Pinnacle®
Midlands Health Network

Section 4

Population health and wellbeing

The primary care workforce

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Section 4

The primary care workforce

Introduction

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Sustainable primary care depends on a strong and adaptable general practice workforce. As the cornerstone of community-based healthcare, general practice teams deliver essential services that support prevention, early intervention and continuity of care.

In each Pinnacle district there are growing population demands, health inequities, and a changing burden of disease. A skilled and well supported workforce is critical to ensuring patients can access timely, culturally responsive care close to home.

The region must prioritise workforce development initiatives that reflect local realities, particularly for rural, Māori, and high need communities. Promoting a further shift toward team based, flexible care models is one way forward.

This report

This report is focused at the regional level. While the majority of issues hold true at the district level, they are at different levels of magnitude so local context is key.

There have been many workforce reports or briefings on general practice and primary care written in the last several years. This report does not attempt to replicate those or cover off every single issue, but focuses on a regional summary of issues.

Workforce forecasting is not included here as it is a specialised methodology and the responsibility sits with Te Whatu Ora. Pinnacle does not have the required data inputs to undertake regional or district level forecasting.

1 Key workforce issues in the rohe

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Workforce shortages across the board

- **GP shortage**: There is a well documented shortage, particularly in rural areas. Recruitment and retention are critical concerns.
- **Nurse shortages**: Primary health care nurses are in short supply, and those remaining often experience burnout due to high patient loads and limited support.
- **Ageing workforce**: A large proportion of the GP and practice nurse workforce is nearing retirement age, especially in rural practices. This threatens continuity of care.
- **Limited allied health and Māori health practitioners:** There are gaps in access to allied health professionals and a shortage of Māori clinicians, potentially undermining culturally appropriate care.
- **Programme coordination and support roles**: Provide important support for clinical roles and for patients/whānau. However, often impact is unrecognised by funders.

Uneven distribution of the workforce

- Urban areas tend to have better workforce coverage, while rural and remote areas face chronic understaffing.
- This uneven distribution exacerbates inequities for Māori and low-income populations who live in these underserved areas.

Fragmented workforce planning

- Historical planning has been reactive and fragmented, lacking coordination across agencies and sectors.
- Data limitations hinder planning. There is insufficient (or not readily available) real-time data on workforce supply, demand, and skills mix at the district level (or lower).

Inflexible funding models

- Capitation funding does not always align with the complexity of care or the needs of high-needs populations. This is now a long-term issue.
- Funding mechanisms often lack the needed flexibility to support team-based models or innovation in rural settings. Funding is often short-term (or for pilots), making it difficult to plan for development of sustainable health services.

Education and training pipeline gaps

- Limited placement and training opportunities for medical, nursing, and allied health students in rural and kaupapa Māori health settings.
- Pathways into primary care for graduates, particularly Māori and Pacific students, are not well supported or incentivised (compared to secondary pathways).

2 Key drivers of change

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Many undercurrents affect the primary care workforce

Pinnacle started referring to a 'perfect storm' back in 2006 following our first Network workforce survey, when analysing how the long-term demographic trends of population growth and ageing, and workforce ageing come together. But it's more complex than that, and since that time a number of other issues have arisen that need to be considered.

	POPULATION & WORKFORCE DEMOGRAPHY	PRIMARY CARE FUNDING	SOCIO-ECONOMIC DETERMINANTS
More recent impacts	Clinician burnout	Continued reform bring uncertainty	Inequity increases for some
	Some practices close books	Continued delay revising capitation	Cost of living crisis worsening for many
	Some practice services scaled back	Nursing workforce depleted - pay parity with hospital nurses	Increasing mental health concerns post COVID
	Decreasing appointment availability		
Long term undercurrents	Increasing pressure from ageing population & chronic disease	Funding model inadequacy	Recalcitrant inequity for Māori
	An ageing primary care workforce	Funding for service not covering costs	Rural inequity: access & health outcomes
	Workforce distribution	Inflexible funding contracts	Inequity for tāngata whaikaha
	Population growth not geographically uniform	Service funding not increasing with inflation	Growing socio-economic & social exclusion

3 Workforce issues summary

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All roles play an important role in general practice, especially in rural and high needs areas. However, some issues may limit effective deployment, integration and growth. This table below highlights some of the most prominent issues, followed by expanded selected comments on issues by workforce role.

