Pinnacle Midlands Health Network

Sections 1-3

Tairāwhiti Network

Population health and wellbeing

Sections

1. Pinnacle's framework
2. Health & wellbeing information
3. Population change & service use

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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Population change and health service use

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Midlands Health Network

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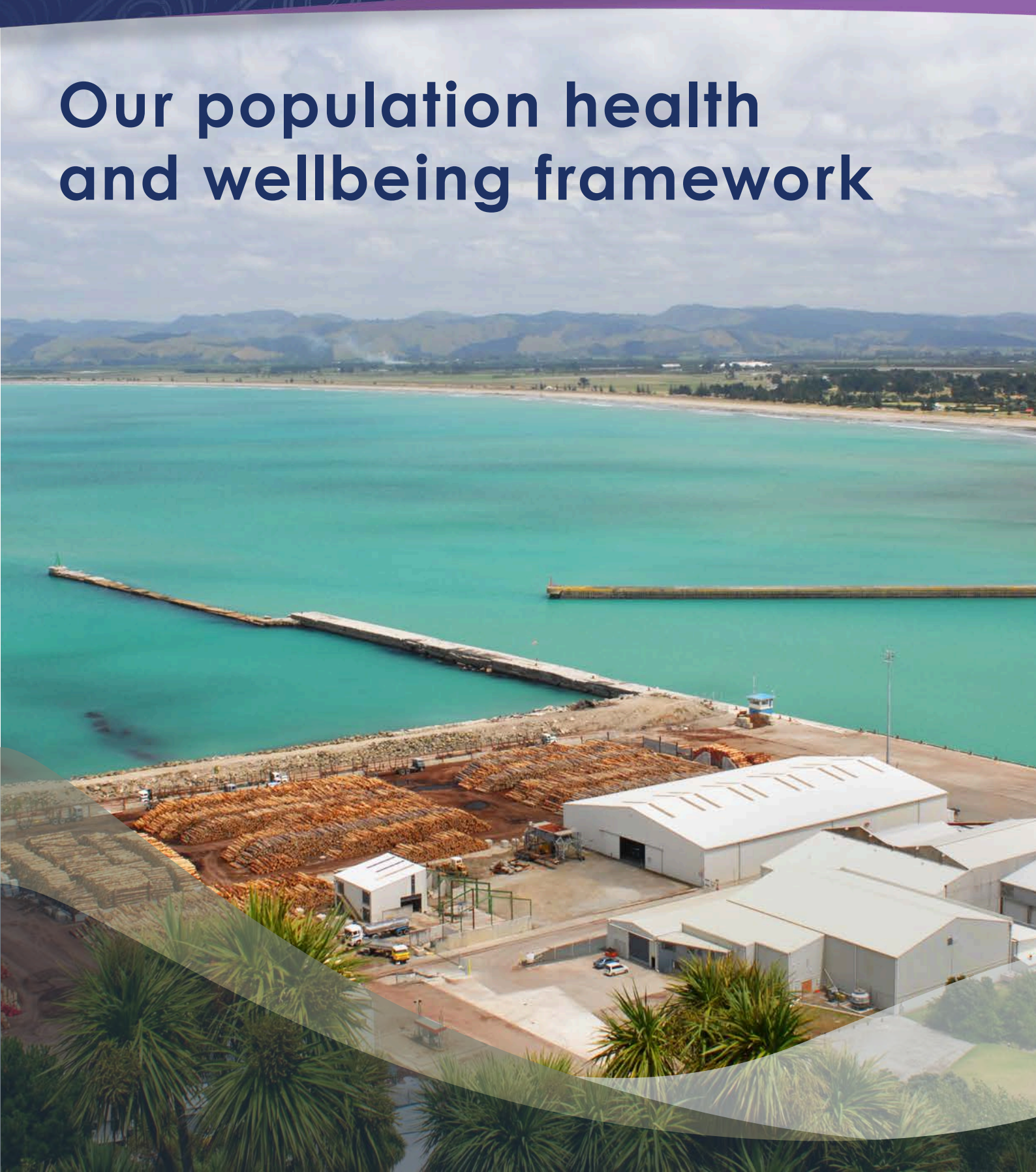
Our population health and wellbeing framework



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.

