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MNZH MAKE NEW ZEALAND HEALTHY

Fix General Practice:
Reduce Burden, Restore Care. In Brief.

THE PROBLEM: General practitioner doctors (GPs) are burdened with paper-work. The time GPs spend engaged with their computer systems rather than directly with their patients may amount to half of their total clinic time. How do we support GPs while keeping patients safe?

Most GPs spend 1 hour of a 4-hour work session on administrative tasks outside of the 3 hours they spend consulting patients. GPs are at risk of fatigue, reduced job satisfaction, while clinics experience difficulties in recruitment and retention.

(a) Outside of clinic hours: The main tasks outside of seeing patients include:

- Creating medication renewal prescriptions requested via phone, email or patient portals.
- Reviewing their inbox which contains results from laboratories, imaging services and Reports from hospital, after-hours care or private specialists.
- Completing tasks arising their inbox: updating medications, entering new or updated diagnoses, entering new or updated recalls for follow-up visits or tests.

Often this entails finishing the day at 5, and then working for another two hours to complete these administrative tasks. Complex cases, emergencies, and distressed patients which require additional support can increase the time spent, while this is important and must be done by the GP, the administrative and procedural tasks can be simplified.

(b) During patient visits: Perhaps another quarter of GP time is spent on administrative tasks while in consultation with their patients rather than communicating with or examining the patient to deal with the issue at hand. These administrative tasks include checking for information in the patient record relevant to the consultation, updating the patient record, checking to see if the patient is due to have any screening checks such as height, weight, blood pressure measurement, lab tests, recalls and vaccinations.

The current general practice environment leaves doctors with insufficient time, support, and institutional backing to deliver the full scope of care expected of modern primary health services.

In practice, GPs do not have adequate time within the working day for protected time for on-the-job learning and professional development which is important to develop or apply key competencies such as informed consent communication, behavioural change coaching, nutrition and lifestyle medicine, psychological care, integrative approaches, and social prescribing.

THE SOLUTION: Reallocate work, redesign workflows, and support general practice with team-based care, health coaching, and bounded digital tools so clinicians can focus on patients rather than process. Realign funding, measurement, and regulation toward prevention, continuity, and health outcomes, so a healthier population reduces workload rather than increasing it.

This is a complex, interdependent problem. It cannot be solved through a single intervention. A coordinated, stepwise approach is required, aligning workflow, funding, workforce, and patient roles.

Step 1: Reallocate Work. Separate Clinical from Clerical. Remove non-clinical tasks from GP workflows and provide GPs with more time to focus on clinical judgement, complexity, and relational care, rather than system processing.

Step 2: Introduce a Bounded Digital Support Layer. Rather than replacing existing systems, introduce a supervised digital layer to support workflow.

- Inbox triage and prioritisation
- Drafting of routine communications
- Structured data extraction and filing
- Recall and screening coordination
- Task routing across the team

This layer must remain, auditable, protocol-bound, and clinician-supervised. Its purpose is to reduce cognitive load and clerical burden, not replace clinical decision-making.

Step 3: Embed Health Coaching as Core Infrastructure. This improves patient health, reduces prescribing demand and stabilises GP workload while maintaining capitation-based revenue. Health coaching is not an adjunct. It is a primary prevention mechanism (See MNZH Policy 2).

Step 4: Realign Funding with Health Outcomes. The funding model must support prevention and continuity in order to This transition the system from activity-driven to outcome-oriented.

- Fund time for longer consultations and care planning
- Introduce incentives for measurable health improvement (e.g. metabolic markers)
- Support non-consultation-based care (follow-up, coaching, coordination)
- Recognise continuity of care as a core value

Step 5: Protect Clinical Judgement and Enable Prevention. Clarify the medico-legal environment to support appropriate care, this is essential to move beyond default prescribing pathways and ensure physician autonomy in decision-making. Support evidence-informed deviation where risk is low including nutritional and non-pharmacological interventions.

Step 6: Strengthen Continuity and Relational Care. Re-establish continuity as a core design principle. Continuity is not elective but a values-based, clinical and system-level intervention.

Step 7: Activate the Patient as a System Participant. Shift patients from passive recipients to active participants to reduce system load while improving engagement and outcomes.

Step 8: Redefine Measurement and Accountability. To support the reforms, and enable over time, them to become embedded in clinical practice. Move beyond activity metrics to health improvement medication reduction and stablish feedback loops at practice and system level.

Step 9: Reposition General Practice. Redefine the role of the GP from a diagnostician & prescriber within a fragmented workflow to a coordinator of care, interpreter of complexity (biological, psychological and social), a leader of prevention & a partner in long-term health.