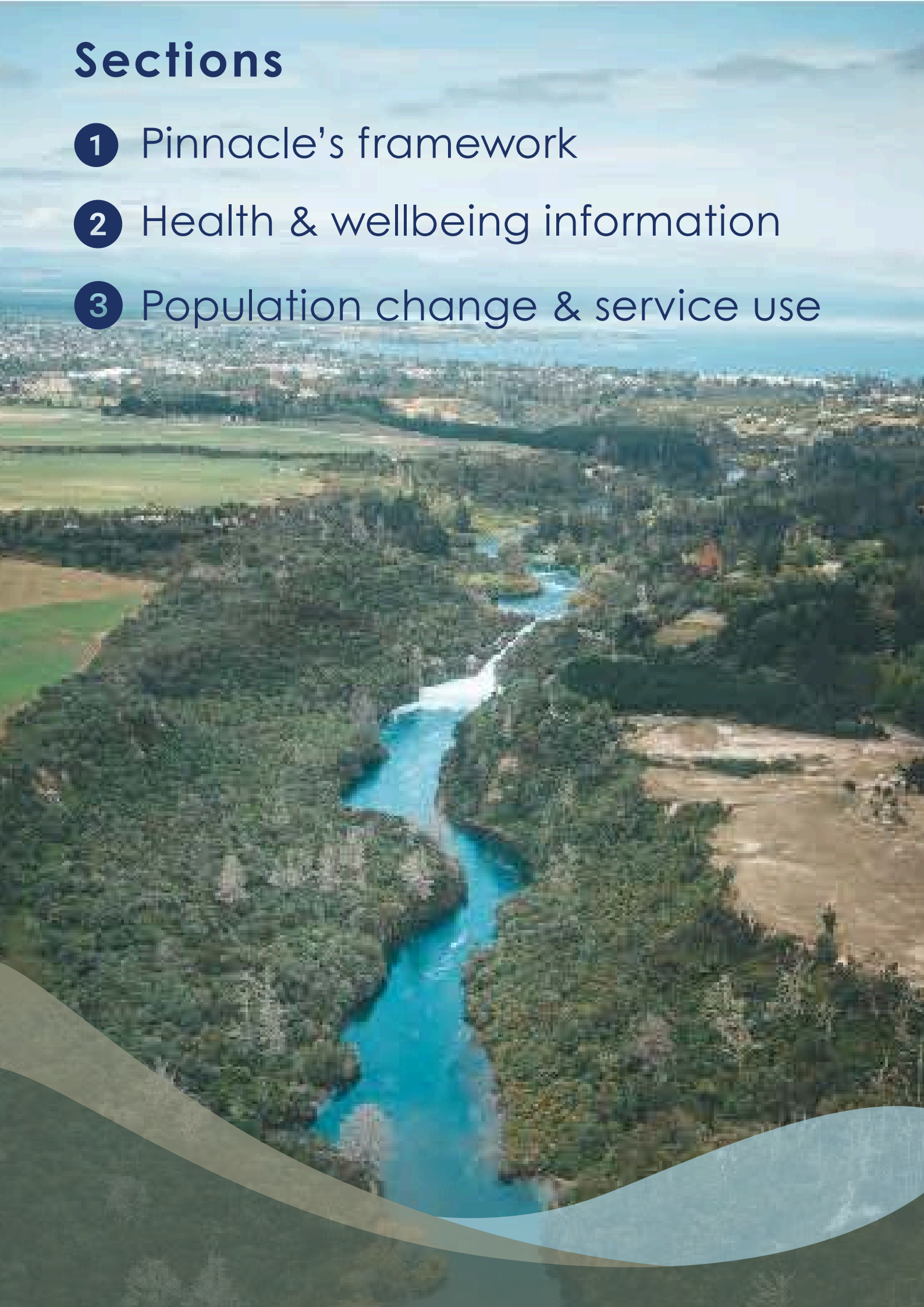
Pinnacle®
Midlands Health Network

Sections 1-3

Lakes Network

Population health and wellbeing

Sections



Foreward

As our communities change, so must the way we plan for health and wellbeing. Pinnacle's vision of "Kia hauora te katoa, kia puaawai te katoa" (everyone healthy, everyone thriving) reflects our commitment to equity, Māori, and the communities we serve.

Primary care is under pressure. Growth, demographic shifts, changing service use and workforce challenges are reshaping how care is delivered. Meeting these needs requires strategic, data-informed, and collaborative planning.

These population health reports provide practical frameworks, projections and insights to help guide decisions about services and workforce. Since our first report in 2007, Pinnacle has listened and adapted, including developing Primary Health Care Limited, introducing the Health Care Home model and extended care teams to strengthen general practice.

I encourage you to use these insights to support your mahi, spark new conversations and strengthen collaboration so our services remain fit for the future.

Nō reira, tēnā koutou, tēnā koutou, tēnā tātou katoa.

Justin Butcher
Kaiwhakatere | Chief Executive Officer

September 2025

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Sections 1-3

1 Pinnacle's population health and wellbeing framework

2 Health and wellbeing: Summary report

3 Population change and health service use

Photo: Richard Lin (Unsplash)

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Midlands Health Network

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Our population health and wellbeing framework

Our approach to population health and wellbeing

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Our purpose

Pinnacle recognises that a strong health system centres around equitable, high quality primary care and community services that are continually developing and evolving to meet local need.

We play our part by ensuring the right resources and capacity are in place so our enrolled population and our network can thrive. We continue to adopt flexible and responsive approaches in engaging with individuals, whānau and communities based on reciprocity, and respect for diversity and difference.

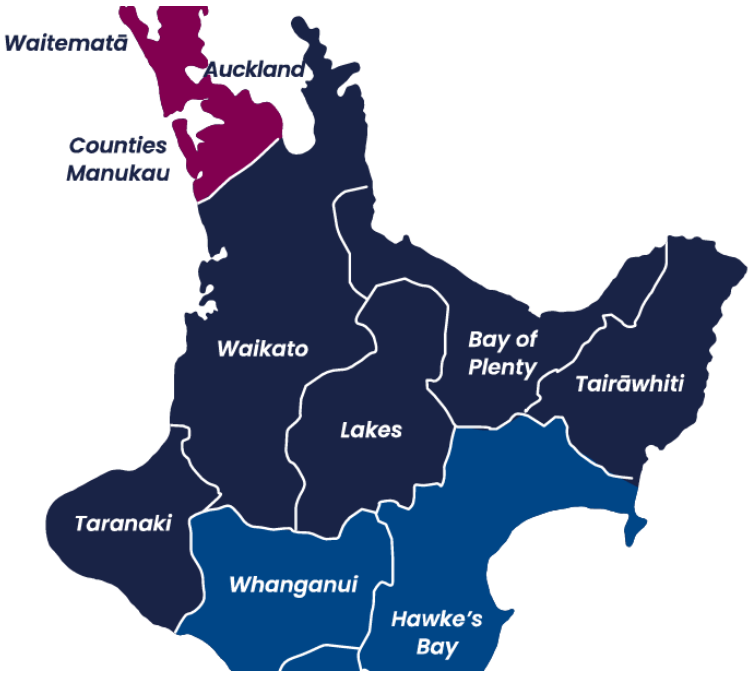
Population health and community wellbeing

Population health and community wellbeing remains central to everything we do. By fostering empowerment and community engagement, we seek to address not only immediate health concerns but also create sustainable improvements in the long-term wellbeing of our community members.

Our commitment extends beyond traditional approaches, encompassing programmes and outreach activities that promote preventive measures, education, and social support.

Four key aspects:

- We will continue to work alongside the community and iwi as they have been critical in determining the differing needs of community members.
- We will share data and tools so that services can be commissioned to reduce the equity gap.
- We will work as part of a community of providers to address population health and community wellbeing, fostering collaboration across the health system.
- We will continue to be innovative in our service delivery to meet the evolving needs of the community.



Population health priorities and measurement

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Defining population health and wellbeing

Population health focuses on the health and wellbeing of entire communities by addressing health outcomes, including disparities influenced by socio-economic factors beyond the influence of primary care. Acknowledging inequities affecting Māori, Pinnacle upholds te Tiriti o Waitangi through planning, resource allocation and frontline services.

Five Population health priorities

Equity and quality continue to be driving forces behind service delivery and our commitment to improving health and wellbeing. Health equity is at the core of each priority. The purpose of each priority therefore builds to address the disparities in health outcomes and access to care.

1 The network provides equitable and timely access to health care services

People have equitable and timely access to general practice, and extended general practice health care, when they need it.

How we will measure this:

- Tracking closed books in general practice (at the district level) and for rural and urban areas
- A national target of 80% of patients to see a primary care clinician within 5 days (target will take effect 1/7/2026 with data definitions to be confirmed)

2 Community mental health and wellbeing services are interconnected and available

People have access to a range of community based mental health and wellbeing supports, with a focus on equitable early intervention and culturally responsive care.

How we will measure this:

- Health Improvement Practitioners provide early intervention in general practice
- Targeted youth and adult populations are accessing early intervention in general practice

3 Interprofessional care is available for the prevention and management of chronic conditions

People with a chronic condition, or needing prevention support, receive interprofessional care in the community, enabling self-management and achievement of health and wellbeing aspirations.

How we will measure this:

- People with diabetes (aged 15-74 years) have good glycaemic control (HbA1c <53mmol/mol)
- People with diabetes (aged 15-74 years) have been prescribed best-practice medication, either SGLT2i or GLP1RA medication
- People with asthma (12+ years) have been dispensed best practice medication dispensed an inhaled corticosteroid (ICS) alongside a Short-Acting Beta-Agonist (SABA)
- People with cardiovascular disease (CVD) have been prescribed best-practice medication (triple therapy)

4 Pēpi and tamariki have a healthy start to life

All pēpi and tamariki have equitable access to prevention and acute health care in the community, enabling a good start to life and setting them up for a healthy future.

How we will measure this:

- Children are fully immunised against preventable disease at 24 months of age
- There is equity in medical service use for children in general practice
- Ambulatory sensitive hospitalisations (ASH) decrease over time

5 Eligible people have access to national screening programmes

People can access screening and prevention programmes they are eligible for. These initiatives improve population health by reducing the burden of disease, improving health outcomes, and promoting equity in health and wellbeing.

