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Aotearoa New Zealand general practice workforce crisis: what are our solutions?

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Introduction

It is not news that Aotearoa New Zealand is in the midst of a general practitioner (GP) shortage. The recent GP workforce documents released by the Royal New Zealand College of General Practitioners (RNZCGP) paints a worrying picture; its notable findings include worsening levels of burnout and a rapidly ageing workforce, with 57% of GPs aged ≥50 years, and more than one-third of the country's GPs planning to retire within the next 5 years.[1,2] Unsurprisingly, this shortage is expected to be particularly acute in rural and high-needs urban areas.[3,4]

Primary health care (PHC) is often recognised as an important determinant of population health and addressing health inequities.[5,6] Having a strong and well-resourced PHC is essential in improving health outcomes for all through timely access to appropriate medical care, the mitigation of preventable diseases, and preserving the viability of health systems.[7,8] GPs are crucial players of a multidisciplinary primary healthcare team as they are pivotal in the organisation of PHC services, including ensuring the continuity of care and acting as 'gatekeepers' to patients' access to specialist (secondary) care. Considering the vital role GPs have on the health and wellbeing of the communities they serve, the reported high levels of burnout and intentions to leave the profession highlights the pressing need for novel solutions to tackle the workforce crisis. So what exactly are our solutions? This viewpoint examines current and proposed strategies aimed at tackling Aotearoa New Zealand's general practice workforce shortages. Additionally, it explores alternative interventions that could be adopted to further strengthen the sustainability of our general practice workforce.

Strategies for addressing GP workforce shortages: current initiatives and proposed solutions

The current Government's plan to increase the number of primary care physicians is essentially a two-folded strategy.

The first part of the strategy focuses on increasing the annual number of graduating doctors through increasing current medial school enrolment quotas and the establishment of a third medical school at the University of Waikato by 2027.[9] Currently, around 25 percent of medical graduates annually choose to pursue a career in general practice, a figure that falls considerably below what is needed to address the shortage of primary care doctors.[10] It is hoped that by opening a new medical school, characterised by an innovative curriculum emphasising primary care career pathways and early clinical exposure to general practice, it would encourage a larger proportion of graduates from this third medical school to pursue specialised training in rural medicine and primary care.

The second part of the strategy focuses on making a career in general practice more attractive by offering financial incentives to those who chose to practise general practice in remote areas or areas with high health needs. This initiative is more commonly known as the voluntary bonding scheme (VBS). Under this scheme, newly qualified healthcare professionals who practise in certain areas of need for a designated period of time would receive a fixed monetary payment. Currently, only doctors in postgraduate training years

3–6, who are either starting or already involved in general practice training, are eligible for a $30 000 lump-sum payout (after-tax) upon completing 3 years of service.[11]

Potential issues with current and proposed solutions

Although it might seem intuitive that the solution to address Aotearoa New Zealand's primary care doctor shortage is to train more doctors, the solution is not as clear-cut as it is made out to be. In order for New Zealand medical graduates to attain full registration with the New Zealand Medical Council, allowing independent practice in a hospital or private practice setting, they must first undergo 2 years of prevocational medical training upon graduation. However, due to limitations on hospital resources and the availability of adequate clinical supervision, securing prevocational training poses a challenge for some New Zealand medical graduates. In recent years, 22 and 23 New Zealand medical graduates were not offered prevocational postgraduate training positions in the 2022 and 2021 training years respectively.[12] In its current form, the Government's plan to increase the number of medical graduates is being done so in a setting of insufficient prevocational postgraduate training positions and thus is counterproductive and morally irresponsible as it would result in an excess of graduates who, despite completing their education, face obstacles at the final stage and are consequently unable to contribute to patient care. Without completing the required 2-year prevocational training, graduates are unable to participate in any subsequent vocational training programme, including general practice. Hence, it is imperative for the Government to provide assurance that, at the very least, every graduate from a New Zealand medical school will be guaranteed a position for prevocational training.

Moreover, it is uncertain whether establishing a medical school that has a curriculum focused on primary care medicine would actually favourably affect the career intentions of medical students. Although evidence indicates that increased exposure to general practice teaching during medical school is linked to a higher likelihood of choosing a career in general practice, it is worth noting that the influence of medical school curriculum is just one of several factors influencing medical students' postgraduation career choices.[13,14] Unfortunately, general practice is often perceived as being inferior to other medical specialties, when considering other factors such as intellectual stimulation, societal perception, self-perceived occupational prestige, and remuneration.[14] Furthermore, it remains uncertain as to the extent to which general practice exposure at medical school influences future career choices.[15] For instance, do graduates prioritise remuneration over intellectual stimulation and clinical exposure when deciding their future career pathways? Which factor(s) carries more weight in their career decision-making process? Certainly, as Fodeman and Factor have indicated, early exposure to general practice would help, but additional actions are needed to adequately address this issue.[15]

