Pinnacle®
Midlands Health Network

Summary Report

Our approach to

Population health & community wellbeing

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

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1 Our direction: Using a population health lens

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First things first

Pinnacle's vision is to deliver equitable primary care that supports people to thrive by realising their health and wellbeing potential. To help achieve this, we identified as part of our 2024 organisational strategy refresh, the need to "create a population health and wellbeing plan connecting population growth changes to workforce needs and capabilities".

Our population health plan is an approach. It doesn't give neat answers to the complexity of change. Instead, it provides a way to bring information together to understand change. The best way to use this information is for a range of people, with knowledge of different parts of the sector, to discuss how it might inform planning and funding decisions.

Pinnacle is not starting from scratch. We are building on a history of responding to challenges, by working collaboratively within the Network and externally to stand up services to meet identified need.

Connecting health and wellbeing and population changes to workforce needs and capabilities

Communities experience varying health and wellbeing outcomes, influenced by the social determinants of health such as housing and education. These factors differ between populations, contributing to unequal health outcomes.

As populations grow and evolve it puts greater strain on existing workforce capacity. At the same time, shifts in population structure, such as an ageing population and more people with complex health and social needs, demand a more diverse and adaptable mix of skills in primary care. We can strengthen workforce capabilities through upskilling, team-based care models, and the use of digital health tools. There is also an opportunity to make better use of other skilled roles in primary care, including paramedics, district and public health nurses, counsellors and podiatrists.

The now and the future workforce: Towards the 2040's

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We know the Network is facing significant workforce pressures that will intensify over the coming years. As the population grows and ages, demand for care will increase. If current service use patterns continue, the Network may need to deliver over 218,000 additional medical consults by 2043. However, growth and decline in enrolments and medical consult demand are not evenly distributed across different ethnic and age groups, or geographic districts.

While the predominantly Pākehā population is expected to drive demand for medical consults among older age groups; Māori, Pacific, and Asian populations will be entering middle age, a life stage where preventative health care becomes increasingly important. At the same time, prevention and effective management of chronic conditions will remain essential for older people, for both quality of life and to help avoid unnecessary use of secondary care services.

There will be service demand in addition to medical consults

The wide variety of other services provided by general practice must continue

General practice delivers a wide range of services beyond medical consults. These services all need to continue. Practices provide preventive care such as immunisations, screening programmes, minor surgery and cardiovascular risk assessments. Other services also contribute to health and wellbeing, including license medicals, insurance and employment medicals, family planning, pregnancy care, smoking cessation, cosmetic, occupational and travel medicine.

The sector has to respond to future demand for palliative care services in the community

There is projected to be a shortage of trained palliative care staff, especially in rural areas. Because of this whānau and informal carers may shoulder a heavier burden of care, potentially with limited training or little respite care available in their community.

More services will be delivered in the community to keep beds free in hospitals (to meet increasing demand for secondary care)

The recent Nelson Hospital business case noted that a fully digital supported ‘hospital-in-the-home and community care’ service model would need to replace the current unsustainable model of care. Workforce constraints, ageing population and available bed numbers are driving the change. The community-based services needed to support this change are not yet in place. The issues and risks identified in Nelson hold true for the geographical area covered by the Pinnacle Network.

The Pinnacle Network: Building on where we've come from

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Where we've come from, the issues & opportunities

1988
Predecessor to Pinnacle forms...

2002
Pinnacle Inc holds shares in Turanganui Health

2003
PHOs start (Lake Taupō, Waikato & Taranaki)

2006
Primary Health Care Ltd starts

2006 & 2009
Pinnacle workforce surveys

2007/08
Extended care team pilot starts

2011
Health Care Home

2014
indici collab. with Valentia Technologies

2022
Joint venture (JV) establishes
Practice PLUS

2023
Workforce survey

2023
JV forms
KA ORA TELECARE

2024
JV forms Fatu Lalaga GP Ltd
Pinnacle strategy refresh

2025
JV forms HealthAccelerator

2025
The Pinnacle network moves forward, with a history of innovation & collaboration

The story of current and future challenges

Health & wellbeing in our communities

Our population is diverse, with different needs and aspirations and ongoing inequities.