How we will measure this:

- People aged 65+ years access the annual influenza immunisation
- Current smokers are offered brief advice or cessation support

Integrated model of health and wellbeing

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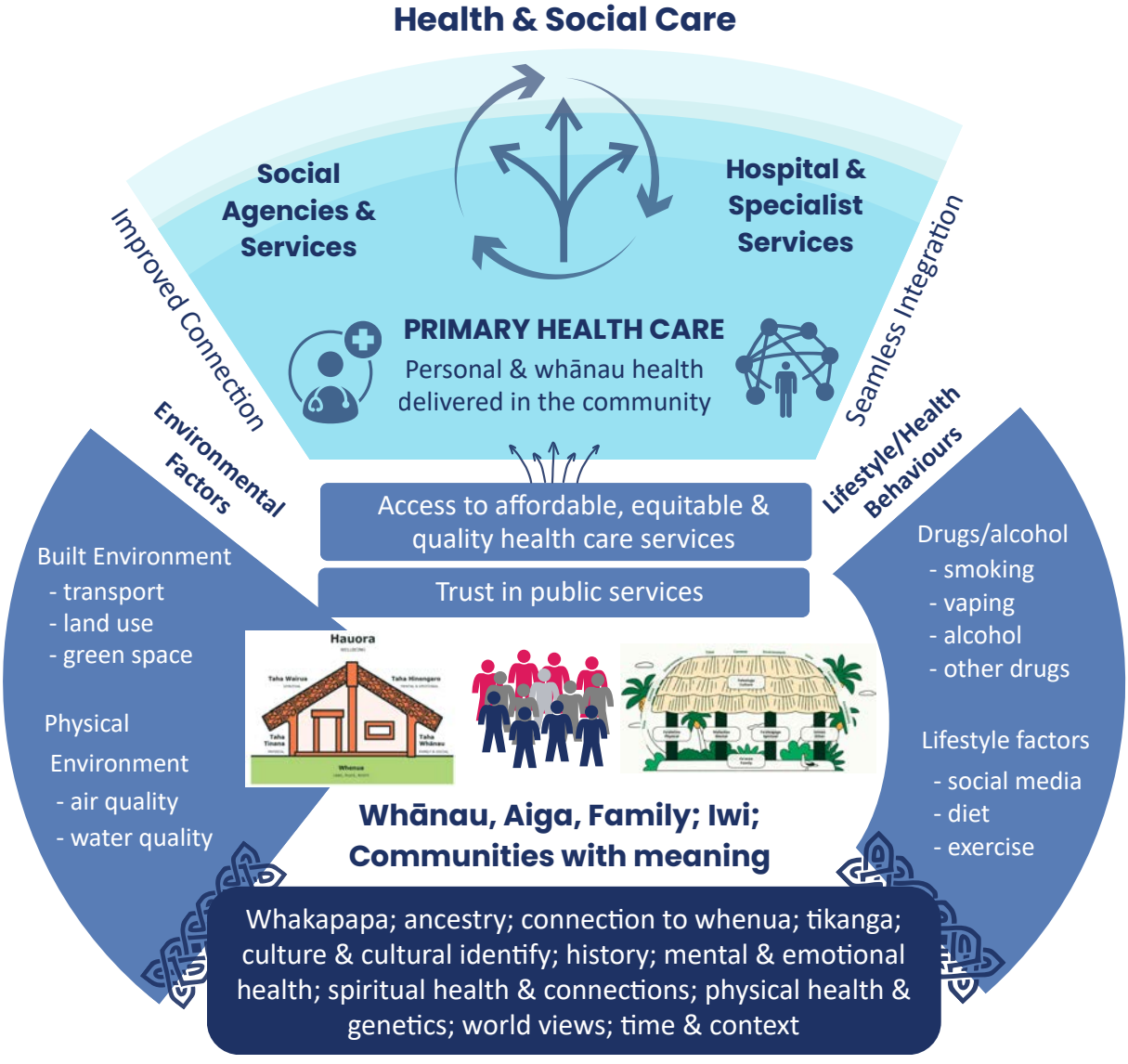
Health and wellbeing are shaped by the conditions in which people are born, grow, live their daily lives, work and age. These determinants are influenced by the distribution of power, resources, and policies at national and local levels. Factors such as income, housing, education, cultural identity and whānau support can either protect or harm health and wellbeing.



Pinnacle model adapted from: Health & Disability System Review (2020), Te Whare Tapa Whā (1984), Pan-Pacific Fonefale model (1984), Dahlgren & Whitehead (1998, 2021).

While environmental and personal factors also affect individual health, they interact with these broader social and economic influences. Personal factors include genetic traits, lifestyle behaviours and cultural and social connections. Strengthening individual health and addressing inequalities are crucial for improving overall wellbeing.

Access to primary healthcare plays a vital role in maintaining health, as health professionals provide preventive care, manage chronic conditions, and treat acute health issues. Ensuring equitable access to care helps reduce health disparities, improves long-term health outcomes, and reduces pressure on the wider healthcare system. Investing in primary care strengthens overall health and wellbeing across the population.

Socio-economic determinants have a significant impact on health and wellbeing

50%
Socio-economic determinants

of the factors that influence a person's health and wellbeing are linked to socio-economic determinants, such as income, education, employment, housing, and access to social support.

30%
Health behaviours

of a person's health and wellbeing is influenced by health behaviours, such as diet, physical activity, smoking, and alcohol use.

20%
Health care services

about 20% of a person's health and wellbeing is influenced by access to and quality of health care services, including primary care.

The contribution of primary care clinicians to population health and wellbeing outcomes

Clinicians are familiar with working with individuals to connect and understand their concerns, organise special tests and create a differential diagnosis list, organise treatment and monitor outcomes to check that the person improves. In a similar way, general practice teams play a vital role in advancing the health of the whole of their enrolled population, and the wider communities they serve.

Population health can be defined as the way practices approach understanding their whole population, explore issues, understand causes, and work with others to support actions that improve outcomes at a population level.

The differences between population health and public health

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Both approaches are concerned with improving the health of communities, but they focus on slightly different aspects in approach and scope. However, the two are now relatively intertwined in Aotearoa.

Regarding scope, public health focuses on safeguarding the health of the overall population, through Government policy, legislative and regulatory requirements. There is a focus on creating the conditions for health, including regulating health-enhancing behaviour (e.g. smoking cessation). Population health focuses on the health outcomes and distribution of outcomes between and within defined population groups.

Example: Childhood immunisation

Public health, front line general practice and population health approaches working together.

While immunisation programmes can be considered public health activities, the majority of childhood immunisations are delivered in primary care settings.

Maintaining high coverage rates requires multiple stakeholders. The table shows how the roles of public health, front line general practice (and extended general practice) and population health work together in the childhood immunisation space.

Public health role	General practice teams	Population health lens
Set policies for a safer environment Looks after relevant legislation, design of any national programmes, monitoring against government targets Media campaigns – including health promotion and protection (core public health activities). Education is a part of promotion Disease control & prevention (tracking and managing outbreaks)	Build and maintain relationships with patients/whānau over time Staff plan pre-calls and re-calls to reach the target population enrolled with their practice Clinicians answer queries and concerns direct from parents/caregivers (it's an ongoing conversation) Registered vaccinators administer the vaccines and record in the practice management system Report notifiable cases to public health colleagues	Looks at any differences in vaccination between ethnic groups, by age, rurality or across districts Looks at how to improve outcomes for populations Aims to address health inequities between groups Looks at determinants of health in addressing change Integrates demography and health data into service planning

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Lakes health and wellbeing summary

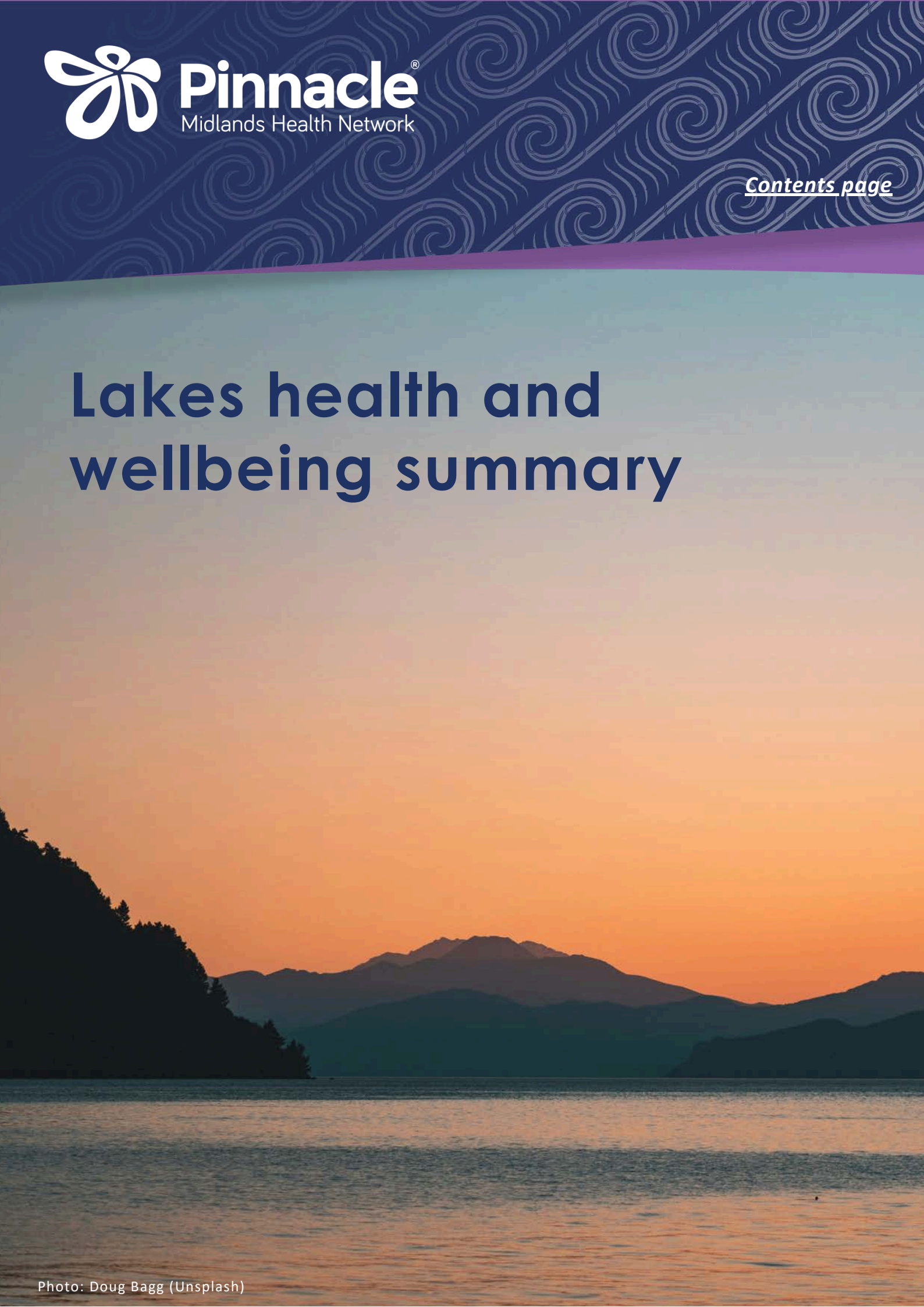

Photo: Doug Bagg (Unsplash)

Health & Wellbeing in the Lakes District

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The Pae Ora (Healthy Futures) Act 2022

The Act is legislation that reformed the country's health system. It replaced the New Zealand Public Health and Disability Act 2000 and established a more centralised healthcare system.

The Act aims to create a more cohesive, efficient, and equitable health system for all New Zealanders. Some key aspects of the Act include:

- Health system restructuring, including creating Te Whatu Ora (from District Health Boards) to manage hospital and specialist services at a national level.
- A greater emphasis on reducing health disparities, particularly for Māori, Pacific peoples, and rural communities.
- A renewed population health and wellbeing emphasis.

The rohe and this report

The Te Whatu Ora Lakes District is part of the Te Manawa Taki region, which is one of four regions established under the health reforms to improve coordination and delivery of health care. The Pinnacle Lakes area mainly covers the Lake Taupo and Turangi area.

Other organisations have released health and wellbeing information relating to the Te Manawa Taki, including Manatū Hauora, Te Whatu Ora, Te Aka Whai Ora, the Tuwharetoa and Te Taua Ora o Waiariki IMPBs and Hauora Taiwhenua.

Selected information is summarised here. This report will support primary care decision makers to design equitable health services that respond to evidence.

This report covers selected information on:

- The Pinnacle network
- Determinants of health and wellbeing
- Health status and wellbeing measures
- Population - now and in the future
- Community identified issues
- Pinnacle identified risks and issues
- Key health system risks and pressures
- Iwi Māori Partnership Board identified issues

Tūwharetoa and Te Taua Ora o Waiariki Iwi Māori Partnership Boards

These two IMPBs (of six in Te Manawa Taki) play a role in the shaping of health services. Working with Te Whatu Ora they represent local Māori perspectives on needs and aspirations in relation to hauora Māori outcomes. Five of six Pinnacle practices are in the Tūwharetoa IMPB area - data presented here are for all practices.

About the Lakes Network

Kia hauora te katoa, kia puawai te katoa
(Everyone healthy, everyone thriving)

The Pinnacle network oversees the healthcare of nearly half a million people. Our service provision reaches across the Te Whatu Ora districts of Tairāwhiti, Taranaki, Lakes and Waikato. Rural communities feature heavily in our geography. Responding to the needs of rural people, and clinicians, is central to our work.

