The Pinnacle General Practice Workforce Survey 2023

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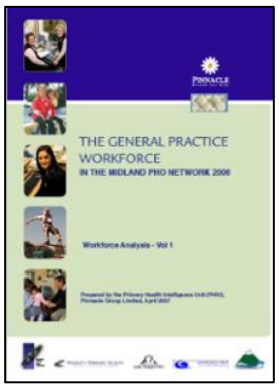
Executive Summary



General practice is the backbone of health and the first interaction for most New Zealanders with the health care system. If the general practice model fails, demand for care will shift towards more expensive and stretched secondary services, leading to worsening sustainability issues. Significant, urgent and imperative change is needed across the health system to improve the sustainability of primary health care, with general practice at its core.

It has been a year since the Pae Ora (Healthy Futures) Act 2022 took effect, providing an opportunity to shift the focus more towards primary care with reviewed funding models, Iwi-Māori partnership boards and empowered localities identifying their needs and priorities. To date, Te Whatu Ora has primarily focused on standing up and restructuring hospital services with clarity on the future of primary care to come.

Pinnacle has been advocating for general practice since the network was founded in 1989. Our first workforce report, published in 2006, highlighted challenges on both the supply side, such as an ageing workforce, and the demand side, including issues related to equity, an ageing population, and an increase in chronic conditions. Those issues were confirmed in subsequent reports and, broadly speaking, the same issues are presented in this report. The current workforce crisis has been years in the making and will now require gargantuan efforts across the entire healthcare system to address.

As a primary care pioneer, Pinnacle has not waited for others to address constraints. Over the last two decades, the network has been an early adopter of solutions to support the general practice team, such as introducing unregulated roles to directly support our frontline clinicians, and promoting the growth of general practice nursing. Over the last decade, the network has embedded new ways of collaboration to meet health and wellbeing needs by establishing interprofessional extended care teams (ECT). These developments originated in the feedback from GPs, practice nurses and management staff in our 2006 and 2009 workforce surveys.

As with all human services, primary care relies on having well trained and highly effective staff. The sector has faced mounting challenges, including, but not limited to, the COVID-19 pandemic; but this is not unique to New Zealand[i]. The workforce and funding supply side pressures are now widely acknowledged. The key demand side pressures of an ageing population, and increasing incidence of chronic conditions and inequity for Māori, Pasifika and rural populations are also well-known. Pinnacle remains committed to developing network identified solutions and is open to collaborate further with others. We have considerable in-house knowledge that positions us well to contribute to health sector reforms, including the coming rollout of comprehensive primary and community teams (CPCT) in the community.

Pinnacle's vision is to continue delivering primary care that supports all people to thrive by realising their health and wellbeing potential. Achieving this requires placing the wellbeing of both patients and health care professionals at the forefront. This report will assist Pinnacle to continue our ongoing advocacy, develop innovative approaches for meeting demand and planning for recruitment and retention of a valued and highly skilled general practice and primary care network.

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Kaiwhakatere (Chief Executive Officer)
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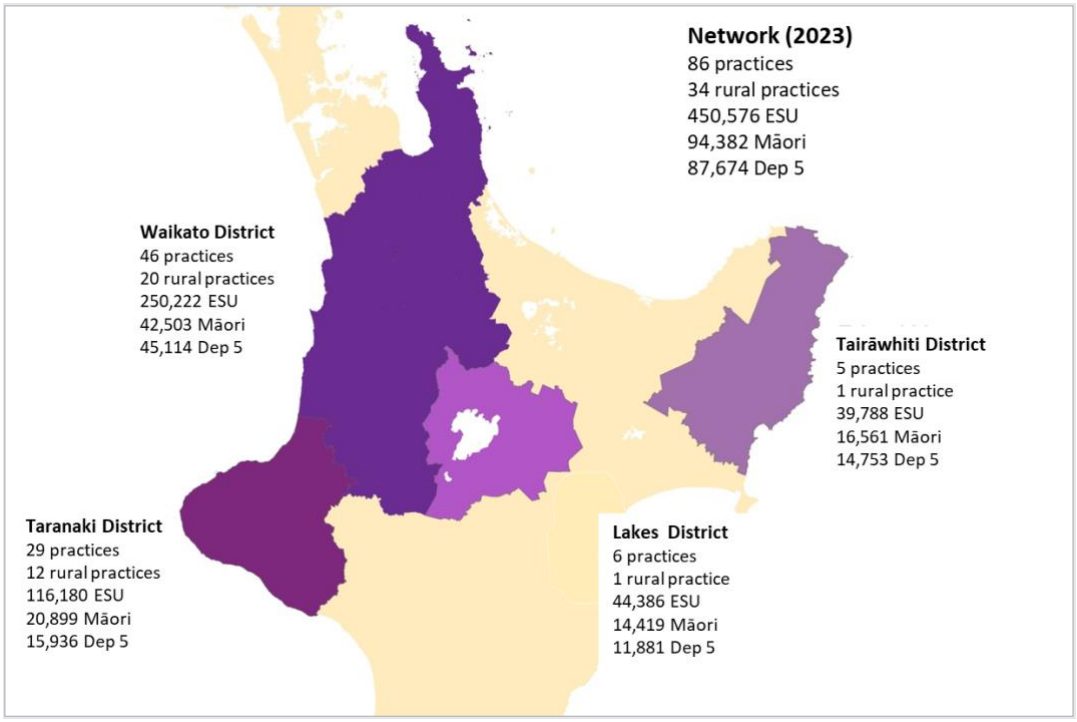
1. The Pinnacle Network

The network covers the Districts of Tairāwhiti, Lakes, Taranaki and Waikato in Te Manawa Taki. Across this rohe, Pinnacle general practices provide primary care services for over 450,000 people. The network services a diverse population, a real microcosm of New Zealand, encompassing rural and urban areas, retirement zones, a high proportion of Māori (compared with the national proportion) and many socio-economically disadvantaged communities.

The unique demography of our region adds to the challenge facing primary health. With ongoing inequities in health access and outcomes for Māori, coupled with a growing and ageing population, growth in the incidence and impact of chronic conditions and population redistribution the network will face a greater increase in workload than are likely to occur in many other regions of New Zealand.

Figure 1: The Pinnacle General Practice Network



General practice is the cornerstone of New Zealand's health system, providing first contact health care, care coordination and acting as gatekeeper to expensive hospital services. It is well recognised that a future of rising demand for health care services due to population growth and structural ageing will place significant strain on general practice, at the same time as there are increasing workforce losses, given that baby boomer GPs and nurses started reaching retirement age in 2011. These frontline clinicians will either decrease their working hours or fully retire. These demand side and supply side challenges are occurring simultaneously.

2. Key Findings for the 2023 Workforce Survey

Pinnacle General Practices and enrolled patients, 2006-2023

Since the first Pinnacle workforce there has been considerable change in primary care, including practices joining and exiting the network, alongside practice mergers and Primary Health Organisation rationalisation. Overall, this has resulted in a reduction in the number of general practices in the network in the context of rising enrolments, an ageing population impacting the network in divergent ways and a growing general practice workforce both in terms of numbers and professional expertise and affiliation.

Table 1: Practice and enrolled patient trends, 2006-2023

Measure	2006	2009	2023	Trend	Comment
Number of practices^	97	95	86	⌄	Practice & PMS mergers, practices exiting & joining the network, PHO mergers (2010/11).
Rural practices	43 (44.3%)	42 (44.2%)	34 (39.5%)	⌄	Decrease by 9 practices over the 17-year period, with a proportional decline of 5%. Includes some practice mergers.
Urban practices	54 (55.7%)	53 (55.8%)	52 (60.5%)	›	Decrease by 1 practice but proportional increase of 5% over 17 years. Some mergers.
Total ESUs	419.9k	440.6k	449.7k	⌃	Most growth between 2006-2009. Note: practice churn and PHO mergers (2010/11).
% Rural ESU	34%	34%	31%	⌄	Proportional and absolute decline.
% Urban ESU	66%	66%	69%	⌃	Proportional and absolute increase.

^ Practice counts PMS systems. One PMS may go across multiple geographical sites.

GP | Specialist GP Highlights

Workforce

- The Pinnacle **GP workforce has grown**, the headcount increasing from 289 in 2006 to 386 in 2023 (including GP Registrars); equating to a 33.6% rise over the 17-year period.

- **A considerable portion of the workforce has remained stable**. 28% of GPs in the network in 2023 were counted in the first workforce survey in 2006. These GPs may have changed practice, vocational status, geographic location or ownership status but they have been counted in the 2006, 2009 and 2023 surveys.
- The **feminisation of the GP workforce continues**. Women are now 52% of the workforce, rising from 35% in 2009 *[RNZCGP 2022 female GPs = 58%].*
- The proportion of **rural GPs continues to fall**. In 2006 almost 1 in 3 Pinnacle GPs worked rurally, this has decreased to 1 in 4 (26%).
- **Māori GPs** have increased (from 0.9% in 2009 to 4.5%). The RNZCP reports a similar low proportion (compared to 17% of New Zealand). In the network there are very few Pasifika GPs.
- The network has a history of reliance on **overseas trained GPs**. A majority remain foreign trained – but only just – at 51% (54% in 2009) *[RNZCGP 2022 = 37%].*
- **The workforce continues to gradually age**. Average age has risen from 47.6 years (2006) to 49.4 years (median 48.4 years) *[RNZCGP 2022 reports median age 52 years].* The proportion of GPs aged 65+ years is now 11.2%, up from 2.1% in 2006.
- **Ownership arrangements are changing**, and owner-operators are no longer the majority in the network. 70% in 2006 were owner-operators, declining to 61% in 2009. In 2023 this has declined to 36% *[RNZCGP reports 31% owner-operators in 2022; 40% in 2014].*
- **Most GPs are vocationally registered**, increasing from 68% in 2009 to 69% in 2023. Female specialist GPs in the network have increased from 57% (2009) to 67%. Slightly fewer rural GPs (69% to 65%) and male GPs (75% to 72%) are vocationally registered specialist GPs.
- Currently 14.8% (57 GPs) of the network GP workforce are taking part in the **GPEP training programme.** Six of these GPs are owner-operators.