Issue	GP	NP	RN+	PN	Allied	Coord	PM
Inadequate pipeline training capacity (supply)	✓	✓	✓	✓	✓	✓	
Need for pipeline reform	✓	✓	✓	✓	✓		
Unequal distribution of trainees/qualified	✓	✓	✓	✓	✓		
Training and supervision constraints	✓	✓	✓	✓	✓	✓	
Retention issues post training	✓	✓	✓	✓	✓		
Underutilisation		✓	✓		✓	✓	
Limited role integration		✓	✓		✓	✓	
Funding (pay) and employment barriers	✓	✓	✓	✓	✓	✓	✓
Pay parity			✓	✓	✓		
Professional isolation and support needs	✓	✓	✓	✓	✓		
Scope of practice and role clarity		✓	✓			✓	
Access to mentoring and clinical support	✓	✓	✓	✓	✓	✓	
Education and credentialling			✓	✓		✓	✓
Career development	✓	✓	✓	✓	✓	✓	✓
Māori underrepresentation	✓	✓	✓	✓	✓	✓	✓
Increased administration burden	✓	✓	✓	✓	✓	✓	✓
Stress and burnout	✓	✓	✓	✓	✓	✓	✓
Role recognition		✓	✓			✓	
Workforce planning / data limitations	✓	✓	✓	✓	✓	✓	✓

***RN+** = nurse prescribers.*

***Coord** = support and coordination roles, such as care coordinators, health navigators, admin or programme support, kaiāwhina, and outreach workers - these roles are often overlooked but are critical to the effective functioning of multidisciplinary teams and integrated care.*

***PM** = practice management and administration professionals.*

4 Workforce issues expanded

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Inadequate training pipeline capacity

- **GPs:** The number of training places funded annually has not kept pace with demand for primary care services, particularly in high-need and rural areas.
- **NPs:** The numbers remains relatively low, especially in rural or underserved areas. Training pathways can be complex, requiring clinical mentorship, advanced education, and workplace support. These barriers are harder to overcome in small or isolated practices.
- **RN+**: There is a limited pipeline of nurse prescribers.
- **Allied Health**: There is a shortage of professionals such as dietitians, podiatrists, clinical pharmacists, physiotherapists, occupational therapists, and social workers working within general practice teams.

Unequal distribution of trainees and qualified staff

- **GP, NP, RN+, RN:** Training opportunities are often concentrated in urban centres, which can make it difficult to attract and retain in rural areas. There may be a lack of incentives and structured support to ensure new graduates are deployed where the need is greatest.
- **Allied Health**: The distribution is uneven, with rural and higher deprivation communities facing the greatest difficulties recruiting and retaining allied health staff. Māori and iwi providers often face even greater workforce constraints despite delivering services to high need populations.

Training and supervision constraints

- **GPs and NPs:** General practice training requires supervised placements in clinics, but there is a shortage of accredited supervisors and teaching practices. Existing GPs and NPs may be reluctant to take on trainees due to high clinical loads, cost and time constraints.
- **Support roles:** Limited supervision where some workers may operate in isolation without clinical oversight or cultural support structures.

Retention issues

- **All clinical roles:** Many opt for part-time work, locum roles, or leave. Younger professionals may seek better work-life balance or avoid (comparatively) under resourced rural placements.
- **Support roles**: Limited career progression, with few pathways for advancement, affecting retention and succession planning.

Underutilisation and limited role integration

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- **NPs**: Some may not be fully utilised. Practices may lack experience in integrating NPs, leading to uncertainty around role and referral pathways.
- **RN+**: There can be variability in how well prescribers are integrated.
- **Allied health**: Are not consistently embedded in general practice teams. Funding mechanisms typically do not support integrated, permanent allied health roles in practices, especially smaller clinics.
- **Support roles**: (1) Integration issues: support staff may be siloed from clinical teams or work across multiple agencies without shared systems or communication channels. (2) Limited access to patient information systems or inability to document interventions reduces visibility of their contributions.

