7.

MAKE NEW ZEALAND HEALTHY

Fix General Practice: Reduce Burden, Restore Care

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.

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MNZH POLICY RECOMMENDATIONS

THE SOLUTION: 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.

The first priority is to 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.

i. Establish clear task ownership across the care team
ii. Automate routine processing (e.g. normal results, recalls, coding)
iii. Shift coordination tasks to nurses, healthcare assistants, and administrative staff
iv. Enable direct-to-patient communication for low-risk information

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.

Health coaching should be integrated as a standard component of primary care teams.

i. Provide structured support for dietary change, physical activity, and behaviour
ii. Focus on metabolic health, chronic disease prevention, and reversal
iii. Enable ongoing patient engagement outside consultation time

This delivers dual benefits, improving patient health, reducing prescribing demand and stabilising GP workload while maintaining capitation-based revenue. Health coaching is not an adjunct, rather, it is a primary prevention mechanism embedded within care delivery.

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, medication reduction)
- ✓ 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.

- Distinguish clearly between guidelines and mandatory standards
- Support evidence-informed deviation where risk is low
- Enable use of nutritional and non-pharmacological interventions without undue professional risk

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.

- Support stable GP-patient relationships
- Align funding and organisation with longitudinal care
- Reduce fragmentation across providers

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.

- Enable patient-led monitoring and reporting
- Provide structured tools for navigation and follow-up
- Support patient access to their own data and care processes

Step 8: Redefine Measurement and Accountability

What is measured effectively determines system behaviour. This will support the reforms, and enable, over time them to become embedded in clinical practice.

a. *Move beyond activity metrics to:*
   - health improvement
   - medication reduction
   - patient-reported outcomes
   - workforce wellbeing
b. *Establish feedback loops at practice and system level.*

Step 9: Reposition General Practice

Restore role clarity. Redefine the role of the GP within the system from a diagnostician and prescriber within a fragmented workflow to a:

- coordinator of care
- interpreter of complexity
- leader of prevention
- partner in long-term health

BACKGROUND TO THIS POLICY

[1] THE PROBLEM: ADMINISTRATIVE LOAD & SECONDARY CARE FOCUS

A quarter of GP time is spent on non-patient contact tasks after visits have ended for the day[1], but when they're with their patients, they're also spending time doing basic administration. General Practice in New Zealand has developed within a predominantly secondary care (hospital-based) paradigm. As a result, training pathways, clinical reasoning, and service delivery are largely shaped by models of care that prioritise access to medical treatments and screenings. While appropriate for acute and specialist settings, this orientation constrains the capacity of primary care to respond effectively to the broader determinants of health.

A central issue is the ongoing conflation of Primary Medical Care with the much wider concept of Primary Health Care. The former, delivered by GPs and practice nurses, cannot reasonably be expected to provide the full spectrum of prevention, health promotion, and societal health development. General practice is additionally increasingly burdened by fragmented communication flows, repetitive documentation, portal messages, recall management, screening follow-up, coding, and reporting requirements.

This situation has led to unrealistic expectations, contributing to workforce strain, reduced morale, and a persistent perception that primary care is underperforming in areas it was never designed to fully deliver, and working long-hours to fulfill basic administrative obligations.

At the same time, primary care must be re-equipped to better meet contemporary health needs. Serious gaps remain in general practice training in relation to the upstream determinants of health and disease. An example of these gaps is the inconsistent understanding and management of metabolic syndrome, its aetiology, prevention, and non-pharmacological treatment, despite its central role in the chronic disease burden.

These include the identification and management of modifiable drivers such as nutritional status, environmental exposures (including chemical and occupational factors), physical inactivity, and the interaction between psychological processes and physiological function.

These limitations are compounded by the relatively weak integration of nutrition science within premedical and undergraduate medical education. As a result, clinicians may not routinely recognise nutrition as a core therapeutic modality for achieving optimal health or preventing and managing the conditions most commonly encountered in practice. In parallel, most GPs receive limited formal training in non-pharmacological and non-surgical therapeutic modalities, including those encompassed within traditional, complementary, and integrative medicine systems.

These include, for example, Rongoā Māori, Traditional Chinese Medicine, Ayurveda, herbal medicine, osteopathy, and chiropractic care. While these approaches sit outside the core scope of general practice, a working knowledge of their principles, evidence base, and appropriate indications would enable GPs to make informed referrals to suitably qualified practitioners and to

[1] Medical Assurance Society GP Remuneration report 2024

better support patient choice. Targeted training in lifestyle medicine, integrative medicine, and functional medicine may help address these knowledge gaps and support a more comprehensive, primary health care–aligned model of practice.

There is also variable training in musculoskeletal medicine, trauma-informed care, and the health impacts of adverse life experiences, alongside limited capability in recognising and addressing social determinants of health, including social isolation, through structured approaches such as social prescribing.

When these capability gaps are combined with time constraints, fatigue, and administrative burden, the likelihood of adopting a prevention-oriented approach is further reduced. Practice patterns instead tend to default toward diagnosis and treatment pathways that are more strongly reinforced by training, clinical guidelines, and professional norms, even where upstream, non-pharmacological interventions may be appropriate. This reinforces a cycle in which the system remains oriented toward downstream management rather than upstream prevention.