We need to understand the social determinants of health and how we can work with others to make the best impact.

A growing & changing population

By 2043, about a quarter of us will be over 65, reshaping demand for health care.

More people with chronic conditions

More people are (and will be) living with 2+ long-term conditions. This increases pressure on care coordination and continuity.

More people will need palliative care

Most people want to die at home. Supporting this requires strong community and general practice teams.

Our young people still need the best start to life

As the population ages, younger people still need timely, accessible care to the full range of child & youth services.

Service use pressure increases

Primary care is stretched. Demand is rising faster than the workforce can grow.

But we have a growing workforce gap

Many GPs and nurses are nearing retirement. Without new ways of working, care gaps will widen. Meeting demand may require expanding and sustaining a more diverse, team-based primary care workforce.

What could a reimagined future look like for the Pinnacle network?

We're not starting from scratch.

In the past we've developed new models of care and collaborated to stand up new services to meet changing and growing need.

Local context is key. Front line teams know their communities and the partners they work with.

including...

- Primary Health Care Ltd
- Health care homes
- Extended care teams
- Marae clinics
- indici
- PracticePlus
- Ka ora telehealth
- Fatu Lalaga GP JV
- HealthAccelerator
- Point of care testing
- GPs in schools
- School nurse clinics
- Outreach screening
- Outreach immunisation

Difficult questions need discussion

How does the way we deliver care need to change?

How do we progress equity for Māori, rural residents and others? Are we aligning with Pinnacle's commitment to Te Tiriti?

Do we strengthen our current approach with new workforce roles in the community and digital supports?

Are there things we should invest in immediately? Maybe some are longer term but can be identified and planned for now

How can we best use our population health lens to support our network and sector partners?

Good ideas and collaboration need sustainable funding

2 Our population health and wellbeing framework

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Our vision

Pinnacle's vision is to deliver equitable primary care that supports all people to thrive by realising their health and wellbeing potential. We are committed to addressing the needs of the community through a population health approach.

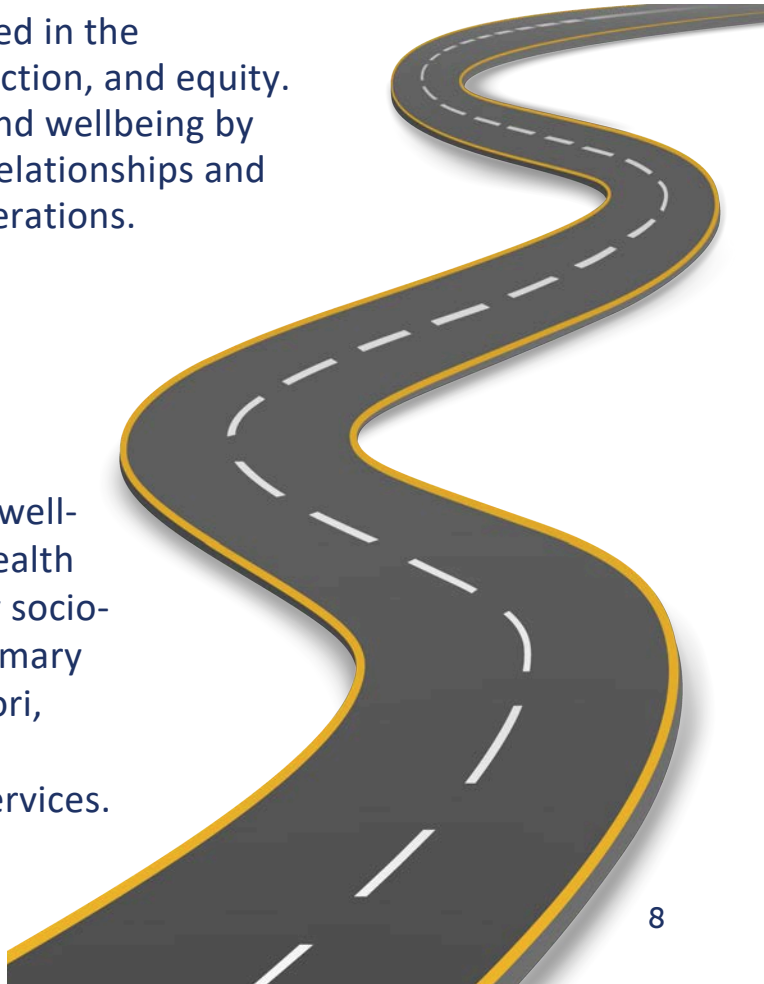
In collaboration with mana whenua and external partners we aim to support the wellbeing of our communities by delivering services that meet the unique needs of diverse populations, across the Pinnacle network.

