GENPRO

General Practice Owners Association
of Aotearoa New Zealand

Function before form:
What does my community need?

A submission to support the development of "Localities"

29th July 2021

Foreword

It is my pleasure to present this brief, but important submission, on behalf of GenPro members, to help inform the development of Localities within the Government's current health reforms.

GenPro is the only national organisation directly mandated to represent general practice and urgent care centre providers. New Zealand has over one thousand such individual contracted businesses with whom almost five million patients are enrolled and who provide over sixteen million community-based, first-contact health consultations per year. General practice is therefore one of the most important linchpins of our primary and community-based (or locality-based) health system and must be integral to the development of any associated reform proposals.

I believe that the development of Localities is a great opportunity to adopt a renewed focus on the needs of patients. The historic success or otherwise of Primary Health Organisations in supporting the 2001 Primary Health Strategy and the delivery of integrated care and better outcomes, suggests we should be very careful about how we develop similar 'MESO-level' organisations of the future. There are also important lessons to learn from the variable success of local level Alliances as enforced through the PHO Services Agreement in more recent years.

The scale of the Government's current programme of structural reform carries with it a significant level of inherent risk. As organisations and individuals jockey for position and for their future protection, it is important to remember that function must come before form.

This submission therefore avoids stipulating a specific organisational framework, structure or operating model that Localities should follow. Instead, we set out a range of principles and criteria which should guide the development of each Locality and which should therefore also be used to judge the success of this development programme.

Improving equity and outcomes for our communities is key. Ensuring the sustainability and continuity of current service provision will be the foundation from which we can build greater collaboration and establish new services. We therefore need to be careful not to undermine the gains that have been made following the 2001 Primary Health Strategy, of which there are many. We should remind ourselves that New Zealand has a primary care sector that is the envy of many in the world and we must ensure that we do not throw the baby out with the bathwater during the current change process which should be cognisant of our already high-quality general practice and dedicated general practice workforce.

Conversely, it is also time for some honesty and realism. Simply saying that primary care must provide more services, more integration and more choice does not magically make it happen. Such developments must be appropriately defined and appropriately funded. That was not the case following the 2001 Primary Health Strategy and, as acknowledged in the final report (March 2020) of the Government's own Health and Disability System Review, the current system is significantly underfunded. To deliver the Government's new vision, baseline services and associated funding will need to be rebalanced prior to ensuring all new services are fully funded.

On behalf of GenPro members, I hope this submission is helpful. As the national representative body for contracted providers of general practice and urgent care centres, GenPro expects to be closely involved in the development of Localities and to ensure our providers continue to play a leading role supporting the health and wellbeing of their local communities.

I therefore offer our support and expertise to build on the principles and criteria set out here and to ensure that function comes before form in fulfilling our response to the needs of each and every community across the country.

Dr Tim Malloy

Chair

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Introduction

In 2018, the Government announced a wide-ranging review of the Health and Disability system in New Zealand, designed to future-proof our health and disability services.

The Review looked at the overall function of the health and disability system and whether the system is balanced towards wellness, access, equity, and sustainability.

The final report on the findings of the Review (Extract provided at Appendix B) was released on 16 June 2020. The report advised that:

> *"Organising services around smaller populations in localities makes it easier to recognise what really matters to people, to build relationships across professions and organisations, and work with other sectors to address the wider determinants of health. The Review has concluded that there is merit in applying a locality model to Tier 1 services in New Zealand".*

In April 2021, the Government published a White Paper providing an overview of the proposed reform of the health and disability system. The supporting narrative advised that "Over the next few years, primary and community services will be reorganised to serve the communities of New Zealand through 'localities'" and went on to say:

> *"Every locality will have a consistent range of core services, but how these services are delivered will be based on the needs and priorities of local communities.*
>
> *Care will be better coordinated and integrated, with information following patients as they move between providers. They will support more convenient care closer to home, including using technology to support a wider range of digital care options.*
>
> *By reorganising primary and community care into localities, we can improve local health outcomes by giving communities more say in the care that is delivered locally and tailoring care to meet local needs and priorities.*
>
> *In most cases people will still have the same relationship with their health providers in the community. The main difference is that those providers will be better supported to provide connected and integrated care".*

The Transition Unit (established within the Department of Prime Minister and Cabinet to support the reform programme) is now seeking input to help to develop Localities (also being called local wellbeing networks). A process to select prototypes of local wellbeing networks will follow and which are expected to go live in early 2022.