Workload

- 68% of GPs (n=111) reported their usual hours spent **completing in-person consults** and said they did at least one face-to-face virtual consult; with 23% spending over 5 hours per week in this consult mode.
- GPs (n=149) were **employed/contracted for an average of 30 hours per week** (median 32) compared with average actual hours worked the previous week of 40 hours (median 40) *[Commonwealth Fund report gave an NZ estimate of average 37 hours worked per week].*
- **GP burnout** (n=149). On a 5-point scale where 1 = I enjoy my work; I have no symptoms of burnout and 5 = I feel completely burned out and often wonder if I can go on…. The average score was 2.7; 43% identified as having some degree of burnout (scores 3-5) *[Commonwealth Fund reported NZ GP burnout, using the same question & scale at 49%].*

- **GPs are generally satisfied with their job**. Using a 7-point scale where 7 = very satisfied; GPs averaged 5.5 in 2023 (n=146; average was 5.4 in 2009). The most satisfied GPs are those in rural areas (average 5.7), owner-operators (5.7) and overseas trained GPs (5.7).

Mātanga Tapuhi Nurse Practitioner (NP) Highlights

Workforce

- The **NP workforce is on average older than PNs**. The average age is 51.3 years compared with PNs at closer to 47 years of age.
- **Most NPs are of European ethnicity**, with 80% of respondents identifying with this.
- **NPs are highly experienced nurses** with an average of 27.7 years since first nursing registration.
- **NPs** had an average of 16 years working outside of the hospital setting.
- Retirement plans are not in the immediate future for NPs.

Workload

- **NPs are not often limited in their practice** but are occasionally limited by access to diagnostic tests, access to medical practitioners and restrictions to prescribing (such as some section 29 restrictions).
- **NPs are most often focussed on clinical practice**. A small number are involved at a management level, with policy development and tertiary education teaching regularly, while professional nursing leadership through Nurse Practitioner NZ and NZNO, policy development and tertiary teaching are occasional additional work for some.
- NPs work collaboratively with Māori clients/patients about their management/treatment plans.
- **NPs feel valued**, but identify being limited in leadership opportunities.
- There are high levels of job satisfaction amongst NPs.

Practice Nurses (PN) Highlights

Workforce

- **The average age of PNs in the network has decreased.** The age distribution of the network PNs has changed since 2009. There has been an increase in the proportion of PNs less than 35 years of age, but this is significantly offset by the large decrease in the proportion of PNs from 35-54 years of age.

- **Greater numbers of Māori and Pacific PN responders give percentages a boost.** The ethnic profile of the network practice nurse workforce has changed since 2009. The majority of PNs remain non-Māori and non-Pacific at 83.6%, down from 95% in 2009. There is a three-fold increase in both Māori and Pacific practice nurse numbers with their proportion going up from 4% and 1% in 2009 to 13.3% and 3.1% in 2023, respectively. However, they still remain underrepresented against the network population and NZ population.

Workload

- **The roles of practice nurses have expanded since our last survey** in 2009, some, more recently, as a result of the COVID-19 pandemic, while others were due to changes in legislation, particularly the change to the Medicines Act which allowed nurses to prescribe to a fuller formulary.
- **One-fifth of PNs (22.2%) are registered nurse prescribers.** This is the first workforce survey to ask about nurse prescribing. The majority are registered with the NZ Nursing Council as registered nurse prescribing in community health (RNPCH) (57.5%) followed by registered nurse prescribing in primary health and specialty teams.
- **A high proportion of PNs are trained vaccinators.** This proportion has increased to 97% from 94% in 2009. The proportion of PNs with specialist qualifications in cervical screening has increased from 63% to 84% during this time and diabetes training has reduced slightly to 51% from 54% in 2009.
- **Newer PN areas of development.** PNs now include ECG interpretation (20%), fitness to drive medicals (19%), long-term conditions (17%) and immigration medicals (17%) in their repertoire.
- **PNs are experiencing burnout** with 40% having one or more symptoms including 13% recognising that their symptoms are not going away.
- **Job satisfaction rating is reducing overall** at an average of 5.4, using a 7-point Likert scale (previously 5.9 in 2007 and 2009).
- **Feeling valued came out strongly as an area requiring more attention.** This was mentioned often in relation to both pay parity and being recognised for the professionalism of practice nursing particularly their work during COVID lockdowns.

Practice Centre Assistants Highlights

Workforce

- Practice centre assistants (PCAs), also called medical centre assistants and primary care assistants, work across the network.
- PCAs are an average of **46.6 years** of age.

- Most PCAs identify as **European** ethnicity followed by **Māori**.
- PCAs average more than 30 hours work per week.
- **A qualified PCA workforce**, with over 60% completing some level of NZQA course.

Workload

- **Their workload is vast** taking the admin tasks and non-clinical work away from PNs and also supporting health professionals in practice.
- PCAs have regular access to nursing supervision.
- Overall, PCAs are not feeling burned out and have high levels of job satisfaction.

The Extended Care Team Workforce Highlights

Workforce

Over the last 17 years, Pinnacle has been growing the interprofessional workforce to support general practice. This is the first time that this part of the general practice workforce has been surveyed.

- There are now at least 51 professionals working in Extended Care Team (ECT) roles supporting the network.
- These roles are a mix of Pinnacle employees and practice employed staff, bring expertise as health improvement practitioners, pharmacists, pharmacist prescribers, dieticians (including diabetes dieticians), health coaches, exercise consultants, kaiāwhina, social workers, physician associates and mental health brief intervention clinicians.
- The majority of the workforce is female, with the average age of those responding to the survey being 46.5 years.
- Inclusive of three-quarters of current team members, Māori make up 31% of the workforce.
- Average time in the current role was 3 years.

Workload

There are differing employment models in use across the region for these professionals. Referrals come in via practice colleagues, by patient self-referral or via external stakeholder agencies such as social service agencies (for Pinnacle employed roles).

- There was an **average score of 2.0 regarding burnout** (on a scale of 1-5 where 5 = completely burned out).

- **Staff are generally satisfied with their job**. Using a 7-point scale where 7 = very satisfied; ECT members averaged 5.6 in 2023. Aspects of the job people were most satisfied with were teamwork (5.7) and feeling valued (5.6). Leadership opportunities had the lowest average satisfaction score (4.7).

The Practice Management Workforce Highlights

Workforce and Workload

It is difficult to establish a denominator for practice management staff outside of those in practice manager type positions and Pinnacle does not hold this information across practices. In 2023 we included those in the role titles of operations manager, business manager, director and CEO. This year, 46 in those roles answered the survey, along with 55 people in administration roles, including receptionists, payroll, accounts/finance and administrators (including those in senior roles).

- The average age of practice managers was 50.9 years and practice administrators 43.2 years.
- 13% of practice managers identified as Māori, compared with 29% of administrators.
- For burnout on a scale of 1-5 (the lower the better); practice managers had an average score of 2.0 and practice administrators 1.9.
- Overall job satisfaction was 6.0 (scale 1-7 where 7 = very satisfied) for practice administrators and 5.7 for those responding who are in practice management roles.
- Combining both roles, 38% of those responding had 10+ years' experience in general practice in New Zealand.

3. Network Implications

At the national level there have been recent policy changes that should positively impact the network, including a strengthened GP training pathway and a commitment to increasing the number of specialist GPs trained each year, with a focus on growing more Māori and Pacific GPs. Likewise, the number of funded positions on the Nurse Practitioner Training Programme has increased. There is also new funding to increase the number of practices that offer community-based attachments for post graduate doctors in the year 1 and 2 intern programme. The recently released national Health Workforce Plan 2023-2024, while not specifically mentioning primary care, does include the aim of growing pathways for Māori and Pacific people into health careers. The plan recognises the current workforce pressures across the system and the challenges to be faced in meeting those.

GPs | Specialist GPs

Ageing GPs

The continued ageing of the network workforce remains a concern. While new, younger GPs are joining the network, it is not occurring in sufficient numbers to combat the ageing patterns of the network, particularly for those in rural areas. It is critical these younger doctors are retained and that they are able to continue on to become specialist GPs.

Men dominate the profession at older ages, meaning men more than women are likely to retire and exit the profession in 5 to 10 years. In addition, older male GPs traditionally work longer hours per week than those GPs entering the workforce.[iv] There is a growing proportion of all GPs aged over 65 years which is in line with national findings of an ageing workforce within an ageing population. However, there is a significant proportion of GPs who shortly will reach 65 years of age – this is evident when considering the proportion of all GPs currently aged 60+ years sitting at 23.8%.

Increasing feminisation of the GP workforce

The feminisation of the workforce has been evident for some years – both at the national level and in our network. This has implications for workforce capacity as women GPs are more likely to work part-time than male GPs. This is not surprising, as many female GPs, particularly in the younger age groups, may be engaged in raising a family as well as maintaining their profession. In 2009, most women GPs in the network worked part-time. This factor has a significant impact on the delivery of health care considering the increasing number (and proportion) of women GPs. Shorter hours impact on workload, and if the trend towards more women GPs continues, the number of GPs available may need to be higher. In terms of retention in the workforce and job satisfaction, this points to the need for flexible ways of working that allow any GP to find a way where they can continue their medical career and combine that with family commitments in ways that work for them.

Māori and Pasifika GPs remain under-represented in the network

The profile of the GP workforce remains majority non-Māori non-Pacific. While the proportion of Māori GPs has increased to 4.5%, in 2023 this remains low and is not reflective of either the Pinnacle enrolled or the resident population in Te Manawa Taki. The issue of low Māori GP representation is not just an issue for the network – it remains a national level issue. Te Whatu Ora and the RNZCGP has an emphasis on attracting and retaining Māori and Pasifika doctors into the GP workforce and this also remains a priority for the Pinnacle network. There are very few Pasifika GPs in the network.

GP Burnout

Burnout is of concern world-wide. In the Royal New Zealand College of General Practitioners 2022 workforce report, 79% reported some level of burnout, with nearly half reporting high levels. This 2023 survey used a different question and scale for measuring burnout. A total of 149 GPs answered this new question (39% of all network GPs). The question was "using your own definition of burnout, how would you describe your current state?" Some 43% self-identified as experiencing some degree of burnout. These GPs were provided with contact information about pathways for assistance. Many factors contribute to burnout and the resulting consequences will have a direct effect on the sustainability of general practice. Burnout will continue to remain an issue in the foreseeable future.

Attracting (and retaining) overseas trained GPs

Global workforce shortages have played a role in the current GP shortage. Shortages mean that practices have been forced to compete more over time. Many countries can offer higher salaries and/or conditions than can be matched here.

