SOLUTION

REDUCE ADMINISTRATIVE BURDEN AND RESTORE PROFESSIONAL AUTONOMY IN GENERAL PRACTICE

MAKE NEW ZEALAND HEALTHY

THE PROBLEM: General Practice is increasingly burdened by work undertaken away from direct patient care. Around one quarter of GP time is spent on non-patient-contact tasks after visits have ended, including essential clinical work such as reviewing results, prescribing, follow-up and care coordination. Alongside this sit fragmented communication, repetitive documentation, recalls, coding and reporting requirements.

The challenge is to distinguish work requiring medical judgement from work that can be simplified, automated or reallocated. Within consultations, navigating records, documentation and system requirements compete with time to listen, investigate and develop care with the patient.

The issue is of key concern in chronic disease and multimorbidity, where metabolic, nutritional, psychological, behavioural, social and environmental factors may interact across several biological and therapeutic domains. GPs require time, appropriate information and professional autonomy to investigate these complexities and flexibly consider reasonable therapeutic approaches for the individual patient.

Health authorities are developing guidance for AI in clinical care, principally addressing safety, privacy, accuracy, accountability and clinical decision support. However, this does not yet address how AI shapes clinical inquiry, or whether its decision-making architecture broadens consideration of underlying physiology, biochemistry and therapeutic options rather than defaulting to established medical pathways and evidence hierarchies.

Health systems therefore need to support rather than constrain clinical judgement, while ensuring digital systems, clinical guidance and professional development broaden access to relevant evidence and therapeutic options.

THE SOLUTION: Restore GP time for patient care, while broadening the knowledge and support available for genuine primary care. MNZH proposes integrated reforms that protect clinical judgement and patient autonomy; enable pharmaceutical, nutritional, behavioural, lifestyle and integrative approaches to be considered and compared; and expand access to evidence and professional development.

These reforms represent a significant shift in the architecture of primary care: from systems organised predominantly around diagnosis and established treatment pathways, towards systems that bring first principles into clinical inquiry, support investigation of underlying drivers of ill health, broaden the evidence and therapeutic options considered, and preserve professional judgement for the individual patient.

Governing principles, decision frameworks and AI-supported clinical inquiry provide the structure for this flexibility while preserving clinical accountability and GP autonomy. Reporting and compliance can be simplified, work that does not require medical judgement reallocated, bounded digital tools used appropriately, and team-based care and health coaching expanded.

Funding and accountability can then align with prevention, continuity and measurable improvements in health without creating additional reporting burdens.

The objective is to give GPs the time, knowledge, professional latitude and institutional support to provide preventive, individualised and longitudinal primary care.

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MNZH POLICY RECOMMENDATIONS

THE SOLUTION: This is a complex, interdependent problem that cannot be addressed through a single intervention. General Practice and Primary Care represent the first point of contact for New Zealanders seeking professionally curated health information and care. GPs require sufficient knowledge, time and professional latitude to investigate the individual patient, exercise clinical judgement and identify appropriate therapeutic options.

The proposed solutions comprise seven interrelated reforms.

The first three reform recommendations strengthen clinical decision-making through (I) Governing Principles that Support Integrative Approaches, (II) a Primary Care Therapeutic Decision Matrix, and (III) Working with AI: Bringing First Principles into Clinical Inquiry. (IV) Education & Professional Development builds the capability to apply these approaches in practice. (V) Health System Indicators & Whole-of-Government Accountability aligns system performance with meaningful improvements in population health. (VI) Reduce GP Burdens & Restore Capacity for Primary Care addresses unnecessary administrative and organisational demands on GP time. Finally, (VII) Primary Care & Patient Partnership for Health aligns incentives with improved health and continuity of care, while strengthening the capacity of patients and communities to participate as informed partners in longitudinal care.

MNZH makes these recommendations to strengthen the GP's role in supporting patient health: a practitioner with the autonomy, capacity and capability to interpret complexity, coordinate care, exercise professional judgement and work with patients over time to prevent disease and improve their long-term well-being and quality of life.

I. GOVERNING PRINCIPLES THAT SUPPORT INTEGRATIVE APPROACHES

Ten Overarching Principles Grounded in Medical Ethics

Modern primary care requires clinicians to integrate different forms of knowledge across pharmaceutical, nutritional, behavioural, psychological and environmental domains, while responding to substantial variation between individual patients. Chronic disease and multimorbidity frequently involve interacting biological and social factors that develop over time.

A principle-based framework provides this foundation. It allows emerging evidence and different therapeutic approaches to be considered within a common structure, while preserving clinical judgement, patient autonomy and accountability.

This is particularly important where different knowledge domains are unevenly represented within existing clinical guidance. Biology-grounded care reintroduces a first-principles understanding of relevant physiology and biochemistry, helping clinicians investigate these interactions, interpret the patient's presentation and consider biological processes that may be contributing to dysfunction or disease. This may be particularly valuable in complex, chronic and/or idiopathic presentations, where symptoms persist but the underlying aetiology remains uncertain.

Pharmaceutical interventions are generally supported by well-developed prescribing pathways, while physiological, nutritional, behavioural and other non-pharmacological considerations may be less systematically incorporated into routine decision-making.

Clinical guidance can be expanded to provide sufficient structure to support consistent, evidence-informed care and investigation of underlying biological processes, without reducing clinical decision-making to adherence to a predetermined therapeutic pathway.

The purpose is not to give equal weight to interventions irrespective of evidence, but to ensure that reasonable therapeutic options can be considered and compared according to consistent principles of evidence, benefit, risk, proportionality and patient context. This enables clinicians to exercise professional judgement without requiring uniformity of practice, while providing a transparent basis for patients, clinicians and regulatory bodies to understand how decisions were reached.

