Working on salary for Newtown Union Health Service

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The recent issue of *NZFP* that looked at 'the business of general practice' described a country that I vaguely recall but that is increasingly foreign to me.

I started practice in a four doctor practice in Waitara. We shared the expenses four ways and kept our own income. We all had 'our own nurse'. I was the fourth partner and did not buy into the property. I was not good at running a business. We were probably typical of many practices, rather unsystematic about employment of staff, no defined focus for the business other than doing what we do. Little input into the running from the patients (I can recall responding to complaints about no toys in the waiting room). The partners met monthly to discuss the running of the practice, we tried to have full staff meetings but often the staff said little, they were paid to do what they were told by their employer and weren't about to rock the boat. Most of the time I was there it worked really well. We provided good care and got along well together. It got harder when the senior partner sold his practice to the highest bidder. The remaining partners had no say in the selection and it turned out that the new partner had not recovered from his alcoholism as he had asserted. I was able to sell my practice in 1992 and moved to Wellington.

By contrast, I applied for a job at Newtown Union Health Service. Despite it being with old class mates who knew me (well, the doctors) I was still obliged to provide references and attend an interview, the main intent of which was to determine whether I would be happy to work to the principles outlined in the constitution (see box). The interview panel was huge and, in addition to one of my doctor friends, included a manager, a nurse and two patients.

Box 1. Constitution

- Accessible, affordable, appropriate care for union members, beneficiaries, unemployed and their family and household members;
- Promote a model of primary care;
- Members involved in policy;
- Improve health status of members;
- Encourage individual responsibility for health;
- Healthy environment for staff;
- Provide health or health-related services needed.

The constitution

This was the first big difference. Staff are selected who explicitly have the same goals. If you don't agree, you don't join and, if there is dispute about where we are heading, then that can always be taken back to the constitution. The important thing that follows from this is that it is impossible to provide a quality service unless you have explicit goals. Whilst it is true that much of what general practitioners do is not in dispute (to provide the best quality medical care...), when it comes to detailed policies the qualifications can be very important.

Community control

The next big difference that pervades the whole place is 'Community Control'. This is a service that is run by and for the people that it serves. It is an incorporated society. The policy board is elected each year from the members (all registered patients) and they appoint the manager who is responsible for employing the rest of the staff.

To survive we have to be a successful business, but success is measured on the quality of care provided within the resources available. Incomes are negotiated and any 'surplus' is budgeted to new expenditure according to the goals of the organisation.

Teamwork

Having had the focus shifted from 'General Medical Practice' to 'Health Service' makes the development of a primary care team much easier. From the start, the relationship between doctors and nurses has been quite different. We are all employed by the service; I do not employ anyone. We share tasks and negotiate who is best to do what. I no longer have 'my nurse'. This means that

service tasks that are predominantly nursing become a nursing responsibility. This is of course true of our immunisation programme (as I suspect it is in most practices) but it extends to many other areas. Organisation of obstetric care (doing the first ante-natal, post-natal and liaison with midwives) is a nursing responsibility with doctor input only as needed. The same is true of our diabetes programme. The major tasks in managing people with diabetes are, in my view, best done by my nursing colleagues; educating and monitoring diet and exercise programmes, ensuring that all screening tasks are done, teaching and monitoring the use of insulin. Of course the doctor has an important input.

We started with nurses, doctors and support staff. Over the years the team has grown in size and skill. We have added a team of midwives to do all our obstetric care. We have a social worker, a Maori community health worker, and interpreters (for the largest of our refugee populations). We devote a lot of time to developing and maintaining our team functioning. We have a full team meeting every week for two hours starting with a shared lunch and proceeding to a varied programme that includes case discussion, enacting our quality improvement programme, guest speakers and service business matters.

The wider team

The traditional fee-for-service GP model had a major flaw, which was that time spent could be divided up into 'income generating' work and 'other' work. An important casualty of this division was that little value was placed on developing and maintaining relationships with other services because this was 'unpaid'. One effect of the way that we work is that we have developed close working relationships with a variety of services with which we share significant numbers of patients. Someone from our team regularly meets with:

- Medical specialists; diabetes, psychiatry, obstetrics;
- Nursing services: community mental health nurses, diabetic nurses;
- Refugee support services: Refugees as Survivors, Refugee and Migrant Service;
- Supported accommodation providers;
- 'Inner City Project' that provides care for homeless people and others having difficulty accessing services.