Lakes Snapshot (March 2025)

	Lakes
Practices	6
Total patients	46,169
Māori patients	15,538
< 14 yrs	18.1%
65+ yrs	19.7%

Enrolled Patients

34% Māori

2% Pacific people

7% Asian

57% Other

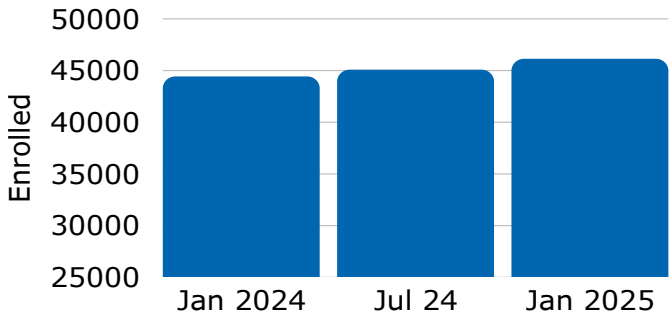
Practice Workforce

2,061 GP/patient ratio

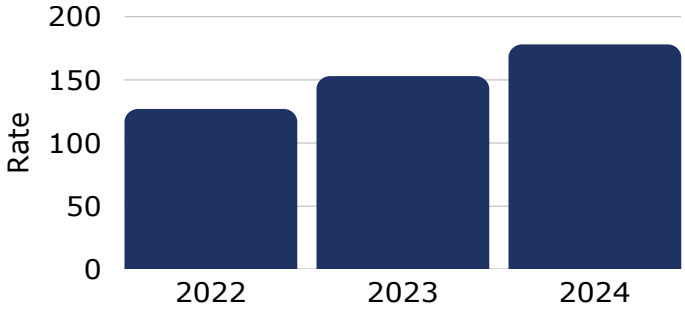
22.4 GP FTE

40.6 Nurse FTE

Pinnacle Lakes, enrolment growth



Non-urgent ED visits per 1,000 patients



Consults delivered in each calendar year

186,805 (2024)

156,473 (2023)

144,684 (2022)

 # Includes medical consults and other claim types

Patients with a Community Services Card **28%**

Patients resident in quintile 4 or 5 **46%**

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PINNACLE identified RISKS & ISSUES

01 Workforce sustainability

The GP and nurse workforce are ageing and experiencing record levels of burnout, and there are workforce shortages.

02 Increased health complexity

We have an ageing population - at the national level we're expected to have 1.2 million people aged over 65 by 2034. Rural, remote and urban issues differ.

03 Changing models of care

Recent changes in the landscape, including events such as COVID-19, have seen the implementation of digital health platforms across the sector.

04 Health inequities

Māori do not live as long as people of other ethnicities.

In general, Māori are less likely to see a GP or visit after-hours or have their needs met and prescriptions filled.

05 Funding models & strategy

Primary care capitation funding and ACC payment funding are insufficient. The models have not been updated for a long time. Costs are increasing and there needs to be a better funding model.

06 Fragmented IT systems

Providers have no (or limited) visibility of people's health records when they are not enrolled in their region. Regional platforms are fragmented.

07 Integrating siloed workforces

Primary care has limited integration with community & secondary care providers.

People

Now & future

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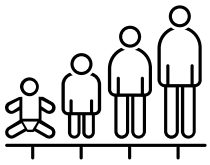
About **2.2%** of New Zealand's population live in the Te Whatu Ora Lakes District (2023)

Age and ethnicity are population characteristics that drive need, alongside continued health inequities.



The rate of growth differs across all districts in the rohe, being highest in the Waikato.

17%
are 65+ years now

24%
65+ years in 2043

Total responses >100% (Census 2023)

Ethnicity in Lakes

39% Māori

5% Pacific

68% Other

9% Asian

Population projections

2023 **118.7 thousand** → 2043 **127.5 thousand**

Population growth is made up of natural increase (births minus deaths), inter-ethnic mobility & migration - from overseas & from other parts of Aotearoa.

Māori in TWO Lakes District

46,200 live in the rohe now

45% are under 25 years

8% Māori are aged 65+

The Māori population has a young age structure

Greater proportions of the Māori populations are younger (as are Asian and Pacific people).

In comparison, a larger proportion of the European & Other population are aged 65 years or older.

Projected population change at ages 65+ years

8% Māori in 2023 increasing to **14%** in 2043

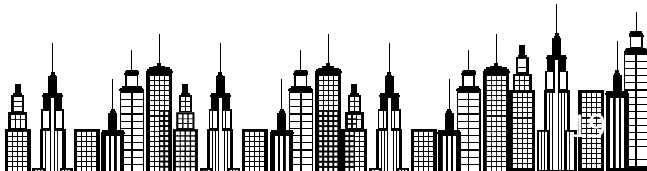
24% non-Māori in 2023 increasing to **33%** in 2043

Where people live

Urban compared to Rural

68% Māori **32%**

56% non-Māori **44%**



Community Identified Priorities

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He Ara Whakapikiora

From the Tūwharetoa IMPB Hauora Māori Priorities Summary Report (2024)

Oranga Hinengaro

All whānau can access kaupapa that support mental health and wellbeing

Oranga Whānau

Whānau determine their own oranga outcomes

Hono Ki Te Hapori

Whānau are enabled to access primary, specialist and emergency care when they need it

Pataka Ora

Sustainable, affordable, oranga solutions that improve whānau standards of living

Tu-Whare-Oranga

Affordable, warm and secure housing is a foundation of whānau wellbeing

Whai Mana

Whānau have access to culturally responsive practitioners

Tūwharetoa IMPB: Identified Priorities

Primary & Community Care

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Primary care

Develop a model of primary care that works for whānau supporting enrolment and access. Reduce non-urgent ED visits by enhancing access to and engagement with primary care services (conduct analysis to determine extent of the issue and remediation strategies).

Oral / dental health

Enable enrolment and treatment rates in community oral health services for tamariki Māori to reduce the incidence of dental disease. Promote awareness at early ages to drink water and avoid sugary drinks.

Primary mental health and addictions

Ensure there are comprehensive suicide prevention and mental wellbeing promotional initiatives (including Mana Ake) in all schools including Kura Kaupapa in the rohe, from the time of first school enrolment through to end of secondary school.

NASC / home care

Develop more aged residential care facilities and home support services, particularly in areas with high Māori populations like Tūrangi. Review the NASC model and determine if a better model exists that will better serve whānau.

Maternal and child health

Strengthen focus on cultural practices around childbirth. Also, increase early registration with Lead Maternity Carers (LMCs) and attendance at antenatal classes, to support reduction in high rates of low birthweight and premature births. Support breastfeeding initiatives to improve rates. Expand the availability of Māori midwives and improve birthing services within the region.

For immunisation: Ensure trained community vaccinators are resourced to contribute to increasing rates.

Long term conditions

There is limited access to local cancer treatment services and a requirement to travel. Develop innovative and cost effective solutions for whānau to access the right treatment at the right time (e.g. a local cottage with chairs for dialysis which could be shared with chemotherapy on other days). Develop a dashboard that monitors optimisation of medicines e.g. ensure real-time data on all cardio-metabolic patients and whether they are receiving the appropriate medication; or that all gout patients are receiving urate-lowering therapy.

Determinants of Health & Wellbeing

The vision of pae ora is where everyone lives a life of wellness, and all communities actively foster health and wellbeing. Success is dependent on collective effort across sectors, including central and local government and non-government organisations.

Housing in Lakes rohe

HOUSEHOLD CROWDING

Requiring at least 1+ bedroom

Māori **25.0%**

non-Māori **9.3%**

HOUSEHOLD HEATING

Living in households where there is no source of heating

Māori **1.6%**

non-Māori **1.3%**

DAMP HOUSING

44.8% of Māori lived in a home that was sometimes or always damp; compared to 25.7% of non-Māori

MOULD IS PRESENT

37.3% of Māori lived in a house that sometimes or always had mould; compared to 20.5% of non-Māori

HOME OWNERSHIP

29.2% of Māori owned or partly owned their own home, compared 42.2% of non-Māori

2018 Census age-standardised

EAT healthy

29% Taranaki

35% Tairawhiti, Lakes, Waikato

Adults eating 3+ serves of fruit & vegetables each day

Towards Equity

Differences in outcomes persist, particularly for Māori and Pasifika.

Addressing the determinants of health requires planning, investment and collaboration between many agencies.

Smoking and vaping in Te Manawa Taki

NZ Health Survey 23/24

8.8% are current smokers

Adults that live in high deprivation areas are more likely to smoke

Ever tried vaping **29.0%**

Daily vaper only **11.1%**

Quitting has profound benefits. After a year, the risk of heart attack drops to half that of a smoker. Over time, risks for conditions like heart disease and cancers decrease, and life expectancy improves dramatically.

Alcohol Use

22.5% of adults

Engaged in heavy episodic drinking at least monthly (past-year drinkers)

1 in 10 adults drink heavily at least weekly

Most people (more than 4 in 5) do not know that drinking alcohol causes cancer (Royal Society Te Aparanga)

NZ Health Survey 23/24

Lakes District

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Health Status & Wellbeing Measures

77.7 years — **71.9 years**

Māori life expectancy

83.8 years — **80.7 years**

non-Māori life expectancy

Te Manawa Taki

10.5%
Est. adults **96,000**

Report high or very high
Psychological distress
in the 4 weeks before the survey

3.6%
Est. adults **32,000**

Loneliness
Said they were lonely most or all of the time (in the last 4 weeks)

26.7%
Est. adults **247,000**

People were of a
Healthy weight
Measured as having a BMI of 18.5-24.9)

36.0%
Est. adults **334,000**

Of adults had a measured BMI of 30+
Obesity

10.7%
Est. adults **97,000**

Unmet need for GP - cost
Had a medical problem but did not visit a GP because of cost

22.5%
Est. adults **203,000**

Unmet need for GP - wait time
Had a medical problem but did not visit - the wait time was too long

Cardiovascular Health ▲

2.2% Stroke prevalence (estimated 20,000 adults)

4.4% Prevalence of Ischaemic heart disease (est. 40,000 adults)

18.7% Medicated for high blood pressure (est. 170,000 adults)

Physical Activity (adults 15+ yrs) ▲

50.1% are **physically active** (at least 30 minutes of walking, five days per week)

35.2% are considered to have **insufficient physical activity**

▲ NZ Health Survey 2023/24, adults (15+)

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Key Health System Risks & Pressures

Workforce shortages

01 **Medical, nursing, allied health & support roles**

Training, recruitment and retention are key issues across the health system - tertiary, secondary and primary care.

Health equity

02 **Culturally responsive & equitable care**

There is strong evidence of inequity (historic and continuing) across the health system. Culturally responsive care has been identified as critical to enable change.

Access to health care

03 **Unmet need, the cost of care, afterhours care**

Evidence shows there are growing issues with access to health care - primary care and secondary care. Access to afterhours care is also a high priority nationally.

Rural health

04 **There are health inequalities for rural residents**

Issues include the workforce crisis, equitable access & outcomes for rural residents, rural funding, services for rural Māori, and an older population (compared to urban areas)

Funding models

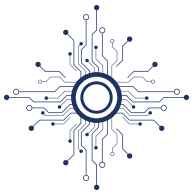
05 **Sustainable & equitable funding models are needed**

Based around inequitable resource allocation, underfunding, prioritising secondary over primary care, workforce impacts and equity gaps.

