biggest barrier is for patients seeing their GP in New Zealand currently?

It really depends on what demographic you are from. Cost and lack of GPs seem to be the main barriers though. Those people who need access to health care the most are doubly hit by cost and wait times. When we talk about cost, it's not just the cost to pay the GP, it's also the cost of taking time off work, getting childcare, transport and paying for prescriptions.

You recounted how your training was "dominated by hospital specialists, who rarely encouraged us to consider general practice as a career option" What do you think we could be doing about this issue here in New Zealand?

This is a huge issue – the universities continue to give their students very little exposure to primary care. We need to apply pressure to ensure that this fundamentally changes. I personally think it should be compulsory for newly qualified doctors to spend at least six months in primary care during their first two postgraduate years. If these young doctors get embedded into primary care they might like it and pursue it as a specialty, and if they decide that they prefer hospital specialties, they will at least have a better understanding and appreciation of the work of GPs.

The key factor is that it should be an aspirational profession. This comes back down to pay parity for GPs and more exposure to primary care in medical school.

Maintaining professional standards is also vital. I think you should be able to call yourself a GP if you have Fellowship or are working towards it. This is the case in Australia, and I think we should follow suit. That first year of GP training especially is really important. It gives you a really good grounding of the knowledge and skills you need and sets the minimum standard you need to reach to practise safely as a GP. It is then an ongoing process of lifelong learning.

What is one takeaway you want your fellow GPs to know or do from your research?

My one takeaway would be to keep encouraging people to speak up. I think we've got to not just complain about the problem but actually talk about solutions. I think it's important to bring that solution focus to the conversation. So instead of just talking about needing more money, it is that we need more funding to allow us to provide continuity of care for our diabetic patients, for example. This will help us to keep them out of hospital, stop them needing dialysis, and we can stop them needing limb amputations. That is what we need the funding for. It changes the perception from needing it for self-serving reasons to tangible evidence-based outputs from the funding.

"...the universities continue to give their students very little exposure to primary care...I personally think it should be compulsory for newly qualified doctors to spend at least six months in primary care during their first two postgraduate years.

Submit your feedback

Any other thoughts you would like to share?

I hope my report also reflects what an amazing job we as GPs still do. My report is called *The Heart of Healthcare* because we're there in the communities and we know our patients. We are holding up the whole health system with 21,000,000+ visits to GP practices every year compared with the 1.3 million ED visits last year. The majority of the work in health care continues to occur in GP practices. Yet we don't receive enough support to do it, with less than six percent of the health budget spent on primary care.

You can read the full report on the New Zealand Initiative's website: www.nzinitiative.org.nz/reports-and-media/reports/the-heart-of-healthcare-renewing-new-zealands-primary-care-system/

Goodfellow Unit podcast: **Violence and adversity**

Janet Fanslow is a Professor at the School of Population Health, University of Auckland, and Chief Advisor of the New Zealand Family Violence Clearinghouse.

In this episode she talks about adverse childhood experiences, intimate partner violence, and non-partner violence in New Zealand and how these issues impact long-term health. We are learning that people's experience of violence and adversity as children and throughout the lifecourse has long-term health effects. Janet explores what we mean when we talk about experiences of violence and what we are learning about the health effects.

The key take-home messages of this podcast are:

- Violence is more common than we would like to believe.
- Health care can play a crucial role.
- It is a preventable problem.

Listen to the podcast

Submit your feedback

Five Key Leadership Lessons for New Zealand Doctors

By Dr Jonathan Hoogerbrug FRNZCGP

Health care today demands leaders, not just healers. The New Zealand health care landscape is volatile, uncertain, complex and ambiguous, where clinical expertise alone cannot solve our most pressing challenges. As physicians, developing leadership skills can help us to drive meaningful change. Based on insights from healthcare leadership experts at institutions like Harvard, Stanford and the Mayo Clinic, here are five crucial leadership lessons for New Zealand's medical community.

1. Leadership is a discipline, not an instinct

Great leaders aren't born – they're taught through dedicated education, experience and mentorship. This learnable set of skills then acts as a force multiplier, allowing individual clinical contributors to create environments where collective action flourishes. Just as we value our clinical training, we should also dedicate time and energy to developing our leadership skills in order to enable ourselves and our teams to operate at the peak of our potential.

2. Invest in people

Forward-thinking health care organisations recognise that their most valuable asset is their people. This means fostering physicians with leadership interests and creating supportive environments that enable growth. This could be through practical steps, including establishing protected time for governance participation, funding leadership training and creating mentorship programmes that pair experienced clinical leaders with emerging talent.

While the US, UK and Australia have established dedicated leadership programmes for physicians, New Zealand has lagged in formalising this education, and there is a huge opportunity for our health care providers to improve in this space.

3. Transforming practice

The old saying goes that leadership is about 'doing the right things' while management focuses on 'doing things right.' Both are essential in health care.

Leadership skills help clinicians to navigate complex situations and inspire change, while management skills ensure operational excellence and consistent execution. Together, they shape organisational culture – 'how we do things around here' – which can transform negative environments into positive ones.