Secondary Care is the Default Skill

General practice remains anchored to a secondary care (hospital-based), an intervention-focused model of training and delivery. This model prioritises diagnosis via screening, and the consequent prescribing of a medication and treatment pathway. GPs and practice nurses are initially trained within hospital environments and carry this orientation into community settings, where practices are funded and equipped to deliver a form of decentralised secondary care rather than a genuinely comprehensive model of primary health care.

Primary care and secondary care differ in both purpose and orientation. Primary care is the first point of contact for individuals and is designed to provide continuous, comprehensive, and person-centred care across the life course, with an emphasis on prevention, early intervention, and the management of multimorbidity in the context of everyday life. In contrast, secondary care is specialist, hospital-based care focused on the diagnosis and treatment of defined conditions, typically through targeted investigations and interventions.

Hospital environments are designed to primarily deal with serious health problems, trauma and illnesses which present a mortality risk. While training in hospital environments is integral to the training process, it emphasises secondary care treatment pathway.

While secondary care is episodic and problem-specific, primary care is longitudinal and integrative, intended to coordinate care, manage complexity, and address the broader biological, behavioural, and social determinants of health.

[2] NUTRITION UNDERMINED

Many factors combine to increase the reluctance of GPs and clinicians to recommend nutrition at optimum levels to their patients, to address chronic metabolic and brain-related issues, including problems relating to digestive function, inflammation, wound healing and skin care.

The problem is compounded by the limited integration of nutrition science within premedical and undergraduate medical training. As a result, clinicians may not routinely recognise nutrition as a

core therapeutic modality for achieving optimal health or preventing and managing the conditions commonly seen in practice.[2]

- Medical education 'regardless of country, setting, or year of medical education' pays insufficient regard to nutrition.[3]
- U.S.-based doctors for example, receive on average, 19 hours of nutritional training.[4] [5]
- A 2024 survey found that fewer than 22% of surveyed medical schools met minimum recommended 25 hours of nutrition education for medical students.[6]
- A review of medical students and doctors examining why nutrition knowledge is lacking, identified a range of complex drivers, including insufficient curriculum time dedicated to nutrition education, perceptions and confidence, stigmas and health habits, and challenges in clinical practice.[7]

When this gap in capability is combined with time constraints, fatigue, and administrative burden, it further reduces the likelihood that clinicians will adopt a prevention-oriented, primary care approach. Instead, practice patterns tend to default toward diagnosis and treatment pathways that are more strongly reinforced by training, clinical guidelines, and professional norms, even where upstream, non-pharmacological interventions may be appropriate.

New Zealand's Medicines Act 1981 contains an the overly broad 'therapeutic purpose' trigger. Section 4 automatically categorises a nutrient as a medicine where nutrients are described as influencing physiological processes, irrespective of dose or intrinsic risk. This blurs the line between the body's normal biology and drug treatment, bringing low-risk nutrients under medicine-style controls when they would be better managed through food and public health systems.

A central difficulty for medical practitioners is that the Australia and New Zealand Nutrient Reference Values (NRVs) are largely constructed around the prevention of overt deficiency, rather than the optimisation of physiological function across the lifespan. Processes of deriving the upper intake levels (ULs), can be confusing. In a number of cases, ULs, that, in the Dietary Supplements Regulations 1985, is referred to as the maximum daily dose, are not established on the basis of direct intrinsic toxicity of the nutrient itself, but on secondary or system-mediated effects, including cofactor interactions, nutrient competition, or downstream physiological responses. Examples include zinc influencing copper status, or vitamin D affecting calcium

[2] Devries S, Willett W, Bonow RO. (2019). Nutrition Education in Medical School, Residency Training, and Practice. JAMA. 321(14):1351–1352. DOI:10.1001/jama.2019.1581

[3] Crowley J, Ball L, Hiddink GJ. (2019). Nutrition in medical education: a systematic review. The Lancet Planetary Health, 3(9):e379 - e389

[4] Adams KM, Kohlmeier M, Zeisel SH.(2010). Nutrition education in U.S. medical schools: latest update of a national survey. Acad Med. 85(9):1537-42. DOI: 10.1097/ACM.0b013e3181eab71b. PMID: 20736683; PMCID: PMC4042309.

[5] Devries S, Dalen JE, Eisenberg DM. et al. (2014). A Deficiency of Nutrition Education in Medical Training.

[6] Eldin MM, Huynh RA, Khan S. et al. (2024). The Current State of Nutrition Education in Medical Schools in the United States: An Analysis of Curriculum, Faculty Perspectives and Resources. bmjnph 2024;7(Suppl 1):A1–A8. https://nutrition.bmj.com/content/bmjnph/7/Suppl_1/A4.1.full.pdf

[7] Khiri N, Howells K. (2025). Nutritional Education in Medical Curricula and Clinical Practice: A Scoping Review on the Knowledge Deficit Amongst Medical Students and Doctors. J Hum Nutr Diet. 38(2):e70031. DOI: 10.1111/jhn.70031.

regulation. However, clinicians may interpret the UL as a hard toxicity boundary attributable solely to the nutrient, rather than as a precautionary limit reflecting broader metabolic interactions.

New Zealand upper levels are in most cases are lower and more restrictive than, for example, Europe, and New Zealand automatically classifies a nutrient as medicine should a nutrient exceed the upper level, while this is not the case in, for example, Europe.