Health complexity

06 **Health complexity is increasing**

Growing medical complexity across communities highlights the urgent need for funding and workforce that aligns with the realities of patient care to ensure the health system can meet evolving demands



Technology

07 **IT systems & infrastructure are not fit for purpose**

Across both secondary and primary care there are longstanding issues with outdated and fragmented IT systems and infrastructure

Secondary backlog

08 **Delays in accessing secondary care are growing**

There are a number of reasons, including; increased demand, resource constraints, COVID-19 impacts; workforce issues; equity concerns and reform pressures

Pinnacle Midlands Health Network

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Population change and health service use

Photo: Evelyn Dutra (Canva)

Summary: Population change

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Population growth

The population in the area served by the Pinnacle network is growing and changing, bringing implications for health service planning in the future.

Structural & numerical change

Numerical population growth masks underlying ethnic differences in age structural change – these have critical implications for health care delivery that meets life-cycle need.

Change is not linear over time

Population change is not linear. It is influenced by a complex interplay of factors such as migration, birth and death rates, and policy changes, leading to periods of growth, stagnation, or decline across the region.

Rural health disparities remain

Established rural health disparities will persist into the future. Planning for the challenges such as limited access to healthcare services and geographic isolation are key to service planning .

Core services and equity matter

No matter the projected population changes, core primary care services must continue to be delivered to the entire population. This also means taking into account what equity for Māori, Pacific and rural residents mean for the mix and level of service provision.

Longer term horizon uncertainty

Population growth comes from a mix of natural increase, immigration and inter-regional migration. These are impacted by things like immigration policy. Best practice is to use 5-10 year projections for operational planning, and longer-term ones for strategic planning.

Ageing is complex and has more impacts than you might think

At a simplistic level the impacts of population ageing include a larger pool of middle aged and older people, consuming a rising proportion of the services provided across the health sector. The situation, however, is more complex and multifaceted. Practical implications may be a mix of doing more of some of what we are currently doing or doing new things in new ways.

Summary: Health service use

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The link with population change

A growing and changing population has implications for service use. Over time chronic conditions are increasing (and demand for care) at the same time that investment in the best start to life, and for optimal youth health, are a necessity.

+ 8,820 medical consults in 2043

The Lakes network will need to provide an additional 8,820 consults (if 2023 rates remain). However, growth and decline in both numbers of people enrolled and the number of medical consults are not uniformly spread by ethnicity and age.

Managing chronic conditions is critical

More older people needing medical care is the key driver for increased consultations in 2043. Given increasing numbers with chronic conditions, the ability of people to better manage their health and wellbeing will be critical.

Primary care is changing in response

Additional clinical and non-clinical roles are becoming part of general practice teams, integrated into the general practice environment. These roles may be either employed by an individual practice (or across practices) or the PHO.

Rural health care disparities

Rural health disparities are likely to persist into the future due to ongoing challenges such as limited access to healthcare services, workforce shortages, and geographic isolation.

The challenge of maintaining all life cycle health services

The full life cycle range of services must continue to be delivered to the entire population, also considering what equity for Māori, Pacific and other populations mean for the mix of service provision and how and where it is delivered.

Interacting issues make for a complex planning environment

There are many contextual issues to be mindful of, including chronic conditions prevalence, workforce capacity, longstanding access and inequalities and ongoing limited financial resources. These interacting issues make for a complex planning environment.

The 2023 estimated resident population (ERP) in Lakes

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Ethnicity and age summary

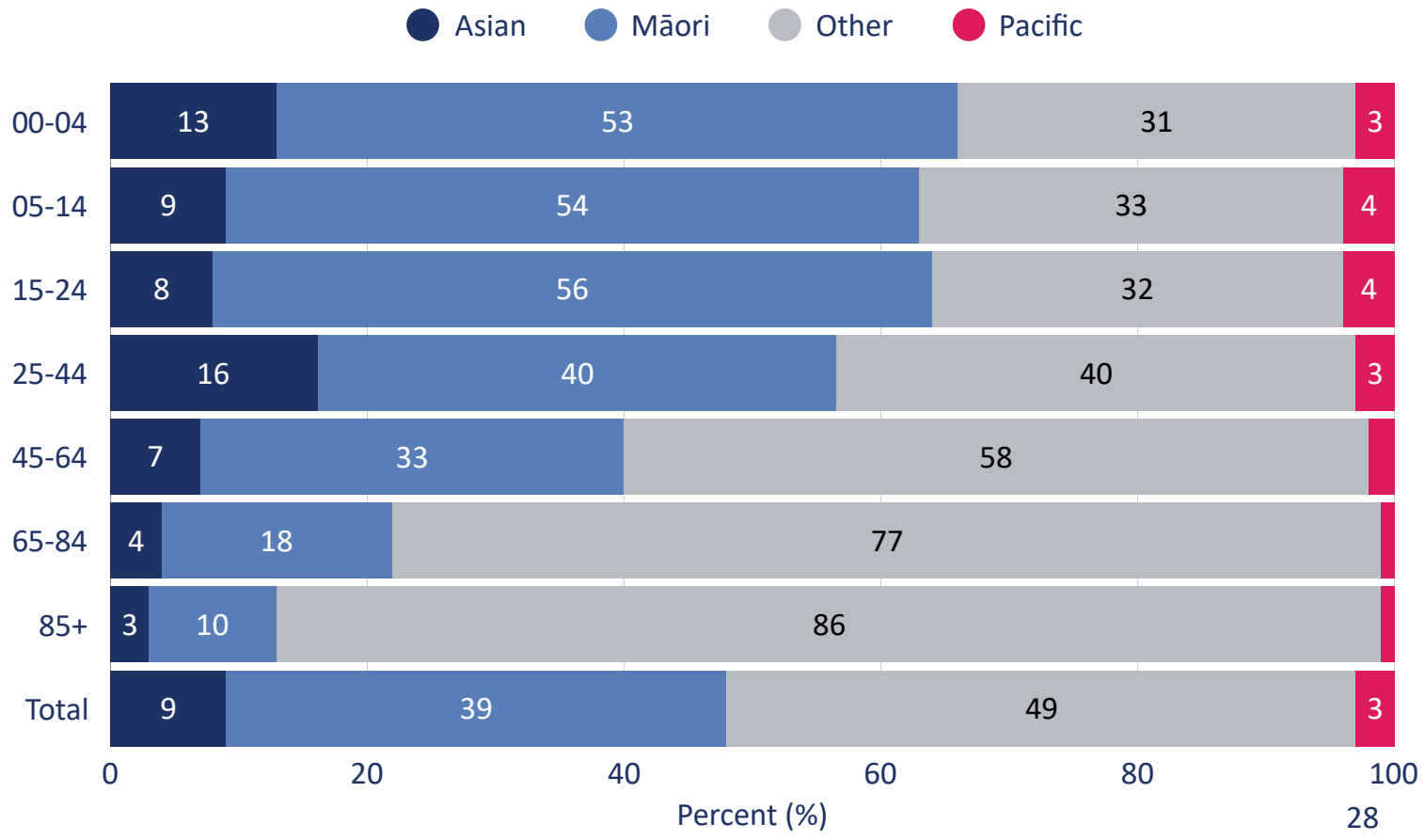
Table 1: ERP, by age and ethnicity, 2023

	Asian	Māori	Other	Pacific	Total
00-04	1,000	4,070	2,330	230	7,630
05-14	1,430	8,980	5,470	650	16,530
15-24	1,090	7,700	4,420	560	13,770
25-44	4,860	12,010	12,040	930	29,840
45-64	2,070	9,750	17,390	680	29,890
65-84	690	3,490	14,630	240	19,050
85+	60	200	1,700	10	1,970
Total	11,200	46,200	57,980	3,300	118,680

Key Points

- Over 118,000 people were resident in the Lakes district in 2023 (using Health NZ boundaries).
- Overall, 39% of people were Māori, with 3% and 9% for Pacific people and Asian respectively.
- Figure 1 shows the difference in the age structure by ethnicity, with a significant proportion of young people (<25 years) being Māori.
- The older age structure of the Other population (mostly Pākehā) is also very clear.

Figure 1: ERP proportion by ethnicity and age group, 2023



Key changes: Numbers and proportion

Figure 2: 2023 (left) and 2043 Estimated resident population

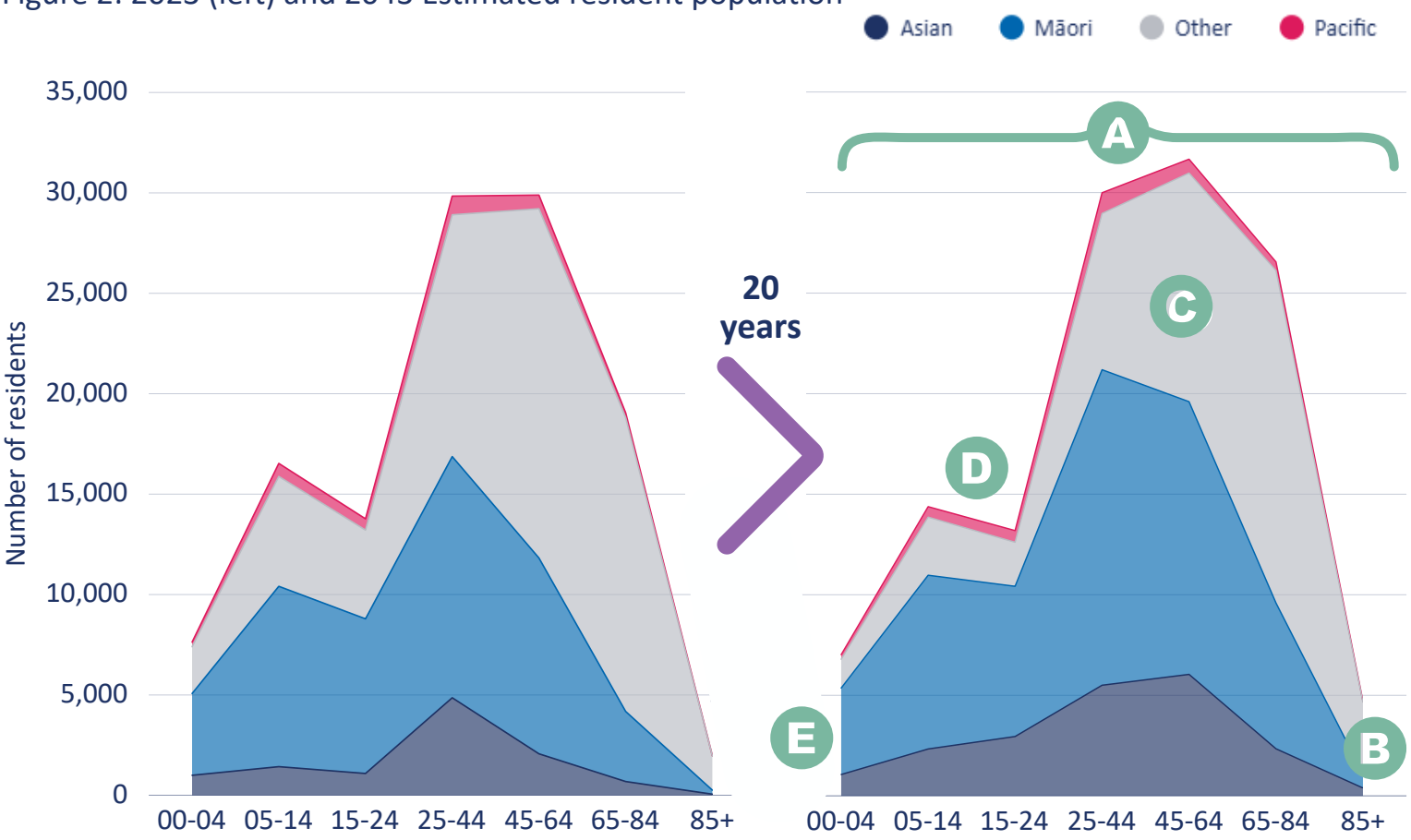
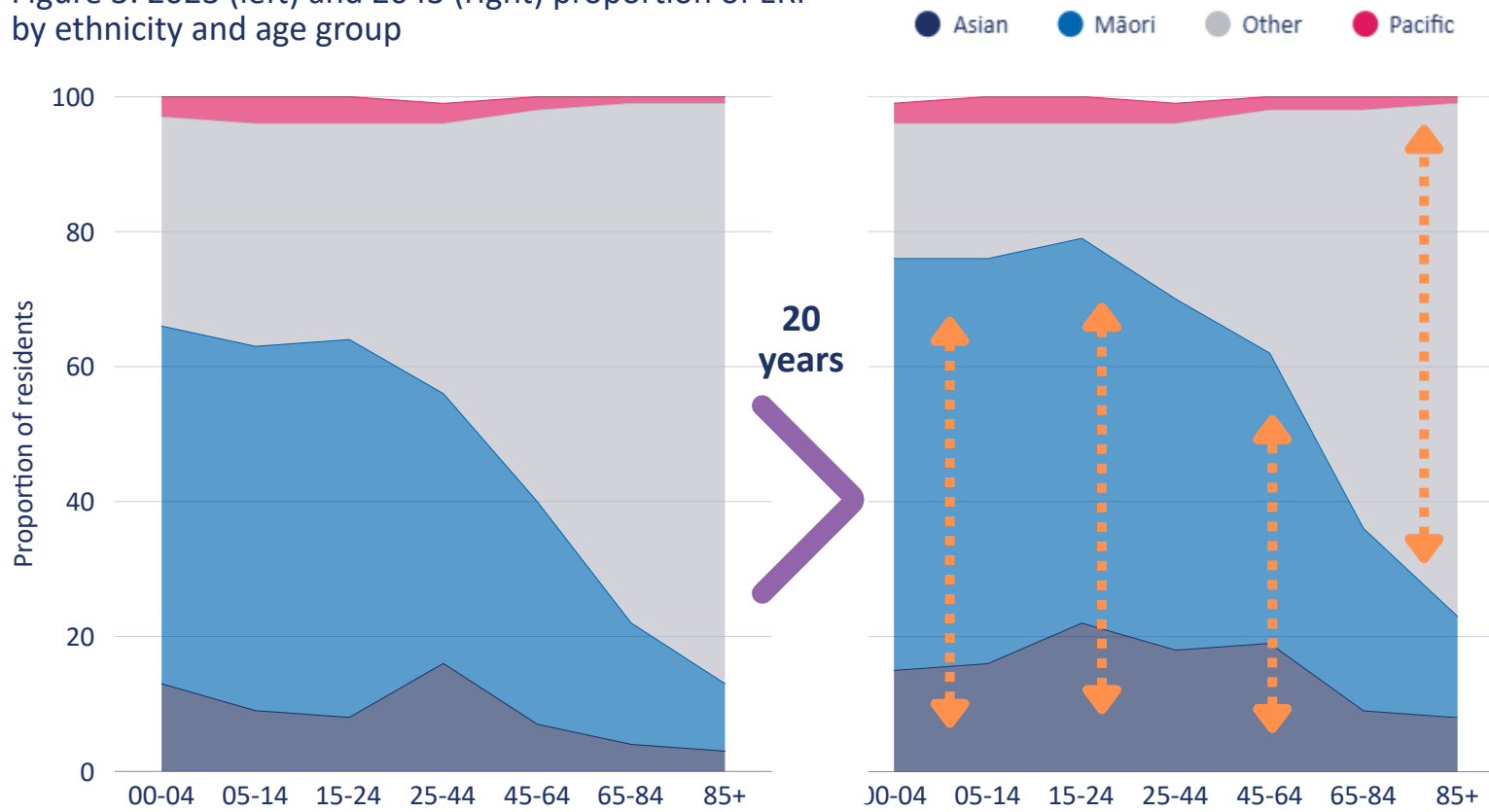