Time for these meetings is paid and budgeted for from our income.

Running the business

Our annual turnover is $2,000,000 or so. Running the business is a serious management task that needs to be done by someone trained and able to do this work. Given the complexity of all the laws that impact on us, the variety of funding streams, the information technology needs, and the property needs, it is my view that the time is past when it is a good use of a highly trained doctor's time to spend it trying to run this sort of business. Clinical staff, of course, have formal input into the management of the

service. Given that we rely on government for a lot of our income we also need to keep a wary eye on health politics and ensure that the needs of our population are not ignored. This happens through local activities and membership of our national body 'Healthcare Aotearoa'.

Training

We have long been a training practice for GP registrars. Training for other primary care health professionals is generally much less developed and yet there is a great need for this. In the past year we have hosted students of:

- midwifery
- social work
- nursing
- dietetics
- undergraduate medicine (4th year students)
- postgraduate medicine (GPEP registrars).

Because we work as a large team it means that each of these students not only gets training within their professional group but are also exposed to the rest of the team. This gives them the opportunity to see primary care provision as a whole rather than artificially split up into professional parts.

Personal benefits

I am on a fixed income. Of course, in the event that the service's income dropped my income could be affected, but unlike a conventional doctor-owned practice I do not bear the risk alone. All the staff would be in the same boat. I have two weeks study leave a year and five weeks annual leave. We no longer employ locums for most holiday cover but instead cover each other. This of course means that I cannot always take leave exactly when I want to.

I have sick leave. This makes a big difference to decisions about whether to work when I am a bit unwell. Whilst I am mindful of the extra stress I might put on my colleagues if I call in sick, I will still get paid and the patients will still get seen.

There are a variety of other benefits in the employment contract. One of the difficulties in discussing income is how to compare my package with a GP in private practice. I am not able to claim tax deductions for an office in home, use of car, travel to conferences etc. but I do have some 'expenses' (indemnity insurance, College membership, some costs for study) paid.

I can leave with a month's notice and do not have the problem of selling a practice. I have no capital tied up in the assets of the practice.

The patient perspective

I have written this article from my perspective as a GP. The most important goal of the service is to provide the best care within the resource available for the people we see. This model of care is not an 'ideal' that everyone should emulate. It is a model developed to provide care for those who usually do not access good care because of cost and other barriers. I believe that there are groups of people for whom we provide much better care than possible under the conventional model. These are people with complex needs, with many agencies involved in their care. Being able to provide for as many of their needs as possible, in a co-ordinated way, from a team under one roof, makes a big difference. The largest groups this would apply to include people with enduring mental health problems and the refugee communities that we care for. As a result of our extended use of nurses we can provide more comprehensive care for many people with chronic conditions (e.g. diabetes, asthma). I do not understand how good perinatal care can be provided under the 'independent midwife' model. Primary care midwives should be part of a primary care team.

Hospitals have functioned as large teams for a long time. Their work has significantly encroached on areas that we can do better (e.g. district nursing, E/D management of primary care cases, some specialist outpatient follow-up). In addition there has been a 'dis-integration' of primary care. Plunket, family planning, independent midwives, pharmacy, smear takers, immunisers and many others are all providing some services to patients registered with us. Much of this is inefficient with duplication of information gathering and poor information sharing.

My vision for primary care is the greater development of primary care teams, both within institutions and across institutions. There needs to be significant community input into how these are run. There is then the potential for much better integration of care and the ability to do more of a person's health care from primary care. The Newtown Union Health Service model of care is one way to achieve that.

The Metrics of the Physician Brain Drain

'Reliance on physicians trained elsewhere is not a universal characteristic of wealthy nations. Aside from the four recipient countries [United States, United Kingdom, Canada, Australia], there are only three among the remaining 26 nations in the Organization for Economic Cooperation and Development in which international medical graduates constitute more than 10 percent of the medical workforce: New Zealand (34.5 percent), Switzerland (17.8 percent), and Norway (12.7 percent). Whereas New Zealand's international medical graduates are similar in country of origin to Australia's, 60 percent of Switzerland's international medical graduates come from Germany, as do 33 percent of Norway's. Virtually none of the international medical graduates in Switzerland and Norway come from outside Europe. International medical graduates constitute three percent of the physician workforce in France and one percent in Japan.'

Mullan F. The metrics of the physician brain drain. N Engl J Med 2005; 353:1810-1818.