(See MNZH Policy 6. Remove Pharmac/Medsafe Barriers to Recognised Safe Nutrients.)

It is not unexpected that many clinicians are already operating with reduced confidence in nutritional therapeutics. With limited nutrients, and regulatory frameworks and reference values that present nutrients in a way that resembles pharmaceutical risk, without clearly distinguishing severity, mechanism, and context, this reinforces a perception that nutrients are either trivial (deficiency-only) or potentially hazardous if used beyond narrow guideline limits. The practical effect is that clinicians are less likely to consider nutritional strategies even where they are biologically plausible, low-risk, and relevant to patient care.

These challenges are amplified by the professional and regulatory environment. In New Zealand, doctors are expected to practise within accepted standards and guidance, and may be subject to scrutiny by the Medical Council of New Zealand if they depart from guideline-based recommendations. Where NRVs and related guidance are interpreted rigidly, clinicians may perceive a professional risk in recommending nutrient intakes above standard reference levels, even when the intended use is preventative, short-term, or based on emerging evidence. This is particularly relevant in areas such as immune support during periods of increased viral or bacterial risk, where higher nutrient intakes may be biologically justified but fall outside conservative guideline ranges.

In the decades since the Medicines Act 1981 was drafted, the underlying science has moved toward a more integrated understanding of metabolism, immune function, and nutrient interdependence. Without a clearer distinction between deficiency prevention, optimal function, and risk thresholds, and without explicit recognition of context (dose, duration, co-nutrient status, patient population), the current framework risks sending a misleading signal: that exceeding reference values is inherently unsafe, rather than conditionally appropriate and often low-risk.

From a public-interest perspective, the issue is not whether nutrients carry risk, they do, but whether risk is being characterised proportionately and mechanistically. Where the predominant real-world adverse effects are mild, predictable, and manageable (e.g. transient gastrointestinal discomfort), treating nutrients as if they carry drug-like hazard profiles can inadvertently restrict appropriate clinical use. Conversely, clearer articulation of risk type (tolerability vs imbalance vs true toxicity), alongside updated evidence for optimal intake ranges, would better support clinicians to make informed, proportionate decisions in patient care.

[3] GP SOFTWARE: FUNCTIONALITY WITHOUT USABILITY

New Zealand

General practice in New Zealand is heavily reliant on a small number of electronic patient management systems (PMS), which function as the operational backbone of clinical care, administration, and reporting. The most common systems in use include:

- Medtech Evolution (and earlier Medtech32)
- Indici
- MyPractice (used by some PHOs and corporate providers)

These systems integrate patient records, prescribing, laboratory results, referrals, recalls, billing, and reporting requirements. Increasingly, they are also linked to patient portals (e.g. ManageMyHealth) and national services such as e-prescribing and screening programmes.

In principle, these platforms should streamline care. In practice, they have become a major contributor to administrative burden. GPs may spend up to half of their clinical time interacting with these systems, both during and after consultations, performing tasks such as inbox management, documentation, coding, recall updates, and prescription processing.

This reflects an industry-wide problem: the systems are not primarily designed around clinician workflow or patient interaction, but around documentation, compliance, and funding requirements.

A consistent theme across both New Zealand experience and the wider international literature on electronic health records (EHRs) is that usability remains a significant limitation. While there is limited published, head-to-head evaluation of specific New Zealand PMS platforms, broader evidence is highly relevant and transferable. Studies across OECD settings repeatedly identify:

- High cognitive load from fragmented interfaces and multi-step workflows
- Inbox burden as a major driver of clinician fatigue
- Documentation duplication and poor interoperability between systems
- Interface design that prioritises data capture over clinical reasoning

Even where systems are functionally comprehensive, they are often experienced as non-intuitive, ‘clunky’, and workflow-disruptive. This is not simply a matter of user familiarity; it reflects underlying design priorities that have evolved around billing, medico-legal documentation, and system reporting rather than clinical usability.

Importantly, the evidence base on “which system is better” is weak. There are no robust, independent comparative studies in New Zealand assessing PMS platforms on usability, efficiency, or clinical outcomes. Most available insights come from:

- vendor-led evaluations or implementation reports
- qualitative clinician feedback
- international EHR usability and burnout studies

These consistently show that system design, rather than specific brand, drives outcomes. In other words, switching platforms does not reliably resolve the problem if underlying architecture and workflow assumptions remain unchanged.

Recent literature has begun to focus less on replacing systems and more on augmenting them, particularly through AI-supported workflow tools. Early evidence suggests that targeted interventions, such as inbox triage, message drafting, and structured data extraction, can reduce perceived burden and cognitive load, even where time savings are modest. However, this evidence

remains methodologically limited and does not yet support broad claims of system-wide transformation.

From a policy perspective, the key issue is therefore not simply software choice, but system design philosophy. Current GP systems:

- are documentation- and compliance-centric rather than clinician-centric
- embed secondary care logic into primary care workflows
- fragment rather than streamline communication and decision-making
- shift clerical and coordination tasks onto clinicians

A future-facing approach would not rely solely on incremental improvements to existing PMS platforms, but would require:

- redesign of workflows around clinical reasoning and patient interaction
- separation of clerical, administrative, and clinical tasks
- introduction of bounded, auditable AI support layers for inbox, documentation, and coordination
- stronger interoperability standards across primary and secondary care

In summary, while New Zealand's GP software systems are functionally capable, they are not optimised for the realities of modern primary care. The absence of robust comparative evaluation, combined with consistent reports of poor usability and high administrative load, suggests that the issue is systemic rather than vendor-specific. Without a shift in design priorities, these systems will continue to constrain both clinician time and the delivery of prevention-oriented care.