Figure 3: 2023 (left) and 2043 (right) proportion of ERP by ethnicity and age group



Five Summary points

[points A-E on Figure 2]

A **Overall change:** Numerical and structural ageing differs between ethnic groups over the 20-year time period. You can see the shift to the right, showing growing numbers of people in the mid and older age groups.

B **Older people:** Numerical increase for both age groups. The number of 85+ (the 'oldest-old') of Other ethnicity will more than double (compared to now), with increasing numbers of older Māori and Asian people.

C **Middle aged people (45-64 years):** Numerical increase. The proportion of Other people in this age group falls and the proportion of Māori and Asian increases.

D **Young people (05-14 and 15-24 years):** Numerically a decrease for both age groups, but proportion of Māori and Asian increase.

E **The first years of life:** Numerically fewer young children overall, however a higher proportion will be Māori and Asian, and to a lesser extent Pacific (compared to 2023).

Photo: Heather Lang

Ethnicity and age summary

To look at service use averages we included only those people who had been enrolled in the network for all four quarters.

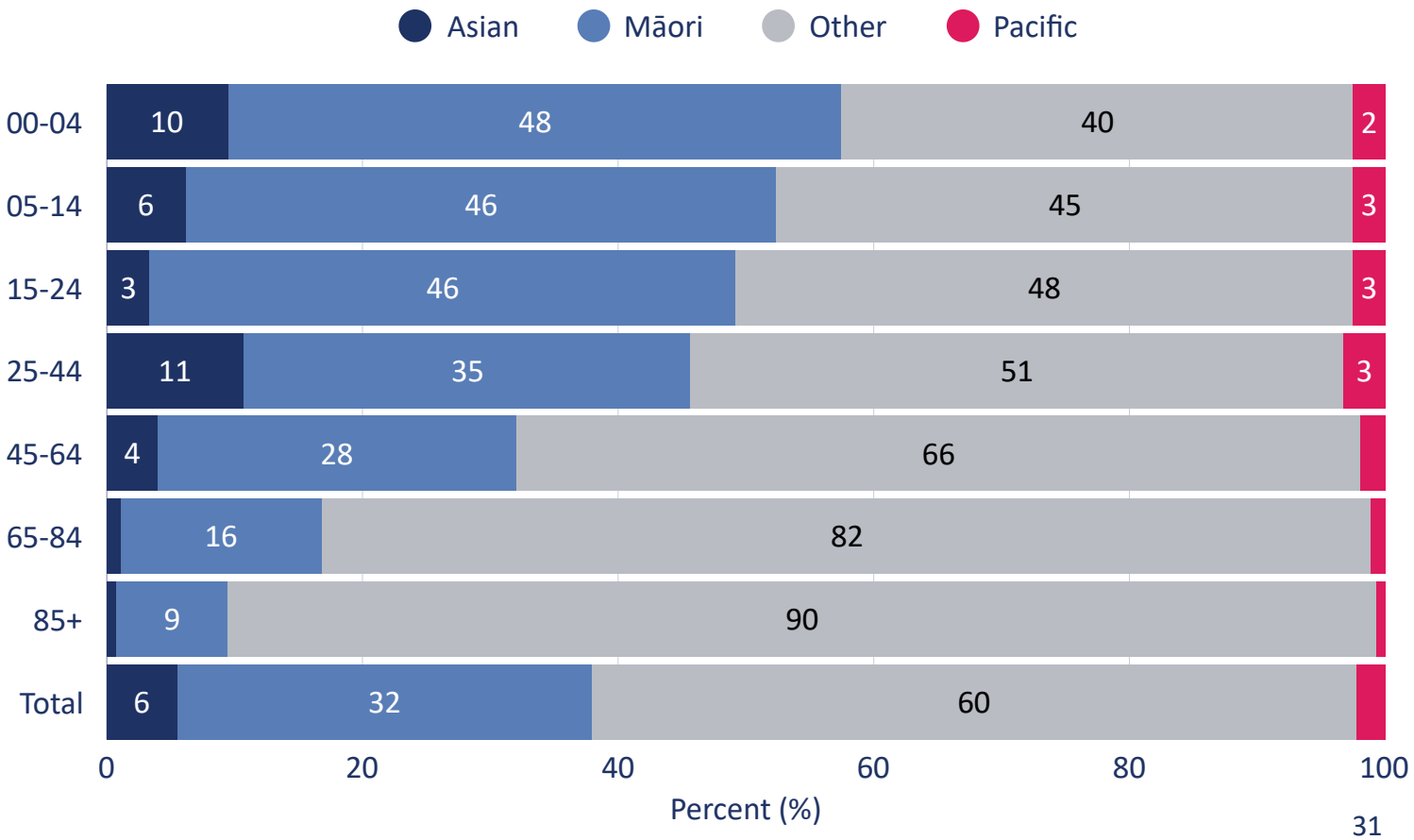
Table 2: Enrolled people, by ethnicity and age

	Asian	Māori	Other	Pacific	Total
00-04	212	1,066	890	55	2,223
05-14	351	2,617	2,555	143	5,666
15-24	152	2,068	2,179	113	4,512
25-44	1,094	3,550	5,191	329	10,164
45-64	436	3,068	7,215	205	10,924
65-84	90	1,255	6,530	85	7,960
85+	6	69	712	5	792
Total	2,341	13,693	25,272	935	42,241

Key Points

- 42,241 people were enrolled for the entire 2023/24 year.
- 6% were of Asian ethnicity, 32% Māori, 2% Pacific People and 60% Other (majority Pākehā).
- Like the resident population, the Pinnacle enrolled population shows very different age structures by ethnicity (Fig. 4).
- The network population is never static, with people joining and leaving the network - such as through births, deaths, immigration and internal migration (or changing PHOs).

Figure 4: Proportion by ethnicity and age group

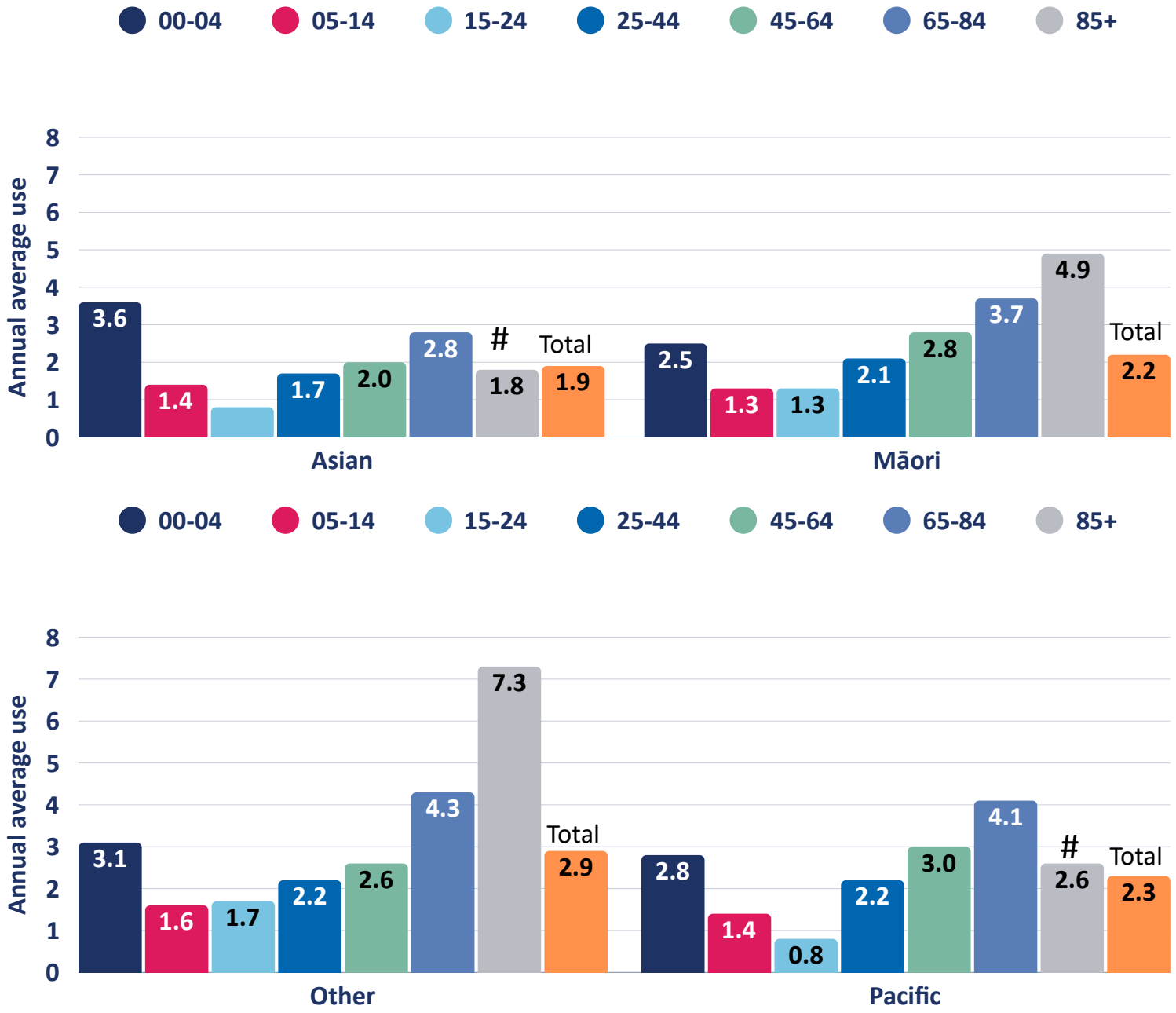


All network practices

Key Points

- 110,870 medical consults were recorded for the 42,241 people enrolled in all four quarters of this year.
- The annual average use of medical consult services differs by age, with higher service use (in general) for those aged 0-4 years and 85+ years. This was the case for Māori and Others, but less so for Asian and Pacific people.
- There are small numbers of Asian and Pacific people in the 85+ age group (# on graph).