Our refreshed organisational strategy (2024) set the direction to develop a population health and wellbeing plan that links population change with future workforce needs and capabilities. This report presents a strategic level summary of that work.

Te Tiriti o Waitangi commitment

Pinnacle upholds Te Tiriti o Waitangi as the nations founding document and is committed to its active expression. We aim to partner with iwi, Māori providers, and communities to support tino rangatiratanga and improve health outcomes.

Our approach to population health is grounded in the principles of partnership, participation, protection, and equity. We are focused on advancing Māori health and wellbeing by embedding these principles in our strategy, relationships and service delivery both now and for future generations.



Defining population health & wellbeing

Population health focuses on the health and well-being 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.

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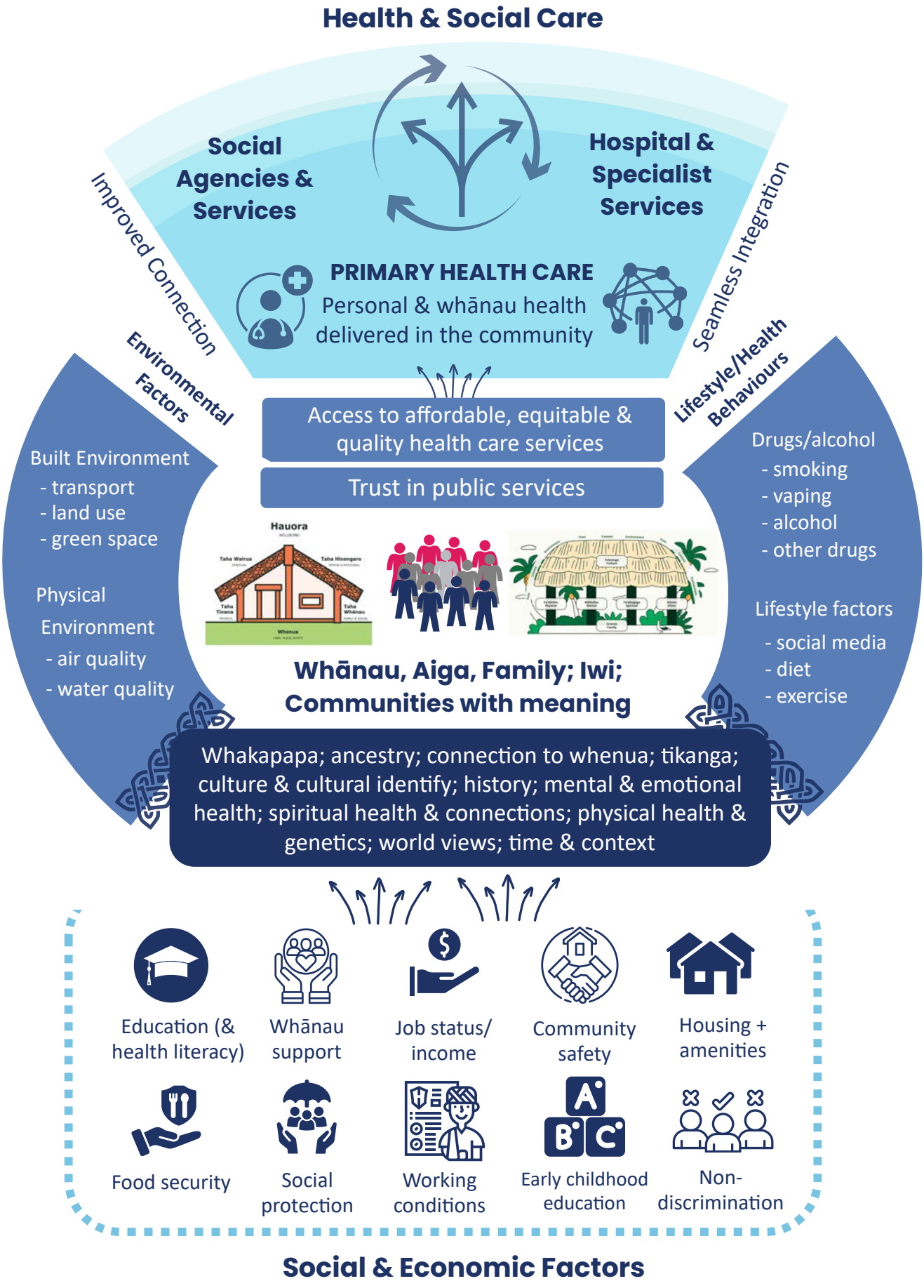
Our population health and wellbeing model