This submission has been prepared on behalf of, and in consultation with GenPro members, to help inform the above process of Locality development. GenPro's intent is through this submission, a set of principles and criteria are offered which will help ensure that the value of localities are greater than the sum of their parts and specifically that they:

- Increase resources going direct to the front-line
- Improve patient outcomes based on the needs of local communities
- Learn from the lessons of the past

Function before form

The Government's current programme of health reform includes possibly the largest structural re-organisation the health system has seen for many years. The abolition of District Health Boards (DHBs), the potential abolition of Primary Health Organisations (PHOs), the establishment of Health New Zealand (Health NZ) with its network of regional and district infrastructure, and the establishment of the Māori Health Authority. By any measure, this is an ambitious re-organisation with significant levels of inherent risk.

The numbers of organisations, directors and senior managers who will now be looking for some form of 'future-proofing' has the potential to side-track the focus of the reforms. Immediate discussions following the publication of the Government's White Paper included the inevitable, but unhelpful and non-productive, predictions of how DHB teams would transition into the new Health NZ structure as well as how PHOs would transition into new Localities. History tells us that such a focus on form before function is likely to come at a high price.

In June 2021, NZ Doctor magazine published an opinion piece by GenPro Chair, Dr Tim Malloy, entitled *Let's put patients before the deck chairs..* This is included at Appendix C to this report and proposes a patient-stratification methodology to ensure the targeted development of Localities.

Similarly, the basis of this submission and its focus on the principles and criteria for successful Localities is intended to ensure that function comes before form and that the focus is maintained on adding value for patients at the front line.

Learning from the past

We cannot afford to repeat the mistakes of the past.

It has long been the case that the New Zealand Health Strategy has sought to rely upon a strong primary care sector which supports the Government's desire to keep New Zealanders healthy and out of hospital. That was certainly one of the main tenets of the New Zealand Primary Health Care Strategy published in February 2001.

The current reform programme includes many similarities to the Primary Care Health Strategy of 2001. Yet the establishment of PHOs to support the original Strategy failed to deliver the intended benefits of multi-disciplinary working, integrated care, system efficiencies, equity of access and, patient outcomes.

There will be many opinions as to why PHOs did not deliver as expected. GenPro believes the key factors include a lack of empowerment and investment in those extended responsibilities, as well as the perverse constraints of a system which remains biased towards hospital-based care through DHBs own provider arms.

Simply saying that primary care must provide more services, more integration and more choice does not magically make it happen. Evidence points to the importance of effective change management to deliver the intended results and outcomes of such processes. This is particularly the case for organisations which rely heavily on human input and expertise. The development of Localities must therefore be appropriately defined, appropriately funded, supported by an alignment of incentives across the whole system and, underpinned by adequately funded change management.

Clear and robust governance

GenPro believes that successful Localities should:

- Be developed from the bottom-up in partnership with whānau, hapu and iwi
- Be clinically led, patient focused and culturally responsive
- Be based on the principles of equity and transparency, including kāwanatanga, tino rangatirotanga and ōritetanga (protects Māori interests, ensures that Māori have control over their own affairs and, upholds equity of Māori and all New Zealanders)
- Clearly identify responsibility for overarching clinical governance
- Avoid duplication
- Be underpinned by an agreed Code of Conduct (for providers *and* patients)
- Ensure that the Locality value is greater than the sum of its parts
- Establish clear priorities based on a health needs assessment and subsequent stratification of the population
- Be held to account for the delivery of those priorities
- Be based on a high-trust, low-bureaucracy environment
- Support continuing clinical autonomy
- Built upon patient and provider input

Appropriate funding and resources

GenPro believes that successful Localities should:

- Be fully and appropriately funded for all services, at all stages of the patient journey, as well as all administrative functions and all associated time demands
- Be funded to support services to be culturally responsive to the needs of the community
- Be funded and supported to provide a new range of early detection and treatment services for a range of conditions which are supported by a case management approach for patients and whānau
- Be funded in a high trust environment which encourages innovation and wider integration of services
- Be funded separately from their constituent Providers (e.g. Avoiding top slicing)
- Be underpinned by a funding framework which ensures sustainability of services for future years
- Be resourced to ensure clinicians are supported by appropriate non-clinical staff that enable the best use of a limited workforce

Patient focussed

GenPro believes that successful Localities should:

- Be driven by the needs of patients and the community with clearly anticipated outcomes (the commissioning cycle)
- Be connected with the community and responsive to the whānau voice
- Be culturally responsive to the needs of the patient and their whānau
- Protect clinical time to focus on the needs of patients

- Empower patients to take control of their own health and wellness with access to an appropriate range of resources and their health data to do so
- Protect and maintain individual patient-practitioner relationships and patient-provider relationships
- Offer timely access to high quality services at a provider of the patient's choice
- Allow patients to access an appropriately trained professional who is qualified and empowered to make the required clinical decisions based on the patient's needs

Effective team working

GenPro believes that successful Localities should:

- Support multi-disciplinary working and a team approach to primary care services (with clearly defined clinical governance accountabilities)
- Support engagement of (and collaboration between) professionals and practitioners, specifically including currently isolated practitioners who may be working in rural and remote locations
- Promote and support essential workforce development and retention
- Support strong relationships between primary and secondary professionals to encourage a whole of system approach (particularly including urgent care services)
- Utilise the collective skills of local providers to support a range of additional services for their community
- Upskill their local providers to support enhanced services that best meet the needs of the local community
- Support primary health professionals, where appropriate, to provide additional services within their scope of practice
- Be innovative across the full service and provider spectrum
- Support the prompt completion and follow-up of all investigations and diagnostics by the instigating clinician
- Be underpinned by nationally funded, robust, inclusive, integrated and secure IT and information systems
- Facilitate seamless referral processes (with fewer, not more decision points)

Supportive provider relationships

GenPro believes that successful Localities should:

- Support continuity and sustainability of essential service provision
- Enable the effective delivery of nationally consistent and nationally determined essential primary care services (avoiding a 'post-code' lottery of service provision)
- Support innovation and development
- Commission services over and above nationally determined and contracted essential services

Appendix A: About GenPro

GenPro is a not-for-profit membership Association representing the owners of New Zealand's essential General Practice and Urgent Care Centres.

There are more than 1,000 General Practices across the country providing first-contact healthcare for the population of New Zealand. Virtually all of those General Practices are private businesses owned, in whole or part, by partnerships of GPs, nurses, other health practitioners, private individuals or one of a number of larger corporate entities directly investing for the better health and wellbeing of the nation.

Our Vision

Sustainable, viable and high-quality General Practice for all New Zealanders

Our Mission

To promote and advocate for sustainable, responsive and high-quality general practice services for the population of New Zealand.

Our Objectives Include

a. To promote, protect and improve the collective interests of Members.
b. To advocate for and support the sustainability and viability of Members businesses and the services they provide in order to ultimately ensure the continuity of locally accessible and high-quality, patient-centric care.
c. To provide strong, credible and effective national representation for New Zealand's network of General Practice and Urgent Care business owners, including, but not limited to, the country's network of smaller, owner-operated providers.
d. To improve the health of the population of New Zealand and advocate for high-quality, accessible and equitable patient care.
e. To support the productivity and efficiency of the New Zealand Health and Disability System.
f. To promote, protect and support the innovation capability of Members.
g. To help Members promote and improve the efficiency of their businesses.
h. To provide sector leadership on issues affecting Members by:
    - Influencing and promoting legislation, regulations and policy for the betterment of the interests of the Members or for the accomplishment of any of the Association's objectives.
    - Liaising and co-operating with Government and other bodies and agencies for the accomplishment of any of the Association's objects
    - To act as agent for the Members (either individually or collectively) in negotiation or consultation with Crown Agents or other funding bodies regarding contractual service arrangements and associated funding.

Appendix B: Extract from the Health and Disability System Review – Final Report (March 2020)

Population health in the driver's seat

For many years, the health sector has talked about the need for a population health approach. A population health approach considers the interrelated factors and interrelated conditions that influence health over the life course, identifies systemic variations, and applies this knowledge to improve the health and wellbeing of the population. In terms of services, a population health approach emphasises prevention, the multiple determinants of health, health equity, intersectoral partnerships, and understanding needs and solutions through community outreach.

It is now almost 20 years since the Primary Health Care Strategy was launched, and there have been many developments that can assist a population health approach to be integrated into service design, e.g. behavioural insights, changing consumer expectations and significant advances in access and use of data and digital technology.

The Review saw examples of a population health approach applied successfully in combination with place-based strategies that organise services around the needs of defined communities.