Funding and pay / pay parity

- **All roles:** Practices may struggle to fund training or support additional responsibilities without targeted investment.
- **RN+, RN:** nurses in general practice earn less than hospital-based nurses of equivalent experience, making it difficult to attract and retain staff.
- **Allied Health**: There is no consistent funding stream for allied health roles in general practice. Some professionals are employed on short-term or piecemeal contracts, limiting workforce stability and continuity of care.
- **Support roles:** Many of these roles rely on temporary or project-based funding, creating instability. Renumeration may be low relative to the complexity and emotional labour of the roles. Value often unseen by funders.
- **Practice Managers / Administrators:** Limited funding and financial pressures are concerns. Budget constraints can hinder the ability to offer competitive salaries, invest in staff development, and implement necessary technological upgrades.

Scope of practice and role clarity

- **RN+**: There can be inconsistency around the scope of nurse prescribing roles. This can affect how responsibilities are delegated and how team members collaborate.
- **Support roles:** Some roles have undefined scopes and lack clear job descriptions, meaning contributions may be undervalued. Also title confusion, with multiple titles for similar roles.

Access to clinical support / career development

- **RN+**: Nurse prescribers may require ongoing access to clinical supervision and mentoring. In smaller or rural practices, this support may be limited.
- **Allied Health:** Limited access to clinical supervision, mentorship and ongoing professional development may make general practice a less attractive option. New graduates might lack structured support compared to counterparts in Health New Zealand employment.

Education and credentialling

- **RN+:** Gaining prescribing authority requires additional postgraduate training and credentialing. This can be a barrier due to the time, cost, and geographic availability of education providers.
- **Support roles:** Lack of training pathways, with few formal qualifications or micro-credential opportunities, especially for cultural focused roles.
- **Practice Managers/administrators:** Ongoing professional development is needed. Access to opportunities can be limited, particularly in rural areas.

Māori and Pacific underrepresentation

- **Clinical roles:** There is underrepresentation of Māori and Pacific health professionals, contributing to cultural safety challenges and limited delivery of kaupapa Māori models of care.
- **Support roles:** Māori and Pacific support roles are often missing or inadequately supported despite their importance in improving equity.

Stress and burnout

- **All roles:** Are experiencing heightened levels of stress and burnout. Factors contributing to this include increased administrative work, managing patients with complex needs and staff shortages.

Increased administration

- **All clinical roles**: A growing administrative burden can take time away from patient care. This includes tasks such as documentation, data entry, and reporting. This may contribute to stress and burnout.
- **Managers/administrators:** These roles are dealing with increasing responsibilities, including compliance with funding requirements and adapting to evolving healthcare policies. This growth in tasks can detract from a focus on strategic planning and staff support.

5 Opportunities for change

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There are a number of opportunities for Pinnacle to develop sustainable and coordinated models of care, build stronger interdisciplinary teams, and ensure services are more accessible and responsive to diverse needs.

The table shows the interprofessional skills in each district, employed by Pinnacle (✓), a network general practice (✓) or other employed/funder (✓).

Workforce role	Lakes	Tairāwhiti	Taranaki	Waikato
Specialist GP	✓	✓	✓	✓
Nurse practitioner (NP)	✓✓	✓✓	✓	✓
Nurse prescriber	✓	✓	✓	✓
Practice nurse	✓	✓	✓	✓
Specialist nursing roles (e.g. respiratory, diabetes)	✓	✓✓	✓✓	✓
School-based nurses (includes NP)				✓
Nurses - immunisation outreach (+ support)	✓	✓	✓	✓
Nurses - mobile / support to screening				✓
Care coordinator (clinical)		✓		✓
Extended care paramedic			✓✓	✓✓
Physician associate				✓
Pharmacist prescriber	✓			✓
Clinical pharmacist		✓	✓	✓
Dietician / specialist diabetes	✓	✓	✓	✓✓
Exercise consultant / physiologist	✓	✓		
Physiotherapist				✓
Health improvement practitioner	✓		✓	
Social worker		✓	✓	✓
Brief intervention clinician		✓		✓
Waiora manaaki / Health coach	✓			
Cultural partner	✓	✓	✓	✓
Smoking cessation facilitator/support				✓
Kaiāwhina	✓	✓	✓	
Programme support / coordination	✓	✓	✓	✓