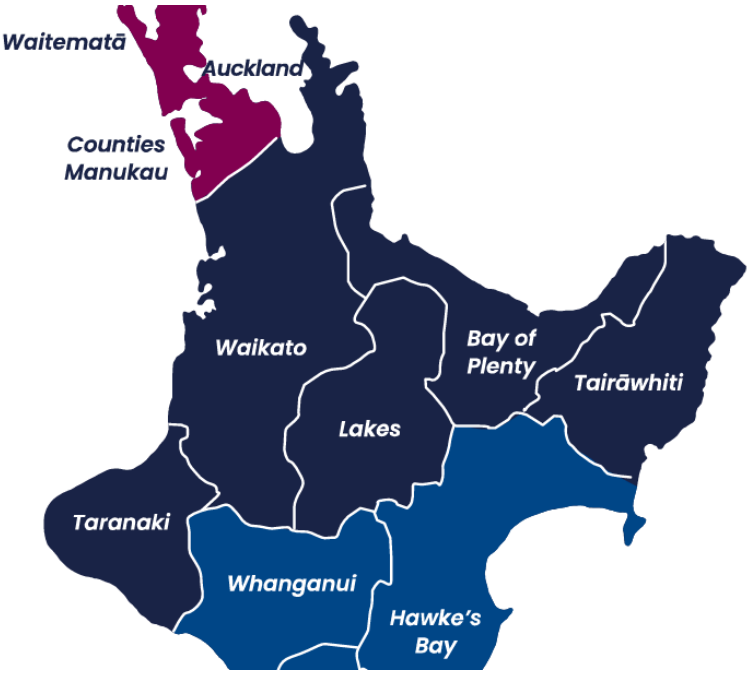
Population health and community wellbeing

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 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 play a crucial role in improving population health by reducing the burden of disease, improving people's 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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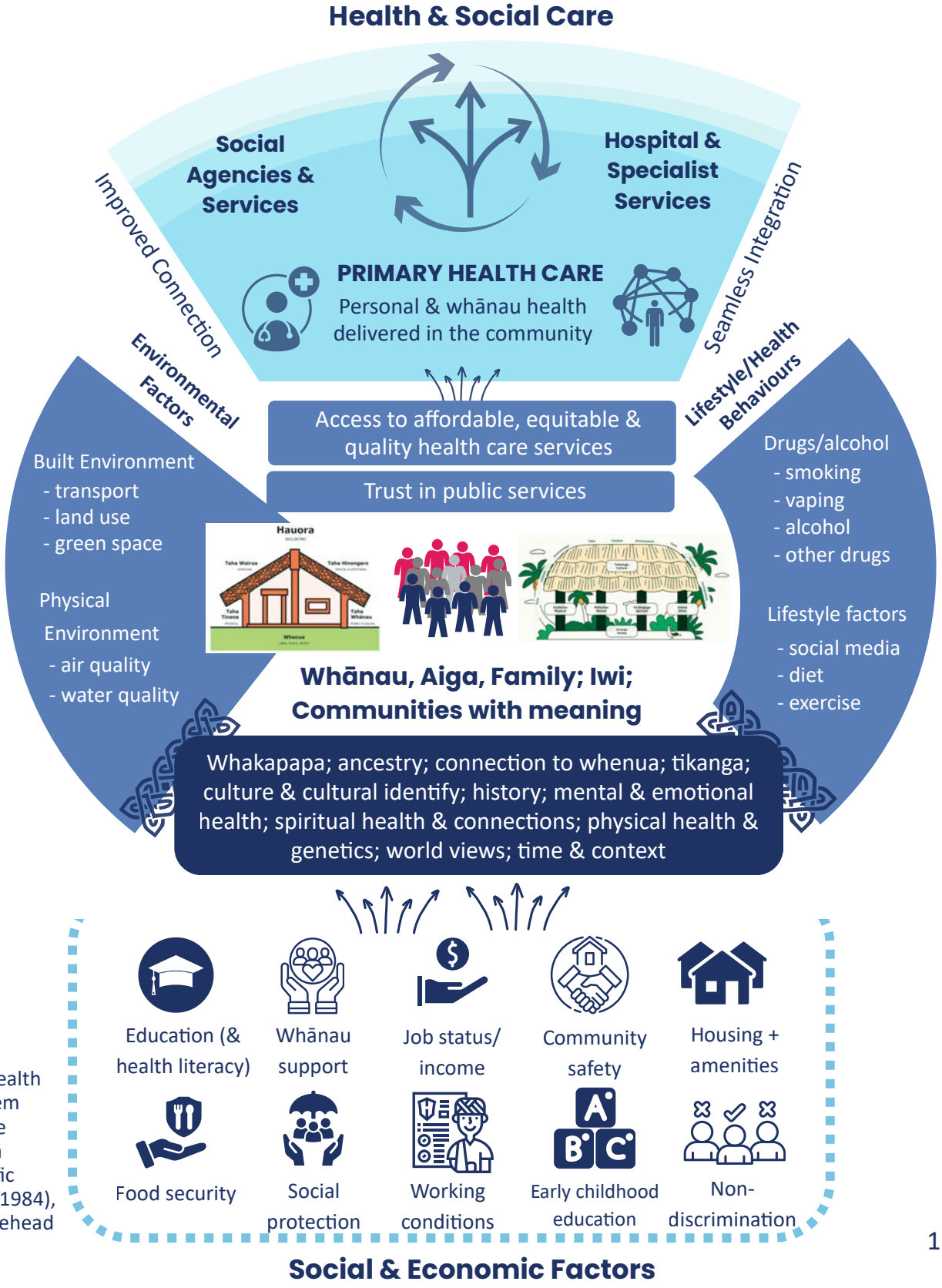
Health and wellbeing are shaped by the conditions in which people are born, grow, live their daily lives, work and age. These determinants are influenced by the distribution of power, resources, and policies at national and local levels. Factors such as income, housing, education, cultural identity and 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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Midlands Health Network