Organising services around smaller populations in localities (see definition below) makes it easier to recognise what really matters to people, to build relationships across professions and organisations, and work with other sectors to address the wider determinants of health.

The Review has concluded that there is merit in applying a locality model to Tier 1 services in New Zealand.

Services planned by localities and needs

The term locality has been adopted to mean a geographically defined area with a population of between 20,000 and 100,000 people, with footprints that make sense for the community being served. Localities could be aligned to council boundaries, iwi, or natural borders. A district health board (DHB) region could include more than one locality, but localities would not generally span multiple DHBs.

Rohe and localities

Within a DHB or region, an iwi rohe may be a defined locality. Responsibility for locality planning and monitoring outcomes could therefore be the shared responsibility of the DHB and the Rūnanga.

District health boards responsible for Tier 1 services

The Review considered ways that a locality approach could be achieved in New Zealand and concluded that governance would sit most appropriately with DHBs, as they have statutory responsibility for the health and wellbeing of their populations. Although still called district health boards, they would be expected to look and behave very differently to how they do now.

For each locality, DHBs would be responsible for ensuring that the mix of Tier 1 services reflects the characteristics of the community, are culturally safe, and improve access for consumers and whānau. Each locality would have a mix of services and business models, with NGOs and Māori providers playing an integral role. A core group of services, strongly focused on prevention, wellbeing and outreach, would be common across all localities in New Zealand, with a varied delivery model to respond to differences in local needs. Other services in the locality would be determined as part of planning, and may be specific to the health and wellbeing needs of its population.

Having reviewed the lessons of previous health sector reforms, it is clear that for this approach to be successful, these next generation DHBs should not just have accountability, but the authority, funding, purchasing and contracting powers to bring a locality approach to life.

Locality plans and funding

As described in the System Settings section, DHBs would be required to develop five-year strategic plans for their regions, approved by Health NZ and the Minister of Health, and supported by intelligence and analytics from Health NZ and the Māori Health Authority. Each locality would have an indicative budget based on age, ethnicity and deprivation of its population. This would be transparent to the public (see funding in this chapter).

Commissioning the right mix and design of services for the population would require effective community engagement to understand the aspirations, capabilities and expectations of the people using the local health system. Understanding and responding to the needs of those who do not access the system, including both Māori whānau and Pacific communities, would be just as important for planning as understanding the needs of those who do access the system. Clinical engagement would also be important for safe and high-quality service design.

Locality plans would show:

- the locality health needs assessment results, including unmet need for different services
- indicative budgets for the locality, based on age, ethnicity and deprivation
- what Tier 1 services would be available to meet these needs, in what settings
- how networks of services would be organised and provided and by whom
- how access would be enabled to suit the community and value the time of consumers and whānau, for example, locations, extended hours, digital services, outreach services and transport options
- how specific populations would be served, for example, kaupapa Māori services to provide choice for Māori whānau, services designed for Pacific fanau, people with disabilities, and rural communities
- the outcomes these activities are expected to achieve for defined populations.

Locality plans would also set out a programme for investment that is transparent to the public, the workforce, Health NZ and the Māori Health Authority about how the service delivery model would be developed over time.

The role of primary health organisations and Alliances

District health board responsibilities for Tier 1 would have particular implications for primary health organisations (PHOs). The Review considered the potential role of PHOs in a locality framework and concluded that split accountabilities between DHBs and PHOs for population health outcomes do not serve the objectives of the future system. While some developments by PHOs, such as the Health Care Home model, are improving service delivery in some places when compared with a traditional general practice model of care, at a system level, they still do little to change the paradigm.

It is recommended that DHBs no longer be required to contract PHOs for primary health care services, and that within five years there is a deliberate move away from the National PHO Services Agreement. Alliance arrangements required by the PHO Services Agreement and DHB Operating Policy Framework should also no longer be mandatory.

While a DHB could choose to continue to fund services via a PHO in the interim using the current PHO Services Agreement, DHBs would be expected to take on the responsibility for population data analysis and the management functions currently contracted out to PHOs. Funding for Tier 1 services would also increasingly be managed by DHBs and paid directly to providers through new commissioning arrangements. Health NZ would monitor this transition.

A local network of services to keep people well

For the most part, historic models of service delivery have prevailed with little adjustment to recognise the differentiated needs of the local community. A largely monocultural approach based on a western biomedical model has consistently failed to achieve equity for Māori. Service delivery needs to evolve to be more holistic and directed to the needs of both Māori and Pacific communities.