The four established principles of medical ethics, autonomy, beneficence, non-maleficence and justice, provide the overarching ethical standard. The following governing principles translate these into a practical framework for primary care decision-making.

TEN RECOMMENDED GOVERNING PRINCIPLES

1. **Medical ethics (meta-principles).** Ground clinical guidance in autonomy, beneficence, non-maleficence and justice. These provide the overarching ethical standard against which therapeutic decisions, risks and patient interests are assessed.
2. **Biology-grounded care.** Clinical assessment considers relevant underlying biological and functional drivers, including metabolic, nutritional, endocrine, immune, psychosocial and environmental factors, rather than relying solely on diagnostic labels or downstream disease markers.
3. **Comparative therapeutic transparency.** Clinicians and patients are able to compare reasonable therapeutic options within a consistent framework, including the strength and relevance of evidence, expected benefit, potential harm, time to effect, treatment burden and reversibility.
4. **Proportionality of risk and intervention.** The intensity and risk of an intervention are proportionate to the patient's condition and circumstances. Lower-risk and reversible approaches are considered where appropriate, with escalation guided by severity, response and clinical need.
5. **Individual patient context.** Evidence and guidance are interpreted in the context of the individual, including age, sex, pregnancy, comorbidity, functional status, biological variation, risk profile and stage of disease. Population-level recommendations inform, rather than substitute for, individual clinical assessment.
6. **Life-course and multimorbidity orientation.** Guidance accounts for cumulative exposures, disease trajectories and interactions between conditions across the life course, rather than treating individual diagnoses in isolation.
7. **Plurality and weighting of evidence.** Evidence appraisal draws on appropriate forms of evidence, including randomised controlled trials, mechanistic evidence, observational and longitudinal studies, primary-care evidence and structured N-of-1 observations. The strength, applicability and limitations of each form of evidence, and areas of uncertainty, are explicitly recognised.
8. **Clinical judgement with accountability.** Guidelines support rather than replace professional judgement. Departure from a standard pathway is supported where there is a

reasonable evidential and clinical basis, proportionate to the circumstances, with the reasoning documented and appropriate monitoring and patient consent in place.

9. **Shared decision-making and informed consent.** Patients receive clear and accessible information about reasonable therapeutic options, including material benefits, risks, uncertainties and alternatives, enabling meaningful participation in decisions about their care.
10. **Equity of therapeutic care.** Guidance supports equitable access to safe, appropriate and effective therapeutic options. This requires recognition that biological risk, nutritional requirements, social circumstances and capacity to benefit from particular interventions may differ between individuals and populations, including children, pregnant women, Māori, Pasifika and other higher-risk groups.

II. A PRIMARY CARE THERAPEUTIC DECISION-MATRIX

The Primary Care Therapeutic Decision Matrix provides a practical framework for applying the Governing Principles to individual patient care. Its purpose is to support systematic clinical reasoning without prescribing a single therapeutic pathway. It enables clinicians to consider the patient's biological and functional state, the purpose of treatment, relevant underlying drivers, available therapeutic options, the evidence supporting them, and their differing benefit-risk profiles within a consistent framework.

This is particularly relevant to chronic disease and multimorbidity, where symptoms and diagnoses may arise from interacting metabolic, nutritional, inflammatory, neuroendocrine, behavioural, psychosocial and environmental factors. Their expression and response to treatment can vary according to genetics, developmental history, life-course exposures, comorbidities and individual circumstances. The Matrix therefore supports investigation beyond individual disease labels while retaining those diagnoses where clinically important.

The Matrix also formalises a central feature of primary care: clinical knowledge develops longitudinally. Response to an intervention can itself provide useful information, particularly where treatment is low-risk, reversible and appropriately monitored. Structured N-of-1 observation can therefore complement population-level evidence by helping clinicians determine whether an intervention is beneficial, ineffective or harmful for the individual patient.

Therapeutic options are compared according to their purpose, evidence, expected benefit, risk, time to effect, treatment burden and reversibility. Risk is considered according to its nature as well as its magnitude, including severity, frequency, reversibility, cumulative effects, dependency and uncertainty. This allows materially different interventions to be compared transparently without assuming that pharmaceutical, nutritional, behavioural or other approaches carry equivalent benefits, risks or evidential support.

PRIMARY CARE THERAPEUTIC DECISION MATRIX

1. **Biological and Functional State:** Assessment begins with the patient's current biological and functional state, alongside relevant diagnoses. The Matrix distinguishes broadly between:

1.1. early dysfunction or adaptive strain, including subclinical disturbance;
1.2. established dysfunction or chronic disease; and
1.3. advanced disease, multimorbidity, complications or declining resilience.

This supports earlier identification of dysfunction and enables the intensity and purpose of intervention to reflect the patient's disease trajectory.

2. **Therapeutic Intent:** Make explicit the purpose of an intervention. Depending upon the patient and condition, treatment may seek to:

   2.1. relieve symptoms and improve function;
   2.2. modify risk or slow disease progression;
   2.3. support biological restoration, reversal or remission where achievable; or
   2.4. improve resilience, adaptive capacity and quality of life.

   Making therapeutic intent explicit helps distinguish interventions that manage downstream symptoms from those intended to alter underlying disease processes.

3. **Mechanistic or Upstream Driver Domain:** Where clinically relevant, ensure that assessment considers biological and contextual factors that may contribute to disease or impaired function, including:

   3.1. metabolic and energetic regulation;
   3.2. nutritional status and biochemical sufficiency;
   3.3. neuroendocrine, stress and autonomic regulation;
   3.4. immune and inflammatory signalling;
   3.5. environmental and toxicological exposures; and
   3.6. behavioural, psychosocial and circadian influences.