New and enhanced models of care

N R L

- Embrace appropriate virtual care and digital health solutions to extend workforce reach, especially in rural communities.
- Expand interprofessional team based models from what is currently in place, either employed by Pinnacle, a practice or other employer/funder.

N National level (inc. advocacy)
R Regional level (inc. advocacy)
L District / local level change

Funding levels and flexibility

N R L

Pinnacle has an important advocacy role in highlighting the need for funding levels that reflect population need and service demand, as well as greater flexibility to support new models of care and local innovation. Contracts need to allow flexibility to respond to change and try different ways of working.

Partnering with other community providers

L

There is potential to strengthen primary care by partnering with community providers, fostering more integrated, culturally grounded, and locally responsive models of care. This could include sharing of front line resources, including coordination resource.

Strengthening the nurse practitioner model

R L

- Expand funded pathways for training and early career support in practice settings.
- Include NPs explicitly in workforce planning and funding models, such as any planned health care home developments.
- Invest in leadership roles for NPs to support mentorship, clinical governance, and workforce development.
- Support rural practices and high-needs areas to employ and retain NPs through targeted investment and workforce planning incentives.

Strengthening the nurse prescriber model

R L

- Provide incentives for rural and Māori providers: Target funding to practices serving high-need populations to encourage prescriber training, recruitment and retention.
- Supported pathways: Increase funded training places for nurse prescribing qualifications, targeting rural and underserved regions.
- Team models: Support models where nurse prescribers function autonomously but collaboratively within the team.
- Role clarity and recognition: Develop clear role descriptions and promote the value of nurse prescribers to other professionals and the public.
- Workforce futures: Align nurse prescribing roles into workforce models to help manage GP shortages and population health needs.

Technological change and digital health R L

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There is significant potential to improve general practice through technological change (including AI) and digital health, enabling more efficient workflows, enhanced patient access, and better use of data to support proactive, coordinated care.

Māori workforce development R L

- Strengthen partnerships with iwi and Māori providers to support the recruitment and development of Māori health professionals.
- Fund and support Māori-led workforce initiatives, such as kaiāwhina workforce development, cultural competency training, and leadership programmes.
- Support community-based roles, such as rongoā practitioners, and community health workers within the extended general practice team.

Growing support and coordination roles (non-clinical) R L

- Advocate for long-term investment in these roles as core infrastructure within general practice (and primary care as a whole).
- Develop or support access to micro-credentials and structured training pathways (e.g. for health coaches, navigators, kaiāwhina).
- Standardise role descriptions and scopes to support consistency and equity across the region.
- Ensure integration into extended care teams and support cultural supervision and peer networks, especially for the Māori workforce.
- Promote these roles as a way to reduce clinician burden, improve access, and deliver on equity commitments.

Strengthen the rural and remote workforce R L

- Develop specific rural workforce strategies including bonded scholarships, relocation incentives, and rural training hubs.
- Enhance local training pipelines and increase rural placements for trainees across all health disciplines.

6 The GPNZ enhanced primary care model scenario

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The General Practice New Zealand (GPNZ) Enhanced Primary Care Model (2020), is an approach aimed at modernising primary care delivery. This model builds upon the Health Care Home framework, emphasising integrated, patient-centered care designed to meet the diverse needs of communities.

Purpose of presenting this scenario

The purpose is to apply the core enhanced primary care workforce model to Pinnacle districts. The aim is not to report where Pinnacle might be under-or-over FTE compared to the GPNZ model, but rather to generate discussion on what should be developed further in our model, within the workforce constraints we have.