If the health and disability system is to be genuinely culturally safe, connected and designed for prevention and wellbeing, the breadth of Tier 1 services that consumers have a right to expect in their community should be actively expanded and commissioning done differently than in the past.

Guaranteed and locally specific services

To ensure fair access to services that are equity focused and tailored to local needs, the system should play a more active role in shaping the mix of services available in each locality. As Tier 1 is usually the first point of contact with the health and disability system, the mix of services should consider the cultural, clinical and social determinants of need, recognising that these are mutual determinants of health status.

It is proposed that each locality be served by a network of publicly funded Tier 1 services. Some services would be common across the country and others tailored to meet the health and wellbeing needs of a particular population. The service mix would be developed through the locality planning process, as described earlier. Some workforces or providers would serve more than one locality.

Table 7.1 sets out the proposed list of services that DHBs should guarantee are available and accessible to the population of each locality (although coverage may be differentiated to respond to local priorities). These services have a strong focus on promoting wellness throughout the life course as much as treating sickness. As with other parts of the health and disability system, services would be culturally safe. A mix of service models, including kaupapa Māori services, would be available.

Table 7.1: Services guaranteed for localities

Service	General description
Care coordination	▸ Team-based activity designed to facilitate the successful navigation of consumers through the health care system, based on their individual needs, preferences, capabilities and support. Intensity of care coordination depends on complexity of need.
Child and adolescent oral health	▸ Basic dental care, including check-ups, cleaning, preventative treatments, and fillings or extractions, for people up to their 18th birthday
Community pharmacy services	▸ Pharmacist-led services in community settings, including dispensing, treatment of minor ailments, acute demand triage and referral and relevant population health services.
General practice services	▸ Services to prevent, diagnose, educate and provide care for patients, and access to other appropriate services in the health system to benefit the patient.
Maternity services	▸ Services related to the care of women and babies from conception to six weeks after birth.
Medicines optimisation services	▸ A person-centred approach to safe and effective medicines used to ensure people obtain the best possible outcomes from their medicines.[121] Services are led by clinical pharmacists and take place at home, or other places that meet consumer and whānau needs.
Mental health services and behavioural support	▸ Support to help people achieve their best possible mental and emotional wellbeing which could include health coaches, health improvement practitioners, counsellors, social workers, youth workers and whānau ora kaimahi.
Needs assessment for disability and aged-care support	▸ Assessing a person's level of need and eligibility for health and disability support services.
Nursing services	▸ The health care and assistance provided to individuals by any qualified nurse across a range of health settings, including in institutions, homes and communities.
Older people's services	▸ Health and wellbeing services for older people, including aged residential care and home-based support services, so they can live well, age well and have a respectful end of life.
Outreach services	▸ Health services provided to people in their homes or convenient locations, often by community health workers, kaiāwhina or social workers.
Palliative care	▸ Services for people and whānau living with progressive, advanced illness, where the primary goal is to optimise quality of life.
Population health services	▸ Preventive interventions delivered to individuals aimed at promoting wellbeing and avoiding the development of disease or disability, eg, screening, immunisation, health promotion.
Well Child/ Tamariki Ora	▸ A package of health and support services for children and their whānau from birth to five years to ensure healthy growth and development.

Coverage of these services is currently variable across New Zealand. The immediate priority should be to achieve coverage within localities with the highest needs. Specific investment would also be required to support the growth of kaupapa Māori services.

Equally, networks would be expected to calibrate their delivery model to the level of need (eg, more frequent dental therapist visits to lower decile schools, more outreach services in areas with higher unmet need), and a shift to localised commissioning would ensure DHBs have the contract levers to achieve this (enabling, for example, more employed lead maternity carers in some locations).

Tier 1 services connected as a network

A key objective of the locality approach is for services to be easy to access and simple to navigate by the people who live and work there. Consumers and whānau should experience all Tier 1 services in their locality as though they were a single service. Services would be expected to operate as a single network, enabled by data sharing and digital platforms, referral pathways, shared protocols and commonalities in terms and conditions. There is no expectation that services would be co-located.

The DHB would be responsible for managing the network, with a dynamic mix of partners to support service delivery that addresses the clinical, cultural and socioeconomic determinants of health, ensures responsiveness to different needs and promote innovation in service design.

NGOs, Māori Health Providers and private businesses would be integral, alongside DHB-owned or operated services. In some localities, Tier 2 services, Whānau Ora services or other social services may be included as part of the network.