   This provides a disciplined basis for considering potential ‘root causes’, grounding investigation in biologically plausible and clinically relevant mechanisms while recognising that several domains may interact.

4. **Therapeutic Modality and Action Pathway:** Consider reasonable therapeutic options across pharmaceutical, nutritional, behavioural and psychological, physical and rehabilitative, procedural, lifestyle and integrative approaches.

   The Matrix also considers what an intervention is intended to do, including symptom control, pathway modification, correction of insufficiency, biological support, exposure reduction or restoration of function. This permits therapies with different purposes and mechanisms to be considered within the same framework without presuming equivalence between them.

5. **Evidence Context:** Assess the evidence supporting each option according to its quality, relevance and applicability to the clinical question. Depending upon the intervention and question being considered, this may include randomised controlled trials, mechanistic and systems-biology evidence, observational and cohort studies, longitudinal primary-care evidence, structured N-of-1 observations, and functional and patient-reported outcomes.

Different forms of evidence answer different questions and may not be treated as equivalent. The Matrix therefore requires the strength, limitations and uncertainty of the available evidence to be made explicit, including its applicability to the individual patient.

6. **Benefit, Risk and Proportionality:** Characterise potential benefit and potential harm rather than simply classify them or present or absent. Relevant considerations include magnitude and likelihood of benefit; severity and frequency of adverse effects; reversibility; cumulative and interaction effects; treatment burden and dependency; uncertainty; and the consequences of both intervention and non-intervention.

   This enables interventions to be selected proportionately, with lower-risk and reversible approaches considered where appropriate and escalation guided by disease severity, response and individual circumstances. It also supports iterative reassessment, clinical accountability and meaningful informed consent.

III. WORKING WITH AI: BRINGING FIRST PRINCIPLES INTO CLINICAL INQUIRY

Recommendation: Develop AI-supported clinical search systems that routinely bring relevant physiology, biochemistry and underlying biological and functional factors into clinical inquiry, broadening the knowledge available to GPs while preserving professional judgement and autonomy.

GPs routinely seek information to answer questions arising in patient care. Increasingly, AI will mediate that process through search, clinical guidance and decision-support systems. AI can make information retrieval faster, but faster access to the same information architecture does not necessarily broaden the knowledge available to the clinician.

What is conventionally described as ‘clinical information’ is itself shaped by the boundaries of established guidelines, databases and search systems. Where these organise knowledge predominantly around diagnosis, pharmaceutical treatment, procedures and referral pathways, the questions asked and answers retrieved may privilege those domains. Relevant physiology, biochemistry, nutrition, metabolism, environmental exposures and other biological or functional considerations can consequently be less readily visible.

AI can amplify this problem or help overcome it. AI systems retrieve, prioritise and synthesise information according to their underlying knowledge sources, evidence hierarchies and system design. If these reproduce existing therapeutic pathways, AI may make the prevailing model of care more efficient without making the clinician (or patient) better informed.

MNZH proposes a different opportunity: use digital guidance to expand the clinician's field of inquiry. The objective is not to replace medical knowledge, but to enlarge the knowledge architecture available to medicine. A first-principles approach can support the GP's existing process of questioning, investigating and learning, rather than directing the clinician towards a predetermined answer.

Integrated digital guidance can routinely bring relevant physiology and biochemistry into the search process, prompting consideration of underlying biological and functional drivers where appropriate. These may include metabolic health, nutritional sufficiency, inflammatory processes, endocrine and immune function, cellular and mitochondrial function, environmental exposures, behavioural factors and psychosocial health.

From this broader field of inquiry, digital systems can retrieve and synthesise evidence across reasonable pharmaceutical, nutritional, behavioural, lifestyle, psychological and other therapeutic approaches. The system does not determine which approach is correct. It makes relevant knowledge easier to find, compare and interrogate. Clinical judgement remains with the GP.

This architecture turns everyday information-seeking into something more powerful: a practical extension of clinical reasoning and professional learning at the point of care. Rather than simply automating established pathways, digital guidance can help clinicians investigate complexity, encounter knowledge outside familiar domains and exercise informed professional autonomy.

The integrated system can flexibly support:

- **Whole-patient assessment.** Bring together clinical history, investigations, patient-reported information and, where useful, longitudinal, home-monitoring and wearable data to develop a more complete picture of health and disease trajectory.
- **Biological and upstream assessment.** Prompt consideration of relevant underlying metabolic, nutritional, inflammatory, endocrine, immune, cellular, environmental, behavioural and psychosocial factors rather than proceeding automatically from diagnosis to treatment.
- **Plurality of therapeutic options.** Present reasonable pharmaceutical, nutritional, behavioural, psychological, lifestyle and integrative options, together with their evidence, expected benefits, risks, uncertainties, reversibility and relevance to the individual patient.
- **Clinical decision support, not clinical direction.** Apply the Primary Care Therapeutic Decision Matrix to support comparison of options while retaining the GP's authority to exercise professional judgement in partnership with the patient.
- **Patient participation and informed consent.** Translate the relevant evidence and therapeutic choices into accessible information so that patients can understand trade-offs, participate in decisions and contribute information about their own responses and outcomes.
- **A learning primary-care system.** With appropriate privacy protections, use longitudinal, anonymised clinical and patient-reported outcomes to build real-world evidence, including structured N-of-1 experience, concerning prevention, treatment, reversal and remission. This creates feedback between clinical experience, guideline development and future care.