Figure 5: Annual average use of medical consults, by ethnicity and age, 2023/24



Data note: These are general medical consults. Most health surveys, including the NZ Health Survey and the General Practice Patient Experience Survey, focus on general and preventative healthcare rather than accident-related visits.

Medical consults in general practice

Capitation payments

General practices receive capitation payments (annual, per-patient subsidies) through PHOs to support the delivery of primary care services. These payments are primarily determined by the age and sex of enrolled patients.

This capitation model has faced criticism for not accounting for factors like ethnicity, socioeconomic deprivation, and comorbidities. A 2022 review by the Sapere Group found that high-need practices would require funding increases between 34% and 231% to meet patient needs adequately. The report highlighted that the current model systematically underfunds services for Māori and Pacific populations, embedding historical inequities.

Capitation payment "unders and overs"

"Unders and overs" refer to the financial risks and benefits practices face when the actual cost of providing care differs from the funding received for an enrolled patient.

Unders (underfunding)

- High-need patients may cost more than the capitation provides. For example, patients with complex chronic conditions, mental health needs, or those facing social barriers may require more time and resources than the funding allocated for their age and sex category.
- Ethnicity, deprivation, and comorbidity are not fully factored in. While there are some adjustments for high-needs populations (e.g. CSC holders, Māori, Pacific peoples), many argue these are not sufficient to cover the true cost of care.
- Unders lead to pressure on services, longer wait times, rushed consults, or reduced service scope, contributing to equity gaps and practitioner burnout.

Overs (overfunding)

- Low-need patients may cost less than the capitation payment. For example, a healthy adult who rarely visits their GP still generates a full capitation payment. In such cases, the practice retains the difference between funding and cost.
- This "cross-subsidises" care for higher-need patients, which is part of the intent of capitation. But if too many patients are high-need and not adequately funded, the overs from low-need patients won't be enough to balance the books.

Capitation's success depends on the mix of patients: practices with a balanced or low-need population may do well; those with high-need or underserved groups face sustainability challenges.

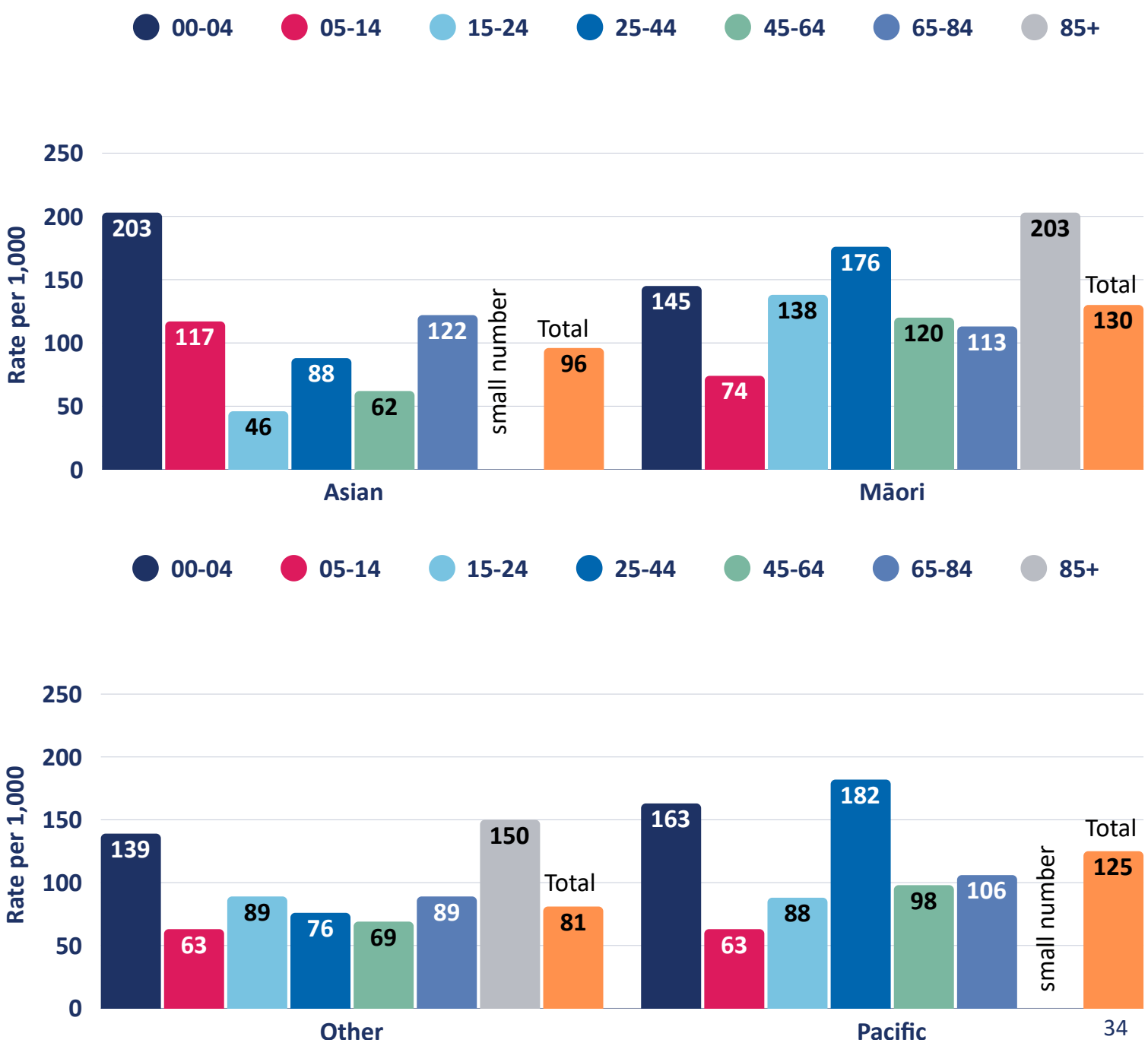
The "unders and overs" in capitation highlight the tension between population-based funding and the reality of individual and community health needs.

People enrolled for all of 2023/24

Key Points

- Overall Pacific people and Māori utilised a similar level of ED visits per 1,000 enrolled people (125 and 130 per thousand respectively).
- In general, ED use was higher for the youngest and oldest people.
- This result is for the 2023/24 year only, and results may move around year to year due to a number of factors. This may include appointment availability in general practice, the cost of care and when the acute event occurs (i.e. on the weekend).

Figure 6: ED visits coded as triage 4 and 5 non-ACC, rate per 1,000 enrolled people



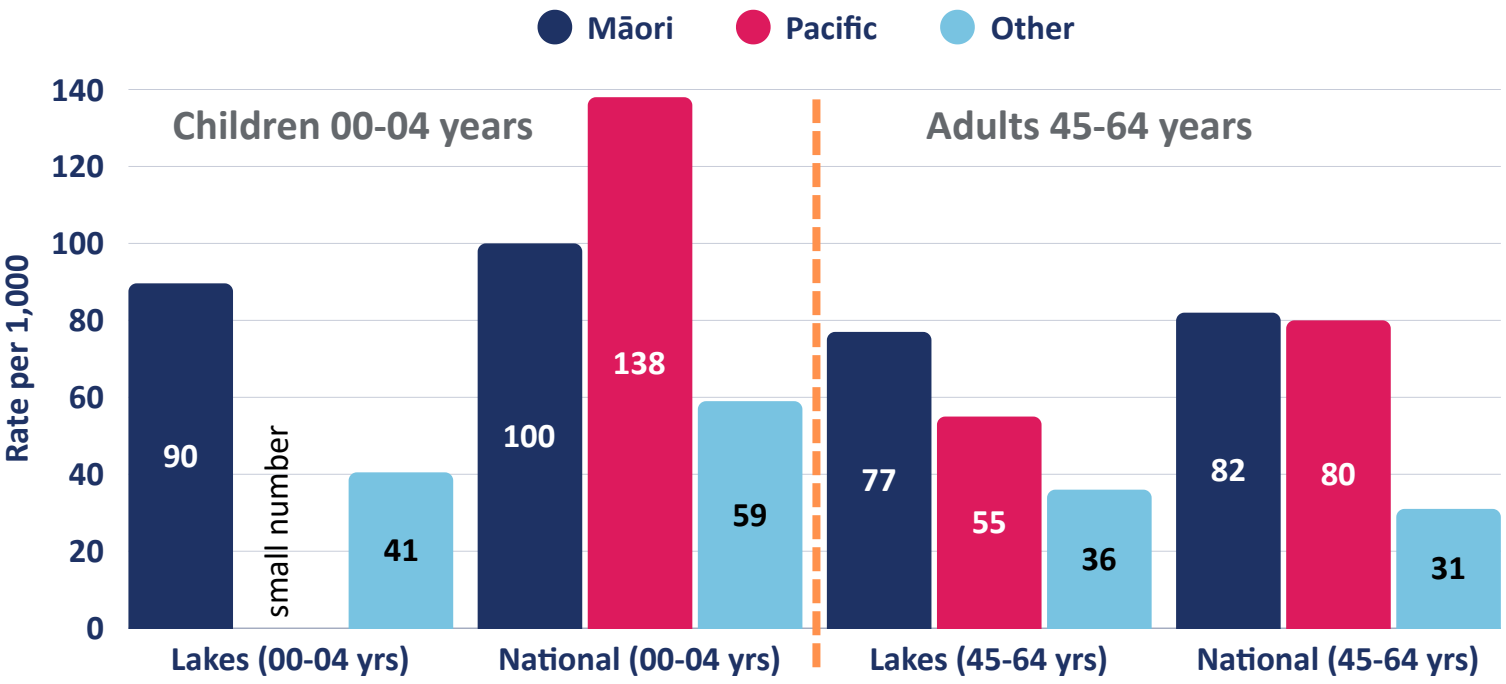
Ambulatory sensitive hospitalisation in 2023/24

Contents page

Ambulatory sensitive hospitalisations (ASH) are hospital admissions for conditions that *could potentially* be managed or prevented through primary care interventions. This is considered a partial measure of the effectiveness of the primary and secondary healthcare system interface, it is often used as a proxy for access to and the quality of primary care.