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Tairāwhiti health and wellbeing information

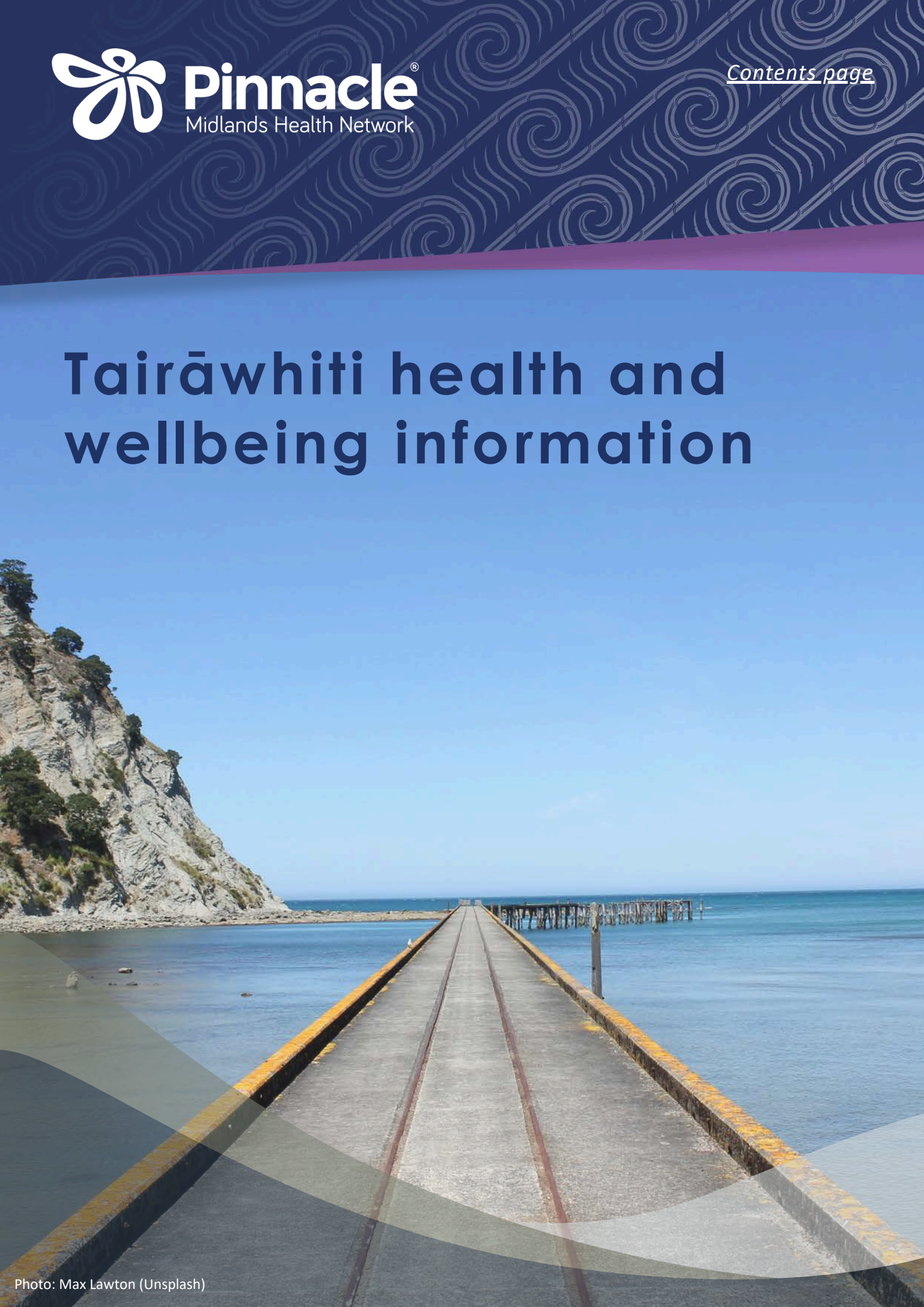

Photo: Max Lawton (Unsplash)

Health & wellbeing in Tairāwhiti

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The Pae Ora (Healthy Futures) Act 2022

The Act reformed the country's health system. It replaced the New Zealand Public Health and Disability Act 2000 and established a more centralised and equity-focused 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 – Health New Zealand (from District Health Boards) to manage hospital and specialist services at a national level.
- A greater priority on equity - 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 Tairāwhiti 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 Tairāwhiti network area covers the same geographical area.

Other organisations have released health and wellbeing information relating to the Te Manawa Taki region, including Manatu Hauora, Te Whatu Ora, Te Aka Whai Ora, Tairāwhiti Toitū Te Ora (IMPB), and Hauora Taiwhenua.

Selected information is summarised here. This report, along with district level reports, will support primary care decision makers to design equitable health services that respond to evidence.

This report covers selected information on:

- The Pinnacle network
- Planning for pae ora in primary care