The proposal is aimed at increasing the flexibility of the architecture through which clinical knowledge reaches the consultation: reasonable therapeutic options are considered by default, rather than requiring GPs to know in advance which alternatives they need to search for.

IV. EDUCATION & PROFESSIONAL DEVELOPMENT

Recommendation: Strengthen primary-care capability through protected, practice-integrated education and professional development across the disciplines required for preventive, individualised and longitudinal care.

The expansion of clinical guidance alone will not ensure that GPs can confidently apply a broader range of therapeutic approaches. MNZH recommends that implementation be supported by continuing professional development that strengthens knowledge across nutrition and lifestyle medicine, behavioural and psychological health, informed consent, integrative approaches and social prescribing, while preserving and extending core medical expertise.

Continuing professional development is an established part of general practice; however, MNZH recommends clearer pathways to encourage GPs to undertake recognised CPD in nutrition, metabolic health, lifestyle medicine and evidence-based integrative approaches, including through accredited courses, case-based learning, clinical attachments and appropriately recognised special-interest training.

MNZH recommends integrating education, wherever practicable, into the working day rather than adding to existing workload. The AI-supported clinical inquiry framework proposed above provides an opportunity for case-based, real-time learning, directing clinicians towards relevant evidence and enabling them to investigate biological mechanisms and therapeutic alternatives as clinical questions arise. Structured learning undertaken through these systems can be recognised and recorded as continuing professional development, reducing the trade-off between maintaining clinical services and developing professional capability.

Professional development can also extend beyond digital and formal education. Opportunities for sessional work in secondary care can maintain clinical breadth, support special interests and strengthen relationships between primary and secondary care. MNZH recommends recognising protected time for professional learning and clinician wellbeing as part of sustaining long-term workforce capability, rather than treating it as activity undertaken outside the working day.

(a) Priority areas for education and professional development

Informed choice and consent communication. Strengthen clinicians' capacity to communicate comparative benefit, risk, uncertainty and therapeutic alternatives in patient-understandable terms, supporting patient autonomy, shared decision-making and robust informed consent.

Health coaching and behavioural change. Develop practical skills to support sustained dietary, physical activity and behavioural change, including recognition of the psychological and environmental factors that influence adherence and long-term outcomes.

Nutrition and lifestyle medicine. Strengthen knowledge of nutrition, metabolic health and evidence-based lifestyle interventions relevant to prevention, chronic disease management and, where achievable, reversal or remission.

Integrative approaches. Improve clinicians' ability to evaluate evidence across relevant non-pharmacological and integrative approaches and to understand when these may appropriately complement conventional medical treatment or warrant referral to suitably qualified practitioners.

Psychological medicine. Strengthen recognition and management of interactions between psychological and physical health, particularly in chronic disease, multimorbidity and medically complex presentations.

Social prescribing. Develop knowledge of community and social resources that can address relevant social determinants of health and provide appropriate non-medical support where medical intervention alone is unlikely to resolve the underlying problem.

The objective is to make continuing learning part of clinical practice itself: enabling GPs to expand their therapeutic knowledge while treating patients, retain professional breadth, and develop the capabilities required to exercise greater clinical autonomy across their workday.

V. HEALTH SYSTEM INDICATORS & WHOLE-OF-GOVERNMENT ACCOUNTABILITY

Recommendation: Extend health-system accountability beyond measures of service delivery to measure whether population health is actually improving. Broad-spectrum indicators of glycaemic control, central adiposity, polypharmacy burden, blood pressure, mental health function and early-life metabolic health can provide longitudinal measures of changes in the burden and trajectory of chronic disease. We recommend that these indicators be used to evaluate performance across primary and secondary care and, where relevant, to inform wider government policy.

Health is a major determinant of government expenditure, productivity, participation and long-term fiscal sustainability. We therefore recommend that Treasury and other central agencies incorporate meaningful population-health indicators alongside conventional economic and fiscal measures when evaluating policy performance and long-term national wellbeing.

Recommended indicators & targets:

1. ***Glycaemic control and remission:*** HbA1c provides a direct measure of metabolic health and disease trajectory. Tracking distribution and remission rates, rather than averages alone, captures both prevention and reversal of dysglycaemia. Improvement reflects effective early intervention and reduced progression to Type 2 diabetes.
2. ***Central adiposity.*** Waist circumference or waist-to-height ratio offers a clinically meaningful measure of visceral fat and metabolic risk, outperforming BMI. Reductions indicate improved insulin sensitivity and lower cardiovascular risk, making it a practical and responsive primary care indicator.
3. ***Polypharmacy burden***. The number of long-term medications is a proxy for disease burden and system dependency. A reduction in polypharmacy can signal improved underlying health and a shift from disease management toward disease resolution or stabilisation.

4. ***Blood pressure distribution.*** Monitoring the proportion of patients within normotensive ranges, rather than simply treated hypertension, captures true cardiovascular risk reduction. Improvements reflect changes in metabolic health, diet, and lifestyle, not just pharmacological control.

5. ***Mental health function.*** Functional measures such as validated symptom scales, alongside patterns of long-term antidepressant use, provide a more accurate reflection of mental health than diagnostic labels alone. Improvement indicates better underlying physiological and psychosocial stability.

6. ***Early-life metabolic health.*** Indicators such as childhood obesity, gestational diabetes, and birthweight distribution reflect the intergenerational trajectory of metabolic health. Improvement signals effective early intervention and long-term population health gains.

Integrated guidelines that genuinely support a shift to improving the metrics above (i.e. the health system indicators) inform the development and integration of policy across all sectors of government, not only health. This includes health research, the evaluation of dietary guidelines, the regulation of food production, water and air quality standards, the minimisation of environmental toxin exposures and other root-cause drivers of ill health across society.