Health and well-being are shaped by the conditions in which people are born, grow, live their daily lives, work and age. These determinants of health 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.

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 care plays a vital role in maintaining health, as health professionals provide preventive care, manage chronic conditions, and treat acute health issues. Ensuring equitable access 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.

Integrated model of 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).

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 clinicians in primary care 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. 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.

3 Population health priorities and measurement

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Equity and quality are the driving forces behind service delivery and our commitment to improving the health and wellbeing of our Māori, Pacific and rural whānau. Health equity is at the core of each priority. The purpose of each priority builds to address the disparities in health outcomes.

Five Population health priorities

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 primary care clinician within 5 days (target will take effect 1/7/2026 with data definitions yet 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 that sets 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

4 Health system, Pinnacle & community identified issues

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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 and 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, ongoing COVID-19 impacts; workforce issues; equity concerns and reform pressures

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Community Identifed Issues

Te Manawa Taki summary

From community engagement processes by Te Whatu Ora Te Manawa Taki and Iwi Māori Partnership Boards

Enrolment

Being able to enrol in a practice and make appointments to see the GP or nurse when needed

Clinician communication

Better communication between GPs and hospital specialists

Rongoā Māori

Increase funding for and access to rongoā Māori

Chronic conditions

Better support for people with long term conditions

Mental health

Being able to access a range of mental health care services in the community

Costs to patients

The cost of care & transport to get there create a barrier for many

Afterhours care

Availabilty (closer to home), cost & responsive health care services

Secondary care backlogs

The wait for a first assessment with a hospital based specialist is too long

More culturally responsive & equitable care

Wait times

Wait times for care - in general practice, afterhours, ED & hospital. People get sicker as they wait.

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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 and secondary care providers.

5 Population change & service use

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Summary: Population change

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.

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Summary: Health service use

The link with population change

A growing and changing population has implications for service use. 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.

+ 218,000 medical consults in 2043

The network will need to provide an additional 218,000+ medical consults (if 2023 rates remain). However, growth and decline in numbers of people enrolled and 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 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.

Five Key points for planning: Pinnacle's population future

What does this mean for how the Network plans and provides services?