Introduced in 2009, the VBS was designed to enhance the income potential of primary care to encourage more graduates to pursue a career in general practice. However, the uptake of the scheme has arguably fallen short of expectations, reportedly with a high attrition rate for doctors in 2012.[16] Interestingly, Te Whatu Ora has not provided data on the current retention rate for doctors under the VBS scheme. Nevertheless, I believe that the primary reason for this poor historical retention rate could be due to the unappealing payment structure and option. Currently, eligible individuals receive a lump sum of $30 000 (after tax) at the end of 3 years, credited to either their student loan balance or directly to their bank account if they do not have a student loan balance.[11] However, the current payment method is considered unfavourable because participants are unable to practically use the money for various essential purposes such as relocation costs or contributing to their day-to-day living expenses. Perhaps the effectiveness of the scheme would be improved if payments were distributed regularly (preferably weekly) over the duration of the scheme rather than provided as a lump sum. Additionally, directing the payments straight to an individual's bank account, instead of crediting it to their student loan balance, would allow clinicians to use the funds more flexibly. This approach would enable clinicians to use their payments in a manner that aligns better with their evolving financial needs and circumstances.

Other solutions

In this section, I explore alternative solutions that could be adopted to further increase GP recruitment and retention.

Greater financial incentives

The present stance of the coalition Government on taxation seems to be quite liberal, particularly highlighted by its emphasis on lowering income taxes for all New Zealanders. Given the prevailing negative sentiments regarding the remuneration status of GPs, an additional strategy could involve offering income tax credits to those currently working in primary care. This approach would not only encourage more doctors to choose a career in general practice but also help retain those who are already practising in this field. Moreover, introducing partial student-loan forgiveness could act as an additional incentive for more graduates to pursue careers in general practice given that the vast majority of New Zealand medical graduates expected to have some student loan debt upon graduation.[17]

Improve general practice trainees' employment conditions

Under the current GP training scheme, all GP registrars beyond year one must find their own training practice, with the requirement that the practice must also have a 'College Cornerstone teaching accreditation' status.[18] Currently, out of approximately 1000 GP practices, only about one-tenth (104) are eligible to support and train GPs.[19,20] The limited number of accredited teaching practices not only causes a backlog in the annual number of fully qualified GPs, but also instils job insecurity, placing the burden on trainees to secure suitable positions for each subsequent training year after year one. Perhaps the most significant issue arising from this situation is the loss of bargaining power when trainees have to find their own training positions. Unlike hospital-based registrars who can join professional associations or unions, GP trainees currently lack such opportunities. This means that they must individually negotiate the terms of their employment, which can often be a daunting task. Due to the limited number of training sites relative to the number of registrars and the potential fear that high employment demands might lead to employers selecting other candidates, individual GP registrars are likely to compromise on their employment terms.

To address these concerns, it is suggested that the Government should provide financial grants or subsidies to non-accredited clinics, offering them funding to cover initial costs and support their development, with the ultimate goal of enabling them to attain accreditation, whereas the RNZCGP should adopt a collective approach on wages and employment conditions, similar to that of Australia's national terms and conditions for employing GP registrars (NTCER). This would entail the College entering into a de facto collective agreement with each of its accredited training practices, guaranteeing registrars have suitable employment conditions that adhere to a minimum standard. This would ultimately create a more favourable and appealing environment for general practice training.

The call for bonded medical places

One approach to ensuring the long-term sustainability of Aotearoa New Zealand's general practice workforce involves implementing a quasi-mandatory bonding scheme for medical students. Under this scheme, a specific proportion of medical school seats at each medical school would be allocated for future bonded GP training. Prospective applicants, when applying to medical school, would have the option to choose between a GP bonded seat or a non-bonded seat. Those selected for a GP bonded seat would be obligated, following graduation and completion of the two postgraduate prevocational training years, to participate in the RNZCGP training program and work in areas facing workforce shortages, including rural and high-needs urban regions, for the duration of their training. To ensure that applicants are genuinely committed and possess the necessary qualities suitable for a career in general practice, medical schools could require applicants to submit a brief personal statement outlining their career intentions and commitments to general practice as part of the application process. Ultimately, this approach provides a more tangible strategy for ensuring the medical workforce is well-distributed, adaptable, and focused on areas with the most pressing needs.

The success of such a scheme, however, relies on ensuring adequate support for practices and supervisors in these often underfunded areas. Doctors in rural and high-needs urban regions typically serve communities with complex medical needs, facing a high demand for their services. Therefore, it is critical that these practices and supervisors receive adequate support and resources so that they are able to maintain a safe working and training environment for the benefit of both patients and clinicians.

Conclusion

Although it is positive to see ongoing and proposed solutions aimed at tackling Aotearoa New Zealand's general practice workforce crisis, it is crucial to recognise that certain implementation issues are hindering the full efficacy of these solutions. Nevertheless, there are other strategies that merit deeper exploration as additional solutions to further strengthen the recruitment and retention of primary care doctors.

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