Global Shift: From Systems to Support Layers

There are a number of international GP clinical software systems that are often regarded as more intuitive or clinician-centred than those currently dominant in New Zealand, although the evidence base comparing them is limited. Systems such as Praxis EMR are notable for being designed explicitly around physician workflow, using adaptive learning rather than rigid templates so that the system conforms to how a clinician thinks and documents.

Others, such as DrChrono and athenahealth, emphasise usability through mobile-first design, cloud architecture, and more flexible workflows, and are often perceived as less cumbersome than traditional enterprise systems. Open-source platforms such as GNUmed take a different approach again, prioritising clinician control, transparency, and adaptability, although they are less widely adopted and depend heavily on local implementation.

However, the broader international literature suggests that differences between named systems are less important than underlying design philosophy.

While some newer systems reduce friction through better interface design or customisation, there is no strong, independent comparative evidence demonstrating that any single platform consistently delivers superior usability or efficiency across settings. As a result, even more modern systems tend to improve workflow only incrementally rather than fundamentally resolving administrative burden.

The more substantive shift emerging in the literature is not the replacement of core practice management systems, but their augmentation. Recent research on AI-supported tools indicates

potential benefits in areas such as inbox triage, documentation support, and workflow coordination, with early studies showing improvements in perceived workload and aspects of burnout, albeit with limited methodological strength and mixed findings on actual time savings. From a policy perspective, this suggests that the central issue is not simply which software is used, but how systems are designed and what functions are delegated away from clinicians. Without a shift toward clinician-centred design and the separation of clerical from clinical tasks, GP software, whether in New Zealand or internationally, will continue to constrain time, attention, and the delivery of prevention-oriented care.

[4] BEYOND TECHNOLOGY: FIXING INCENTIVES & WORK FLOWS

What remains underdeveloped within the current framework are several institutional and funding levers that sit beneath, and in many ways determine, the pressures experienced by general practice.

Most fundamentally, the funding model continues to reward activity rather than outcomes. General practice operates within a capitation and throughput-oriented system in which time spent on prevention, behavioural change, or complex care is not explicitly valued. This perpetuates an ongoing tension: GPs are funded similarly regardless of whether patients remain well or present with high levels of need, while the administrative and clinical workload associated with more complex patients continues to rise. In this context, prevention becomes economically and operationally marginal, even where it is clinically appropriate. A reorientation toward funding time, continuity, and measurable health improvement would better align incentives with the long-term reduction of disease burden.

Closely linked to this is the role of the GP inbox, which has evolved into the de facto integration point for the entire health system. Laboratory results, hospital correspondence, patient communications, recalls, and prescribing requests all converge on the GP, who becomes the default processor of information and coordinator of care.

This is not simply an issue of software inefficiency, but of system design. Responsibility for routine tasks remains insufficiently distributed, resulting in highly trained clinicians performing large volumes of clerical and coordination work. A more effective model would explicitly allocate tasks across the team, with automated handling of normal results, nurse- or assistant-led recall systems, and direct-to-patient communication where appropriate. This redistribution of work is as important as, and more immediately achievable than, technological augmentation.

Within this context, health coaching represents a particularly underutilised and high-leverage intervention. Structured health coaching, focused on dietary change, physical activity, and behavioural support, can assist patients to adopt and sustain healthier patterns, particularly in relation to metabolic conditions.

This has two important system effects. First, it directly addresses upstream drivers of disease, with the potential to reduce medication dependence and slow or reverse progression of chronic conditions. Second, it supports general practice sustainability. Where GPs are funded on a per-patient basis, improving the health status of enrolled populations reduces downstream demand without reducing revenue, thereby easing workload pressure while maintaining financial viability.

Integrating health coaches into primary care teams therefore aligns clinical, economic, and workforce objectives, and provides a practical mechanism for shifting from reactive care to proactive health management.

Another under-recognised constraint is the medico-legal and regulatory environment within which GPs operate. While guidelines are intended to support safe practice, they are often experienced as de facto rules, particularly where deviation may expose clinicians to scrutiny.

This can discourage the use of preventative or non-pharmacological approaches, especially in areas such as nutrition or integrative care where the evidence base is evolving and not always reflected in formal guidance. The result is a system that defaults toward standardised diagnostic and prescribing pathways, even when alternative approaches may be low-risk and appropriate. Clarifying the distinction between guidance and mandate, and providing explicit support for evidence-informed clinical judgement, would be necessary to enable meaningful change in practice patterns.

Continuity of care is another area that remains implicit rather than explicitly protected. International evidence consistently demonstrates that sustained GP-patient relationships are associated with improved outcomes, reduced hospitalisation, and lower overall cost. However, current system settings tend to prioritise access and throughput over continuity, leading to fragmentation of care and reduced capacity for longitudinal, preventive engagement.

Strengthening continuity as a core design principle, through funding, measurement, and organisational structures, would reinforce the relational foundations of effective primary care.