Dr Jonathan Hoogerbrug is the host and creator of the podcast Clinical Changemakers, which explores how effective leadership can transform health care systems. In this artical he shares five leadership lessons that he's learned through his research. Stay updated on groundbreaking conversations in health care leadership by subscribing to Clinical Changemakers on your favourite podcast platform.

Elements of a positive work environment include psychological safety, where team members can speak up without fear and are encouraged to harness intrinsic motivations which often focus on wanting to get better at their work, having some control over how they do their work, and feeling like their work matters. When staff understand the 'why' behind initiatives and feel empowered, engagement and innovation flourish!

4. Overcome blind spots

Medical training can instil a narrow worldview on approaches to health care, creating an 'us vs them' mentality between different health care professions and non-clinical colleagues. We must recognise our blind spots when engaging with the broader system and build broad partnerships across disciplines. Diverse perspectives and skillsets create a nimble and powerful toolbox for change. We can't do this alone.

5. Extend leadership beyond clinical walls

Our influence shouldn't stop at the clinic door. Physicians are trusted voices in their communities and shouldn't hesitate to engage with broader societal issues, particularly in New Zealand, where tall poppy syndrome can discourage public visibility. We often hold back from joining public discussions or debates because we feel we're not experts, but we are in the world of health. By participating in community organisations or policy discussions, we can influence the social determinants of health beyond medical care.

“

By participating in community organisations or policy discussions, we can influence the social determinants of health beyond medical care.

Dr Jonathan Hoogerbrug is a New Zealand Senior Harkness Fellow in Health Care Policy and Practice. Over the past 10 years, he has had diverse clinical experience both in hospital and community-based settings. He is currently a general practitioner at a non-profit Māori health provider in Auckland and is Product Manager at Te Whatu Ora.

For more visit www.clinicalchangemakers.com

Do you have a story you'd like to share?

Make your voice heard

Submit your article to the Editorial team:

communications@rnzcgp.org.nz

The common imitator

Coeliac disease

By Dr Angharad Dunn BHB MBChB DipOMG FRNZCGP, Dr Samuel Fussey MBChB FRNZCGP PGCipGP(Dist) and Prof Andrew Day MBChB MD FRACP AGAF

*Members of the **Coeliac New Zealand** team have written this opinion piece in support of Coeliac Awareness Week, 9–15 June.*

Many conditions over the years have been referred to as 'the great imitator'. For a long time it was syphilis, but now it's time for GPs to be thinking about a more common imitator in town – coeliac disease.

This is a chronic systemic disease affecting more than one percent of New Zealanders, and its prevalence appears to be increasing over time. Unfortunately, many people are yet to be diagnosed, in part because of the widely variable symptoms and the possibility of being asymptomatic.

It isn't an intolerance or an allergy but an immune-mediated disease with multi-organ effects – not just the digestive tract that immediately springs to mind. Exposure to gluten triggers inflammation in the small intestine leading on to flattening of the villi which reduces nutrient absorption.

Coeliac disease has a strong hereditary component with a 10% prevalence in first-degree relatives but higher if more than one relative has the disease. Like most immune diseases, it has a higher prevalence in women than men.

Systems coeliac disease can affect

If we look at a breakdown of systems that coeliac disease can affect, it really is quite remarkable:

- **Haematological**: Iron and B12 deficiencies can cause anaemia with easier bruising possible. Coeliac disease can also cause deficiencies in folate and zinc as well as vitamins A, E, D and K.
- **Endocrinological:** low vitamin D levels can cause osteopenia or osteoporosis which can then lead to, low trauma fractures. Secondary hyperparathyroidism can also occur due to low calcium levels.
- **Gynaecological**: Coeliac disease can cause menstrual irregularities, fertility issues and recurrent miscarriages.
- **Dermatological:** dermatitis herpetiformis is one skin manifestation that can be seen with coeliac disease but other skin changes can occur, especially those linked to vitamin deficiencies.
- **Gastroenterological**: abdominal pain, cramping, bloating, constipation or diarrhoea, nausea, vomiting, foul-smelling stools and flatulence.
- **Oral and Dental**: aphthous ulcers, enamel defects or angular stomatitis.
- **Neurological**: coeliac disease can lead to recurrent headaches or migraines, numbness or tingling in the hands or feet, balance issues, poor memory and concentration.

- **Mental health**: coeliac disease can contribute to symptoms of anxiety and depression.
- **Systemic**: fatigue, irritability, weight loss, faltering growth in children, low appetite, muscle aches or spasms, weakness and bone pain.

It might have been easier to list symptoms that haven't been described with coeliac disease! Furthermore, some people with coeliac disease can be (or at least seem to be) asymptomatic. Following diagnosis, management with a strict gluten-free diet is important regardless of the presence of symptoms to reduce the risk of various complications listed above and others such as lymphoma.

How GPs can help

General practitioners are at the frontline of patient presentations. Having coeliac disease as part of a differential diagnosis is an important and potentially life-changing step for your patients.

So, with Coeliac Awareness Week coming soon, adding 'coeliac screen' to your patient's laboratory order could make the world of difference – **just make sure they are consuming adequate gluten in their diet for at least six weeks beforehand.**

Also, it is important to note that gluten can be found in pharmaceuticals, primarily as a component of inactive ingredients or excipients used to bind medications together. Individuals with coeliac disease need to check medication labels and if unsure ask the pharmacist.