Key components of the enhanced primary care model

1. **Team-based care**: Multidisciplinary teams, including GPs, nurses, and allied health professionals collaborate to provide comprehensive care (right care from the right professional at the right time).
2. **Patient-centred services**: The model focuses on tailoring services to individual patient needs, promoting self-management, and enhancing the patient experience.
3. **Integrated health information systems:** Utilisation of shared health records and digital tools facilitates seamless communication among providers, supporting coordinated care and reducing duplication of services.
4. **Proactive population health management**: By leveraging data, at-risk populations can be identified, to implement preventive strategies and monitor health outcomes.
5. **Continuous quality improvement**: Regular evaluation and feedback mechanisms are embedded to enable ongoing improvements in service delivery and patient outcomes.

Key assumptions in the GPNZ enhanced model

Change in GP clinical role: That there will be less of a focus on individual Dr consultations, and medical roles will see an increased proportion of activity that is not directly patient related (e.g. planning complex care, contributing to training, providing care remotely).

More nurses: That there will be an increased proportion of nurses in the core team and a substantial proportion will work to a high scope (including nurse practitioners, nurse prescribers and clinical nurse specialists). Note: following sector feedback the nursing FTE in the model was reduced in 2020.

Workforce components: That these will be similar between communities of differing need, but it will be the level of input that varies.

Comprehensive teams: Assumption that there will be co-location where feasible. Where this is difficult services will still be provided but could be via PHO or other organisations.

Training: Assumes involvement in medical, nursing and allied health training will be routine in all services.

Health information: Assumption that there will be an increasing focus on health information and health literacy, assisting individuals and whānau to navigate their way through health information.

Two workforce scenarios - high need and general need populations

There is no 'one size fits all' approach to the makeup of roles in the workforce. However, there are broad principles of a flexible, team-based interprofessional approach working as an extension of general practice that is integrated across the primary and secondary environment.

There are a few important points to note before looking at the application of the GPNZ enhanced model to the Pinnacle enrolled population:

1. These models do not account for how resources would need to be **geographically spread** across each Pinnacle district – just according to the enrolled patient count in 2023.

2. **Role substitution and role difference** between the GPNZ models and the extended care team as operational in Taranaki, Lakes and Tairāwhiti . Some roles grouped together are not the same e.g. social worker and navigator, although there is some cross over in the type of work undertaken. For a role such as social worker, registration with a national board is required. Several professional backgrounds may be useful for a navigator, including nursing, and lived experience.

3. **The use of trainees** (Dr, nurse, allied health) and of student FTE in the GPNZ model. The FTE for trainees is quite high and perhaps the assumption that training will be integrated as routine in all services is some way off how things currently work on the front line.

4. In the **Pinnacle scenario based on population projections to 2033**, it is unknown how many new residents will enrol in the network, or what the network will look like then.

Table 1 shows the enhanced primary care model by role, per 10,000 high needs and general patients. It shows the original 2019 FTE model and 2020 update. GPNZ note that this workforce picture represents a typical distribution of resource. The reality will reflect community need, the vagaries of recruitment/workforce availability.

Table 1: GPNZ enhanced care model, high need and general scenarios, original (2019) and 2020

	Original		Updated	
Personnel	FTE per 10,000 high need patients	FTE per 10,000 general patients	FTE per 10,000 high need patients	FTE per 10,000 general patients
GP	7.9	5.5	7.9	▲ 6.0
Nurse practitioner	5.0	2.0	▼ 4.0	2.0
Nurse	8.4	7.3	▼ 6.0	▼ 4.5
Reception/administration	6.7	5.0	6.7	5.0
Behaviourist/counsellor	1.0	0.5	▲ 3.5	▲ 2.5
Social worker/Kaiawhina/Navigator	2.5	1.0	2.5	1.0
Health care assistant	4.0	3.0	4.0	3.0
Clinical pharmacist	0.5	0.3	▲ 1.0	▲ 1.0
Physiotherapist	0.5	0.5	▲ 1.0	▲ 1.0
Trainee doctor	1.0	1.0	1.0	1.0
Trainee nurse	1.0	1.0	1.0	1.0
Trainee allied health	1.0	1.0	1.0	1.0
Student clinicians (at any one time)	2.0	2.0	2.0	2.0
Manager	1.0	1.0	1.0	1.0
Total team FTE	**42.5**	**31.3**	▲ **42.6**	▲ **32**

Model applied to the Pinnacle 2023 enrolled population

Results are shown in Table 2 for the 'high need' scenario where 1/3 of the enrolled population is considered high need and the remainder as 'general' patients. The 'general' model assumes all enrolled patients are not high need (so in a sense a minimum FTE scenario for the GPNZ model).