There is also scope to further reposition patients within the system. While current models, including emerging digital tools, begin to support patient engagement, the patient is still largely treated as a recipient of care rather than an active participant in its organisation. A more effective approach would support patients to take a greater role in information gathering, monitoring, and navigation, supported by structured tools and guidance. This aligns with the concept of a patient-side ‘health advocate’, but extends beyond technology to a broader shift in expectations and capability.

Finally, measurement and feedback loops remain underdeveloped. The current system relies heavily on process indicators and activity measures, such as screening rates or service utilisation, while giving less weight to meaningful health outcomes. Without a shift toward metrics that capture metabolic improvement, medication reduction, functional health, and patient-reported outcomes, the system will continue to reward activity rather than progress. Similarly, workforce wellbeing is not routinely measured as a core system outcome, despite its central importance to sustainability.

These gaps, considered jointly, point to a common underlying issue: responsibility, risk, funding, and workflow remain misaligned with the goals of modern primary care. Addressing administrative burden and improving software usability are necessary but not sufficient. A more comprehensive approach requires redistribution of work across the care team, integration of health coaching and preventive support, protection of clinical judgement, strengthening of continuity, and realignment of funding and measurement toward health outcomes. Without these shifts, the system will

continue to default toward downstream management, even as the burden of preventable disease continues to grow.

[5] AI-ENABLED PATIENT ADVOCACY & ADMINISTRATIVE SUPPORT IN GENERAL PRACTICE

A well-designed AI layer has genuine potential to improve the functioning of general practice, but its appropriate role must be carefully designed and stewarded to ensure a proportionate response to the present state of the evidence on the capacity of the systems, when data and privacy risks are considered.

A 2025 systematic review of AI and EHR-related burnout found that documentation burden and inbox burden are now major targets for AI deployment, with the available studies reporting promising effects on workflow efficiency, documentation time, and burnout symptoms, while also noting that the evidence base remains methodologically limited and not yet sufficient for broad claims of system-wide benefit.[8]

For policy purposes, this matters because the burden being shifted away from clinicians is often not 'clinical care' in the substantive sense, but clerical sorting, structured extraction, repetitive message handling, recall identification, coding, filing, and workflow coordination.

Those are precisely the areas where a bounded AI system may improve productivity without requiring the law or policy architecture to treat the technology as an independent clinical actor.

The justification for AI is strongest where it supports the health workforce, but does not displace professional responsibility. OECD's 2024 paper on AI and the health workforce similarly stated that while AI may help address workforce pressures, implementation raises governance, liability, training, and workforce-design issues that governments and institutions have not yet adequately resolved.[9]

Therefore, strongest current case is not for an autonomous clinical substitute, but for a tightly governed digital support layer that reduces administrative burden, improves coordination, strengthens patient navigation, and supports clinicians to focus on higher-value judgement, relationship, and care-planning tasks. Recent primary care reviews identify the most credible near-term applications as documentation support, inbox management, triage assistance, administrative workflow support, and population-health functions, rather than unsupervised clinical decision-making.[10] [11]

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[8] Sarraf B, Ghasempour A. Impact of artificial intelligence on electronic health record-related burnouts among healthcare professionals: systematic review. Front Public Health. 2025 Jul 3;13:1628831. doi: 10.3389/fpubh.2025.1628831.

[9] Almyranti, M. et al. (2024), Artificial Intelligence and the health workforce: Perspectives from medical associations on AI in health, OECD Artificial Intelligence Papers, No. 28, OECD Publishing, Paris, https://doi.org/10.1787/9a31d8af-en.

[10] Katonai G, Arvai N, Mesko B. (2025) AI and Primary Care: Scoping Review. J Med Internet Res. 2025 Aug 15;27:e65950. doi: 10.2196/65950.

[11] Iannone, S., Kaur, A. & Johnson, K.B. (2026). Artificial Intelligence in Outpatient Primary Care: A Scoping Review on Applications, Challenges, and Future Directions. J GEN INTERN MED 41, 364–373 (2026). https://doi.org/10.1007/s11606-025-09938-0

The emerging literature supports the view that AI could materially improve quality of working life in general practice and enhance patient navigation if deployed as a supervised, standards-based, protocol-bound support system. The best-supported use cases are administrative burden reduction, inbox support, documentation assistance, recall and screening workflows, and structured patient communication. The evidence is weaker, and the safety concerns greater, where AI is permitted to function as an unsupervised clinical intermediary. A sound policy framework should therefore endorse AI as an adjunct infrastructure for primary care coordination and patient advocacy, while preserving clinician accountability, clear escalation pathways, auditability, interoperability, and informed governance

AI: Potential to Support Administrative and workflow functions.

Within a GP clinic, the evidence now supports serious consideration of AI for inbox and record-management functions under supervision. This includes classifying incoming messages, drafting routine replies, extracting structured information from correspondence, identifying recall or screening tasks, and routing work to the most appropriate team member. A 2024 quality-improvement study of AI-generated draft replies to patient inbox messages found reduced clinician burden and burnout-related measures, although it did not show time savings overall. A separate 2024 study found clinicians often valued AI drafts as a useful starting point, but message read time increased and reply time did not materially improve, indicating that the gains may lie more in cognitive relief and standardisation than in raw time reduction.[12] [13]

Recent work on patient-message classification is also relevant. A 2026 quality-improvement study of a natural-language-processing messaging tool found that accurate classification of high-acuity portal messages was associated with shorter time to first read, suggesting a plausible patient-safety benefit from structured inbox prioritisation.[14] At the same time, qualitative work with primary care physicians shows that inbox triage is a continuous, cognitively demanding activity, which means any AI tool operating in this space has direct implications for access and safety and should therefore be treated as clinical workflow decision support rather than as a purely back-office utility.[15]

AI permissions could be extended to:

- Sort and classify incoming communications;
- Flag probable urgency;
- Draft routine non-diagnostic communications;
- Extract structured data for clinician verification;
- Update recalls, reminders, and screening prompts;
- Route tasks to nurses, healthcare assistants, or administrative staff according to protocol; and prepare summaries for GP review.