Sign post patients to Coeliac New Zealand

Living with coeliac disease can be hard, and though a diagnosis is often the beginning to improved wellbeing, it is important your patients get the support, resources and information they need to help them on their gluten-free journey. We recommend you refer your patients once diagnosed with coeliac disease to Coeliac New Zealand (CNZ). As an independent charity, CNZ helps people live well, by providing trustworthy advice and support.

Coeliac New Zealand's website is a useful resource for your patients.

Goodfellow Unit podcast: **Coeliac disease**

Suzanne Aitken is a New Zealand–registered dietitian with over 16 years' experience. She has extensive experience in primary health care working alongside GP teams to support vulnerable populations. In this episode Suzanne discusses gluten-free diets in patients living with coeliac disease.

The key take-home messages of this podcast are:

- Keep eating gluten until fully diagnosed
- Get support and advice from a trusted source
- Get rid of all the obvious gluten from the house
- Find gluten-free alternatives
- Have fun creating a new diet from the abundance of gluten-free foods.

Listen to the podcast

Use of carbamazepine during pregnancy

Growth risks for babies

In response to the recent Medsafe Alert regarding carbamazepine use during pregnancy, The Royal New Zealand College of General Practitioners and the Pharmaceutical Society of NewZealand have worked collaboratively to provide guidance and action points for health professionals prescribing and dispensing carbamazepine.

Carbamazepine should be used during pregnancy only if the potential benefit justifies the potential risks to the fetus. Congenital malformations and neurodevelopmental disorders have been reported in children following prenatal carbamazepine exposure.

A recent observational study found that prenatal carbamazepine exposure was associated with increased risks of being born small for gestational age or with microcephaly in both the overall population and in children born to people with epilepsy. Babies born small for gestational age or with microcephaly may have short- and long-term health problems.[1]

We recommend the following action points:

- Review patients on carbamazepine to identify those of childbearing potential.
- Proactively inform people about the risks of fetal harm if they become pregnant while taking carbamazepine. Carbamazepine should only be used during pregnancy if the potential benefit justifies the potential risks to the fetus.
- Where appropriate, give Medsafe-written information: '**Epilepsy medicines and pregnancy**' and **consumer medicines information** (CMI).
- Document discussions in patient notes.
- Ensure that anyone who could become pregnant uses effective contraception (such as an IUD or medroxyprogesterone injection) during treatment and for two weeks after the last dose. Due to enzyme induction, carbamazepine may result in a failure of the therapeutic effect of hormonal contraceptive drugs containing oestrogen and/or progesterone.
- People who are planning a pregnancy should be switched to an appropriate alternative treatment prior to conception and before contraception is stopped.
- Refer people taking carbamazepine who become pregnant for specialist advice.

The **data sheet** has been updated to include information on the risks.

PHARMACEUTICAL SOCIETY of New Zealand Incorporated

1. Christensen J, Zoega H, Leinonen MK, et al. Prenatal exposure to antiseizure medications and fetal growth: a population-based cohort study from the Nordic countries. Lancet Reg Health Eur. 2024 Feb 8;38:100849. doi: 10.1016/j.lanepe.2024.100849.

Functional Neurological Disorder (FND) in Aotearoa

By Melanie Grace, Functional Neurological Disorder Aotearoa (FNDA)

Functional Neurological Disorder Aotearoa (FNDA) is a group made up of FND patients, parents and partners, and we are shining some light on this misunderstood disorder.

Neurological disorders are the world's leading cause of disability and FND is the most common reason for being referred to a neurologist in New Zealand. Alarmingly, some evidence suggests that rates tripled during COVID-19.

Historic trauma is usually involved, but even when it isn't, gender politics is always present. FND is the most statistically likely medical outcome of sexual assault in early life. The prognosis for FND is worse than most doctors expect. Even with treatment, only 20% achieve remission, and 40% get worse over time. FND can now be seen on FMRI and this has enabled researchers to prove that FND symptoms are not feigned.

Last year FNDA published a website resource which has been reviewed and endorsed by local specialists and world-leading Professor Jon Stone. The site contains:

- advice for medics on patient communication strategies
- direct links to local specialists
- advice on ACC claims
- clearly written basic information for patients and parents
- patient recovery tools.

We encourage you to use this resource yourself and to refer your patients to it. Our website also publishes our 2024 research into the experiences of FND patients in New Zealand. Our qualitative study employed a survey and semi-structured interviews. We recorded the experiences of 50 FND patients and parents.

The results were startling. Stigma and misinformation in the medical system was far more entrenched and damaging than we expected. Most respondents had experienced this stigma from multiple sources. Only 15% of our respondents said that they had been consistently treated well.

We also documented the harm that this causes to our whānau. We found that this stigma causes four types of harm:

- Harm to a patient's sense of self
- Harm to the doctor–patient relationships resulting in whole whānau being driven away from primary care
- Harm to whānau relationships, causing our support people to doubt our honesty and the validity of our symptoms
- Harm to our community relationships resulting in long-term social isolation and economic dependence.

Late last year, in response to FNDA's research, Health New Zealand | Te Whatu Ora launched a review of FND services. Last month, they decided not to proceed with the review. Undeterred, FNDA will go ahead with the review.