Reading Table 2 (over page, using Waikato example):

- For the 'high need' population scenario, if we assume that 1/3 of the Pinnacle enrolled patients are 'high need' and the remainder of 'general' need, in such a scenario we might need a total FTE of 166.1 GP; 66.8 NP; 37.6 social worker type FTE and 25.0 clinical pharmacist FTE.
- In the Waikato, if all Pinnacle enrolled patients were not 'high needs' but classified as of 'general' need, in this scenario we might need a total FTE of 150.2 GP; 50.1 NP; 25.0 social worker type FTE and 25.0 clinical pharmacist FTE (etc).
- The total team FTE for the high need scenario comes to 889.8 compared to 801.3 in the general scenario - a difference of +88.5 FTE for high need.

Table 2: GPNZ enhanced primary care model (FTE) applied to the high need and general population in each District (2023 enrolled patients)

	Waikato		Tairāwhiti		Taranaki		Lakes	
	High need	General	High need	General	High need	General	High need	General
GP	166.1	150.2	26.4	23.9	77.2	69.8	29.4	26.6
NP	66.8	50.1	10.6	8.0	31.0	23.3	11.8	8.9
RN	125.2	112.7	19.9	17.9	58.2	52.4	22.2	20.0
Admin	139.4	125.2	10.0	19.9	64.8	58.2	24.7	22.2
Counsellor	70.9	62.6	11.3	10.0	33.0	29.1	12.6	11.1
Social worker / kaiawhina	37.6	25.0	6.0	4.0	17.5	11.6	6.7	4.4
Health care assistant	83.5	75.1	13.3	11.9	38.8	34.9	14.8	13.3
Clinical pharmacist	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Physiotherapist	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Trainee Dr	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Trainee nurse	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Trainee Allied Health	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Student clinicians	50.1	50.1	8.0	8.0	23.3	23.3	8.9	8.9
Manager	25.0	25.0	4.0	4.0	11.6	11.6	4.4	4.4
Total Team FTE	**889.8**	**801.3**	**141.5**	**132.2**	**413.6**	**372.4**	**157.5**	**141.9**
FTE diff high need v general scenario	**+ 88.5 FTE for high need**		**+ 14.1 FTE for high need**		**+ 41.1 FTE for high need**		**+ 15.6 FTE for high need**	
FTE difference from 2023-2033	**+ 89.2 FTE high +80.4 FTE general**		**+ 5.3 FTE high + 4.8 FTE general**		**+ 19.6 FTE high +17.7 FTE general**		**+ 7.5 FTE high + 6.7 FTE general**	

Applying the GPNZ model to Pinnacle Lakes

Case Study

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We have applied the GPNZ enhanced model to the actual Pinnacle Lakes population and FTE employed in general practice and Pinnacle MHN on 1 July 2023. FTE data for clinician and non-clinician roles employed in general practice was sourced from the 2023 Pinnacle workforce survey and FTE model run by Pinnacle.