The network has historically relied on overseas trained GPs to address persistent workforce shortages. This remains the case overall, at 51% of GPs. Earlier surveys showed the reliance on overseas trained GPs was higher in rural areas – this also remains the case, with 57% of rural GPs compared with 49% of urban based GPs. Given the ongoing global shortage of GPs (that is predicted to worsen) this reliance is likely to become a riskier proposition in the future. The network will need to continue to implement options such as skill-mix solutions, workforce composition and changes to models of care to support GPs.

Specialist GPs

Almost 7 in 10 Pinnacle GPs are vocationally registered. Slightly more NZ trained doctors are specialist GPs compared to those trained overseas, with this pattern holding since 2006. However, at the time of the 2023 survey almost 15% of network GPs were in the GPEP training programme. This is positive news for all patients, whether those GPs stay in the network or leave once they have attained this specialist qualification.

GP working arrangements

Working arrangements are increasingly complex, with a greater variety of ways to work and flexibility of arrangements. There are small numbers of GPs working for more than one employer and working part-time virtually. For those undertaking virtual work, the consults are not necessarily occurring with the Pinnacle enrolled population. This growing flexibility, while making it harder to categorise GP working arrangements, is a positive development. The workforce has responded to demand by organising scarce resources more effectively; and a portfolio career is becoming a reality for GPs. Flexibility of arrangements may assist with career satisfaction and workforce retention, including for GPs reaching the traditional retirement age.

General practice ownership arrangements are changing

The proportion of GP owner operators has decreased since the 2006 survey. Owner-operators are no longer the majority, decreasing from 7 in 10 to less than 4 in 10 GPs in 2023. This is not an anomaly, but aligns with national findings from the RNZCGP reports, where it was reported that 3 in 10 were owner-operators (down from 4 in 10 in 2014).[iv] Sector leaders have called for a national discussion on what this decline in owner-operators means for the provision of health care.[ii] It may be that some elements of practice ownership/partnership are particularly unattractive, or out of reach.

Improving the attractiveness of working in general practice

GPs were asked what they thought would help general practice to thrive. A wide range of topics were put forward, key themes were around the funding model (both changing the funding model and increasing funding), training, recruiting and retaining GPs alongside reviewing and reducing bureaucracy to free up clinical time (and lessen frustration). Growing and supporting the interprofessional workforce in general practice also came through.

There are network practices with closed books and potentially more may limit enrolments if longstanding workforce issues deepen. There are obvious impacts for access to care, where the New Zealand Health Survey results show the most reported barrier to seeing a GP was the time taken to get an appointment, alongside the barrier of cost.[iii] These bring the potential for an increase in unmet need in primary health care and the potential for continued equity impacts.

Nursing

Nurses bring clinical knowledge, skills and expertise to the fore when supporting clients/patients to manage their health conditions and to support the functioning of general practice. The scope of nursing has changed considerably since our 2006 survey, in part to meet the complexities of primary health care due to an ageing population and greater prevalence of long-term conditions.

Nursing roles continue to evolve; more recently enabling nurse prescribing, as well as skills more often considered the remit of other health professionals. Nurses might work autonomously, strengthened by expert decision-making skills in providing consistently high-quality care. In addition, nurses play a key role

in leading the way toward a future primary care that extends from general practice into the wider community for practice-registered and non-registered clients/patients alongside GPs, Māori health organisations, pharmacists, physiotherapists, dieticians and other health workforce.

The past three years have been difficult

Natural events, such as COVID and floods, have impacted practices. The pressure on general practice has been immense and this has shown in the survey where commentary was requested. In helping primary care to thrive, pay parity was the largest issue, along with the overwhelming pressure on primary care, the work to strengthen the frontline COVID response with no additional workforce and disruption to life in general (living separately to the family to prevent passing on the virus), the need for more funding to primary care, more staff including Allied Health, and more recognition for what practice nurses do. Nurses showed that their job satisfaction, teamwork and professional development was somewhat satisfactory, however leadership opportunities, managing workloads and feeling valued rated lower. Burnout levels were higher than previous surveys.

Pay parity for nurses

There was a recent increase in funding for primary and community providers to support pay increases for nurses and health care assistants working in primary and community settings. On the back of this, however, a further increase was announced soon after for hospital employed nurses, thus maintaining the gap between hospital nurses and practice nurses. Pay parity remains a critical issue for both recruitment and retention, in an environment where nurses have choice in where they work.

Nurse leadership and supervision of clinical skills

Over two-thirds of nurses have access to a nurse lead. The descriptors of the role of nurse lead that were provided described day-to-day operations and staff management, as opposed to strategic, direction setting, vision-aligning leadership. In addition, nurses often supervise clinical skills in practice. Training in leadership and supervision of clinical skills was often provided ‘on-the-job’ and nurses were keen for more formal training in these areas.

Non-client/patient facing care

Practice nurses identified working up to 10 hours per week on non-client/patient facing work relating to client/patients but without them present. This work might include follow-ups, results filing, and work identified on discharge summaries or community referrals. In addition, non-client/patient facing work which does not relate directly to client, i.e. recalls, inventory, pre- and post-surgical room preparation, filing, and moving equipment were also consuming up to one-sixth of the workload of practice nurses. There remains room for increased task substitution to free up valuable nurse resource away from administration duties.

Supporting patients in preventative health and to manage their care

Practice nurses coordinate health care for patients that include preventing illness through vaccination, screening programmes, management of long-term conditions and diabetes monitoring. Through this, nurses support GPs to meet their quality targets and contribute to providing care in a coordinated way. Practice nurses will also provide clients/patients with the opportunities to take charge of their own care through education and improving health literacy. These responsibilities will remain a high priority as they relate to strategic goals at the national level.

Younger nurses coming through

The average age of practice nurses has reduced since the 2009 survey. As the baby boomer cohort retire from general practice, a younger cohort is coming in to replace them, but the numbers are not enough to fill the gaps. A focus on retention is equally as important as bringing nurses into the profession, into what is currently an ageing profession.

Nurse prescribing

Our network has higher numbers of nurse prescribers (8.5%) compared with those accredited by the New Zealand Nursing Council registered nurses who identify themselves in practice nursing (4%). These nurses have been able to put their training to good use, adding to the seamlessness of service for patients/clients. Most nurse prescribers have the registered nurse prescribing in community health (RNPCH) qualification, which has a limited formulary and allows prescribing to normally healthy individuals.

Across all general practice roles

Increasing roles that work with general practice and other referrers

Patients often prefer, for a variety of reasons, to receive their care in the community. Pinnacle has built a well-functioning Extended Care Team (ECT) that can go to a patient's home or another more neutral setting. This can overcome barriers to access that can be overwhelming. This team provides interprofessional care, taking referrals from GPs, nurses and social service providers and ensures a more wrap around service for the patient and their family. This way of working may also appeal to health professionals, helping with workforce retention. Given what we know about the current health reforms this will be an area where support grows, and Pinnacle is well placed to implement further as well as support other providers based on our in-house knowledge.

Increasing the Māori extended care interprofessional workforce

Aligned with the above point, for those professionals in extended care roles that responded to the survey, a third identified as Māori. This is a positive development given that the service has an equity focus and the wider teamwork in the community with those that need additional assistance to meet their health and wellbeing aspirations. A recent survey of Pinnacle stakeholders (general practice and external social service

agencies) noted that more capacity would be welcomed in this service to meet the needs that can be identified in the community.

Improving the attractiveness of working in general practice

Comments made in response to various free text questions have outlined some reasons/changes that would increase the attractiveness of working in general practice, including the following.

- Reduced administrative work, bureaucratic demands, and compliance arrangements. Some people suggested all bureaucracy requirements be reviewed with the view to reducing the overall burden. This would, among other things, free up clinical time.
- Future automation of routine administrative tasks.
- Improving salaries/incomes. One reason is to have parity with secondary care colleagues (all roles), making recruitment and retention more likely.
- Improved recognition of general practice from secondary care and national level organisations. This would include recognition of the role played and how workforce shortages etc in secondary care impact on the work of general practice.

4. Methodology and Analysis

Survey context

Survey response rates in 2023 were lower than previous surveys. Several factors have been identified as causative, but it is difficult to apportion the degree of contribution.

- There have been many surveys involving general practice over the period 2020-2023. Some of these have been related to aspects of COVID-19 such as vaccinations, others to staff burnout or issues of pay parity for practice nurses. At the same time this workforce survey was live, there were pay parity/funding surveys taking place also.
- Pinnacle resourcing less in 2023 than previous surveys and coinciding with an organisational restructure affecting staff who regularly interacted with practices.
- Survey fatigue – goodwill has its limits.
- Given the busyness of each day, the survey probably needed to be done in unpaid time.
- Noted nationally (and internationally) a decline in survey response rates over time.
- Less incentive for GPs this time to complete the survey – previously received 50% off their annual Pinnacle membership fee. This year it was a random draw for a morning tea shout based on the response rates of all practice roles.
- Surveying in 2023 did not exclude those on leave at the time of the survey. However, as the survey took place over two weeks, with multiple reminders, most of the network may, or may not, have had the opportunity to take part. Also excluded were casual locums for whom Pinnacle may not have an email address recorded.

Survey approach and development

This survey used a cross-sectional study design to assess the current situation of the general practice workforce – including this time people in extended care general practice roles. Cross-sectional surveys were also used to gather information on the Pinnacle workforce in 2006 and 2009 but were carried out via manual forms (paper surveys), with existing fields pre-populated where possible, and utilising both quantitative and qualitative questions. The 2023 survey was electronic only. Although the same methodology was used for all surveys in 2023, there were some individual variations across the five surveys. The survey questions were developed by Pinnacle personnel involved in various aspects of workforce planning and development and were finalised following cognitive testing and piloting.