We have gathered a highly skilled team of FND-affected medics, policy consultants, researchers and activists. Our intended research seeks to expand on our work on patient communication strategies. We hope to work with key medics to:

- understand the gaps in information and understanding
- identify ways to improve communication
- develop culturally safe, targeted resources to support medical professionals.

If you would like to help us, we would love to hear from you. You can contact us via email: melanie@fnda.nz

HealthPathways Education

Navigating menopause – key insights into Menopausal Hormone Therapy (MHT)

The Menopause and Menopause Hormone Therapy (MHT) pathways have been aligned nationally across most New Zealand HealthPathways regions.

In a recent webinar, Dr Helen Roberts, Hon. Associate Professor Women's Health, Consultant Menopause Clinic Greenlane Clinical Centre, Dr Susannah O'Sullivan, Endocrinologist, Te Whatu Ora and Dr Janice Yin Hoi Lee, General Practitioner, Clinical editor, Auckland Region HealthPathways provided a succinct, relevant discussion of MHT use, aimed at enhancing the knowledge of general practitioners and nurse practitioners already prescribing MHT.

The key take-home messages are:

- The main indication for MHT is for vasomotor symptoms which can last >10 years in some women. Also indicated for genitourinary symptoms and bone protection. There is no evidence for preventing other chronic diseases.
- Most women can safely be prescribed MHT:
  - < 60 yr old – Starting MHT – the benefits outweigh the very low risks; it is safe to start MHT for menopausal symptoms such as hot flushes and night sweats or bone protection.
  - > 60 yr old – Starting MHT – the risks may outweigh the benefits. If continuing MHT for menopausal symptoms – identify benefits, these may outweigh risks, do an annual assessment
- Particular risks vary depending on whether using combined MHT or oestrogen alone, age and length of use. The safest preparations are transdermal oestrogen and oral utrogestan.
- If history of breast, endometrial, hormonal cancers, cardio/cerebro-vascular disease, or VTE – seek advice from the relevant specialist to support shared decision-making around personal risks, benefits and options.
- HealthPathways > Menopause Hormone Therapy has information around 'how' to use MHT. Menopause and MHT are now two separate pathways.

Watch the webinar recording. You will also find the recording in the 'for health professionals' section at the bottom of the Menopause and Menopause Hormone Therapy (MHT) pathways.

Check out the Menopause Hormone Therapy (MHT) pathway on HealthPathways. Click the link and then select your region. If you haven't logged into HealthPathways before, you will need to request access.

nzportal.healthpathwayscommunity.org/30269=chp

Better for patients, better for the planet

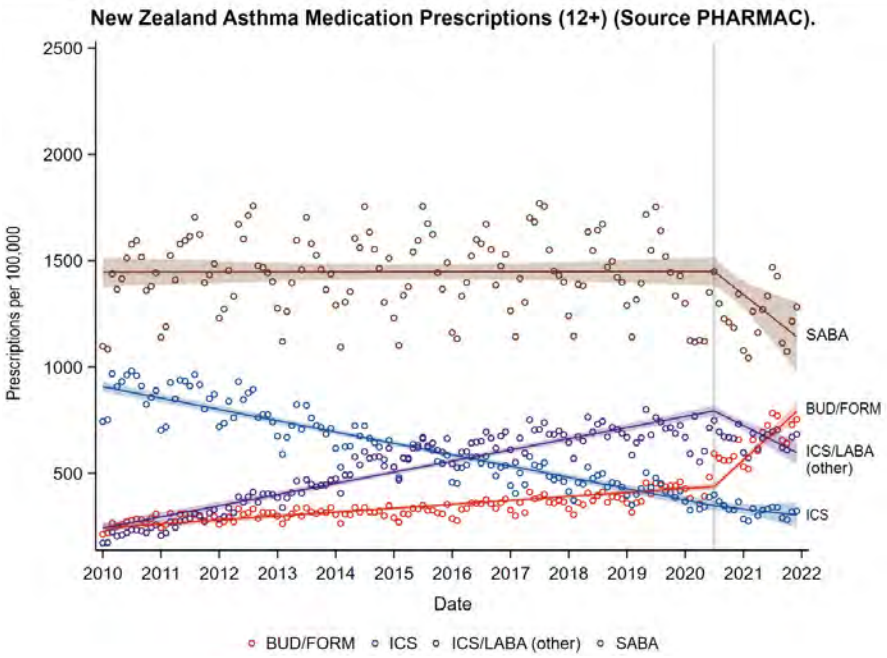
Fewer SABA inhalers

By Dr Rob Burrell and Simon Wright

Here's some good news for asthma care and the climate. Since the release of the 2020 national asthma guidelines, prescribing of budesonide+formoterol has risen sharply, particularly in dry powder inhaler (DPI) form. This shift is delivering real benefits: patients and their families are less burdened by illness, workers can be more productive and better preventative therapies keep patients out of hospitals.

Hatter et al.'s study on dispensing patterns in relation to the 2020 national asthma guidelines shows a steep rise in budesonide+formoterol prescribing from 2020 onwards (Graph 1). It also shows a drop in prescribing of short-acting ß$_2$-agonists (SABAs). This seems to fit with a reduced reliance on SABAs because of the effectiveness of budesonide+formoterol medications.