Table 3: GPNZ enhanced primary care model (FTE) applied to Pinnacle Lakes

Lakes general practice + PHO FTE	Actual 2023	Diff to 2023 high need	Diff to 2023 general
GP	21.6	**-7.8**	**-5.0**
NP (inc. PHO NP)	3.8	**-8.0**	**-5.1**
Nurse	31.85	**+9.8**	**+11.9**
Reception / Admin (inc. PHO)	31.7	**+7.0**	**+7.0**
Manager (inc. PHO district manager)	4.75	**+0.3**	**+0.3**
Health Improvement Practitioner	3.5	**-9.1**	**-7.6**
Social worker / kaiawhina / navigator	0.8	**-5.9**	**-3.6**
Health care assistant	8.8	**-6.0**	**-4.5**
Clinical pharmacist	0.3	**-4.1**	**-4.1**
Physiotherapist	0	**-4.4**	**-4.4**
Traine Dr	0	**-4.4**	**-4.4**
Trainee nurse	0	**-4.4**	**-4.4**
Trainee allied health	0	**-4.4**	**-4.4**
Student clinicians	0	**-8.8**	**-8.8**
PHO Dietician	1.0	**+1.0**	**+1.0**
PHO Health coach	2.2	**+2.2**	**+2.2**
PHO Exercise practitioners	2.0	**+2.0**	**+2.0**
Total FTE	**112.3**	-	**-**
FTE difference from 2023 actual	**NA**	**-45.0 FTE**	**-29.4 FTE**

Assumptions made (in Pinnacle application)

- The behaviourist/counsellor role in the GPNZ model is similar enough to a PHO HIP to be compared.
- That the PHO health coach role is materially different than the GPNZ role of social worker/ kaiawhina/ navigator.

Comparison - GPNZ enhanced and Pinnacle model

Remembering that there is no right or wrong, just difference for comparison and discussion between the GPNZ model (2020 update) and the Pinnacle Lakes 'actual' FTE in mid-2023.

- There is a -45.0 FTE difference between the Lakes actual and the GPNZ high need scenario, and a -29.4 FTE difference between the actual Lakes and GPNZ general scenario.
- Key differences (in both scenarios) are less FTE for GPs, NPs, behavioural/counselor roles, social worker, clinical pharmacist, physiotherapist, HCA and trainee roles in the Lakes actual model. Conversely, the 2023 Lakes team had a higher FTE for nurses (excluding NPs) and reception/admin roles.
- The Lakes model has roles that are not included in the GPNZ scenarios (dietician, health coach, exercise practitioners and PHO support functions). In the Lakes extended model the mix of roles has developed over ten years of trialing new approaches to the needs of the community.
- Differences between GPNZ model, Pinnacle and case study of Lakes ECT model – some of the difference in FTE totals is due to the GPNZ model commitment to have integrated training as the norm and that practice and PHO involvement in medical, nursing and allied health training will be routine in all services. This currently is not in place to any real degree.
- Following sector feedback, GPNZ updated their model in 2020. The greatest change was the reduction in nursing FTE.

Some issues for consideration

Expanding the GP and NP workforce during a time of expected workforce contraction. We will be looking for additional clinical staff while others are (world-wide) and in a contracting pool of qualified people.

System costs/issues

There are currently well known and significant constraints to accessing high quality primary health care. This includes the fragmented and not-fit-for-purpose general practice funding model and the pay parity issue for practice-based nurses. There also continues to be unmet need (as measured by the Health Survey), particularly for Māori and Pacific as well as the ongoing (and well known) workforce constraints.

Funding constraints

Funding will continue to be a constraint in the development of workforce models. However, it is not just the level of funding, it is the funding timeframe. Developments have historically been hampered by funders very short-term approach to piloting new ways of working. This has meant Pinnacle has developed various ways to fund the extended care models in Lakes, Tairāwhiti and Taranaki (and commencing in a different approach in the Waikato).

Facility mismatch to need

There are currently issues with services having the physical space required. Any additional team members carrying out an array of extension services will need space. The GPNZ report notes that co-location is important, both for clinicians and managers to interact and for patients to attend extended care in a familiar environment. They note that referral to a service in a different location may be a barrier to accessing that service.

Level of service required for equity (to change headline statistics) | More social integration

Into the mix of planning for service delivery is the level of service provision that will be required to address inequities, at the same time as there is an ageing population, increasing complexity of care required and entrenched workforce shortages.

The future use of remote technologies, telemedicine and AI

Potential future developments – particularly the development, role and best use of remote technologies and telemedicine in extended general practice teams; and of AI to streamline administrative tasks may mean less FTE is required for certain types of tasks.

Public expectations will continue to change

Patient expectations have grown over time. There are now high expectations of treatment in primary care and access to secondary care and medicines.