The Genuine Progress Indicators (GPI), originating in Nova Scotia, provide one such framework for measuring societal wellbeing beyond GDP, including dimensions of health, equity and environmental sustainability. However, direct health-system indicators remain important to ensure that the public, members of Parliament and the healthcare workforce can recognise progress against key endpoints that reduce illness and suffering.

Where practicable, these indicators can be derived from routinely collected and appropriately anonymised health data, avoiding additional reporting burdens on clinicians.

VI. REDUCE GP BURDENS & RESTORE CAPACITY FOR PRIMARY CARE

Recommendation: Redesign primary-care workflows, reporting requirements and funding to restore GP time for clinical judgement, prevention, continuity and complex patient care.

The preceding reforms expand the information, therapeutic options and professional capability available to GPs. Their value will be limited, however, if clinical time continues to be absorbed by administrative processing, reporting requirements, fragmented workflows and short consultations.

MNZH recommends a systematic review of non-clinical demands on GPs, with the objective of removing unnecessary administrative work, simplifying reporting and compliance requirements, making better use of primary-care teams and digital technologies, and aligning funding with preventive and longitudinal care.

1. **Systematically review non-clinical demands on General Practice.** The Royal New Zealand College of General Practitioners' Your Work Counts project has demonstrated the substantial proportion of GP working time undertaken outside direct patient consultations,

including essential non-contact clinical work. MNZH recommends building on this evidence through a system-wide review specifically of the administrative, reporting, compliance and information-processing requirements imposed on General Practice. The review would identify the source and purpose of these requirements, quantify the demands they place on GP time, and determine where tasks can be removed, simplified, automated or appropriately reallocated.

2. **Separate clinical from clerical and administrative work:** MNZH recommends that tasks not requiring medical judgement be identified and, wherever practicable, removed from GP workloads or allocated appropriately across the primary-care team. Routine coordination, recalls, coding, form completion and low-risk communications can be undertaken by administrative staff, healthcare assistants, nurses or appropriately supervised digital systems. The objective is to reserve GP time for work requiring clinical expertise, including diagnosis, complexity, informed consent, therapeutic decision-making and relational care.

3. **Reduce reporting, compliance and information-processing burden:** MNZH recommends reviewing reporting and administrative requirements imposed on general practice to determine which provide sufficient clinical or system value to justify the time required. Information already held within clinical systems can, where appropriate and with suitable privacy protections, be captured automatically rather than repeatedly entered, coded or reported by clinicians. The expanded health indicators recommended in Part V are intended to improve system accountability, not create additional manual reporting obligations for GPs.

4. **Use bounded digital systems to reduce administrative burden:** Digital tools can assist with inbox triage, routine communications, structured data processing, recalls, coding and task allocation. MNZH recommends that these systems remain auditable, protocol-bound and clinician-supervised, with clear boundaries between administrative automation and clinical decision-making. Their purpose is to reduce cognitive and administrative load, not transfer additional monitoring responsibilities to clinicians or replace professional judgement.

5. **Expand team-based prevention and health coaching:** MNZH recommends integrating appropriately trained health coaches and wider primary-care teams to provide sustained support for dietary change, physical activity and behavioural interventions, particularly in metabolic health and chronic-disease prevention. This enables continuing patient support outside the GP consultation while retaining appropriate clinical oversight and concentrating GP time where medical expertise is required.

VII. PRIMARY CARE & PATIENT PARTNERSHIP FOR HEALTH

Recommendation: Align funding, workforce design and clinical systems with an integrative primary-care model that rewards improved health and continuity of care, and strengthen the capacity of patients and communities to participate as informed partners in preventive, individualised and longitudinal care.

(a) Align Primary Care Incentives with Health Outcomes

Reorienting general practice requires the organisation and funding of care to support its primary-care purpose. An integrative approach depends on the capacity to understand the patient over time, observe responses to intervention, reassess contributing factors and adapt care as circumstances change. Continuity of care is therefore integral to this model, rather than an additional service objective.

New Zealand's capitation formula is being reweighted to better recognise multimorbidity, rurality, deprivation, age and other drivers of health need. This is an important shift towards funding according to patient complexity. MNZH recommends extending this principle by progressively recognising measurable improvements in health, while avoiding a target-heavy funding system that rewards activity or isolated metrics.

Practices could, for example, receive additional funding for sustained improvements in HbA1c distribution, diabetes remission, central adiposity, blood-pressure control without escalating treatment burden, functional mental-health outcomes, and clinically appropriate medication reduction following structured review. Medication reduction is not an objective in itself: the relevant outcome is a clinically appropriate reduction in long-term medication burden accompanied by stable or improved clinical and patient-reported outcomes.

Funding also needs to recognise the work required to achieve these outcomes, including longer consultations where necessary, longitudinal review, health coaching, dietary and behavioural support, medication review and coordinated team-based care. This provides practices with greater latitude to invest in prevention, reversal and remission where achievable, rather than tying revenue predominantly to consultations, activity and throughput.

MNZH further recommends that funding, workforce design and performance measures explicitly recognise continuity of care. System settings that prioritise throughput and immediate access can fragment longitudinal GP-patient relationships and reduce the capacity to understand complex illness, evaluate responses to intervention and provide preventive care over time.

(b) Patient Communities as an Extension of Continuity

Complex, chronic and idiopathic presentations can require substantial investigation, specialist knowledge and adaptation over time. The breadth of knowledge involved may exceed what can reasonably be explored within routine consultations, while specialist expertise may be constrained by cost, availability or long waiting periods. Neither the GP nor the patient can reasonably be expected to carry this informational and practical burden alone.