1 Numerical increase overall, but a complex picture underneath

While overall population growth is expected across the region, the reality beneath the headline numbers is more complex and varies significantly between districts. Some areas, particularly urban centres, are experiencing rapid growth driven by migration and higher birth rates. These increase demand for child and youth services, urgent care, and long-term condition management. In contrast, other districts face ageing and declining populations, with shrinking school rolls, workforce shortages, and growing demand for elder care and home-based support.

Population growth is not evenly distributed across communities; Māori, Pacific and migrant populations are increasing at a faster rate in many locations, often with higher health needs and existing barriers to care. These dynamics mean each district will require tailored and equitable data-informed responses that reflect its unique population trends, health needs and capacity challenges.

2 More older people needing health care are the key driver of increased medical consultations

Increasing numbers of older people will be a key driver of demand for health care. As people live longer (often with multiple long-term conditions, frailty, or complex care needs) medical consultations will rise significantly. This demographic shift will place growing pressure on primary care to deliver more frequent, coordinated, and multidisciplinary care that supports older adults to maintain independence and wellbeing. Addressing the needs of older people effectively will be essential to maintaining the overall health of the region and reducing pressures on hospital and specialist services. Planning for this change is critical to ensuring the health system is responsive, equitable, and sustainable.

3 Prevention and maintenance of chronic conditions will be critical (for both middle aged and older)

Preventing and proactively managing chronic conditions will become even more essential to achieving equitable health outcomes, particularly populations disproportionately affected by long-term illness. Positive outcomes here will go towards ensuring a sustainable, culturally responsive health system that can meet the growing needs of an ageing population.

4 Key life-cycle health care must continue for younger people

While primary care must respond to the growing needs of an ageing population, it is equally important to maintain strong investment in key life cycle health services for younger people. Services such as maternal health, childhood immunisation, mental health support, sexual health, and early intervention for long-term conditions are critical foundations for wellbeing. Neglecting these areas risks embedding future inequities and increasing health burdens later in life. A balanced approach is needed, one that recognises the importance of prevention and early support across the life course, not just in older age.

5 A good start to life will remain critical

A strong start to life, from pregnancy through the first five years, will remain one of the most critical areas of focus for primary care. Early childhood is a foundational period that shapes long-term health, development, and equity outcomes. Primary care plays a vital role in delivering acute care, immunisations, developmental checks, and whānau support during these years.

Investing in these early years is one of the most effective ways to prevent future health issues, reduce disparities, and support tamariki to thrive. As primary care responds to population pressures, maintaining a clear focus on the early years will be essential.

6 The primary care workforce

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Workforce opportunities and issues in our Network

Primary care is the foundation of a high-functioning health system, providing accessible, continuous, and cost-effective care that helps to prevent illness, reduce hospital demand and improve long-term outcomes.

As we look to the future, ensuring a sustainable and responsive primary care workforce is central to delivering on national health priorities and achieving equitable outcomes for all.

Within the Pinnacle Network, pressures on the workforce are mounting, particularly in rural areas and in practices serving Māori, high needs, and growing populations. Long-standing GP shortages, gaps in the training pipeline, and increasing workload complexity are testing the capacity of current models of care.

However, there are also opportunities for investment in innovation, interdisciplinary teams, and more community-aligned approaches. Well targeted funding can enable scalable solutions that not only stabilise the workforce, but also deliver better value and outcomes for the populations we serve.

This section covers a summary of key drivers of change, workforce issues and considers future opportunities for change across our workforce.

Key drivers of change

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Many undercurrents affect the primary care workforce

Pinnacle started referring to a 'perfect storm' back in 2006 following our first Network workforce survey, when analysing how the long-term demographic trends of population growth and ageing, and workforce ageing come together. But it's more complex than that, and since that time a number of other issues have arisen that need to be considered.