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[12] Garcia P, Ma SP, Shah S, et al. Artificial Intelligence–Generated Draft Replies to Patient Inbox Messages. JAMA Netw Open. 2024;7(3):e243201. doi:10.1001/jamanetworkopen.2024.3201

[13] Tai-Seale M, Baxter SL, Vaida F, et al. AI-Generated Draft Replies Integrated Into Health Records and Physicians' Electronic Communication. JAMA Netw Open. 2024;7(4):e246565. doi:10.1001/jamanetworkopen.2024.6565

[14] Nguyen D, Lee S, La K, et al. Performance of an Intelligent Messaging Tool for Clinical Communications. JAMA Netw Open. 2026;9(1):e2553174. doi:10.1001/jamanetworkopen.2025.53174

[15] Rule A, Shah R, Dudley D, Micek MA, Arndt BG, (2025) Primary care physicians' experiences with inbox triage, JAMIA Open, Volume 8, Issue 5, October 2025, ooaf105, https://doi.org/10.1093/jamiaopen/ooaf105

These functions are increasingly evidence-aligned because they remain bounded, auditable, and reviewable.

Future AI: The patient-facing 'AI health advocate'

The idea of a patient-side AI health advocate is more ambitious, but it is not implausible. The literature supports a role for conversational systems and chatbots in helping patients obtain health information, navigate services, schedule appointments, receive reminders, and access support outside staffed hours. A CADTH review found that chatbots can assist patients to identify providers, facilitate appointment scheduling, and access standardised information, although the clinical-effectiveness evidence remains emergent rather than settled. More recent patient-facing chatbot work likewise suggests potential benefits for access, but also warns that digital exclusion and variable digital literacy may widen inequities if such systems become a default rather than an optional support channel.[16] [17]

A patient AI advocate may be a realistic future tool, when it acts as a navigator, explainer, organiser, and relay mechanism. A patient AI advocate could help a patient understand care instructions, gather symptom updates, prompt authorised monitoring, support attendance at tests or follow-up appointments, prepare questions for a consultation, and transmit structured updates back into clinic systems.

Such a role would be materially different from an AI that independently determines care pathways, changes medication records, or decides which clinical information need not be seen by a doctor. The current evidence base does not justify broad autonomy of that kind.

AI Boundaries: Limits of autonomy and why they matter clinically

The literature already reveals a non-trivial safety risk when clinicians rely on AI outputs in patient messaging. A 2025 simulation study in npj Digital Medicine found that primary care physicians did not reliably detect and correct errors in AI-generated draft portal responses; a substantial proportion of erroneous drafts were submitted either unedited or without adequately addressing the embedded error. That finding is important for policy because it shows that "human in the loop" is not, by itself, a sufficient safeguard unless workflow design, training, audit, and risk stratification are also in place.[18]

Patient mistrust and the risk of AI models generating inaccurate outputs (hallucinations) are concerns that must be addressed. Establishing rigorous standards for data security, privacy, and

[16] Clark M, Bailey S. Chatbots in Health Care: Connecting Patients to Information: Emerging Health Technologies [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2024 Jan. Report No.: EH0122. PMID: 38564540.

[17] Moore AA, Ellis JR, Dellavalle N, Akerson M, Andazola M, Campbell EG, DeCamp M. Patient-facing chatbots: Enhancing healthcare accessibility while navigating digital literacy challenges and isolation risks-a mixed-methods study. Digit Health. 2025 Apr 28;11:20552076251337321. doi: 10.1177/20552076251337321.

[18] Biro, J.M., Handley, J.L., Malcolm McCurry, J. et al. (2025) Opportunities and risks of artificial intelligence in patient portal messaging in primary care. npj Digit. Med. 8, 222 (2025). https://doi.org/10.1038/s41746-025-01586-2

transparent reporting of LLM use is critical and communities are proposing potential frameworks for AI use.[19] [20]

- administrative autonomy, where the AI may execute low-risk, protocol-bound actions;
- clinical support, where the AI may generate suggestions, summaries, or prompts for human review; and
- clinical authority, which should remain with licensed clinicians.

That distinction is likely to be essential if the system is to be medically credible and legally durable. WHO's recent guidance on AI for health emphasises governance, transparency, human oversight, and protection against unsafe or inequitable use.[21] The National Academy of Medicine has similarly argued that AI in health care should augment human capability within a code-of-conduct and governance framework, rather than be treated as a self-validating solution.[22]

Interoperability and technical feasibility

From a systems perspective, integration with GP and hospital systems is increasingly feasible with standards-based architectures are now well established. The SMART App Launch framework has been specifically designed to allow third-party apps to launch inside or alongside electronic health records and patient portals, while SMART Backend Services supports server-to-server connections. In practical terms, this means an AI support tool can be designed to read and write constrained classes of data, operate with patient or clinician context, and sit between the user and the record system without requiring a wholly separate platform.

