Out of Hours

International primary care snapshots:

New Zealand and Japan

THE STATE OF PRIMARY CARE AND GENERAL PRACTICE IN NEW ZEALAND

As in the UK general practice in New Zealand (NZ) has evolved from the solo GP providing comprehensive cradle-to-grave care to predominantly group practices, often with after-hours care supplied by 24-hour centres, especially in urban settings. While many are still private businesses, there is an increasing trend for practices to be bought by corporations or, in low socioeconomic areas, to be owned by trusts. The workforce has become increasingly feminised, and it is not uncommon for a GP to only work for several sessions a week, often on a salary.

District health boards (DHBs) provide New Zealanders with free access to emergency, hospital, maternity, and some well-child services, but there has always been a fee-for-service component to visiting the GP. GPs are predominantly the point of first contact and 'gatekeepers' into other primary care services and the secondary care system.

In 2001 the government introduced the *Primary Health Care Strategy*.[1] This required the formation of not-for-profit primary health organisations (PHOs). These direct money to practices through the DHBs under a capitation formula for provision of essential primary healthcare services to an enrolled population. The formula varies according to the socioeconomic mix of the population served. General practice now has a blended payment system, with a combination of universal capitated funding, patient co-payments, and targeted fee-for-service for specific items. There are currently 32 PHOs nationally to which general practices belong, varying considerably with respect to size and structure. These network organisations now provide administration, budget-holding, incentivised programmes, data feedback, peer review, education, human relations, information IT support, and other resources.[2]

NZ general practice was an early adopter of IT, starting from the 1980s. The establishment of PHOs with capitation, requiring a formal system of patient enrolment, led to further computerisation, the national Health Index (unique identifiers for patients), and accumulation of rich datasets including practice population demography.

GPs and practice nurses have worked together for decades, but there has been an increasing move to interdisciplinary teamwork, with expanded roles for nurses, and greater involvement of community pharmacists and other allied primary care practitioners in patient care. There has also been increasing fragmentation of care over the past 25 years, with the growth of family planning and sexual health clinics, accident and emergency centres, and hospices, leading to a greater proportion of general practice consultations focused on addressing chronic disease.

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The Nurses Amendment Act 1990 allowed midwives to care for pregnant women independently, and a new maternity structure, with lead maternity carers, was officially introduced in 1996. This led to the rapid decline of the GP obstetrician, who up to this time conducted 50% of all deliveries in NZ.[3] The current generation of GPs have little or no obstetric experience, although attempts are now being made to share antenatal and postnatal care with midwives.

NZ faces an ageing general practice workforce. Many GPs, particularly in rural areas, are struggling to find buyers for their practices. Reduced work hours for those entering the profession means two GPs may be needed to replace one who is retiring. Both the UK[4,5] and NZ[6] have an aim of 50% of their medical graduates becoming GPs, but both currently fall well below this target. Considerable effort is being undertaken in undergraduate curricula to promote general practice as an interesting and engaging career choice.

To balance this out, there is increased recognition of the importance of general practice and primary care in preventing morbidity and premature mortality, as well as being associated with a more equitable distribution of health in populations.[7] There is job flexibility and the attraction of continuity, establishing and maintaining relationships with patients and their families over time, with a holistic rather than a disease-based approach to care. There is a strong team-based approach, working in an integrated way with colleagues from other health professions to provide community-based services. However, in NZ, the profession still suffers from less remuneration and

REFERENCES

1. King A. *The primary health care strategy.* Ministry of Health, 2001. http://www.hauora.co.nz/assets/files/PHO%20Info/Primary%20Health%20Care%20Strategy%20-%202001.pdf (accessed 20 Jan 2015).
2. Goodyear-Smith F, Gauld R, Cumming J, *et al.* International learning on increasing the value and effectiveness of primary care (I LIVE PC) New Zealand. *J Am Board Fam Med* 2012; **(25 Suppl 1):** S39–S44.
3. Ferguson W. The decline of general practitioner involvement in maternity care and its possible consequences for maternal and infant health. *NZ Med J* 1999; **112(1098):** 410–411.
4. Department of Health. *A high quality workforce. NHS next stage review.* London, 2008.
5. Peile E. General practice careers: choices and judgements. *Br J Gen Pract* 2013; **63(616):** 565–566.
6. McMillan V. A medical test no new student can pass. http://www.nzdoctor.co.nz/news/2012/november-2012/30/a-medical-test-no-new-student-can-pass.aspx (accessed 6 Feb 2015).
7. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83(3):** 457–502.

perceived lower status than other medical specialities. Much needs to be done to raise the standing of general practice and present it as a viable career choice in the future.