	POPULATION & WORKFORCE DEMOGRAPHY	PRIMARY CARE FUNDING	SOCIO-ECONOMIC DETERMINANTS
More recent impacts	Clinician burnout	Continued reform bring uncertainty	Inequity increases for some
	Some practices close books	Continued delay revising capitation	Cost of living crisis worsening for many
	Some practice services scaled back	Nursing workforce depleted - pay parity with hospital nurses	Increasing mental health concerns post COVID
	Decreasing appointment availability		
Long term undercurrents	Increasing pressure from ageing population & chronic disease	Funding model inadequacy	Recalcitrant inequity for Māori
	An ageing primary care workforce	Funding for service not covering costs	Rural inequity: access & health outcomes
	Workforce distribution	Inflexible funding contracts	Inequity for tāngata whaikaha
	Population growth not geographically uniform	Service funding not increasing with inflation	Growing socio-economic & social exclusion

Key workforce issues across our Network

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Workforce shortages across the board

- **GP shortage**: There is a well-documented shortage, particularly in rural areas. Recruitment and retention are both critical concerns.
- **Nurse shortages**: Nurses are in short supply, and those remaining often experience burnout due to high patient loads and limited support.
- **Ageing workforce**: A large proportion of the GP and nurse workforce is nearing retirement age, especially in rural practices. This threatens continuity of care.
- **Limited allied health and Māori health practitioners:** There are gaps in access to allied health professionals and a shortage of Māori clinicians.
- **Programme coordination and support roles**: These roles provide support for clinical roles and for patients and whānau. However, often impact is unrecognised by funders.

Uneven distribution of the workforce

- Urban areas tend to have better coverage, while rural and remote areas face chronic understaffing.
- Uneven distribution exacerbates inequities for Māori, rural residents and low-income populations who often live in underserved areas.

Fragmented workforce planning

- Historical planning has been reactive and fragmented, lacking coordination across agencies and sectors.
- Data limitations hinder planning. There is insufficient (or not readily available) real-time data on workforce supply, demand, and skills mix at the district level (or lower).

Inflexible funding models

- Capitation funding does not always align with the complexity of care or need. This is now a long-term issue (with review of the funding formula now underway).
- Funding mechanisms often lack the flexibility to support team-based models or innovation in rural settings. Funding is often short-term, making it difficult to plan.

Education and training pipeline gaps

- Limited placement and training opportunities for medical, nursing, and allied health students in rural and kaupapa Māori health settings.
- Pathways into primary care for graduates, particularly Māori and Pacific students, are not well supported (compared to secondary pathways).

Future opportunities: Workforce change and development

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N National level (inc. advocacy)
R Regional level (inc. advocacy)
L District / local level change

National, regional and local opportunities

New and enhanced models of care N R L

- Embrace appropriate virtual care and digital health solutions to extend workforce reach.
- Expand interprofessional team-based models from what is currently in place

Funding levels and flexibility N R L

Pinnacle has an advocacy role in highlighting the need for funding levels that reflect population need and service demand, with flexibility to support new models of care.

Māori workforce development R L

- Strengthen partnerships with iwi and Māori providers to support the recruitment and development of Māori health professionals.
- Fund and support Māori-led workforce initiatives, such as kaiāwhina workforce development, cultural competency training, and leadership programmes.
- Support community-based roles, such as rongoā practitioners, and community health workers within the extended general practice team.

Technological change and digital health R L

There is significant potential in technological change (including AI) and digital health, enabling more efficient workflows, enhanced patient access, and better use of data to support proactive, coordinated care.

Growing support and coordination roles (non-clinical) R L

- Advocate for long-term investment as core infrastructure within general practice.
- Support access to micro-credentials and structured training pathways.
- Standardise role descriptions and scopes to support consistency and equity.

Partnering with other community providers L

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There is potential to strengthen primary care by partnering with community providers, including iwi providers, fostering more integrated, culturally grounded, and locally responsive models of care.

Strengthening the nurse practitioner model R L

- Expand funded pathways for training and early career support in practice settings.
- Include NPs explicitly in workforce planning and funding models.
- Support rural practices and high-needs areas to employ and retain NPs through targeted investment and workforce planning incentives.

