Thoughts on General Practice in New Zealand

Midway through my last locums placement here in New Zealand, and preparing to return home, seems an appropriate time to share my thoughts about patterns of practice, and my daily life as a General Practitioner.

As a background, I am a US Family Physician, and while in New Zealand I have worked in four different practices in three very different rural locations (Central and North Otago, South Island, and Hokianga, North Island). Each have very distinct patient populations and socioeconomic differences (the first mostly European heritage, less transient and slightly better off; the second a larger town of medium diversity; the third mostly Māori, much higher unemployment, and suffering greater economic and health disparity). I’ve been a specific practice replacement for six individual GPs, and experienced a variety of on-call situations, including after-hours and some hospital care.

Broadly speaking, WHO rankings show New Zealand to have equal quality of care, and better health outcomes, with less than half the total spending, of the United States. There is about 1 GP per 1400 persons, about the same as the US, but as a percentage of health spending primary care is greater than twice that of the US. General Practice is more at the center of the health system, with clear attribution of enrollment to the GP, clear and population-accepted gatekeeping functions, and expectations of open access.

It's been a delight to work here. Seeing 23 patients per day on average, I provide about 20% more "good" to my patients in total than a workday at home, partly with the slightly higher number of patients but also with more efficient care. And this in a two hour shorter workday (9am-6pm including all charting, one or two mid-session 15 minute "tea" breaks, and a real 1-2 hour lunch break, often spent at home). Some days can be hard (injury, illness and emotional suffering happen, and we are there) but there is also about 30% less heartache, handwringing and frustration per day than at home in the US. Therefore, primary care "burnout" is just much less of an issue.

So, basically reflecting the overall health system value noted above, my GP day “costs” about half as much effort to provide an equal amount of good. How is it that more service and value can be provided with substantially less total work? Or, put another way, why so much less waste? I’ll divide the answer into three parts: the system, the patients, and the GP’s work.

1) The system: There basically is only one integrated health system here. Private insurance or payments are available to cover out-of-pocket expenses (e.g. $40 for most GP visits, $5 for most medications), some elective non-covered tests and procedures, or to shorten waiting lists) but these are not often pursued except by the wealthiest (and/or most somatic) patients, and all tertiary and high acuity care is within the public system. Patients, and just importantly, their doctors trust that what “rationing” (whether queuing or availability) exists is fair, not a source of profit, and evidence- and value-based by a trusted system. With everyone covered, less money pouring through, and a single payor, there is no “fighting over the bill” and all the attendant waste we experience in our documentation-for-payment (or care) driven system. Included in this dynamic are the attempts to make primary care more robust. While tools for patient safety, efficiency and organization, better inter-provider communication, and patient registries for population health are being deployed, they are much more likely to rely on direct communication, patient responsibility, and provider professionalism then complex, duplicative, redundant or labor-intensive, systems.
2) **The patients**: The patients provide a substantial portion of the increased efficiency for each visit. They bring a mutually shared value of provider and system continuity; appreciate good, open access availability (which can be provided during 9-5 office hours for most medical problems because schools and employers respect a patient's access to medical care), and with lower costs and improved convenience, patients average nearly four GP visits per year in these practices. The system and the patients value team-based care (nurses do most population health and chronic disease management). But more so, I attribute patients’ better baseline health and preparation for the visit, and therefore each visit being both less “work” for the GP and better service and efficiency to the patient, to three things: better levels of exercise and fitness, better general and health literacy, and less stress in daily life. These factors also affect how well people age here. According to the WHO, New Zealand is one of only nine countries in the world where life expectancy is now greater than 80 years for both men and women, ranking overall sixth. The US is 35th. I routinely underestimate my "elderly" patients' age by a decade or more.

Each of these deserves comment.

A. Exercise: Vigorous walking, cycling, team sports and activities are the norm here. At home I find myself recommending, cajoling or negotiating exercise with patients. Here, rather than identify barriers patients are either exercising already or, if sedentary, accept the fact that they should or, more likely, used to exercise. Barriers to exercise including cost, social, and particularly time at work (c.f. stress levels, below) aren't as high. Examples include bike trails and rec centers, $5-$15 greens fees at the golf courses, community clubs for sports and activities (kayaking, climbing, bowls, boxing) that integrate smoothly with school-funded programs, and lots of self-organized walking, cycling clubs and the like. For example, it's not unusual for a retired person in their mid-70s to be in a walking group that walks for 2-3 hours three times per week, a middle-aged hairdresser to be on a thrice weekly basketball (netball!!) team, or a group of women in their 60s to go on organized multi-day hike, bike or horseback rides for 2 vacation weeks per year, staying fit enough to do so.