- 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

Tairāwhiti Toitū Te Ora Iwi Māori Partnership Board

Tairāwhiti Toitū Te Ora is one of six in the rohe that plays a role in the shaping and delivery of health services. They represent local Māori perspectives on the needs and aspiration of Māori in relation to hauora Māori outcomes, ensuring Te Whatu Ora knows and understands their priorities.

About the Tairāwhiti 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.

Tairāwhiti Snapshot (March 2025)

	Tairāwhiti
Practices	5
Total patients	41,570
Māori patients	17,704
< 14 yrs	19.4%
65+ yrs	18.4%

Enrolled Patients

43% Māori

3% Pacific people

5% Asian

49% Other

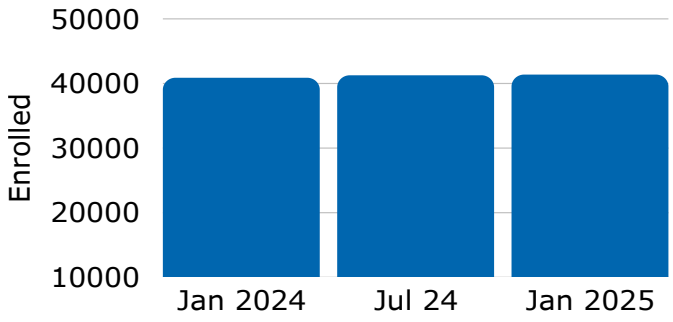
Practice Workforce

1,772 GP/patient ratio

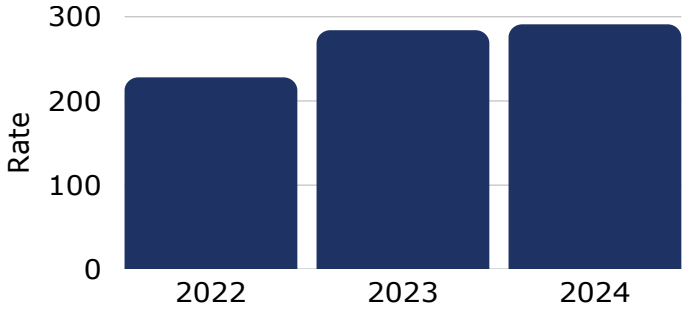
23.5 GP FTE

33.7 Nurse FTE

Pinnacle Tairāwhiti, enrolment growth



Non-urgent ED visits per 1,000 patients



Consults delivered in each calendar year

176,337 (2024)

133,527 (2023)

130,764 (2022)

 # Includes medical consults and other claim types

Patients with a Community Services Card **31%**

Patients resident in quintile 4 or 5 **64%**

PINNACLE

identified RISKS & ISSUES

Contents page

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 aging 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.