Graph 1: Piecewise regression of medication prescription rates for adolescents and adults (12+ years)
Monthly from January 2010 to December 2021.



The grey vertical line indicates the date of the publication of the New Zealand adolescent and adult asthma guidelines. BUD/FORM, Budesonide/formoterol; ICS, inhaled corticosteroid; ICS/LABA (other), other inhaled corticosteroid/long-acting ß^2 -agonist (not budesonide/formoterol); SABA, short-acting ß^2 -agonist.

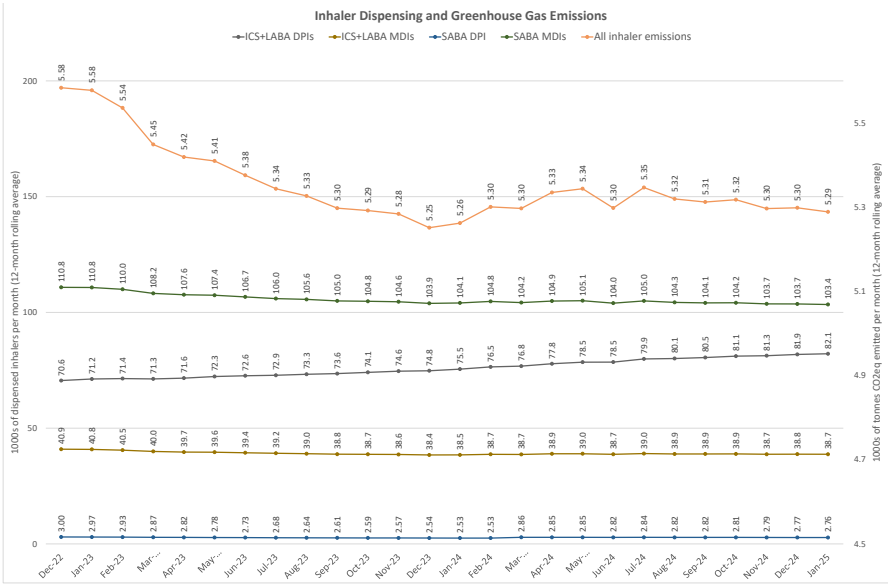
Dr Rob Burrell mixes his anaesthesia job at Middlemore Hospital with his clinical lead role in Health New Zealand's Sustainability team.

Simon Wright is the College's Principal Advisor – Policy, Advocacy and Insights, and was a member of the project team for the Porirua Assembly on Climate.

The environmental benefits associated with these changes are also significant. Metred-dose inhalers (MDIs) contain propellants that are extremely potent greenhouse gases. A single salbutamol MDI has the same climate impact as burning 12 litres of petrol. With 1.2 million dispensed annually, that's a massive carbon footprint for a medicine now considered second-line. Reducing the use of SABA MDIs will help protect both patients and the planet.

Hatter et al. concluded that national guidelines could drive positive change by encouraging the use of safer, more effective therapies. Their data suggests Aotearoa was doing a great job up until December 2021.

Graph 2: Dispensed inhalers and inhaler CO_2(eq) emissions (Health NZ data)



However, more recent data (Graph 2) shows progress has been mixed since then. On the one hand, the prescribing of budesonide+formoterol DPIs – the ICS+LABA DPI line of the graph – has continued to increase and at an accelerating rate: that is by 6 percent in 2023 and 8.7 percent in 2024. On the other hand, the 6 percent decline in SABA MDI dispensing in 2023 has stalled and dispensing has flatlined since January 2024.

This suggests that not all patients – and not all prescribers – have fully embraced the guidelines. Budesonide+formoterol DPIs are generally the recommended treatment for asthma and their carbon footprint is about one-tenth that of SABA MDIs. So why haven't we seen further reductions in SABA use?

Are some clinicians still issuing repeat SABA prescriptions out of habit? Do patients refuse to give up on SABAs because of their perceived superiority at rapid symptom relief?

It is important that we continue to reduce the use of SABA inhalers not only for the environmental benefits but also for patients' health: the risk of hospitalisation increases with the use of three or more SABA cannisters per year, and there is an increased risk of death for 12 or more per year – even for patients with minimal symptoms.

These are difficult habits to shift but simply switching patients from one type of SABA inhaler to another, e.g. from salbutamol MDIs to terbutaline DPIs, won't solve the problem. That might reduce emissions – but it won't improve health outcomes. True progress means supporting patients to understand and embrace safer, more effective ways of treating and managing their asthma.

Fewer SABA inhalers in the community is a worthy goal: it means better outcomes for patients and a lighter environmental footprint. With new national chronic obstructive pulmonary disease (COPD) guideline expected in October, there may be fresh opportunities to reduce unnecessary reliance on SABA MDIs across both conditions.

Goodfellow Unit podcast: **The nocebo effect**

Dawn is a GP and GP educator with a special interest in supervision, palliative care, communication skills, pain/symptom management and the use of hypnotic language in clinical settings, sports and performance. She has over 30 years' experience in General Practice and has been an examiner and clinical exam case writer for The Royal New Zealand College of General Practictioners and is currently a fellowship assessor.

In this episode Dawn explores how language in health care impacts patient outcomes, focusing on the nocebo effect – where words can unintentionally harm.