B. Literacy: good, universal, publicly funded education remains the norm here. I can deliver explanations and instructions to patients, and that they are simply understood and accepted (despite my accent, different vocabulary and colloquialisms.) Brief notations and written instructions suffice. Anatomical, statistical, or "meaning of life" references and explanations, and general discussions that enrich the doctor-patient encounter, are simply easier to have. Medication and treatment instructions are better understood and therefore adherence is much higher. Detailed materials, “teach-back” and pill and pharmacy counts, are needed only in rare cases. Interestingly, the Internet is probably less widely used than at home (libraries are busy, reading shelves full) but when people do, they better access and self-regulate trusted information.

C. Stress. New Zealand was number one in the Social Progress Index for 2014 (Michael Porter, Harvard Business School derived: [www.socialprogressimperative.org/](http://www.socialprogressimperative.org/)). Based on social indicators that serve economic growth, the index reflects lower levels of
socioeconomic and opportunity inequality, and sustainably providing basic human needs, including education. With education, access to healthcare, and the existence of a solid social safety net, even the relatively disadvantaged here live without the fear (or realization) of immediate eviction and homelessness, lost opportunity for one’s children, serious health consequences, lack of access to food, transportation or social services, that my patients have in the US. These social problems are thus not shifted to the relatively resource-rich medical system, a frustrating and daily event at home. Indeed, when I moved to practice in a rural Maori area, many warned that I'd be facing the challenges and consequences of socioeconomic and health disparities. What I found was that these, while real, paled in comparison to the difficulties one finds in, for example, rural or inner-city poverty, or Native American reservation practice in the United States. Family, cultural and social support systems were available and relatively intact. Literacy and education, exercise, recreation, and nutrition remained accessible, or even enhanced, in areas of need.

This is not only advantageous to the disadvantaged. Those better off, without the worry and stress of losing what they've attained, or feeling that they have done so at the expense of their fellow citizens, are less anxious and overworked. As an example, successful managers (in medical practice and elsewhere) are more likely to use that success to arrange shorter working hours, or increased community service, than greater income or organizational enlargement.

More directly relevant to health status and office-visit care plans, greater equity allows people to focus on quality of life and healthy habits without overworking. If they are sick or need physical therapy or recovery time, they take it. Most people work a 40 hour workweek, enjoy breaks for social (and work-enhancing) interaction with their coworkers mixed into the day, and are able to find the time for a doctor’s visit or routine exercise. Weekends, vacation weeks, and friend and family time are well valued, and people generally realize, enjoy, and vigorously protect work-life balance.

3) The GP’s work: Templates are simple: twelve 15 minute appointments (3 hour sessions) for morning and afternoon, with rarely more than half the schedule filled at the start of clinic. Minor procedures and some complex geriatric reviews are 30 minutes. There are a couple of nurse-visit “back up” opinions, and nurse-triaged overbooks, most days. Nursing home or home-visits (usually booked for beginning or end of session) or ambulance patients (examples: acute chest pain, immobilizing back pain, amputated digit, angulated fracture) a few times a week. Refills and various virtual care tasks are at about the same pace as a full provider panel at home but more likely to be partially nurse processed. There is a $40 fee for a GP visit (matched by public coverage, waived for children under 6 and for some high-needs patients), $20 for a nurse visit, and $15 fee for refills in most practices. Call is shared across practices in each town, and most practices have had one monthly lunch M&M meeting with shared case discussion of a consultant guest, and one administrative meeting.

A national value-based purchasing system has been very effective at keeping drug costs down. The formulary is adequate for ninety percent of a GP’s day with a patient only having a $5 co-pay; a few times per week I may need to certify that basic prescribing or diagnostic criteria have been met, a specialist recommendation, or similar, and another few times per week I may recommend a patient purchase a non-covered item, but prices on these are usually very
reasonable. I’ve noticed no lack of availability of newer, expensive therapeutics, e.g. adalimumab for rheumatoid or Crohn’s.