Survey processes and response rate

Table 2: Summary of survey processes and response rate by role group

Role group	Summary comment
GPs | specialist GPs' response rate: 41%	Using information from HubSpot and website checks, survey invites were sent out to 386 GPs. There were 158 responses: a response rate of 41%. For non-responding GPs if they were in the network in 2006, 2009, 2013 or 2017 demographic information held from previous surveys (secured in locked folders) was used. In addition, for non-responding GPs some publicly available information was used from the NZMC Register, including place and date of initial medical qualification, date of first registration as a Dr in New Zealand, whether the Dr was vocationally registered and if they were part of the GPEP training programme. Reminders were set halfway through sent through Survey Monkey to non-responders. Reminders also in weekly practice newsletters (with contact details for the project team) and via the medical director on the network GP Facebook page. Reminders also given to practice managers to remind staff.
Nurses response rate: 50%	Aimed at all clinical nursing roles within general practice, community teams and school nursing. This survey was developed in consultation with Pinnacle nursing leads, school nurse leads and an independent nurse practitioner. The survey was sent to all nurses via email, practice newsletter, a survey link posted on the Nurses Facebook page (by nurse leads) and through word of mouth. Process summary: Reminders in weekly practice newsletters (with contact details for the project team). Reminders also given to practice managers via their online meetings to remind practice staff.
PCA response rate: 67%	(Also called medical centre assistants, primary care assistants and other variations of this.) The survey was developed with Pinnacle nurse leads and sent to PCAs through emails provided on HubSpot and a survey link through the practice managers. Reminders in weekly practice newsletters (with contact details for the project team). Reminders also given to practice managers via their online meetings to remind practice staff.
ECT response rate: 65%	51 people were identified as working in ECT roles, both Pinnacle employees and practice employed. In total 33 responded; a response rate of 65%. A list of Pinnacle employed staff from HR, supplemented with information from HubSpot and individual general practice websites (to verify people and their role if not Pinnacle employed). Reminder halfway through sent through Survey Monkey to non-responders. Reminders in weekly practice newsletters (with contact details for the project team). Reminder in the CEO email to Pinnacle employed staff. Reminders from project team members in any meetings during the period the survey was open.
Practice management	101 practice-based managers and administrators responded to the survey. Of these, 46 were practice managers, directors, CEO or business managers. Survey links were sent through email and the practice newsletter and via FB posts. Reminders in weekly practice newsletters (with contact details for the project team). Reminders from project team in any meetings during the period the survey was open. Reminder sent in calendar invite to set time aside to undertake the survey.

5. Part A: Specialist GPs | GPs

Demographic Characteristics

The Pinnacle GP workforce has increased 33.6% from 2006 to a headcount of 386 in 2023. In this 17-year period there has been considerable change within the primary care sector, including a period of PHO consolidation around 2010/11. Since then, there have been smaller movements of practices both joining and exiting the network, and some practice mergers.

Network GPs bring considerable experience to the patients they serve with an average of 24 years since their first medical qualification and an average 19 years' experience in health care in this country. 35% have more than 30 years of experience as a doctor with 22% working in New Zealand for more than 30 years.

In 2023 Māori and Pasifika GPs remain underrepresented in the network, and this is not reflective of the enrolled Pinnacle or wider Te Manawa Taki population.

Historically the network has had a greater proportion of GPs working in rural areas. The number of rural GPs has increased marginally, but as a proportion of all GPs has decreased to 26% in 2023. Alongside this, as shown in Table 1, the proportion of enrolled patients in the network living in rural areas has deceased as a proportion of all enrolments (from 34% to 31%).

Table 3: GP workforce overview

Measure	2006	2009	2023	Trend	Summary
Number of GPs	289	323	386 Inc Regs	^	11.8% increase from 2006 to 2009; 19.5% from 2009-2023 (2006-2023; 33.6%).
GP registrars	-	9 (2.8%)	57 (14.8%)	^	Nearly 15% of GPs are in the GPEP programme.
Female GPs	91 (31.5%)	113 (35.0%)	201 (52.1%)	^	Increasing feminisation of the workforce continues.
Male GPs	198 (68.5%)	210 (65.0%)	185 (47.9%)	v	Proportional decrease from over two-thirds of the network GPs being male to under half.
Māori GPs	4 (1.5%)	2 (0.9%)	15 (4.2%)	^	An increase of 11 GPs over 17 years. Still a low proportion and not reflective of the population.
Pasifika GPs	0	0	0.6%	>	Very small number and proportion in 2023. Not reflective of the regional population.
GPs in urban practices	197 (68.2%)	226 (70.0%)	285 (74.0%)	^	The number and proportion in urban practices has increased to almost three quarters of the network.
GPs in rural practices	92 (31.8%)	97 (30.0%)	100 (26.0%)	v	Small numerical increase over 17 years (note this is not FTE) but overall, the proportion working in rural areas has declined.
Overseas trained	53%	54%	51%	v	The majority of network GPs remain foreign trained, but only just.
Average years since 1st qualification	-	-	24 years	NA	Using survey data and the MCNZ Register all GPs are included. Median 22 years (2-56 years).
Average years registered in NZ	-	-	19 years	NA	Using survey data and the MCNZ Register all GPs are included. Median 16 years (0-54 years range).

Average age measures shown in Table 4 give a quick point-in-time snapshot. The age-gender population pyramids (Figures 2-5) show snapshots of the age structure of the workforce in 2009 (bars) compared with 2023 (lines). Key points include the following.

- The continued gradual ageing of the network for both females and males, but more so for male GPs and for owner-operators.
- Younger GPs are entering the network, both male and female. In 2023 there is a growing proportion of GPs aged under 40 years compared with 2009.

- There has been a hollowing out of the male GP workforce in the ages of 40-54 years, due in part to the ageing of the 2009 workforce (those remaining in the network since then).
- Over time a growing proportion of female GPs have moved into the 55+ groups. As for males, this is due in part to those remaining in the network ageing. For example a GP in the prominent group (Figure 2) aged 40-44 years in 2009 will be aged around 53 to 59 years now.
- Male GPs have a significant proportion aged 60+ years in 2023, compared to the age structure in 2009. This is not surprising as the significant baby boomer cohort started to reach the age of 65 years in 2011.
- In 2009 there was only a small proportion of female GPs aged over 60+ years. This has increased in 2023 but remains well below that for male GPs.
- On average rural GPs are older than those in urban areas. Since 2006 this average age gap has increased.
- There is a growing proportion of all GPs aged over 65 years and this is in line with national findings of an ageing general practice workforce within an ageing population. However, there is a significant proportion of GPs who shortly will reach 65 years of age – this is evident when considering the proportion of all GPs curently aged 60+ years sitting at 23.8%.
- The most common source countries for GPs trained overseas are the UK and Ireland followed by Africa (majority South Africa). However, both these categories have declined in proportion over time. There have been small but increasing proportions trained in Asia, USA/Canada and Australia. The source area with the largest increase over time is Other Europe.

Table 4: Selected aspects of GP age

Measure	2006	2009	2023	Trend	Summary
Average age of all GPs	47.6	48.6	49.4	^	Average age has risen by just under 2 years over the period 2006-2023.
Male GPs	49.0	51.0	52.4	^	Average age has increased by over 3 years.
Female GPs	45.0	44.1	46.5	>	In 2023 the average age remains lower than male GPs in 2006.
Owner-operators	48.4	50.2	54.1	^	By GP subgroup the oldest GPs at 54 years.
Urban GPs	47.0	48.2	48.6	>	Average age has increased over the 17 year period, but less than rural GPs.
Rural GPs	49.0	49.3	51.8	^	Gradual increase continues over time.
NZ trained GPs	48.0	49.1	48.5	>	Increase between 2006 and 2009 has not continued.
Overseas trained	47.3	47.4	50.5	^	Change between 2009 and 2023.
Proportion aged 65+ years	2.1%	3.0%	11.2%	^	Baby boomers started turning 65 in 2011. There is a 'bulge' nearing 65 years. Just over 1 in 10 are now aged 65+; the proportion aged 60+ in 2023 is heading towards 1 in 4 GPs (23.8%).