MNZH recommends enabling General Practices and PHOs to support voluntary, condition- or health-focused patient communities as an extension of longitudinal primary care. These communities can provide structured environments in which patients share experience, review accessible evidence, develop practical knowledge and support one another in implementing and sustaining agreed approaches to health.

The model has parallels with citizen science: participants are not substitutes for clinicians or researchers, but active contributors to observation, learning and knowledge exchange. More experienced members can help newer participants navigate information, formulate questions, recognise patterns worth discussing with clinicians and maintain engagement between consultations. Digital platforms can support curated resources, educational material, structured patient-reported outcomes and links to appropriate clinical services.

Such communities also provide something clinical systems have limited capacity to supply: time, connection and sustained peer support. Nutrition, behavioural change, symptom tracking and management of chronic illness unfold over months or years. Shared learning can reduce isolation, strengthen health literacy and enable patients to become more informed participants in their own care.

Clear boundaries remain important. Patient communities complement rather than replace professional care; clinical decisions remain between patients and appropriate health professionals. Community knowledge, clinical expertise and individual patient experience can therefore become mutually reinforcing components of continuous primary care.

BACKGROUND TO THIS POLICY

[1] REORIENT GENERAL PRACTICE TO A PRIMARY CARE MODEL

These reforms are designed to support a health system transformation: from episodic disease management towards continuous, integrative primary care, in which GP time and expertise are concentrated on the patient, clinical judgement, prevention, complexity and enduring therapeutic relationships.

(a) Strengthen Primary Care

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.

(b) Prevention as a Core Public Value

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.

(c) Communities Leading

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.

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

Current health system approaches have not stemmed the non-communicable disease burden. Preventable chronic disease imposes a substantial and ongoing fiscal burden, including healthcare, productivity, and informal care costs. A large global review recently found that the prevalence of metabolic syndrome had doubled in the two decades 2000 to 2023.[1]

Investment in early intervention and root-cause management represents one of the highest-return opportunities available to the health system. The cost of inaction materially exceeds the cost of reform.

(a) Guidelines and Health Targets

Unlike purely pharmaceutical treatments, which require relatively little active patient or external involvement, dietary, nutritional and integrative health approaches require significant government, societal and patient partnership. Patients need to become active participants in their own healthcare, and their ability to understand and engage with their options is essential to good outcomes. Society has an invaluable role as social prescribing initiatives are demonstrating. All of government, not just the Ministry of Health, needs to be accountable to upholding Public Health as an overarching priority. The application of the Precautionary Principle is a key collective responsibility for all aspects of government to protect the public health.

General Practitioners (GPs) currently rely on Best Practice Advocacy Centre (BPAC) guidelines, which are government-funded and remain predominantly oriented toward pharmaceutical disease management. Although newer BPAC guidance acknowledges the value of dietary and behavioural approaches, it does not provide sufficient depth or structure to enable confident application in practice. They are not formally integrated as clinically equivalent therapeutic options, effectively remaining advisory rather than operational within routine primary care practice.

[1] Noubiap, J.J., Nansseu, J.R., Nyaga, U.F. et al. Worldwide trends in metabolic syndrome from 2000 to 2023: a systematic review and modelling analysis. Nat Commun 17, 573 (2026). https://doi.org/10.1038/s41467-025-67268-5

GPs work in a broader system where current health policy in New Zealand is characterised by an inconsistent approach across indicators, targets, and underlying drivers of health.

Health targets reflect medical outcomes: faster cancer treatment, improved immunisation, shorter stays in emergency departments and shorter wait times for specialist assessments and elective treatment.

Health System Indicators reflect wellbeing and equity: However the operational targets focus predominantly on service delivery, access, and treatment throughput. This disconnect means that upstream determinants of health, particularly metabolic function and nutrition, are largely excluded from measurable policy action. As a result, health targets do little to address the socio-economic and biological drivers of chronic disease and multimorbidity, and instead reinforce downstream, treatment-focused responses.

(b) Why do targets and guidelines need to change?

In other areas of practice, such as prescribing authority, procedural credentialling, and scope-of-practice decisions in nursing and pharmacy, clinicians are permitted to exercise judgement within defined frameworks of training, monitoring, and accountability. An equivalent framework is largely absent for metabolic health, nutrition and integrative approaches.

As a result, many patients are not offered the full spectrum of evidence-based therapeutic options available to them. At the same time, the evidence base for dietary, nutritional and integrative health approaches has expanded substantially, particularly in relation to conditions such as metabolic syndrome. Given the scale of the associated health and economic burden, reform is now clinically necessary, legally required, and both an ethical and economic imperative.

This approach applies to all institutions with oversight or which provide guidance for primary care practitioners. Primary care guidance is distributed across system-level policy documents, condition-specific guidance, and external platforms including:

- The Royal New Zealand College of General Practitioners
- The New Zealand Formulary
- Heart Foundation New Zealand
- Ministry of Health New Zealand
- HealthPathways
- ACC
- Medical Council of New Zealand

Reform is essential to ensure clinicians are supported to apply individualised nutritional interventions within a structured, auditable model of care, but that the broader institutional architecture supports clinician autonomy. A reformed framework shifts the emphasis from managing illness to mitigating or removing its drivers, with the genuine possibility of sustained remission. It can only succeed if it is operationalised across the health system, and if health

system indicators reflect meaningful changes in the human disease trajectory, rather than medical and hospital service delivery alone.