The electronic health record uses the same software in 85% of GP practices, but each practice is on a separate server and direct data sharing or aggregation is cumbersome (often print-fax-scan). There is not much e-prescribing; prescribing and diagnostics are done within the EMR encounter but then printed. About 50% of practices use web-based referrals but office notes are easily converted to these or to letters then faxed to consultants with medication, allergy and problem lists inserted. Population health programs (smoking reduction, diabetes, cancer screenings, cardiovascular risk reduction, immunizations) use regional and national web-based best practice registries with practice-level call-in lists and reporting, generally independently managed by nurse staff with physician input for special circumstances.

While waits for non-urgent consultation can be long (2-3 months), or 2-3 hours distant (many specialties have visiting rural clinics), prioritization is fair and transparent, and regional consultants are easily contacted by phone and are very helpful. Most routine paperwork is standardized and integrated with the HER, and requires only simple statements of new or ongoing permanent medical disability which are re-certified every 3-6 months, and the 10-20 percent of visits under the liability system (described below) have standard new or on-going claim forms, similar to but simpler than a U.S. Workman’s Compensation form in its clarity of date of injury, diagnosis, and activity restrictions.

In summary, the GP’s administrative patient care work, data gathering, visit and problem-oriented charting, diagnostic and therapeutic actions, referrals and administrative records are simple, use common platforms, and population health is managed with non-complex but universal team-based care systems.

A few words about behavioral health: There is roughly the same scope of knowledge by GP’s of psychiatric treatment and medications, and behavioral health is referral based and less integrated than in our Medical Homes. Substance abuse is less prevalent, and alcohol is the largest share. Like other referrals, behavioral health and substance abuse may have modest waitlists, but access points are clear and well-defined, acuity prioritization is fair and sensible, and telephone consultation easily obtained. As for chronic opiates in non-malignant pain, New Zealand never fell into U.S. patterns and problems; many fewer patients take opiates regularly, and those that do are on much lower doses. Maintenance therapy for opiate addiction, buprenorphine and methadone, is done by addition specialists, but in close coordination with, or delegation to, GPs. The frequency of opiate dependence is much lower, but enrollment in medication assisted treatment rates are higher.

Finally a word about liability, medical and otherwise. In the 1970s, building on previous precedent, New Zealand accepted a broad social compact where coverage, compensation and liability for injury whether accidental, workplace, medical, or occupational, was brought together into a single no-fault system that also vigorously funds injury prevention, safety standards and the like. Due to this, New Zealanders accept, but also feel protected from both personal and liability risk. Yes, it’s the original home of bungee-jumping, the playgrounds still have slides, and kids climb trees at school (barefoot!). Annual medical liability premium for full-time GP practice is $1,200. A modestly dangerous occupation, such as sheep shearing, will have of about a 6% total payroll add-on for combined health insurance and Workmen’s Compensation cost. This is one less way to “fight over the bill” in healthcare, and my
practice notes are further simplified, with no medico-legal or (billing requirement) justifications, only what is needed for the patient, my partners or consultant, to know.

Things are not perfect here. Breadth of scope and procedural skills for GPs are more limited, and new skills such as bedside ultrasound diffuse slowly. There is room for improvement in health outcomes and system operational efficiencies, particularly to reduce wait list time for consultation, diagnostics and some elective procedures. Rural GPs face partner recruitment challenges, although the training system has responded and the shortage is easing. The system of flexible and relatively routine use of locums has helped, and groups like NZLocums are skilled at matching up providers with appropriate practices and keeping things running smoothly; orientation, contracting arrangements, and transitioning between practices consistently went very smoothly for me.

New Zealand General Practice has been an example of how a different health system operates, and maybe what we can aim for in our own practices: equal or better service to our patients with greatly improved efficiency, through shared responsibility, simplified systems, accepted and trusted expenditure control. It will also require continued advocacy for equity in education and opportunity, the meeting of basic human needs, and a work-life balance for everyone that includes social interaction, recreation, and exercise.

Dr Nick Gideonse, MD | Oregon, USA | January - June 2014 locuming around New Zealand