Figure 2: GP age pyramid, male and female GPs in 2009 and 2023

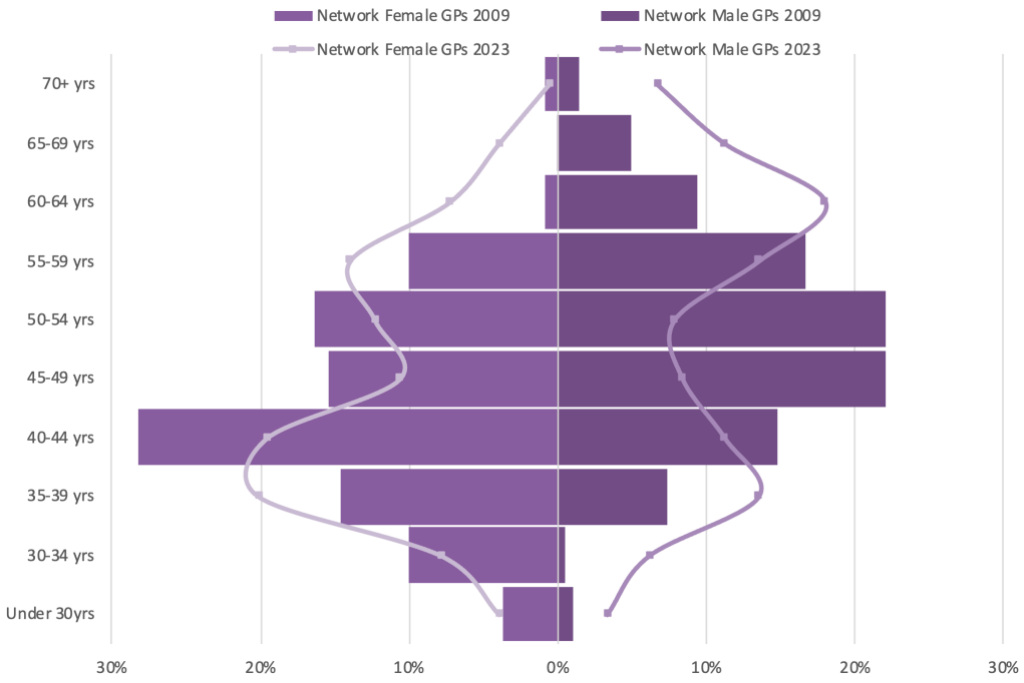


Figure 3: Age structure, rural and urban GPs, 2009 and 2023

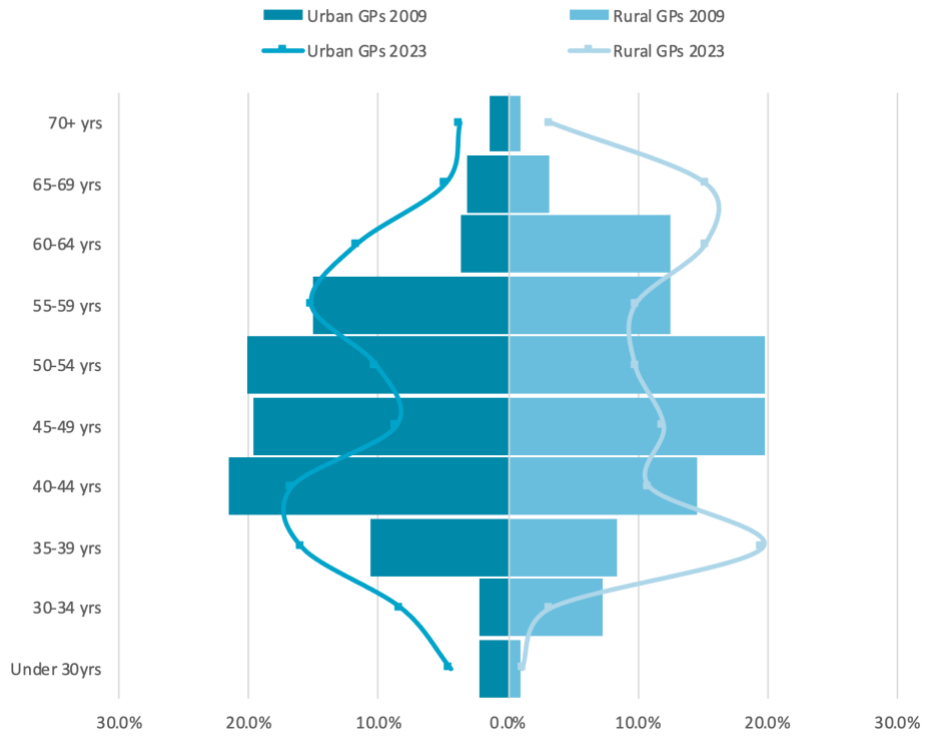


Figure 4: Age structure, New Zealand and overseas trained GPs, 2009 and 2023

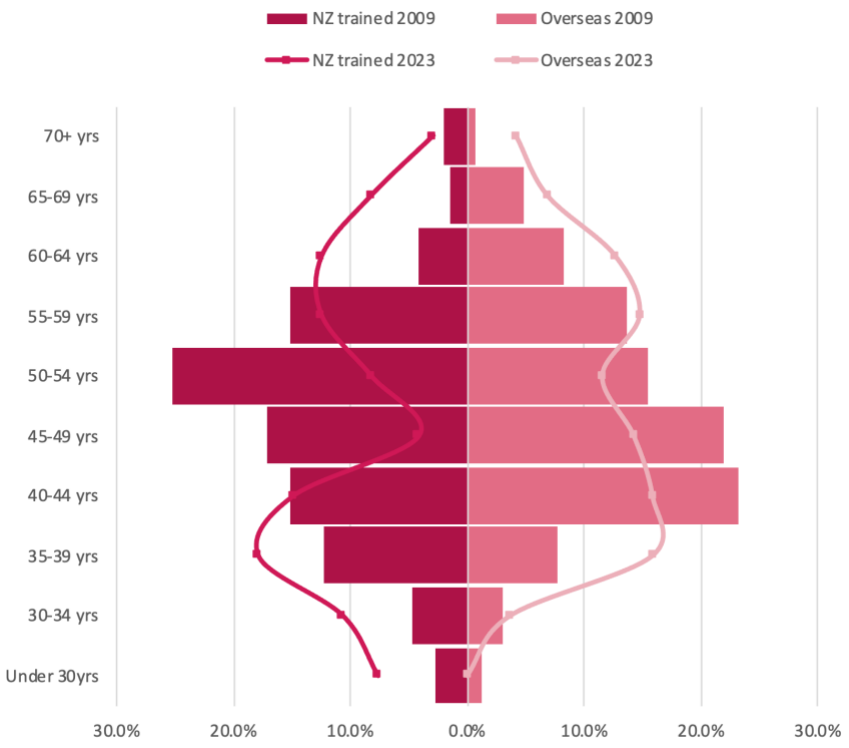


Figure 5: Overseas trained GPs – location of initial medical degree, 2009 and 2023

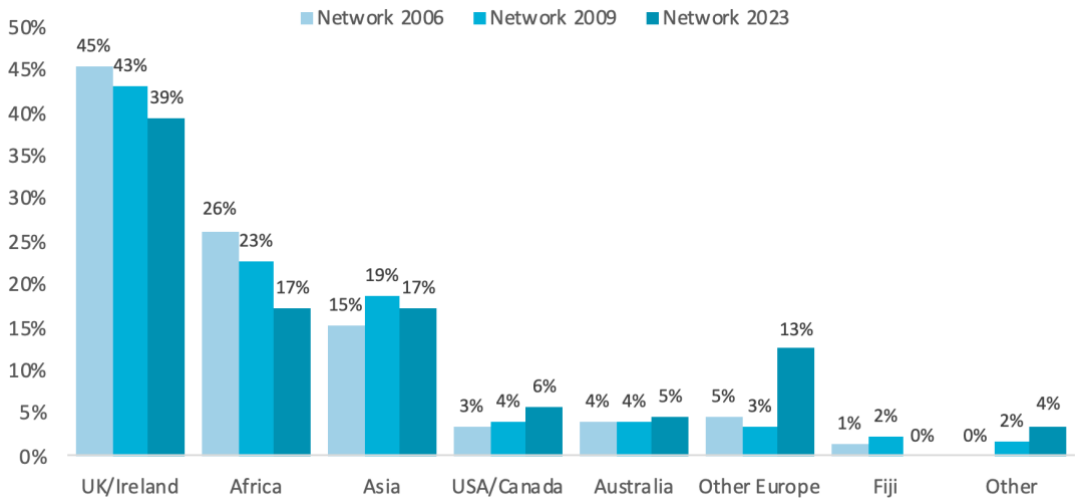
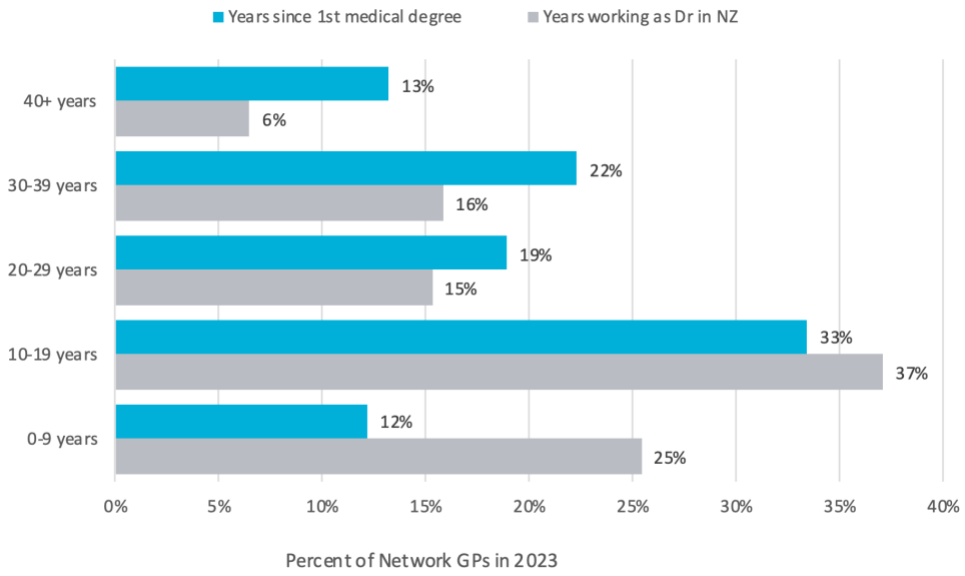


Figure 6: GP years' experience since initial medical degree and years working in New Zealand



GP Owner-Operators

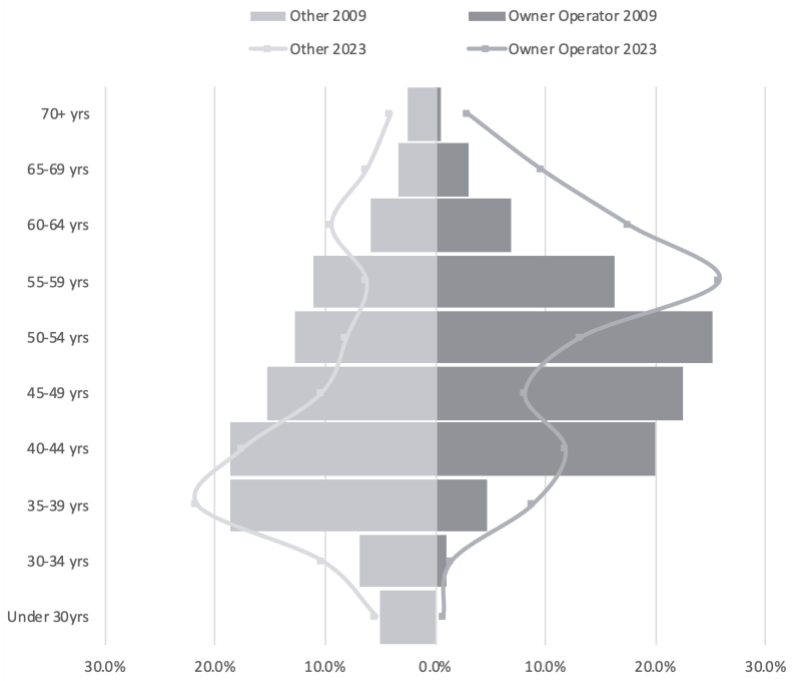
The regular RNZCGP survey reports show that at the national level GP owner-operators are a declining minority. They report just under 40% of respondents were practice owners in 2014, declining to 34% in 2020, and the new low of 31% in 2022.[iv]

The overall trend within the Pinnacle network (Table 5) follows the same trend as nationally, with GP owner-operators declining from 70% of the network in 2006 to 36% in 2023. This decline in both the number and proportion of GP owner-operators is in the context of a growing number of GPs overall in the network over the same period. While there have been declines across all categories, this is particularly so for male GP owner-operators, New Zealand trained owner-operators and owner-operators working in rural areas.

Table 5: Number and percentage of GP owner-operators, selected aspects

Measure	2006	2009	2023	Trend	Summary
Number of owner- operators	203	191	139	⌄	Included are 6 owner-operators who are currently in the GPEP training programme.
Percent GP owner-operators	70.0%	60.8%	36.0%	⌄	Previous years exclude registrars (there were very few).
Percent male owner-operators	-	68%	42.2%	⌄	Significant decline of 26%.
Percent female owner-operators	-	47%	30.3%	⌄	Decline of 17%.
Percent rural owner-operators	-	69%	39.0%	⌄	Signficant decline of 30%.
Percent urban owner-operators	-	57%	35.1%	⌄	Significant decline of 22%.
NZ trained owner-operators	-	65%	36.7%	⌄	Significant decline of 28%.
Overseas trained owner-operators	-	57%	35.4%	⌄	Significant decline of 22%.