Strengthening the nurse prescriber model R L

- Target funding to practices serving high-need populations to encourage training, recruitment and retention.
- Increase funded training places, especially targeting rural and underserved regions.
- Align nurse prescribing roles into workforce models to help manage workforce shortages and population health needs (e.g. ageing, multimorbidity).

Opportunities for change

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Understanding the current Pinnacle workforce

Understanding the Network workforce provides a foundation for shaping a future that is fit for purpose and responsive to community need. Mapping current roles, skills and distribution highlights where capability is strong and where gaps or pressures are emerging. These insights create opportunities to plan for growth and adapt service models.

There is scope for Pinnacle to build more flexible and multidisciplinary teams, making the most of the skills of the wider health workforce. Understanding the current workforce profile can guide targeted recruitment into areas of highest need, support succession planning for an ageing workforce, and shape strategies that can address workload, wellbeing, and career satisfaction.

By linking workforce understanding with service delivery planning, Pinnacle can explore expanding roles for nurse practitioners, physician associates, kaiāwhina, and other allied health professionals, as well as enhancing collaboration with iwi and community partners. These opportunities provide one opportunity to build on the current workforce for the future.

Table 1 shows the interprofessional skills in each district, employed by Pinnacle (✓), a network general practice (✓) or other employed/funder (✓).

Table 1: Workforce roles employed in each Pinnacle district

Workforce role	Lakes	Tairāwhiti	Taranaki	Waikato
Specialist GP	✓	✓	✓	✓
Nurse practitioner (NP)	✓✓	✓✓	✓	✓
Nurse prescriber (all scopes)	✓	✓	✓	✓
Practice nurse	✓	✓	✓	✓
Specialist nursing roles (e.g. respiratory, diabetes)	✓	✓✓	✓✓	✓
School-based nurses (includes NP)				✓
Nurses - immunisation outreach (+ support)	✓	✓	✓	✓
Nurses - mobile / support to screening				✓
Care coordinator (clinical)		✓		✓
Extended care paramedic			✓✓	✓✓
Physician associate				✓
Pharmacist prescriber	✓			✓
Clinical pharmacist		✓	✓	✓
Dietician / specialist diabetes	✓	✓	✓	✓✓
Exercise consultant / physiologist	✓	✓		
Physiotherapist				✓
Health improvement practitioner	✓		✓	
Social worker		✓	✓	✓
Brief intervention clinician		✓		✓
Waiora manaaki / Health coach	✓			
Cultural partner	✓	✓	✓	✓
Smoking cessation facilitator/support				✓
Kaiāwhina	✓	✓	✓	
Programme support / coordination	✓	✓	✓	✓

Strategic discussions on current workforce and future opportunities

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Making the best use of each skill set in meeting future demand

Developing team based models can redistribute clinical and non-clinical tasks. Some in the Network are already doing some of these things, including inbox management and use of extended care teams.

Current workforce roles and future potential

We can look at current workforce roles by Pinnacle district and consider the level of future opportunity for these roles. Table 2 summarises opportunities and gaps for 35 workforce roles. Within districts there will be sub-districts where there is difference (e.g. Coromandel peninsula compared to Hamilton in the same large district).

Table 2 is provided with the aim of assisting discussion on the current state of the workforce, and the potential for change to meet future demand (there is no one right answer). This exercise could also be undertaken at the sub-district level.

Table key: Current opportunity state by workforce role

Significant opportunity for expansion or change of current role now
The role is underutilised; scope exists for broader responsibilities, or extended practice.

Moderate opportunity for expansion of current role now
Some development underway or possible; role could be enhanced.

"Hard to say" level of opportunity
Needs further discussion on costs, availability and task shifting or additional resources into preventative or early intervention roles.

Workforce role not currently in the Network
Discussions could consider these roles in the context of each district.

Table key: Future potential to meet service demand (quantity of workforce)

If the role is not currently in the district, potential for the future as been left blank, to both keep the table from being cluttered and the discussion open about potential.