The network may be Taha Māori or consist of kaupapa Māori services (see the Hauora Māori chapter for definitions). It is expected that networks and localities would share learning to help achieve Māori equity and wellbeing.

Appendix C: Let's put patients before the deck chairs..

There's a lot of talk about the proposed establishment of "Localities" as part of the Government's health reforms. That's probably not a surprise given that the proposal sits alongside a separate proposal to remove the requirement for PHOs. What maybe *is* a surprise, is the fact that there are very few answers to questions such as what Localities will look like, how will they work and, how will they relate to established contracted providers?

I, like many, have been giving this a lot of thought. I've been reflecting on what the problem is that we are trying to solve. The ultimate aim should be, and must be, better health outcomes for New Zealanders. I believe therefore that this is a great opportunity to adopt a real focus on the *needs* of patients rather than perhaps the personal *wants* of some of the sectors organisational leaders.

Let's consider where we can make most difference. The inverse care law [Julian Tudor Hart 1971] is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served. Imagine a pyramid where the bottom of the pyramid represents the bulk of the population (let's say 80%) for whom good health and good access to services is predominantly the norm. Now at the narrow top of the pyramid we see a representation of the 20% of the population whose needs are higher and yet for whom access to the system or the right services is lacking. These theories around health needs assessment are everyday fodder to any health economist, public health specialist and many of the rest of us seeking to serve our communities and who are well accustomed to population health approaches.

Instead of establishing and resourcing Localities to serve the whole pyramid, perhaps we should adopt the well evidenced methodology of stratification of the population to enable a more-bang-for-the-buck approach which focuses on the 20% with greatest need at the top of the pyramid.

How would we do this? Fortunately, New Zealand has a primary care system built upon list-based general practice. We know that where such a system exists around the world it predominantly supports better access to healthcare, better population health, and better whole-of-health-system efficiency. We must not only be careful to protect that bedrock of one of the worlds best health systems, but also further use the significant value of the relationship it creates between patients and their general practice (which should not be confused with their individual General Practitioner).

That relationship of mutual trust and respect would enable each and every general practice to identify those patients at the top of the pyramid (which for some will be much higher than 20% and for some it will be lower) as well as agreeing with each patient what the gaps are within their own personal health needs assessment.

Through our new Localities, we then need to give those patients and their general practice access to the services and support that are currently unavailable or unaffordable to meet those gaps. That might be extended appointments, a specialist mental health nurse, polypharmacy management, a physiotherapist, culturally sensitive midwifery support, a housing advice worker, or even extra food and heating support. The list is quite probably endless. But it is quite probably very affordable with the sums of money which the Government appear to be setting aside for the reform programme.

This approach would also rightly prioritise high-need Māori patients and their whānau who are, and may well have proactively chosen to be, enrolled with mainstream general practice providers

who may not be formally recognised as kaupapa Māori. In many communities across New Zealand, such providers have by far the greatest absolute number of Māori patients enrolled with them. It does not mean their needs are any less and they offer a captive market around which the new Māori Health Authority could work with Health NZ and those general practices to structure the right Locality services and support for.

If we put function before form and focus on the patient, we can achieve great outcomes. We must protect the significant patient and system benefit which is provided by list-based and relationship-based general practice. We must ensure more funding gets direct to front-line services and is not diverted by investment in restructuring intermediate infrastructure that is not directly underpinned by a patient focused approach. Maybe the term Localities is misleading; localities are about places, *communities* are about people.

We only need take a quick sideways glance towards traditional secondary care settings to see the potential impact of a system which does not support or resource its valuable health workforce to provide for the real needs of the 20% of the population that may need them. For example, if we were to see a similar exodus of primary care practitioners into a private market for general practice, the impact upon New Zealand's vulnerable communities and the sustainability of the health system as a whole could be potentially catastrophic. Some general practice business owners and some general practitioners believe we are almost at that point – I hope the reforms are an opportunity to ensure that common sense prevails and our most vulnerable patients can ultimately benefit from the direct support they need.

As ever, GenPro is keen to support our sector colleagues to ensure optimum outcomes are secured from these very high-cost health reforms. We can collectively do that by supporting a patient focus and accepting that many of the deck chairs may have had their day.

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Dr Tim Malloy *is a GP, a business owner and, the chair of GenPro: the General Practice Owners Association, which was established in April 2020 to fill the gap in national representation for general practice business owners.*

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