Figure 7: Age structure, GP owner-operator and Other working arrangments, 2009 and 2023 comparison



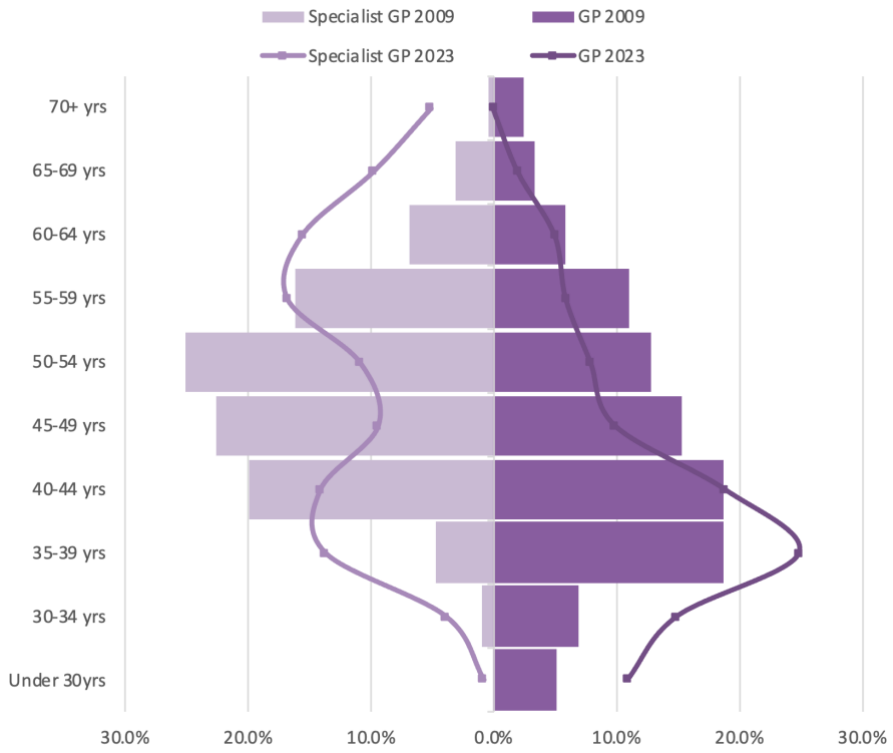
Vocational Registration

Almost 7 in every 10 GPs in the network are specialist GPs. A noticeable change in the context of a growing network is the number of GPs currently taking part in vocational training. At the time of the survey nearly 15% of GPs were involved. A high proportion of owner-operators are specialist GPs.

Table 6: Vocational registered GPs, 2009 and 2023

Measure	2006	2009	2023	Trend	Summary
Vocationally registered	-	68%	69.4%	→	The overall proportion of GPs who are specialist GPs is almost 7 in 10, a marginal increase from 2009.
Rural	-	69%	66.0%	↓	A small decline.
Urban	-	68%	70.5%	↑	Small increase.
Female GPs	-	57%	66.2%	↑	The proportion of female GPs who are specialist GPs has increased.
Male GPs	-	75%	72.9%	↓	One of the two subgroups where there was a proportional decline over time.
NZ trained	-	73%	73.9%	→	Currently 38 NZ trained GPs are in the GPEP training programme.
Overseas trained	-	65%	65.2%	→	Currently 19 overseas trained GPs are in the GPEP training programme.
Owner-operators	-	83%	86.3%	↑	Small increase over time. A high proportion.

Figure 8: Age structure, Specialist GPs and GPs, 2009 and 2023 comparison



Hours employed or contracted & hours worked

Hours contracted or employed to work averaged 30.0 hours (median 32.0; range 8-60) compared with actual hours worked the previous week, were there was an average of 40.0 hours (median 40; range 4-80). 149 GPs answered these questions. The RNZCGP 2022 survey[iv] found the average hours worked in general practice was 35.9 hours per week.

Estimated hours spent completing in-person consultations

In recent years there has been an increase in the use of remote consults. GPs were asked to estimate the number of hours spent each week in different types of in-person consultations, with 111 providing a response to all four parts of the question. While in-person at the surgery make up most of the time spent on in-person consults, there are small proportions of face-to-face virtual and in-person in other setting consults.

Table 7: Estimate hours spent in in-person consultations each week in 2023 (n=111)

Measure	0 hrs/wk	>0-5 hrs/wk	6-9 hrs/wk	10-14 hrs/wk	15-19 hrs/wk	20-24 hrs/wk	25+ hrs/wk
In-person at GP surgery	2.7%	-	3.6%	9.0%	13.5%	27.9%	43.2%
In-person home visit (inc ARC)	55.9%	44.1%	-	-	-	-	-
Face-to-face virtual	32.4%	53.2%	6.3%	2.7%	2.7%	1.8%	0.9%
In-person in other setting	72.1%	18.9%	3.6%	4.5%	0.9%	-	-

Provision of training

Of the 143 GPs responding, almost half were not currently involved in providing any formal training. Outside of the provided training types, GPs also noted roles as nurse prescriber mentors, RNZCGP fellowship assessor, oversight for overseas trained GPs, NZREX tutor, supervision for a PA and ECP. Some GPs noted that they did not have an official position but did provide unofficial support.

Table 8: GPs involved in providing training (n=143)

Training provision	N (%)
Teacher of undergraduate medical students	56 (39%)
Nurse practitioner training (clinical supervision)	29 (20%)
PGY1 or PGY2 CBA placements	25 (17%)
Mentor of GPEP 2/3 registrar	22 (15%)
GPEP1 teacher	20 (14%)
GPEP medical educator	12 (8%)
Teacher or educational facilitator DRHM programme	3 (2%)
None of the above	64 (48%)

Job Satisfaction – "all things considered, how satisfied are you with your job?"

Job satisfaction overall was calculated from use of a 7-point Likert scale question. Some 38% of GPs in 2023 responded (n=146). Responses for the same question, same scale in 2009 was 82% responding. Although there are differences in response rates between surveys, overall job satisfaction has remained very similar.

Table 9: Job satisfaction, GPs 2009 and 2023

Measure	2006	2009	2023	2023 number
Total	-	5.4	5.5	n=146
Female GPs	-	5.5	5.5	n=68
Male GPs	-	5.3	5.6	n=78
Rural GPs	-	5.5	5.7	n=49
Urban GPs	-	5.3	5.5	n=97
Owner-operator	-	5.4	5.7	n=62
NZ trained	-	5.5	5.4	n=71
Overseas trained	-	5.3	5.7	n=75

1= very dissatisfied

2= moderately dissatisfied

3= somewhat dissatisfied

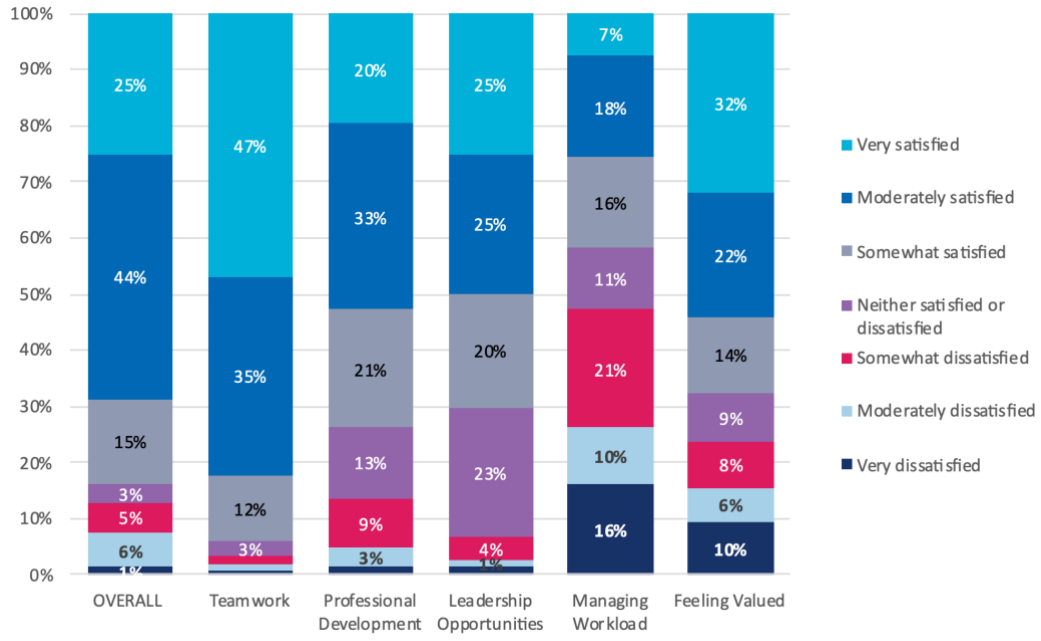
4= neither satisfied or dissatisfied

5= somewhat satisfied

6= moderately satisfied

7 = very satisfied

Figure 9: Job satisfaction, all GPs overall and by selected aspect in 2023



GPs Burnout

A total of 149 GPs answered this new question (39% of all network GPs). The question was “using your own definition of burnout, how would you describe your current state?”

A total of 68 of 149 responding GPs (43%) self-identified as experiencing some degree of burnout (with scores of 3-5 on the burnout scale). These GPs were provided with contact information about multiple pathways for assistance, including the resources available through the RNZCGP and contact details for the Pinnacle Medical Director.

Table 11: GP burnout in 2023

Measure	2023
Burned Out - average score (1-5 scale).	2.7
(1) I enjoy my work. I have no symptoms of burnout.	11
(2) Occasionally I am under stress, and I don't always have the energy as I once did, but I don't feel burned out.	70
(3) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	22
(4) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	39
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	7

Degrees of ‘burnout’

Responsiveness to Māori

The foundations of our new health system, outlined in the Pae Ora (Healthy Futures) Act 2022 are:

- health equity matters for everyone
- embedding a Tiriti-dynamic health system
- implementing a population health approach
- ensuring a sustainable health service delivery system.

The survey was an opportunity to establish a baseline for how general practice clinicians were working with patients in a manner that sought to uplift the mana of all patients.