The key take-home messages of this podcast are:

- Negative expectations, often stemming from clinician–patient interactions, can lead to real, adverse health outcomes
- The words and phrases used by health care providers can significantly influence patient perceptions and experiences
- Effective and empathetic communication is crucial in preventing unintended negative effects on patients
- Adopting positive framing, providing balanced information, and building trust can help mitigate the nocebo effect
- Awareness and proactive measures by clinicians can lead to improved patient satisfaction and health outcomes.

Listen to the podcast

Refugees experiences of health care and medicines in southern New Zealand

By Molly George PhD and Professor Pauline Norris

Molly George PhD
Social Anthropology Programme | Mātai Tikaka Takata

Professor Pauline Norris
Va'a o Tautai – Centre for Pacific Health

Refugees often arrive in host countries with complex health needs. They also arrive with pre-existing expectations of health care and understandings of what constitutes care. In two recent studies conducted on refugees' experiences of health care and access to medicines in southern New Zealand, we found significant dissatisfaction with the health care system, largely due to refugees' pre-existing expectations and understandings of care.

Many refugees arrive in New Zealand having experienced dramatically different health care systems, notably hospital-based systems including timely, direct access to specialists. One refugee said, "*It was shocking that we can't go directly to see a specialist!*" while another explained that going through a GP felt strange, even futile: "Why we should see a GP first?… If I have a certain health problem, I'm going to see an expert doctor in that field. They wouldn't let me."

Prior to arrival in New Zealand, 'health care' often meant specialist consultations, physical exams, more frequent tests and procedures, follow-ups, and often-times ample medicines. Patel (2022) has called these "positive markers of care." These actions constituted care in refugees' previous experience so the absence of them was seen as a *lack of care*. Participants recalled leaving GP consultations feeling dismissed and frustrated, even when they had a good relationship with a GP, which many did. They appreciated the warmth and oversight of a good GP, but to them, this still did not constitute *health care*.

Long waitlists for specialists and procedures added to this frustration and generated doubt that the system would care for them at all. The importance of this cannot be overstated. One participant created a 'Plan B' to access healthcare: learn English, save money and go overseas for care. Others hesitated to bring family members to New Zealand, believing the inadequate health care system was holding them back. For example, a long delay for ear surgery left one participant unable to hear well enough to attend English classes or pass her driving test.

Refugees reported mixed feelings about prescribing practices in New Zealand. Sometimes they felt GPs prescribed too many medicines as a way of 'fobbing off' the patients instead of providing 'real care.' Specifically, a perceived over-reliance on paracetamol was described again and again. In these cases, medicines were seen as suboptimal treatment. On the other hand, some

participants felt they were not provided with enough medicine, especially compared to overseas. The lack of some over-the-counter medicines such as antibiotics, was frustrating: “Antibiotics are like gold here.”

Participants were also confused about which medicines were funded, which required prescriptions and what was available over the counter. Without interpreters in pharmacies, they couldn’t ask questions.

Suggestions and resources

We hope that sharing refugees’ perspectives helps primary carers better understand their expectations, which could improve the care experience for both parties. We have created the following three resources:

1. Learn about refugees’ previous experiences of health care overseas and how these shape expectations of care with **this 10-minute video**.
2. Learn about how barriers to care and medicines manifest and overlap in refugees’ everyday lives in **this 10-minute case study video**.
3. Check out this **Quick Reference Guide** informed by several health care providers, our research and relevant literature. Some main points include:
   - Designate ‘champions’ across practice roles (GPs, nurses, receptionists) who undertake extra training, do outreach, and/or create resources for staff.
   - Label ‘refugee background patients’ in your PMS (but avoid using the label in person).
   - The ‘right’ professional interpreter is imperative.
   - Remember, pharmacies do not have interpreters. Explain medicines.
   - Avoid a ‘deficit lens’ – refugees are survivors; acknowledge their skills and capacity.

References

Patel P, Muscat DM, Trevena L, et al. Exploring the expectations, experiences and tensions of refugee patients and general practitioners in the quality of care in general practice. Health Expectations 2022 Apr; 25(2): 639-647. DOI: 10.1111/hex.13411. ***Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 25(2), 639–647**.

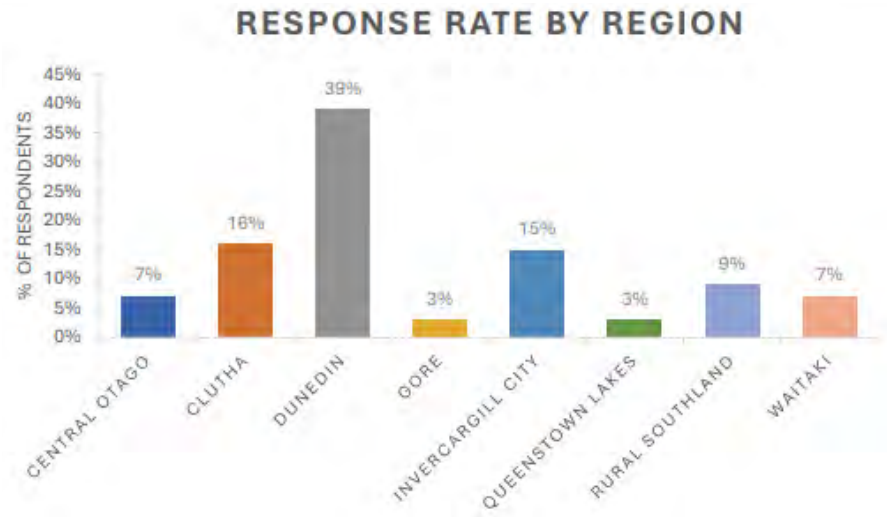
Author Affiliations

Molly George, PhD
Social Anthropology Programme | Mātai Tikaka Takata
University of Otago – Ōtākou Whakaihu Waka
Email: **molly.george@otago.ac.nz**