Significant potential for more people working in this role in the future (compared to now)

Moderate potential for more people working in this role in the future (compared to now)

Potentially the same, or less workforce needed (compared to now e.g. due to changing population numbers)

Table 2: Current state and potential future opportunities for 35 workforce roles

Pinnacle workforce role		Lakes	Tairāwhiti	Taranaki	Waikato
Specialist GP / GP					
Liasion Psychiatrist (hospital based)					
Nurse practitioner (NP)	Nursing roles and skills				
Nurse prescriber	Nursing roles and skills				
Practice nurse	Nursing roles and skills				
Specialist nursing roles (e.g. respiratory, diabetes)	Nursing roles and skills				
School-based nurses	Nursing roles and skills				
Nurse - immunisation outreach (and support)	Nursing roles and skills				
Nurse - mobile health / support to screening	Nursing roles and skills				
District nurse	Nursing roles and skills				
Public health nurse	Nursing roles and skills				
Physician associate					
Midwives (community)					
Pharmacist prescriber					
Clinical pharmacist					
Specialist diabetes dietician / dietician					
Extended care paramedic (in general practice)					
Paramedic (in ambulance crew/shift)					
Podiatrist					
Exercise consultant / physiologist					
Physiotherapist					
Social worker					
Rongoā Māori					
Care coordinator (clinical role)					
Care coordinator/programme support (non-clinical role)					
Primary mental health brief intervention clinician	Mental health skills				
Primary mental health clinician	Mental health skills				
Waiora manaaki / Health coach	Mental health skills				
Psychologist	Mental health skills				
Counsellor	Mental health skills				
Health improvement practitioner	Mental health skills				
Kaiāwhina					
Kai Manaaki					
Smoking cessation facilitator/support					

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Leveraging Pinnacle's Extended Care Team model

The Pinnacle model is an enabler towards a more sustainable model of primary care. The model, operating in Lakes, Taranaki and Tairāwhiti districts, has proven valuable in improving access to holistic care.

Social return on investment (SROI)

The teams are dedicated to kia hauora te katoa, kia puaawai te katoa - everyone healthy everyone thriving. They provide interdisciplinary tailored health support and education which aims to help people better manage their health and wellbeing.

Pinnacle contracted ImpactLab to estimate the social value of the work, to better understand the impact and how it might be enhanced. Social value is an estimate of the impact a programme achieves for the people it supports, measured in dollar terms. It is calculated using academic evidence, government population data and ECT programme data.

ImpactLab looked at data for people with pre-diabetes and diabetes who were supported between 1 July 2022- 30 June 2023. Excluded from the scope were external referrals.

SROI

$1:$6.80

For every $1 invested, an estimated $6.80 of social value is returned to Aotearoa.

SOCIAL VALUE

$9,816,518

The combined social value for all 1419 participants engaged was $9,816,518.

Key outcomes

- Improve physical health
- Reduce diabetes
- Improve mental health

ImpactLab estimated a total social value of $9,816,518; social value per person of $6,918, with an SROI of $1: $6.80. This means for every $1 invested, an estimated $6.80 of social value was returned. The majority of the value came from three outcomes: Improved physical health, reduce diabetes *(the health costs associated with type-2 diabetes)*, and improved mental health. There were important outcomes that couldn't be quantified, so the true social value is likely to be higher.

Outcomes that drive social value

The majority of the estimated value came from two outcomes; 'improve physical health' (51% or $4,978,096) and 'reduce diabetes' (42% or $4,072,514). Following those, 'improve mental health' contributed 6% ($571,357).

Monetary and intrinsic benefits

There are two types of social value estimated in the SROI: monetary and intrinsic. Monetary benefits (43%) are linked to government departments who may experience cost savings in the future because of improvements in people's lives. Intrinsic benefits (57%) reflect improvements in peoples' subjective wellbeing.

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