This does not eliminate implementation difficulty. Integration still depends on local vendor capability, FHIR maturity, access controls, workflow redesign, consent settings, and data-quality constraints. But it does mean that the proposal is technically realistic. The policy question is therefore less whether such a system can exist, and more under what legal, clinical, and governance boundaries it should operate.

New Zealand regulatory and professional context

In New Zealand, the direction of professional guidance is already moving toward cautious adoption under clinician responsibility. The Medical Council of New Zealand's March 2026 guidance expressly includes AI used in patient care, including AI scribing tools and AI systems that manage clinical inboxes, and states that doctors remain responsible for the care they provide and

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[19] Pencina MJ, Goldstein BA, D'Agostino RB. Prediction Models - Development, Evaluation, and Clinical Application. N Engl J Med. 2020;382(17):1583-586. DOI:10.1056/NEJMp2000589

[20] Adams L. (2024) Artificial Intelligence in Health, Health Care, and Biomedical Science: An AI Code of Conduct Principles and Commitments Discussion Draft. National Academy of Medicine, Fontaine E, Nat. Ac Med., et al., eds. NAM Perspectives. 2024;3. DOI: 10.31478/202403a

[21] WHO (2024). Ethics and governance of artificial intelligence for health. Guidance on large multi-modal models. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

[22] National Academy of Medicine (April 2024). Adams et al. Artificial Intelligence in Health, Health Care, and Biomedical Science: An AI Code of Conduct Principles and Commitments Discussion Draft. Perspectives | Expert Voices in Health & Health Care

must ensure patient safety and privacy.[23] ACC's March 2026 guidance for providers similarly sets expectations for safe and ethical use of AI in treatment, assessment, and rehabilitation contexts.[24]

A New Zealand policy case can be made for AI-enabled administrative support and patient navigation, but only within a model that preserves professional accountability, protects health information, and does not obscure who is responsible for clinical decisions. A policy that describes the technology as a support layer integrated into primary care workflows is therefore far more defensible than one that implies independent AI clinical agency.

Often, global organisations and industry sectors take charge of standards development with only brief consultation or limited research on end user needs and concerns. There are risks that systems could prioritise medicines and prescribing practices, effectively streamlining these processes, while failing to integrate more complex scenarios which include nutrient prescribing and broader protective and preventative health approaches.

Small countries such as New Zealand may have unique practices and protocols that larger global systems may fail to integrate.

Implications for service design

A medicine-facing policy should therefore describe the proposed system not as an 'AI doctor' or autonomous substitute, but as a bounded digital health advocate and administrative orchestration layer. Its purpose would be to reduce low-value clerical load, improve continuity and follow-up, help patients navigate care, and support multidisciplinary allocation of work. That model aligns with the strongest current evidence and with the direction of professional regulation.[25] [26] [27]

In practical terms, such a system could be authorised to:

- receive and classify patient communications;
- identify routine administrative actions;
- prepare structured updates for the patient record;
- prompt overdue screening or monitoring;
- facilitate booking of already-authorised tests or reviews;
- collect patient-reported information between visits;
- generate funding and activity reports from validated data fields; and
- escalate uncertain, high-risk, or clinically material matters to a human clinician.

By contrast, diagnosis entry, medication-list alteration without verification, autonomous test ordering outside protocol, and suppression of clinically relevant information from GP review

[23] MCNZ (March 2026). Guidance on using artificial intelligence (AI) in patient care. Medical Council of New Zealand. https://www.mcnz.org.nz/assets/standards/Guidance-on-using-artificial-intelligence-AI-in-patient-care-March-2026.pdf

[24] ACC (March 2026). Working with AI in Healthcare. A position statement for ACC - health providers. https://www.acc.co.nz/assets/provider/Working-with-AI-in-healthcare_March-2026.pdf

[25] Katonai G, Arvai N, Mesko B. (2025) AI and Primary Care: Scoping Review. J Med Internet Res. 2025 Aug

[26] Sarraf B, Ghasempour A. Impact of artificial intelligence on electronic health record-related burnouts.

[27] Almyranti, M. et al. (2024), Artificial Intelligence and the health workforce: Perspectives from medical associations.

should be treated as higher-risk functions requiring either prohibition or tightly delimited protocol authority.[28]

[6] REORIENT GENERAL PRACTICE TO A PRIMARY CARE MODEL

Improve GP recruitment and retention. A more sustainable, professionally rewarding model of care is likely to attract and retain clinicians, addressing workforce shortages and continuity gaps.

Improve GP team perception of time value and job satisfaction. Restoring control over time allocation reduces cognitive overload and administrative fragmentation, enabling clinicians to practise at the top of their licence and re-engage with relational, continuity-based care, core features of effective primary care.

Improve productivity, supporting sustainable income for GPs and teams. Shifting low-value administrative tasks away from clinicians increases clinical throughput where appropriate, while improving the quality of consultations. This supports financial sustainability without reliance on high-volume, short-duration encounters.

Enable longer consultations and more effective informed consent. Protected consultation time allows for comprehensive history-taking, risk communication, and shared decision-making, strengthening informed consent processes and reducing downstream clinical uncertainty and re-attendance.