Professor Pauline Norris
Va’a o Tautai-Centre for Pacific Health
University of Otago – Ōtākou Whakaihu Waka
Email: **pauline.norris@otago.ac.nz**

Pressure cooker in rural general practice

A recent primary care report recently by WellSouth, the primary health organisation (PHO) for Otago and Southland, shows that general practices in these rural regions are feeling the pressure, and compared to their urban counterparts, are more likely to struggle to retain workforce and recruit staff and therefore provide care to the communities they live in.



The survey was first launched in 2024 and evolved from the earlier COVID-19 monthly workforce surveys. Now undertaken every six months, this survey is designed to regularly capture perspectives from primary care providers in the southern regions so WellSouth can better understand what is happening regionally in primary care and focus their support on where it is needed most.

The results highlighted three core themes that reflect the ongoing pressure across primary care. These challenges are not new and are being faced by primary care teams across the country.

1. Workforce

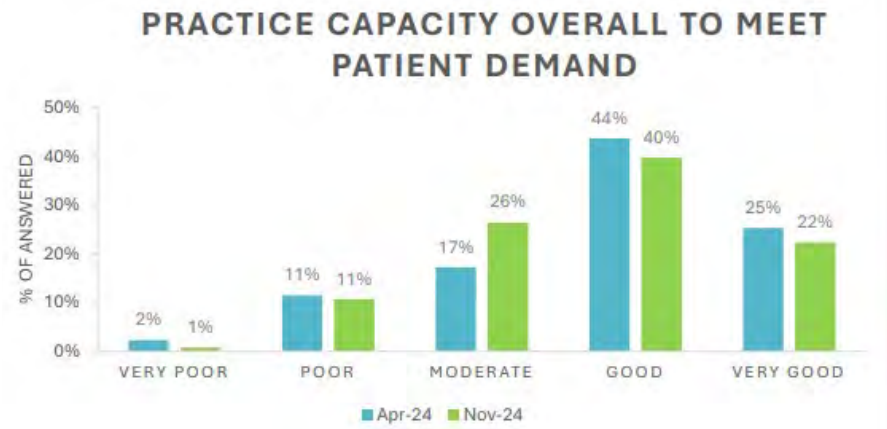
"*We support each other but it is not enough to ease the strain*" – respondent

Recruitment, retention and burnout remain persistent pressures in primary care and are highlighted by rising demand and limited resources. The results showed that while morale and job satisfaction appear stable, they're often upheld by team culture not system support.

2. Capacity

"*Proactive care has to take a back seat if we are busy fighting fires at the bottom of the cliff*" – respondent

Capacity remains strongest in acute care but there is a clear gap between what practices want to provide and what's manageable. Rising complexity and time pressures are forcing teams to prioritise immediate care over proactive care.



Results from Q14 – "*How would you rate your practice's overall ability to meet demand and deliver its services?*" (respondents n=121).

3. Funding

"*Primary care is only surviving because GPs are personally propping up the system*" – respondent

There are frustrations over outdated complex systems that don't reflect the realities of primary care, including a lack of transparency around how funding is distributed, complex processes with limited flexibility and underfunded services, nurse pay parity and rural funding shortfalls.

WellSouth CEO Andrew Swanson-Dobbs has called for urgent action to be taken to address the rural shortfall and support the health needs of those who live in these rural communities and commended the practices who are constantly adapting to the pressures in the workforce – both in rural and urban areas.

"Triage improvements, expanded nursing roles and telehealth are offering partial relief. However, acute demand continues to take priority over proactive care, and financial barriers prevent implementation of effective solutions.

"A system-wide approach is needed with targeted funding and workforce investment to ensure primary care and in particular our rural general practices and staff are not just sustainable but an attractive sector to work in offering high job satisfaction," says Mr Swanson-Dobbs.

These results echo many of the findings from the College's Your Work Counts project that shine a light on the demands being placed on the workforce and that there needs to be a change in thinking around GP workloads and the funding model.

The Your Work Counts project was developed to highlight the amount of work that is actually required to look after a primary care patient load as a specialist GP or rural hospital doctor.

In response to the survey results, WellSouth has collated a list of actions that include:

- Developing information outlining PHO funding streams and services.
- Supporting workload management through inbox delegation frameworks and the safe use of AI.
- Scoping options to improve locum cover.
- Delivering Pacific health training aligned with provider needs.
- Updating the WellSouth website to more clearly show team roles and the support that is available to practices.

Read the full Primary Care Survey Report.