Table 12: GP approaches to working with Māori patients in day-to-day work (n=151).

Day-to-day practices being used	N (%)
Reaching consensus with Māori patients about their management/treatment plans	108 (72%)
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	104 (69%)
Checking back (teach-back technique)	104 (69%)
Greetings using te reo Māori	102 (68%)
Enquiring about whānau and their health needs	101 (67%)
Recalls focused on increasing Māori engagement / participation in screening or health initiatives	83 (55%)
Working to a Māori Health Plan developed within the workplace that sets out the broad direction to address inequity	59 (39%)
Partnership with Māori organisations / groups in service provision or community initiatives	55 (36%)
Karakia in meetings / consultations	42 (28%)
None of the above	6 (4%)

Provision of Services Outside of GMS, ACC

GPs were asked "In addition to your core general practice work, do you have an extended role? i.e. do you provide a separate service that you need (and have) additional qualifications/training?" A list was provided, with space for other services to be specified.

Table 13: Additional services provided, where training or a qualification is required (n=83).

Day-to-day practices being used	N (%)
Minor surgery	62 (75%)
Dermoscopy	44 (53%)
LARC (long-acting hormone)	44 (53%)
LARC (IUD)	35 (42%)
Palliative care	33 (40%)
Travel medicine	23 (28%)
Mental health services	19 (23%)
PRIME	18 (22%)
Musculoskeletal medicine	14 (17%)
Sports medicine	9 (11%)
Assisted dying	6 (7%)
Appearance/cosmetic medicine	4 (5%)
Early medical abortion	2 (2%)
None of the above	41 (49%)

Years Until Planned Retirement

Respondents were asked in how many years they planned to retire from working in primary care. From 148 respondents, 12% stated they were unsure, with a total of 32% responding they planned to retire in less than six years. Our results are based on a sub-set of the GP workforce but follow the general direction of other reports around the future retirement plans of GPs. While the workforce is ageing, younger GPs in the network report considering leaving the sector due to issues of burnout etc.

Table 14: Years until planned retirement (n=148)

Timeframe	N (%)
Less than one year	7 (5%)
1-2 years	14 (9%)
3-5 years	27 (18%)
6-10 years	23 (16%)
11-15 years	10 (7%)
16+ years	49 (33%)
I'm really not sure	18 (12%)

If you could make one suggestion for how primary care could thrive?

> "Prevention is the forgotten entity in primary care. Primary care as the ambulance at the bottom of the cliff, becoming primary health care at the top of the cliff."

In this section comments have been combined with closing remarks. There were comments made regarding burnout that spanned almost all the below themes. Therefore, when reading this section, it could be taken that addressing these themed concerns will contribute to reducing GP burnout (and assist with workforce retention). In total 138 GPs made comments in at least one of the two free text questions.

Change the funding model, increase funding

- The current capitation model is not fit for purpose and will not get us where we need to go.
- Acknowledge that for years funding increases have been under inflation.
- Change would show GPs what they do is really valued.
- Change that would allow us to employ the administrators we need to make the most of a GP's clinical time.
- Need a model that makes locums affordable – would help burned out GPs take time off.
- Funding for smaller patient loads which reflects the increasing complexity and time needed.

- True pay parity for nurses under a fair model.
- To reduce co-payments for patients, including for longer consultations for those who need it.
- For GPs to be paid for paperwork time.
- Pay equity with hospital SMOs and same benefits and paid time for CME.
- Better access to mental health services. Need for counselling and psychiatry are at critical level.
- Primary options paperwork is excessive. The funding doesn't cover service costs.

> "Sort the capitation saga so we have confirmation/certainty around the future of general practice in New Zealand."

Increase interprofessional working that supports general practice

- Leave GPs dealing with clinical issues and diagnosis and bring more professionals in and use their expertise to deal with the wider determinants of help.
- With the upskilling of Allied Health workers, GPs are increasingly left with the complex and chronic health conditions which is demanding and time consuming.

> "Much greater central and community focus on addressing social determinants of health, such that these can occupy less space in healthcare delivery, and therefore we can focus more on the clinical side, which is what we are best at."

Train/recruit more GPs and actively retain them

- The pay issue/disparity with SMOs (and other like countries) will need to be addressed.
- Train more, show them primary care during training, then retain them.
- Train more GPs rather than focus on everyone working at the top of their scope as the answer – sure fire way to burnout.
- Support the Waikato Medical School initiative that has a focus on GP and rural health.
- Work on making GP job sharing easier (so you don't have to do admin work on days off).
- Train people interested in rural health and make sure there is exposure to rural general practice during their time at medical school and PGY1 and PGY2.

- Every general practice should be assisted to become a teaching practice.
- More help for foreign medical graduates is needed to help retain them.
- The RNZCGP should recognise US Family Medicine Board certified physicians. This is an impediment to recruiting GPs from the US.

> "To value the workforce and support paid paperwork time. Ask GPs what can be done to support their professional development."

Formalise a Physician Assistant training system and registration

- We need a formal PA training and registration system – opportunities for task substitution.

> "Continuity of care. I think episodic care and urgent care modelling is resulting in a poor service and amplified inequalities. Unfortunately, I can see that the workforce pressure is having a negative impact on our ability to provide regular and preventative care. I think the use of physician assistants has been a major help and has allowed our doctors to concentrate on the more complex patients. Formalising a PA registration/programme in NZ would be helpful."

Train more nurses and grow them into senior roles

- Nurses should be able to completely cover acute demand, should be able to do all WINZ forms, drivers' medicals and ACC forms.

Review bureaucracy with a view to reduce unnecessary paperwork

- Review all current paperwork requirements. It is a burden that takes up critical clinical time and often seems like just a box ticking exercise.
- Set up a recruitment entity/hub for GPs/rural GPs so that practices are not spending huge amounts of time replicating the same thing.

> "Ensure that doctors do what only doctors can do and not tie them down in tedious administrative tasks that could be done by someone else. A Dr's minute can only be used once. If you choose to use it to copy out a prescription form 3 times… then you cannot then use it for seeing a patient. It just demonstrates that you do not value the time."

Technology

- IT costs are increasing due to the bureaucracy burden and are excessive for small practices.
- Available platforms (the big two) both need to be advanced.
- Look at AI to see if any admin burden could be lessened.
- Have all secondary medical records on one electronic system instead of regional lock outs.
- More remote consults won't solve everything and does increase the risk to patients.

> "Have ALL medical records especially tertiary / hospital care on 1 electronic system instead of regional lock outs."

Te Whatu Ora / Te Aka Whai Ora / Ministry of Health

- There is a growing unpaid workload coming from secondary care. Acknowledge that GPs are shouldering a lot of the burden for hospital wait times.
- Value general practice. Engage and actually listen to the general practice workforce.
- Have more people who know primary care in leadership positions and governance roles.
- Value continuity of care more.
- Put the money into the frontline so that change can happen – funding system structures and duplication will not make a material difference.

> "We need the support and recognition from secondary care to be able to do our job. Currently feel underappreciated and not valued. Also, our referrals are often bounced back which puts more pressure on us to manage patients with very complex health issues that should be seeing specialists."

6. Part B: Extended Care Roles

Extended Care Teams

There are at least 51 professionals working in extended care roles supporting the network. These roles are a mix of Pinnacle employees and practice employed staff. A total of 33 responses were received – a response rate of 65%.

Of those currently in extended general practice roles, 27% are health improvement practitioners; 21% pharmacists (including prescribers); 12% dieticians and 10% health coach/Waiora Manaaki. There are also exercise consultants, kaiāwhina, social workers, physician associates and mental health brief intervention clinicians.

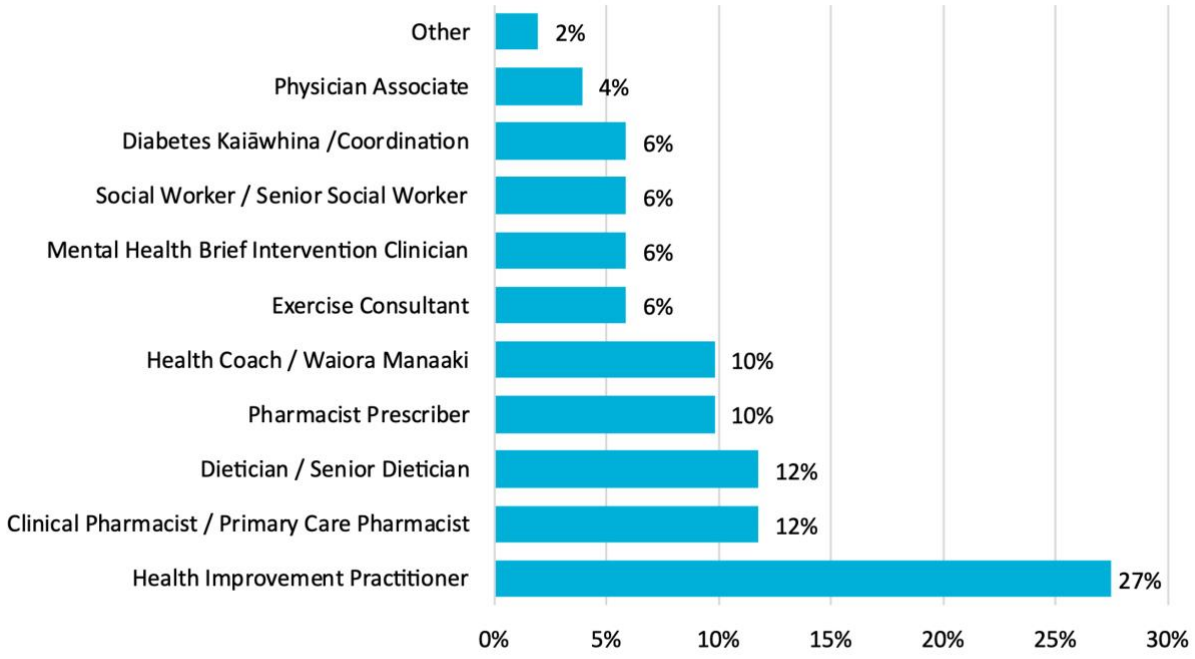
Respondents had an average age of 46.5 years with the majority being women. In the current wider team 31% are Māori (with n=13 unknown).

- 31 people answered questions on burnout, with an average score of 2.0 (on a scale of 1-5 where 5 = completely burned out).
- People were also asked their overall satisfaction with their job; with an average of 5.6. The aspect of job satisfaction that scored the lowest was ‘leadership opportunities’ at 4.7; with ‘teamwork’ the highest at 5.7.