The scientific basis for integrative approaches, including nutrition, is broad and expanding. Principle-based guidance that is grounded in underlying biology can retain scientific rigour while accommodating complexity, uncertainty, and clinical judgement. This requires providing clinicians with a structured suite of evidence-based options that support interpretation and application in the interests of the individual patient.

(c) The Exhausted GP

A quarter of GP time is spent on non-patient contact tasks after visits have ended for the day[2], but when they're with their patients, they're also spending time doing basic administration. The GP inbox has become a de facto integration point for the health system, with laboratory results, hospital correspondence, patient communications, recalls and prescribing requests converging on the GP.

Highly trained clinicians consequently spend substantial time processing information and undertaking clerical and coordination tasks. MNZH recommends systematically reviewing these functions to identify work that can be removed, simplified, automated or appropriately redistributed across primary-care teams, while protecting work that requires clinical judgement.

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, while requiring GPs to work 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

[2] Medical Assurance Society GP Remuneration report 2024

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 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.

(d) 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 pathways.

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.

[3] 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.[3]

- Medical education 'regardless of country, setting, or year of medical education' pays insufficient regard to nutrition.[4]
- U.S.-based doctors for example, receive on average, 19 hours of nutritional training.[5] [6]
- A 2024 survey found that fewer than 22% of surveyed medical schools met minimum recommended 25 hours of nutrition education for medical students.[7]
- 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.[8]

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

[3] 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
[4] Crowley J, Ball L, Hiddink GJ. (2019). Nutrition in medical education: a systematic review. The Lancet Planetary Health, 3(9):e379 - e389
[5] 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.
[6] Devries S, Dalen JE, Eisenberg DM. et al. (2014). A Deficiency of Nutrition Education in Medical Training.
[7] 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
[8] 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.

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 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, which, in the Dietary Supplements Regulations 1985, are 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 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 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. Limited training in nutritional therapeutics compounds the problem. Regulatory frameworks and reference values can present nutrients through a pharmaceutical-style risk lens, without clearly distinguishing the severity, mechanism or context of potential harm.

This can reinforce a perception that nutrients are either trivial, relevant only to overt deficiency, or potentially hazardous when 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.

[4] GP SOFTWARE: FUNCTIONALITY WITHOUT USABILITY

(a) 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 are intended to 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.

(b) 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.

[5] AI-ENABLED PATIENT ADVOCACY & ADMINISTRATIVE SUPPORT

AI in healthcare has moved rapidly from prospective discussion to implementation. In 2026 the Medical Council of New Zealand issued guidance for doctors using AI in patient care, while Health

New Zealand has established national governance arrangements and is evaluating AI technologies intended to reduce administrative burden and support clinical workflows.[9] [10] [11]

Health NZ currently prohibits its workforce from using generative AI or large language models for clinical decisions or personalised patient advice, illustrating the continuing uncertainty over the appropriate boundary between administrative assistance, clinical decision support and clinical authority.

The policy question is therefore no longer simply whether AI will enter healthcare, but how these systems are designed, governed and bounded. AI can reduce clerical workload, improve access to information and support clinical reasoning, but it can also reproduce the assumptions, omissions and evidence hierarchies embedded in existing clinical guidance. If digital systems primarily retrieve information organised around diagnosis and pharmaceutical or procedural treatment, AI may reinforce that orientation at greater speed and scale.

MNZH therefore distinguishes between administrative support, patient-facing support, clinical decision support and clinical authority. Carefully governed automation offers particular potential for administrative functions, while clinical decision-support systems can broaden the information available to GPs while preserving therapeutic plurality, transparency and professional autonomy. Clinical authority remains with the clinician.

Current evidence supports this bounded approach. A 2025 systematic review found promising effects of AI on documentation burden, workflow efficiency and burnout, while finding the evidence insufficient for broad claims of system-wide benefit.[12]

Primary-care reviews identify the most credible near-term applications as documentation, inbox and workflow support, triage assistance and population-health functions, rather than unsupervised clinical decision-making. [13] [14]

These applications can shift clerical sorting, structured extraction, repetitive messaging, recalls, coding and workflow coordination away from clinicians without treating AI as an independent clinical actor.

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[9] MCNZ (March 10, 2026). Guidance on using artificial intelligence in patient care. https://www.mcnz.org.nz/our-standards/current-standards/guidance-on-using-artificial-intelligence-in-patient-care/

[10] Health New Zealand (May 21, 2026). Using generative AI and large language models. https://www.healthnz.govt.nz/health-professionals/guidance-standards/topic/digital-technologies/using-generative-ai-and-large-language-models

[11] Health New Zealand (July 22, 2026). National Artificial Intelligence and Algorithm Expert Advisory Group. https://www.healthnz.govt.nz/about-us/who-we-are/expert-groups-and-networks/expert-groups/artificial-intelligence-and-algorithm-expert-advisory-group

[12] 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.

[13] 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.

[14] 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 OECD similarly identifies potential workforce benefits alongside unresolved questions of governance, liability, training and workforce design. [15]

The strongest current case is therefore for a supervised, auditable and protocol-bound digital support layer that reduces administrative burden, strengthens patient navigation and supports clinical reasoning, while retaining clear escalation pathways and professional accountability. Evidence and safety concerns do not presently support AI functioning as an unsupervised clinical intermediary.

(a) AI: Potential to Support Administrative and workflow functions.