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PRIMARY CARE IN JAPAN: THE LONG AND WINDING ROAD

Japan is currently encountering difficulties in establishing a national system of primary care. Real GDP growth was unexpectedly negative and the government has shelved a planned consumption tax increase. The growing social security budget also frustrates the nation financially. Although medical reforms to reduce waste and enhance cost-effectiveness are urgently needed, the country's financial authorities continue to accept the trade-off between the quality and cost of health care since financial authorities, as well as patients, tend to believe that higher quality care costs more and that less expensive care is poorer quality. For example, it may be difficult to reassure a patient having a simple tension-type headache without ordering a CT and/or MRI.

Diagnosing only by careful history taking and physical examination, and managing only by watchful waiting and advice in primary care can hardly be recognised as high quality care in Japan, even though they are evidence-based and recommended by the clinical guideline. Among medical providers, there is a lack of understanding regarding quality assurance and management.

The fee-for-service schedule allows doctors to gain higher income by ordering more expensive tests and prescribing more expensive drugs. It should be important to consider clinical guidelines and research evidence if applicable, not to overuse unnecessary medical resources. However, not many doctors are keen to do so, which is a moral hazard.

Japanese medical education has lacked national systems to accredit postgraduate training programmes and to certify specialist doctors in all medical and surgical disciplines, including general practice. Therefore, quality of care is not standardised and varies substantially from doctor to doctor, depending mainly on their experience levels. Historically, several names have been used to describe doctors working within communities but these lack sufficient consideration regarding their defined roles in primary care. As described in a recently published review by the OECD:

'Primary care in Japan is typically delivered by a cadre of semi-generalist/ semi-specialists — that is, physicians who leave hospital practice after an unspecified amount of time to set up as generalists (with no compulsory further training) in the community.'[1]

A group of RCGP Junior International Committee members were invited to discuss medical generalism with their Japanese colleagues at the Japan Primary Care Association's Annual Conference in May 2014 in Okayama, Japan.

Recognising the urgent need to address this issue, the government finally decided to introduce appropriate systems, starting in 2017. A national ad hoc committee, (of which I am one of 15 members), was organised to discuss the many issues surrounding how we can establish and foster medical generalists: a new species of doctor within Japanese health care. The position of the committee on this issue, however, remains uncertain and unpredictable due to the fact that only a few members appear to truly value general practice as an independent clinical and academic discipline.

The Japan Primary Care Association (JPCA), a Japanese member organisation of WONCA, was founded in April 2010 by merging three different organisations of family medicine, general medicine, and primary care. Although we are a heterogeneous organisation comprising those who pursue medical generalism of the global standard, those who practise general internal medicine in hospitals, and those who work in community clinics, we have overcome various obstacles to establish in 2011 our own systems to accredit vocational training schemes (VTSs) and certify members by examinations. As of the 2014–2015 academic year, 167 VTSs have been accredited, 456 doctors have been certified, and 366 GP registrars are currently undergoing training. These achievements may seem modest if one considers all 128 million people in Japan's rapidly ageing population, but we believe that a significant breakthrough can be achieved and our initiative should be used as a successful model with which to construct a national system of primary care.

The JPCA Committee for International Learning and Professional Development, which I chair, worked with the RCGP Junior International Committee (JIC) to launch a reciprocal exchange programme in 2013. So far we have invited 10 JIC members to Japan, where each participant stayed in a different region to observe our VTSs and attended the JPCA's Annual Conference and presented a poster on GP training in the UK. In return, we have sent eight Japan First5 members to the UK, who visited and stayed with their counterparts in different regions and also attended the RCGP's Annual Conference. The programme has been so successful that the participants:

'... hope that this will continue to flourish and benefit many new and future family doctors in both countries.'[2]

It is my belief that our journey on the long and winding road to societies underpinned by high-quality primary care will be more enjoyable for future doctors who have benefited from, and been inspired by the pioneers on the international exchange programme.

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REFERENCES

1. Organisation for Economic Co-operation and Development. *OECD reviews of health care quality: Japan. Raising standards. Assessment and recommendations*, 2014, http://www.oecd.org/els/health-systems/ReviewofHealthCareQualityJAPAN_ExecutiveSummary.pdf (accessed 20 Jan 2015).
2. Ramsay R, Geeranavar S, Baines M. Partnering with Japan: the power of international exchange. *InnovAit* 2014; doi:10.1177/1755738014523736.