Table 15: Summary of ECT responses

Measure	2023	Comment
Extended care roles	51	In total 51 across the region could be identified – a mix of Pinnacle MHN employed, and practice employed staff.
Average age (years)	46.5	Range 25-68 years. Median 48 years.
Based in a practice or across practices	55%	Remaining 45% are part of the Pinnacle ECT in Lakes, Taranaki and Tairāwhiti (n=51).
Females	88%	Of those responding to the survey.
Māori in ECT roles	31%	If n=13 unknown are excluded, then 42% Māori in ECT roles.
Burnout – average	2.0	N=31. Using a 5-point Likert scale where 1 = I enjoy my work, I have no symptoms of burnout and 5 = I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.
Job satisfaction (overall)	5.6	n=28. 7-point Likert scale where 1 = very dissatisfied and 7 = very satisfied.
Teamwork	5.7	Teamwork had the highest average satisfaction score.
Prof dev opportunities	5.4	
Leadership opportunities	4.7	Leadership opportunities had the lowest average satisfaction score.
Managing workload	5.3	
Feeling valued	5.6	
Average hours per week doing admin in own time	3 hours	31 ECT members provided an answer with the average of three hours spent doing administrative related work in unpaid time (range 0-12 hours).
Average years in current ECT role	3 years	30 respondents provided a job start date with an average of three years in their current role (range 0 / less than a year to 13 years).

Figure 10: Role Type, ECT roles (n=51)



Responsiveness to Māori

The foundations of our new health system, outlined in the Pae Ora (Healthy Futures) Act 2022 are:

- health equity matters for everyone
- embedding a Tiriti-dynamic health system
- implementing a population health approach
- ensuring a sustainable health service delivery system.

The survey was an opportunity to establish a baseline for how staff were working with patients in a manner that sought to uplift the mana of all patients. In addition to the following approaches, one respondent noted the use of Whanaungatanga, Manaakitanga, Tautokotanga, Tangihanga and Te Ahuatanga.

Table 16: Approaches to working with patients.

Day-to-day practices being used	N (%)
Greetings using te reo Māori	28 (90%)
Enquiring about whānau and their health needs	27 (87%)
Checking back (teach-back technique)	26 (84%)
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	26 (84%)
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	21 (68%)
Partnership with Māori organisations/groups in service provision or community initiatives	20 (65%)
Karakia in meetings/consultations	19 (61%)
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	10 (32%)
Working to a Māori Health Plan developed within the workplace that sets out the broad direction to address inequity	5 (16%)

Estimated time allocation per week by consult type

Those in extended care roles work across a variety of sites and in different ways, depending on the team they are part of and whether they are employed by Pinnacle or a general practice. Table 17 shows the estimated hours in a week spent working in different ways.

Table 17: ECT estimated time allocation per week

Measure	0 hrs/wk	>0-4 hrs/wk	5-9 hrs/wk	10-14 hrs/wk	15-19 hrs/wk	20-24 hrs/wk	25+ hrs/wk	Total
In-person in the work setting	-	19%	23%	9%	6%	10%	32%	31
In-person home visit	26%	39%	30%	4%	-	-	-	23
In-person other venue	30%	40%	25%	5%	-	-	-	20
Virtual (video, phone)	11%	64%	18%	7%	-	-	-	28
Non-client facing (email etc)	3%	55%	16%	10%	13%	-	3%	31

If you could make a suggestion for how your role could work better for you or your patients?

The themes identified include the following.

- Better communication and engagement with clinicians in the practices.
- Better IT support and systems, including being able to access the PMS from home.
- More administrative help (scheduling home visits etc).
- More group-based interventions to reach more people.
- Free consults with the pharmacist in general practice would allow for reducing inequity.
- Have more planning and collaborative time within the team and with general practice colleagues.
- More flexibility in the HIP role to meet people's needs.
- Greater ability to visit people at their workplace.
- More Allied Health staff across the board – to better meet demand and free up time for GPs, nurses.

> "Value the clinicians no matter the role. Better communication at transitions of care – documentation of care plans and responsibilities. Provide more funding and resources at primary care level to prevent preventable admissions."

If you could make one suggestion for how primary care could thrive?

- Pay Allied Health staff appropriately | higher salaries – on par with DHB salaries. This would help to both attract and retain staff.
- More GPs, NPs, nurses, mental health clinicians and support staff to meet the demand/need and to enable the needed equity focus.
- Ongoing training and clear pathways.
- Clarity of roles and responsibilities between community based and Te Whatu Ora staff.
- Provide more funding and resources at primary care level to prevent preventable admissions.
- Increased collaboration and integration with community health supports – 'hub' buildings with easy access to a variety of services to prevent barriers and silos.

- Access to care and receiving care for patients.
  - Create a more comfortable environment at the GP where people can come in and feel heard.
  - Cheaper if not free consults for those that need it – have an equity focus.
  - Longer GP consults (for those with chronic conditions this is not enough).
  - More cultural understanding and Te Tiriti training (ongoing not just the basics).
  - Focus on communicating with the patient and meeting their needs rather than what is convenient for the practice.
  - Ensure there is no delay in repeat prescriptions as some patients will go without.
- Establish an audit function for each practitioner – maybe from a third party. Could include aspects of managing caseload, improving client/pt outcomes, bias, practitioner wellbeing, optimising time-management, utilisation of tech.

> "Shift in focus to funding to support increased services from primary care using appropriately trained and qualified interdisciplinary team members as opposed to secondary care, with appropriate salaries. This would include appropriate training pathways, for example for pharmacists wishing to move into primary care practice roles to ensure the patients have the opportunity to benefit from seeing appropriately trained and resourced clinicians, and to eliminate health inequities."

Closing Comments

Responders were given the opportunity to provide a closing comment if they had anything further to say. Seven people in extended care roles took this opportunity. Their edited responses (to ensure anonymity) are below.

- Don't let the fear of what could happen, make nothing happen. Kia kaha!
- Getting the work life balance is very challenging.
- …Te Whatu Ora pays significantly higher *[for the same role].*
- … I have many years' experience in health and can honestly say that this is the most organised team operating with compassion and diligence for its staff and patients.
- It would be good to have better support for *[role]* in this setting. Particularly in rural areas it would be good to have opportunities to network with *[other people in the same role]* and have some form of mentoring or guidance for those entering the role.

7. Part C: Practice Management

Practice Management & Administration

This year 46 people in practice management (PM) roles answered the survey, along with 55 people in practice administration (PA) roles, including receptionists, payroll, accounts staff and administrators.

- The average age of PMs was 50.9 years and PAs 43.2 years.
- 13% of responding PMs identified as Māori, compared with 29% of PAs.
- For burnout, on a scale of 1-5 (the lower the better); PMs averaged 2.0 and PAs 1.9.
- Overall job satisfaction was 6.0 (scale 1-7 where 7 = very satisfied) for PAs and 5.7 for PMs.
- Across both groups, 38% of respondents had 10+ years' experience in general practice.

Table 18: Summary of selected findings

Measure	2009	2023	Comment
Practice managers	67	46	In 2023 includes titles of practice manager, operations or business manager, director, CEO.
Average age: PMs	50.0	50.9	Range 35-65 years (2023).
Ethnic group Māori	9%	13%	
Female PMs	96%	83%	
Burnout	-	2.0	Likert scale of 1-5; where 1 = I enjoy my work, I have no symptoms of burnout and 5 = I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.
Job satisfaction: PMs	6.1	5.7	Calculated from a 7-point Likert scale.
Practice admin	23	55	Administrators, receptionists, finance, accounts (senior roles included).
Average age: PAs	-	43.2	Range 18-64 years (2023).
Ethnic group Māori	-	29%	
Female PAs	-	95%	
Burnout	-	1.9	Likert scale of 1-5; where 1 = I enjoy my work, I have no symptoms of burnout and 5 = I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.
Job satisfaction	-	6.0	Calculated from a 7-point Likert scale.

If you could make a suggestion for how your role could work better for you or your patients?

The following main themes were identified.

- More appointments needed – for GPs and nursing staff | more frontline staff (including for cover).
- Better funding, flexibility around funding options i.e. funded to provide own mental health support and to fund equity projects.
- More time to work on the practice not in it | more strategic planning time. Time to plan process improvements | LEAN implementation etc. Time to work on better business structures.

- More time for staff to collaborate.
- Better access to online education sessions for support staff and more types of professional development for all staff. Including, for example helping patients with mental health issues.
- Equity in costs between practices to see clinicians.
- Being able to pay support staff what they are worth to attract and retain them.
- Review paperwork with a view to reduce it where it is just box ticking.
- More help with foundation standards.
- Improved IT experience so that time is not wasted | so we can be more efficient.
- Procedure manuals both paper and electronic. All practices engage and work in generally the same way.

> "More time to work on the business strategic goals – at the moment a lot of time is being spent fixing all the problems that were created through the 3 years of COVID."

If you could make one suggestion for how primary care could thrive?

Practice managers and administrators were asked this question (combined with themes from any closing comments that were made). Four main themes were identified.

1. **Funding – increases needed across the board if general practice is to achieve the wanted outcomes.**

- More funding for nurses – pay parity, to recognise the work done and retain all that experience.
- For more services in the community to meet need, including primary options and for mental health.
- Reduce fees for patients or make it free for those who really need it.
- To be truly patient centric for those with complex needs.
- To attract and retain GPs and Allied Health staff.
- Incentives for training and to retain general practice staff (across roles).
- To pay support staff adequately for the work they do.
- Apprenticeship type training so that people can afford to change path.
- Free fees for those training to be in frontline health roles.

- For keeping up with technology.

2. **More frontline staff are needed – both clinical and support staff who are empowered and trusted to do their jobs.**

3. **Focus on people instead of hospitals.**

4. **More transparency around how the system works and is funded.**

"Having a consistent and streamlined approach to primary health where all races, cultures, religions, and genders are accepted and treated with sensitivity to ensure equal access to good health care services. To keep educating patients in our communities on making healthy life choices and becoming more health literate for themselves, and their families."

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8. Part D: Nursing & PCA Details – see separate document

References

[i] "Stressed and overworked: What the Commonwealth Fund's 2022 International Health Policy Survey of Primary care Physicians in 10 Countries means for the UK (March 2023). Available at: https://www.health.org.uk/publications/reports/stressed-and-overworked

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