Within GP clinics, the evidence supports supervised use of AI for inbox and record-management functions, including classifying messages, drafting routine replies, extracting structured information, identifying recalls or screening tasks, and routing work across the primary-care team. Two 2024 studies of AI-generated inbox replies found potential reductions in clinician burden and value as a drafting aid, but little or no overall time saving, suggesting that benefits may lie more in reducing cognitive load and standardising routine work than simply saving time.[16] [17]

A 2026 study also found that accurate classification of high-acuity portal messages was associated with faster first review, suggesting a potential safety benefit from structured prioritisation.[18] However, inbox triage is itself a continuous and cognitively demanding clinical activity.[19] AI operating in this space therefore requires appropriate clinical oversight rather than being treated as a purely administrative utility.

Bounded AI permissions could be extended to:

- Sorting and classifying incoming communications;
- Flagging probable urgency;
- Drafting routine non-diagnostic communications;
- Extracting structured data for clinician verification;
- Updating recalls, reminders, and screening prompts;
- Routing tasks to nurses, healthcare assistants, or administrative staff according to protocol; and
- Preparing summaries for GP review.

These functions offer a relatively bounded, auditable and reviewable pathway for reducing administrative burden while retaining clinical oversight.

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[15] 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.

[16] 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

[17] 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

[18] 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

[19] 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

(b) Future AI: The patient-facing 'AI health advocate'

A patient-side AI health advocate is more ambitious, but increasingly plausible. Conversational systems can already help patients obtain health information, navigate services, schedule appointments, receive reminders and access support outside staffed hours. Reviews suggest potential benefits for access and navigation, although evidence of clinical effectiveness remains emergent and digital exclusion or low digital literacy could widen inequities if these systems become a default rather than optional support.[20] [21]

A future AI advocate could act as a navigator, explainer, organiser and relay mechanism: helping patients understand care instructions, record symptom changes, undertake authorised monitoring, prepare questions, attend tests and follow-up appointments, and transmit structured information back to the clinic.

This is materially different from an AI independently determining care pathways, altering medication records or deciding which clinical information need not reach a doctor. Current evidence does not support autonomy of that kind.

(c) AI Boundaries: Limits of autonomy and why they matter clinically

Human oversight alone does not guarantee safety. A 2025 simulation study found that primary-care physicians did not reliably identify and correct errors embedded in AI-generated portal responses, demonstrating that "human in the loop" requires appropriate workflow design, training, audit and risk stratification.[22]

Inaccurate outputs, patient trust, privacy and data security therefore require explicit governance and transparent standards. Establishing rigorous standards for data security, privacy, and transparent reporting of LLM use is critical and communities are proposing potential frameworks for AI use.[23] [24] A useful distinction is between:

- 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 remains with licensed clinicians.

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[20] 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.

[21] 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.

[22] 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

[23] 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

[24] 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

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.[25] The National Academy of Medicine has similarly stated 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.[26]

(d) Interoperability and technical feasibility

Integration with GP and hospital systems is increasingly feasible because standards-based architectures are now well established. The SMART App Launch framework enables third-party applications to operate within or alongside electronic health records and patient portals, while SMART Backend Services supports server-to-server connections. In practical terms, an AI support layer can be designed to access constrained classes of data, operate within patient or clinician context, and interact with existing record systems rather than requiring a wholly separate platform.

Implementation nevertheless depends on local vendor capability, FHIR maturity, access controls, workflow design, consent settings and data quality. The proposal is therefore technically realistic; the more consequential questions concern what AI is permitted to do, what information it presents, and under what clinical, legal and governance boundaries it operates.

(e) New Zealand regulatory and professional context

New Zealand professional guidance is moving towards cautious AI adoption under clinician responsibility. The Medical Council's March 2026 guidance encompasses AI used in patient care, including scribing and clinical-inbox systems, while retaining doctors' responsibility for patient care, safety and privacy.[27] ACC's March 2026 guidance for providers similarly sets expectations for safe and ethical use of AI in treatment, assessment, and rehabilitation contexts.[28]

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.

These are important safeguards, but AI governance also needs to address the information architecture through which clinical decision support operates. AI systems may reproduce the assumptions, omissions and evidence hierarchies embedded in the guidelines and information

[25] 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.
[26] 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
[27] 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
[28] 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

sources from which they retrieve knowledge. Systems organised predominantly around diagnosis, medicines and procedural treatment may consequently reinforce those pathways while giving less visibility to nutritional, metabolic, behavioural, environmental and other reasonable therapeutic approaches.

This is particularly relevant where standards and systems are developed internationally or by large industry providers. New Zealand requires the capacity to ensure that AI systems reflect local clinical practice and policy, while supporting therapeutic plurality, transparent evidence appraisal and GP autonomy.

There is a risk that global organisations and industry sectors take charge of standards development with only brief consultation or limited research on end user needs and concerns and that these are harmonised or integrated into New Zealand without considering the effect from an integrated perspective.

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

MNZH recommends describing the proposed system not as an 'AI doctor' or autonomous substitute, but as a bounded digital health advocate and administrative orchestration layer.Administrative functions can be progressively automated where they are low-risk, auditable and protocol-bound; patient-facing systems can support navigation, monitoring and communication; and clinical decision-support systems can broaden the evidence and therapeutic options available to clinicians.[29] [30] [31]

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

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

By contrast, autonomous diagnosis, unverified alteration of medication records, test ordering outside defined protocols, or suppression of clinically relevant information from GP review would

[29] Katonai G, Arvai N, Mesko B. (2025) AI and Primary Care: Scoping Review. J Med Internet Res. 2025 Aug
[30] Sarraf B, Ghasempour A. Impact of artificial intelligence on electronic health record-related burnouts.
[31] Almyranti, M. et al. (2024), Artificial Intelligence and the health workforce: Perspectives from medical associations.

constitute higher-risk functions requiring substantially stronger controls or prohibition.[32] Clinical authority remains with the clinician.

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