Provide protected time for education without displacing clinical care. Embedding learning within the working day supports continuous professional development and maintains clinical competence, without creating a trade-off between service delivery and capability development.

Support on-the-job learning through integrated systems. Structured, workflow-integrated learning systems enable real-time acquisition of knowledge linked to clinical cases, improving retention, relevance, and application in practice.

Training in effective informed choice and consent communication. Enhances clinicians' ability to translate complex risk and treatment information into patient-understandable terms, improving autonomy, adherence, and medico-legal robustness.

Training in coaching and behavioural change techniques. Equips clinicians to support sustained lifestyle and behaviour change, addressing upstream drivers of chronic disease rather than relying solely on downstream medical intervention.

Training in nutrition and lifestyle medicine. Strengthens capacity to manage metabolic and chronic conditions through evidence-based non-pharmacological approaches, aligning care with primary prevention and disease reversal where possible.

Training in integrative and functional medicine approaches. Broadens clinical frameworks to include systems-based and multi-factorial drivers of illness, improving the ability to manage complex, chronic, and multi-system presentations.

Training in psychological medicine. Enhances recognition and management of mental health conditions and their interaction with physical illness, supporting more holistic and effective care.

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[28] Biro JM, et al. (2025) Opportunities and risks of artificial intelligence in patient portal messaging in primary care.

Training in social prescribing systems. Enables clinicians to address social determinants of health by linking patients with community resources, reducing reliance on medicalisation where non-clinical interventions are more appropriate.

Opportunities for sessional work in secondary care. Maintains clinical breadth, supports development of special interests, and strengthens integration between primary and secondary care, improving referral quality and system cohesion.

Protected time for clinician self-care (including nutrition and exercise). Supports physical and mental wellbeing of the workforce, reducing burnout and preserving long-term clinical capacity and decision-making quality.

Expanded on-the-job learning with time recognition systems. Formal recognition and logging of learning activity within the workday reinforces professional development as a core function of practice, rather than an additional burden.

Rebalancing Primary Care, Prevention, and Workforce Integration

A future model should therefore strengthen, rather than overextend, primary care by integrating it more effectively with secondary services. This includes enabling GPs to work regular sessions within hospital-based teams, such as outpatient clinics or procedural units, aligned with areas of clinical interest.

Such an approach would improve professional satisfaction by providing a more collegial working environment, while also strengthening clinical capability and continuity of care. It would allow GPs to develop specialist interests, contribute to service design, and act as a functional bridge between community and hospital systems. In turn, this would improve interoperability, referral pathways, and shared understanding across the health system, while also providing additional workforce capacity within secondary care settings.

More fundamentally, the health system requires a decisive shift toward prevention. At present, publicly funded preventative activity remains limited to a narrow set of interventions, including screening, vaccination, smoking cessation, and basic lifestyle advice. This approach is insufficient in the context of a disease burden that is increasingly environmentally and behaviourally mediated. An effective preventative framework requires a whole-of-government approach in which health is recognised as a core public value. This would involve aligning all ministries with measurable health-related outcomes and expanding the indicators of national progress beyond purely economic measures. It also requires sustained investment in independent scientific research to inform policy and regulatory decision-making, alongside a commitment to a whole-person model of health that integrates physical, mental, social, environmental, and cultural dimensions.

Key enabling components of such a system include:

- High-quality, independent, and accessible health information to support informed decision-making
- Early-life interventions, including nutrition, food skills, and supportive school environments

- Structured behavioural support, such as health coaching, to enable sustained lifestyle change
- Regulatory measures to reduce exposure to harmful influences, including restrictions on marketing unhealthy products to children and measures addressing alcohol-related harm
- Improved access to safe, non-pharmacological and preventative health approaches

Current regulatory and public health institutions also require strengthening. Agencies responsible for food, water, and environmental exposures have been subject to ongoing criticism regarding limited independent scientific capacity, insufficient application of precautionary principles, and vulnerability to commercial influence. Without addressing these structural issues, efforts to improve population health will remain constrained by the quality and independence of the evidence base informing policy.

Within primary care itself, improving time availability is essential. Advances in IT and AI, alongside system redesign, offer the opportunity to reduce administrative burden and free clinical capacity. This would enable a greater focus on prevention, more personalised care, and deeper engagement with patients. It would also improve workforce satisfaction and support recruitment and retention, addressing one of the system's most pressing challenges.

In parallel, there is a role for community-led health initiatives to complement publicly funded services. These may take the form of subscription-based, self-organising health learning communities, supported by digital tools and shared knowledge systems. Such models enable individuals to become active participants in their own health, supported by peer networks and independent information. Over time, these communities can generate valuable real-world insights, contribute to collective learning, and provide social support structures that are often absent from formal healthcare systems. They also offer a pathway toward a broader cultural shift in which health is recognised and valued as a shared societal priority.

In summary, a sustainable future health system requires a rebalancing of roles and expectations. Primary medical care must be supported to function effectively within its scope, not burdened with responsibilities that sit beyond it. Integration with secondary care, investment in prevention, strengthening of independent science, and the empowerment of both clinicians and communities are all essential components. Without such changes, the system will remain misaligned with the primary drivers of modern disease, and both workforce and population health outcomes will continue to fall short of their potential.