Addendum to Workforce and Resources for Future General Practice

July 2020 Update

This discussion document has been prepared by GPNZ with intellectual input from Sapere Research Group incorporating feedback to the original report released in April 2019 and incorporating a number of lessons learned during Covid-19.

INTRODUCTION

This document is an addendum to the Workforce and resources for future general practice. It incorporates feedback on the discussion document by some GPNZ members in the context of Covid-19 disruption and how this could affect the general practice workforce in the future.[1]

The changes are to Fulltime Equivalent (FTE)[2] estimates and estimated total service cost for 10,000 enrolled population. We explain the rationale for the changes and the implications for estimated service cost.

UPDATED WORKFORCE ESTIMATES (FTE)

Figure 1: Estimated workforce FTE comparing the original estimates to those updated based on feedback

	Original		Updated	
Personnel	**FTE per 10,000 high need patients**	**FTE per 10,000 general patients**	**FTE per 10,000 high need patients**	**FTE per 10,000 general patients**
GP	7.9	5.5	7.9	▲ 6.0
Nurse practitioner	5.0	2.0	▼ 4.0	2.0
Nurse	8.4	7.3	▼ 6.0	▼ 4.5
Reception/administration	6.7	5.0	6.7	5.0
Behaviourist/counsellor	1.0	0.5	▲ 3.5	▲ 2.5
Social worker/Kaiawhina/Navigator	2.5	1.0	2.5	1.0
Health care assistant	4.0	3.0	4.0	3.0
Clinical pharmacist	0.5	0.3	▲ 1.0	▲ 1.0
Physiotherapist	0.5	0.5	▲ 1.0	▲ 1.0
Trainee doctor	1.0	1.0	1.0	1.0
Trainee nurse	1.0	1.0	1.0	1.0
Trainee allied health	1.0	1.0	1.0	1.0
Student clinicians (at any one time)	2.0	2.0	2.0	2.0
Manager	1.0	1.0	1.0	1.0
Total team FTE	**42.5**	**31.3**	▲ **42.6**	▲ **32**

[1] https://gpnz.org.nz/wp-content/uploads/Workforce-Resources-FINAL-DISCUSSION-DOC.pdf

[2] One FTE is equivalent to 2080 hours per year or 40 hours per week for 52 weeks of the year.

UPDATED COST OF THE PRIMARY HEALTHCARE SYSTEM

The changes would result in an annual cost of primary health care of $2.29 billion. This is an increase of $102 million per annum compared to our original estimates.

Figure 2: Cost of primary health care based on the updated FTE estimates

	Original		Updated	
Personnel	**High Needs**	**General Population**	**High Needs**	**General Population**
Salaries[3]	$4,305,030	$2,930,785	$4,338,005	$3,133,506
IT/Communications	$30,000	$25,000	$30,000	$25,000
Rental / Capital[4]	$269,578	$223,168	$335,215	$276,208
Consumables	$177,001	$122,031	$173,520	$122,031
Cover for Leave	$430,503	$305,078	$433,801	$313,351
ACC / Kiwisaver etc	$199,126	$137,285	$195,210	$137,285
Total per 10,000 patients	$5,543,239	$3,863,348	$5,625,750	$4,127,380
Scaled to NZ population[5]	$923,873,167	$1,287,782,667	$937,625,071	$1,375,793,183
Total cost	**$2,211,655,833**		▲ **$2,313,418,254**	

RATIONALE FOR THE CHANGES

There were three key points raised in feedback relating to the distribution of clinical FTE, these were:

1. The need for more highly skilled nurses in general practice, but overall, the number of nurses was too high.
2. Time savings for GPs from the use of other roles and technology efficiencies should be reinvested back into the management of complex care. Many saw a big opportunity, post Covid-19, to work more closely with secondary care to manage some cases in the community.
3. The use of clinical pharmacists, Health Improvement Practitioners, physiotherapists, counsellors, therapists, social workers, and health coaches in general practice has been successful and many see a need for these roles to be more widely utilised in primary care.

Based on this feedback we have made some changes to the FTE estimates.

Finally, we also received feedback that the cost of rental/capital was too low and did not reflect the rental that some members were currently paying, particularly in and around major cities. We have increased the facility cost per sqm by 25% to account for this feedback.

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[3] The nurse salary rate has been increased from $77,443 to $78,993 per FTE. This is a move from step 6 to step 7 on the nurse MECA and reflects the need for more experienced senior nurses in primary care.

[4] Updated rental/capital costs have been increased by 25% per sqm based on feedback from GPNZ members.

[5] Assumes a population of 5 million with 1/3 of the population classified as high needs.

GP AND NURSE PRACTITIONER FTE

We have increased the allocation of total GP/NP FTE for general patients and decreased it slightly for high needs populations. The GP/NP FTE to population ratios are now:

- General population: 1 GP/NP FTE per 1250 people (1:1333 originally)
- High needs populations: 1 GP/NP FTE per 840 people (from 1:775 in the original estimates)

For both the high needs and the general population this is a more sustainable ratio than the status quo as it allows more time for managing patient care in work hours and for complex care. The slight drop in FTE for high needs populations is offset by an increase in allied heath staff meaning total FTE has increased slightly overall.

Maintaining high ratios of GPs was also seen as important. The disruption on outpatient services caused by Covid-19 has highlighted the opportunity to manage some complex care in the community. This is not a new idea but there may be greater motivation to progress this in the post-Covid era. Essentially this means GPs would manage traditionally secondary care cases in the community that are simple, predictable, and supported by clinical pathways with support from secondary care clinicians as needed.

NURSE FTE

We have reduced the number of nurses from our original discussion document and redistributed these resources into other roles within the care team. The majority of the nursing workforce would be highly skilled nurses and our estimates include 0.5 FTE to 1 FTE for a specialist role such as a diabetes nurse specialist. We have also increased the salary for nurses in our cost estimates from step 6 of the nurse MECA to step 7 to reflect the skills and seniority of the nursing workforce.

BEHAVIOURAL AND OTHER ALLIED HEALTH ROLES

We have increased the number of behavioural roles to 2.5 FTE for the general population and to 3.5 FTE for high needs. This reflects growing support for the use of Health Improvement Practitioners (HIP), psychologists, counsellors, therapists working across general practice to handle mental health needs. A health coach is also included within this FTE.

We have increased the clinical pharmacist resource to 1 FTE per 10,000 and increased the physiotherapist role to 1 FTE based on feedback.

All other FTE estimates have remained unchanged.

This workforce picture represents a typical distribution.

We reiterate the comments made in the original discussion document:

> *"…this workforce picture is intended as a typical distribution of resource for each of the two scenarios. Any individual health centre might have a different distribution of (for example) nurse practitioners, nurse prescribers and registered nurses to reflect community need, the vagaries of recruitment and workforce availability, and the best balance of skills with other individuals in the team. Nor is there an intention to enforce a specific model in detail, which could preclude innovation and community responsiveness. The workforce picture is intended to be a typical scenario, not a straitjacket, and is primarily a starting point for thinking about how much resource would be needed to implement such a model."*