About WellSouth

WellSouth's network consists of 79 general practices, 34 (43%) of which are rural and collectively serve 337,000 enrolled patients (as of 1 January 2025). These practices are supported by 336 GPs, 31 nurse practitioners, 422 nurses and a range of non-clinical kaimahi, including administrators and practice managers.

Is there an app for that?

Not sure which health apps to trust? Healthify He Puna Waiora has checked them out for you.

Dr Emma Dunning, Clinical Editor and Advisor, Health Navigator Charitable Trust

With the number of health apps available, it can be difficult to rapidly identify which ones are reliable, evidence-based and genuinely helpful for your patients. The New Zealand Health App Library hosted on Healthify provides a solution by offering health app reviews you can trust.

A rigorous review process

Apps are reviewed by independent registered health professionals. Criteria such as functionality, privacy and security, and relevance in a New Zealand context are assessed. Each app is rated in stars out of 5 to provide a clear indication of its overall quality. The library currently includes 350 app reviews across 100+ categories in the library, with mental health and wellbeing being the most commonly visited category. There's a focus on free apps but some useful paid apps are included.

Supporting clinical practice and patient self-care

You can use this resource to find trusted apps, direct patients to find an app on a relevant clinical topic or find out about the app your patients are all raving about. Whether it's managing long-term conditions, medication reminders or improving lifestyle, such as CBT-based sleep apps, the App Library is a valuable tool for encouraging self-care.

Stay informed

Want to stay updated? Sign up for the App Library newsletter or check out the What's New page. If you'd like to suggest a topic or join as a reviewer yourself, email hello@healthify.nz – your expertise can help.

Explore the App Library today – you might find that one app which solves a curly problem.

Submit your feedback

The Heart of Aotearoa

Fighting for urgent reform in cardiac care

A new heart organisation backed by leading cardiologists is calling time on New Zealand's failing heart health system. The Heart of Aotearoa – Kia Manawanui Trust has been established to tackle the escalating crisis in cardiac care.

With excessive wait times, staff shortages and growing disparities in access to life-saving treatment, the country's cardiac services are under extreme pressure. Late last year, the situation hit a critical point when health officials floated the idea of sending patients to Australia for heart surgeries.

National standards, as agreed by the New Zealand National Cardiac Surgery Clinical Network and the New Zealand Branch of the Cardiac Society of Australia and New Zealand, state that cardiac patients should receive treatment and/or surgery within 90 days. Currently, more than half of all patients are waiting longer.

The Heart of Aotearoa Chief Executive Ms Letitia Harding says New Zealand's heart health system is in crisis and we need to take urgent action.

"The system is on the verge of collapse, and no one is coming forward with a plan to help. That's why we stepped up. We aren't just highlighting the cracks in the system; we are offering solutions."

The organisation's Cardiac Advisory Board – made up of some of New Zealand's top cardiologists and led by Medical Director Dr Sarah Fairley – is helping shape a blueprint for improving outcomes, reducing wait times, and ensuring fair access to care.

Dr Fairley, a Wellington-based cardiologist, says the country has reached a point where preventable deaths are a reality.

"The system is buckling under pressure, and patients are paying the price as they wait for essential heart surgeries, procedures and access to medical devices and medicines."

There is a desperate need for more resources, access to cardiac medicines that save lives, reduced wait times for diagnostic procedures, and more trained cardiac staff, Dr Fairley says.

This month, The Heart of Aotearoa launched its first nationwide appeal aimed at addressing atrial fibrillation (AF). AF affects one in 35 New Zealanders aged 35–74 and can lead to stroke or heart failure if undiagnosed. Yet many patients – especially in rural areas and among Māori and Pacific communities – may not have easy access to ECGs.

"The system is on the verge of collapse, and no one is coming forward with a plan to help. That's why we stepped up. We aren't just highlighting the cracks in the system; we are offering solutions.

Ms Harding says that limited access to ECGs could leave patients undiagnosed in the early stages of atrial fibrillation – when timely intervention could make all the difference.

"In addition, as the healthcare system buckles under long wait times for cardiology appointments, the burden is falling harder than ever on already-stretched GPs and community nurses.

"These frontline providers are now expected to identify and manage complex, high-risk heart conditions – like arrhythmias and possible heart failure – often without the tools or support they need."

Kia Manawanui Trust is fundraising to help place portable KardiaMobile ECG devices in GP clinics and with community-based specialist nurses. Each device costs $350 and can detect AF in under 30 seconds.

These devices can also be used by specialist nurses in the community to manage medication increases based on basic clinical observations, such as resting heart rate.

The Heart of Aotearoa is asking health professionals and the public to help fund as many devices as possible and get them into the hands of providers who need them most. We aren't here to offer short-term fixes, Ms Harding says.

"We want to help build a system where every New Zealander, no matter their postcode, gets the timely, high-quality cardiac care they deserve."

Kia Manawanui Trust
The Heart of Aotearoa New Zealand

For more information or to donate, scan the QR code or visit: www.kmtrust.org.nz

Leave feedback and follow us

Help us improve the reading experience of GP Voice by completing our short survey.

Submit your feedback

@RNZCGP

@The Royal New Zealand College of General Practitioners

@RNZCGP

@RoyalNZCollegeofGPs