Children aged 0-4 years & adults aged 45-64 years

Figure 7: Standardised ASH rate per 1,000 pop by ethnicity, 12 months to June 2024



Children

- Standardised rates for young children in Lakes were lower than national level results (in that year).
- The top eight ASH conditions for those aged 00-04 years were:

1. Asthma
2. Upper and ENT respiratory infections
3. Dental conditions
4. Gastroenteritis / dehydration
5. Lower respiratory infections
6. Cellulitis
7. Pneumonia
8. Constipation

Adults

- Standardised rates for adults were lower or similar to the national level results (in that year).
- The top eight ASH conditions for those aged 45-64 years were:

1. Angina and chest pain
2. Myocardial infarction
3. Cellulitis
4. Pneumonia
5. COPD
6. Gastroenteritis / dehydration
7. Kidney / urinary infection
8. Congestive heart failure

Data note: ASH data presented here are from Te Whatu Ora and available on their website. The rate is calculated by dividing the number of ASH events by the number of people in the PHO enrolled population. This is calculated quarterly with a rolling 12-month data period. The rates presented are age-standardised at the PHO level to the Statistics NZ standard population.

Future population and medical service use

We have taken the projected 2023-2043 percentage change in the Lakes resident population (by ethnicity and age) and applied it to the 2023 enrolled population. Across Lakes from 2023 to 2043 there are a projected 3,825 more people enrolled. Figure 10 applies the population change to the pattern of medical consults in 2023 by age and ethnicity.

Figure 9: Projected numerical difference in 2043 (from 2023 base)

Points A-E explained over page

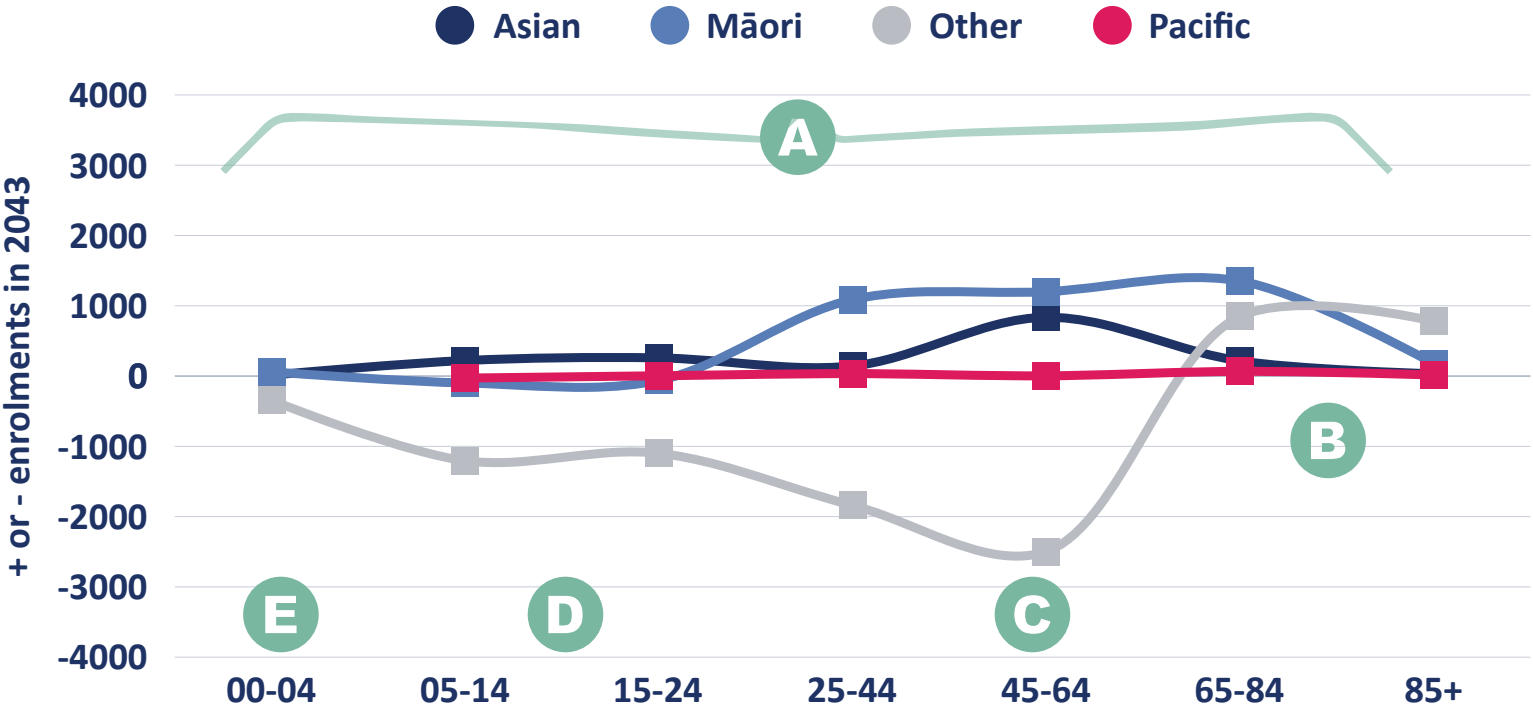
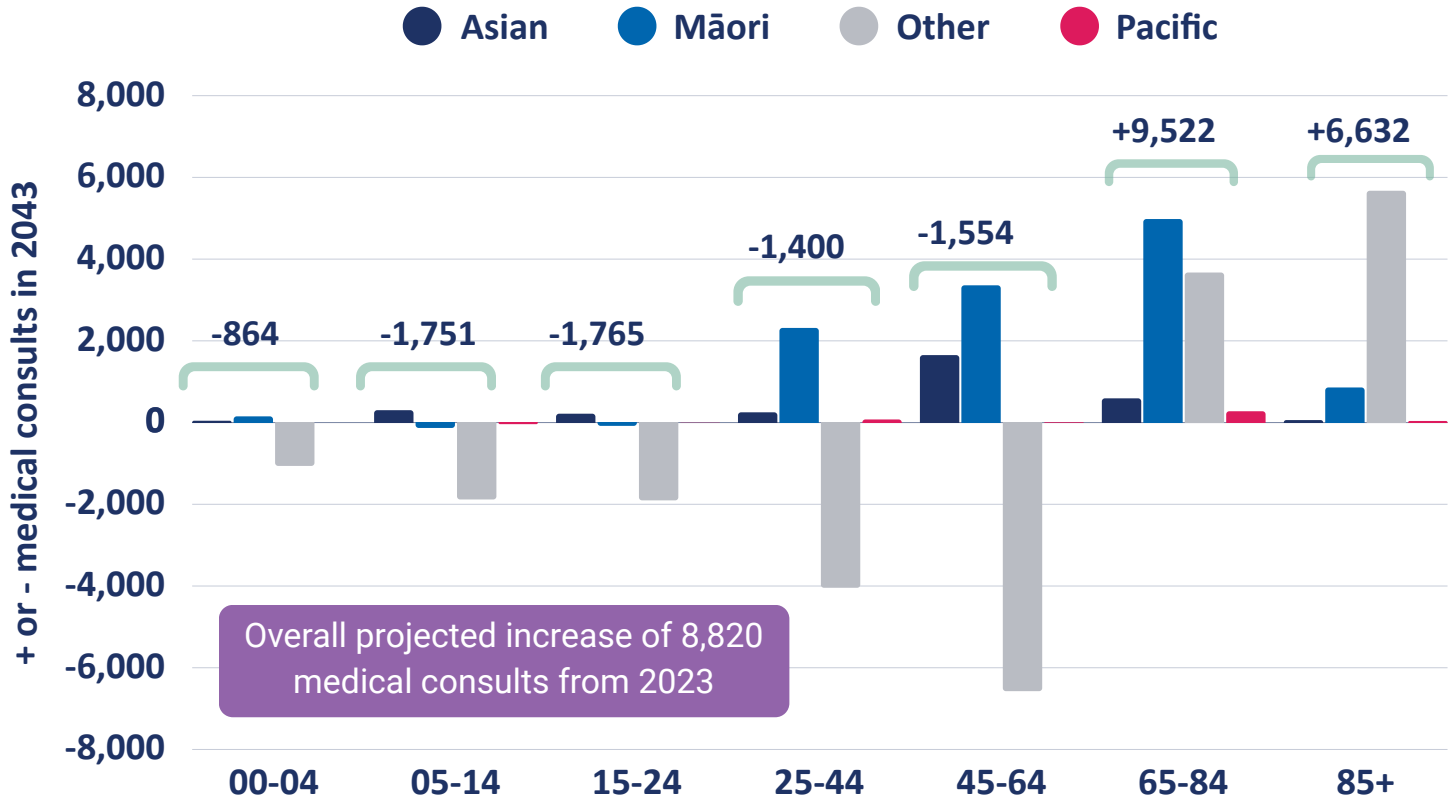


Figure 10: Projected difference in medical consults in 2043 (from 2023 base)



Summary points for Pinnacle

[Points A-E on Figure 9 & corresponding Figure 10]

The enrolled population in Lakes differs from the 2023 ERP (compare Figure 1 and Figure 4). The Lakes network has lower proportions overall of Māori and Asian people, and a higher proportion of Other people (for Pacific People it's similar).

In 2043, if medical consults are accessed the same as they were in 2023, there are some significant changes to be preparing for. Five summary points are chosen here (refer to figures on the previous page).

A **Numerical increase overall, but a complex picture underneath**

Overall, we are projecting the Lakes network may need to provide an additional 8,000 medical consults in 2043, should the scenario of Pinnacle's enrolled population growing at the medium series rate, and service use by ethnicity and age holding true over time. However, as shown, growth and decline in both numbers of people enrolled and the number of medical consults are not uniformly spread.

B **More older people needing medical care - the key driver for increased consultations**

65-84 years: There are considerable increases in medical consults projected for Māori and Other people in 2043. These people are currently aged 45-64 years. The youngest baby boomers will be in this age group in 2043 (at around 79 years of age, so born in 1964).

85+ years: This 'older old' age group are historically the highest users of health services. In 2043 there could be an additional 6,632 medical consults across all ethnic groups. The main drivers of this are the ageing Other (predominately Pākehā) population moving through the life cycle. The oldest baby boomers, if still alive, will now be in their late 90's.

C **Middle aged people (45-64 years) - projected decline for Others but growth elsewhere**

Projected increases for Māori, less so for Asian and Pacific people. Projected fewer Others aged 45-64 years. The projected decline in numerical consults for Other people is partially offset by projected increases for all other ethnic groups. These people are mostly in the 25-44 year group now.

D **Young people (5-14 years and 15-24 years)**

Projected to be more Māori and Asian people enrolled aged between 5-24 years. This will be offset by fewer Others. It is important to remember that these projections are for medical consults only - there are key lifecycle health care services alongside this that still need to be delivered.

E **The very first years of life (0-4 years)**

These children will be born around 2039-2043. The overall projected decline is driven by fewer Other children. There are however, within this smaller increases for Asian and Māori. Immunisation related work is not included in this category.

Rural residents enrolled

To look at service use averages we included only people who had been enrolled for all four quarters. People without a coded address were excluded (1.5% of Pinnacle network total).

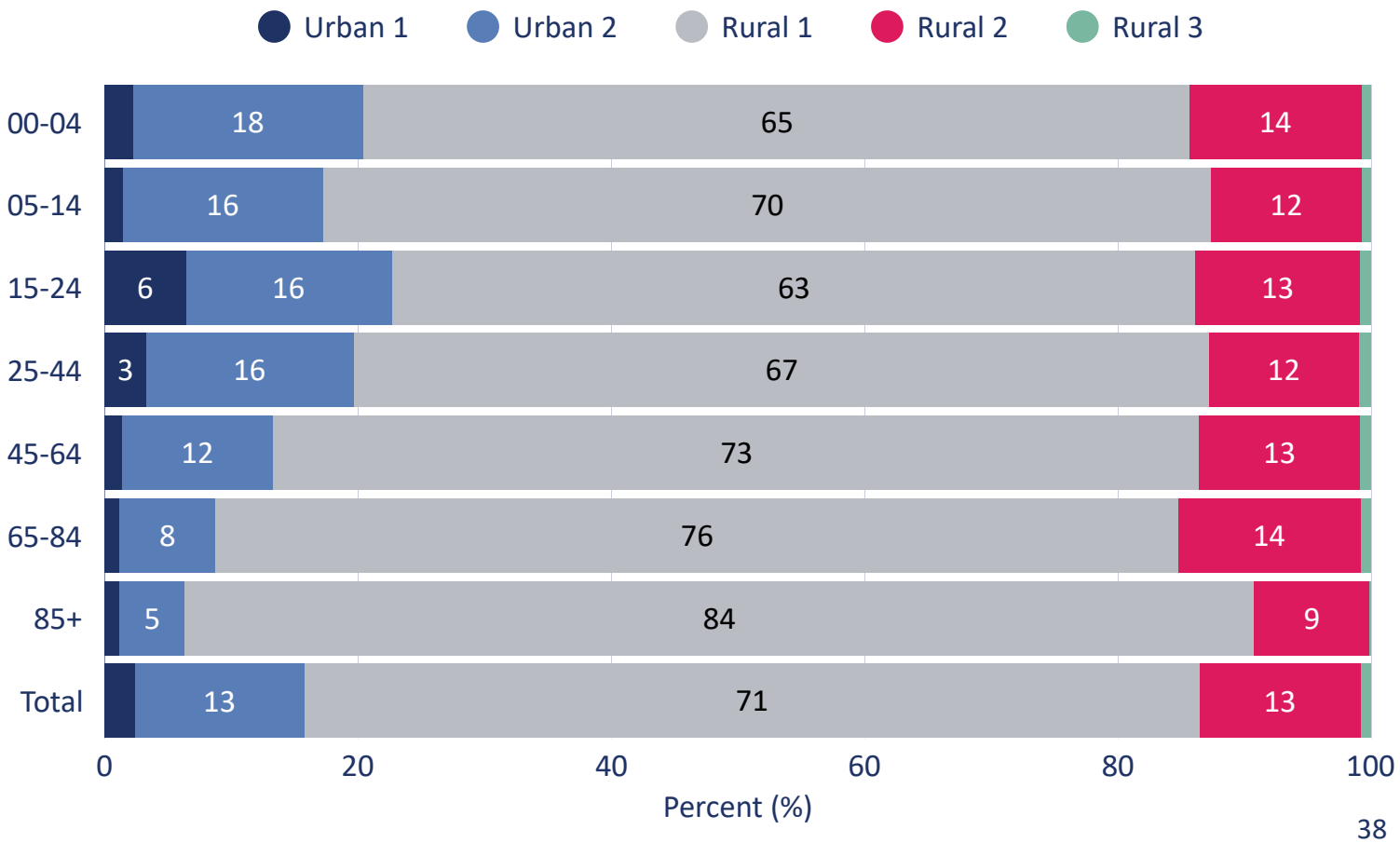
Table 3: Enrolled people, by age and GCH rurality

	Urban 1	Urban 2	Rural 1	Rural 2	Rural 3
00-04	50	402	1,440	300	16
05-14	82	885	3,916	666	39
15-24	285	719	2,804	576	38
25-44	329	1,646	6,757	1,187	93
45-64	151	1,280	7,840	1,365	92
65-84	91	603	6,007	1,137	64
85+	9	41	665	72	1
Total	997	5,576	29,429	5,307	343

Key Points

- Overall, 84% of people enrolled in Pinnacle Lakes practices lived rurally.
- Most rural residents lived in R1 areas, using the geographical classification of health (83.9% of rural).
- Few people lived in the most remote areas; 1.0% of rural residents, 0.8% of all enrolled.
- The proportion of people by age group living in each rural or urban category are shown in Figure 11.

Figure 11: Proportion by age group and rurality



Average service use - by residence category

The previous section established the rural or urban residence of enrolled people. Here we look at average medical consult service use in the 2023/24 year by residence category.

Figure 12: Annual average use of medical consults, by residence and age

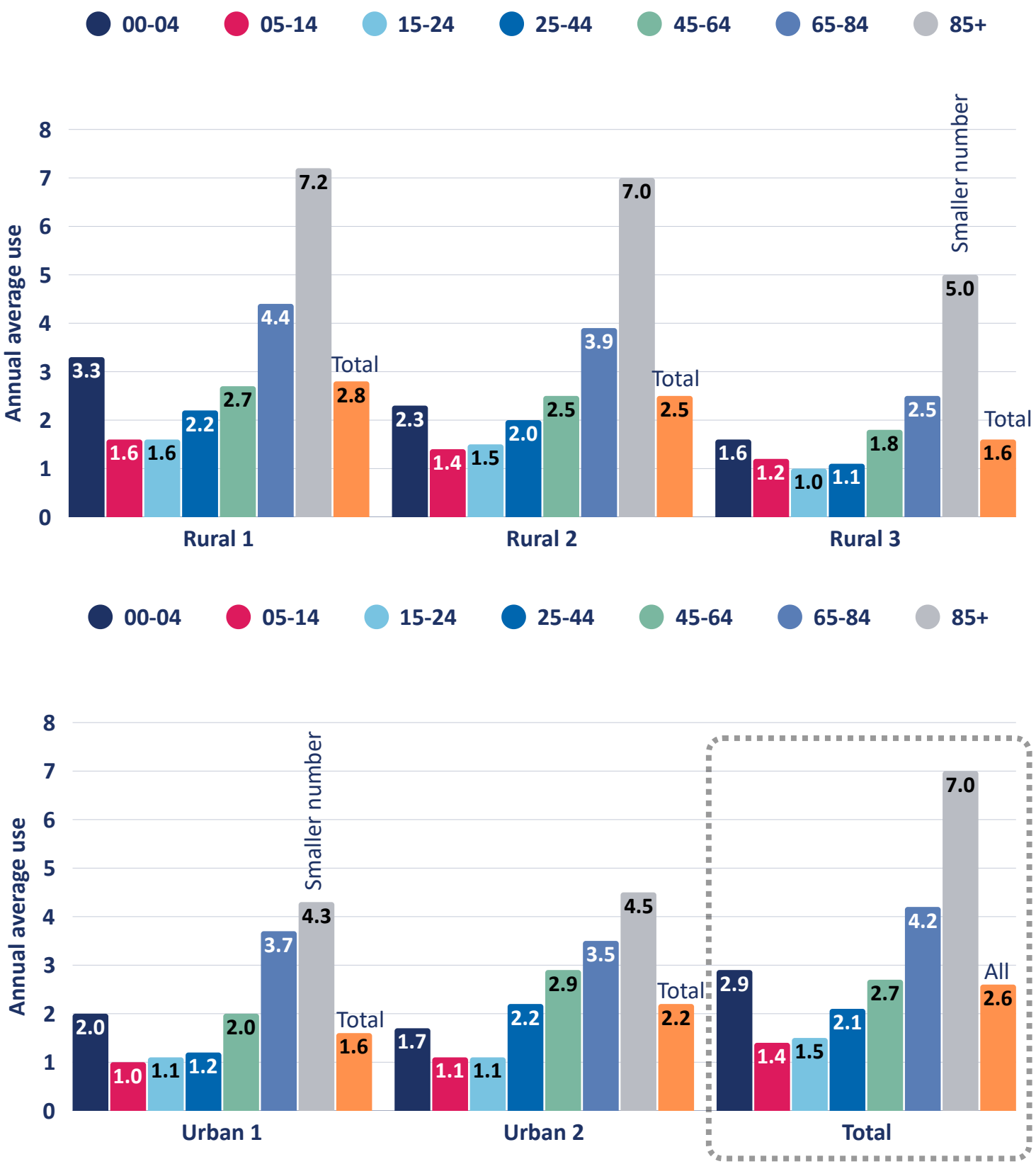
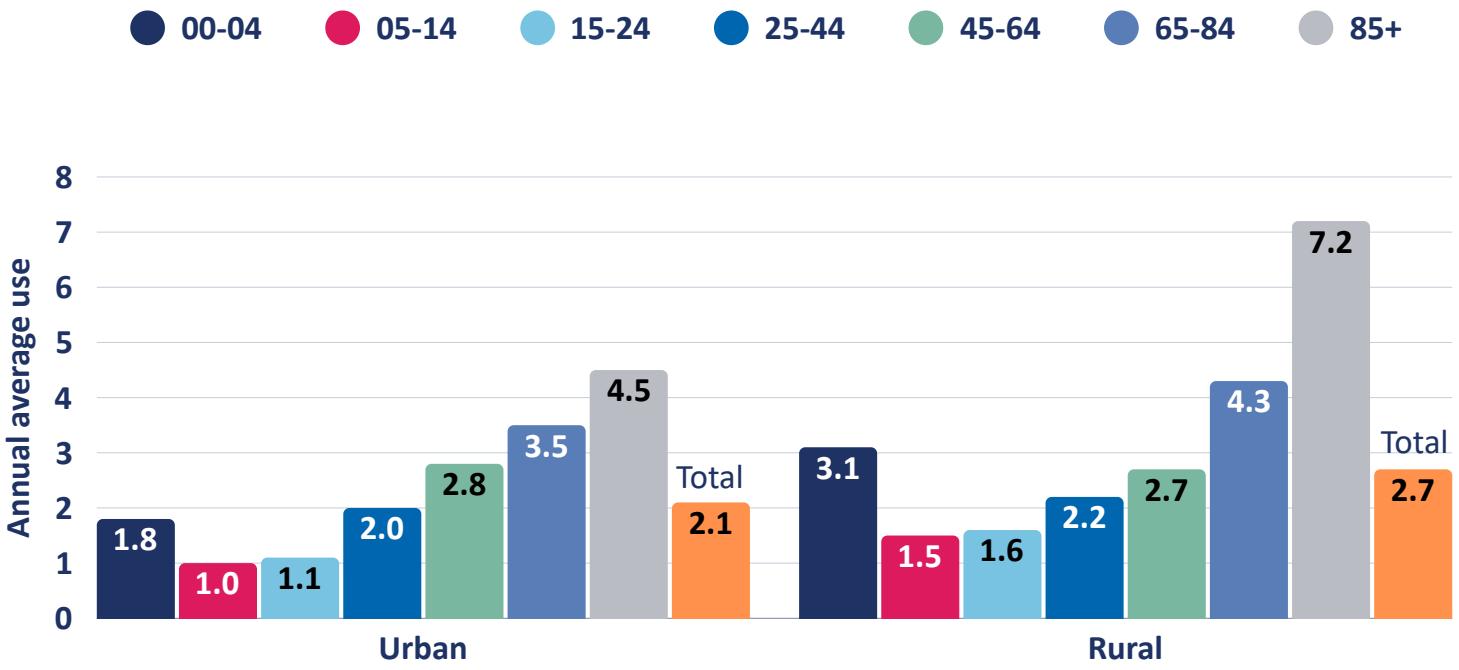


Figure 13: Annual average use of medical consults, by aggregated residence and age



Key Points

- There is (in general) a pattern of higher medical service use by the very young and the oldest (65+ years). This is perhaps no surprise.
- While the overall pattern is similar, there is difference in the actual annual average figures by each age group and where they live.
- **Urban vs Rural:** Across each age group, average use by rural residents is higher than for urban dwellers. At the total level, rural people used on average 2.7 medical consults, compared to 2.1 for urban people.
- Those aged **00-04 years**: There was higher use of medical consults in general practice for rural dwellers - this may be partly due to people in urban areas having easier access to after hours and ED services (this will be further explored in a rural primary care focused report).
- Those aged **85+ years**: Perhaps the most noticeable rural/urban difference is in this age group; 7.2 for all rural residents compared to 4.5 for urban residents (with those in Rural 1 areas driving this difference).