People
Now & future

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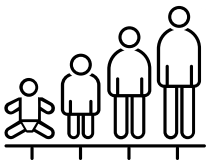
About **1%** of New Zealand's population live in the Te Whatu Ora Tairāwhiti District (2023)

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

Ethnicity in Tairāwhiti

Total responses >100% (Census 2023)

54% Māori

6% Pacific

58% Other

4% Asian

Population projections

2023: **52 thousand**

2043: **55 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 Tairāwhiti District

29,730 live in the rohe now

42% are under 25 years

11% 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).

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

Projected population change at ages 65+ years

11% Māori in 2023 ⌄ increasing to **19%** in 2043

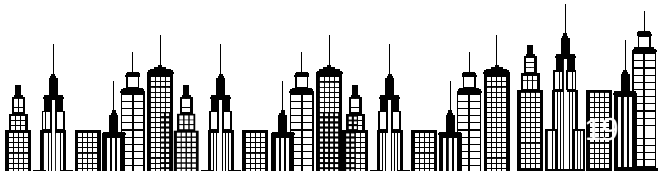
25% non-Māori in 2023 ⌄ increasing to **34%** in 2043

Where people live

Urban compared to Rural

79% Māori **92%**

21% non-Māori **9%**



Community Identifed Issues

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Toitū Te Ora summary

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

Whānau-Centered Health System

The need for a system that is centered around their needs, allowing them to exercise rangatiratanga over their own hauora.

Culturally responsive services

There is a strong desire for health services that are culturally aligned with Māori values and practices. Whānau emphasized the importance of services that respect and incorporate te ao Māori.

Accessibility of health services

Whānau highlighted challenges in accessing services, particularly in rural areas. They called for improved physical and cultural accessibility to ensure that services are within reach and appropriate.

Integration of services

Better integration of health services to ensure seamless care pathways. Whānau noted that fragmented services can lead to gaps in care and emphasised the need for coordinated approaches, especially for those with chronic conditions.

Kaumātua Care

The importance of providing adequate care and support for kaumātua was emphasised, recognising their vital role in the community and the need for services that cater specifically to their needs.

Mental health and addiction services

Whānau identified the need for better mental health and addiction services, advocating for more community-based and culturally appropriate support systems to address these issues effectively.

Workforce development

There is a need to increase the number of Māori health professionals and ensure all staff are trained in cultural competency to provide culturally safe care.

Data and information

Whānau stressed the importance of improved collection and use of data to inform decision-making and resource allocation that aligns with their needs.

Toitū Te Ora IMPB: Identified Priorities

Primary & Community Care

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Better access to community and primary care

Better access to primary and community health care will be a key factor in achieving our health and other aspirations across the region. This is especially true for rural areas. We know that effective access to primary care leads to better long-term health outcomes and can reduce hospitalisations and amenable morbidity and mortality.

Improving whānau experience with health services

The need to provide a different experience of the system if we want whānau to engage, came through loud and strong from both providers and whānau.

Themes include; follow through from providers in the system, addressing discrimination, accessibility within communities and the resilience of our health services.

Resilience of our health system and services

The recent cyclones Hale and Gabrielle, the cumulative effects of earlier severe weather events and the COVID 19 pandemic have highlighted critical vulnerabilities in our health system and services. Building resilience into systems, including our health system will be critically important.

Achieving equity

Key goals across the whole region are to achieve equity between Tairāwhiti and the rest of Aotearoa, between Māori and non-Māori and between other communities with interests and the general population.

Whānau, hapū, iwi, community involvement in service design

There is a long way to go in our region in building an equitable system that works for all. Our whānau, hapū, iwi and communities need to be front and centre in the system and service design process if we are going to build the kind of system that is responsive to their priorities and aspirations.

Sustainable and available workforce

The nationwide shortage of healthcare workers has been felt particularly hard in Tairāwhiti. This is a critical issue across Te Tairāwhiti and has additional impacts in rural areas where even small gaps in the (already small) workforce are strongly felt.

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 Tairāwhiti

HOUSEHOLD CROWDING

Requiring at least 1+ bedroom

Māori **26.7%**

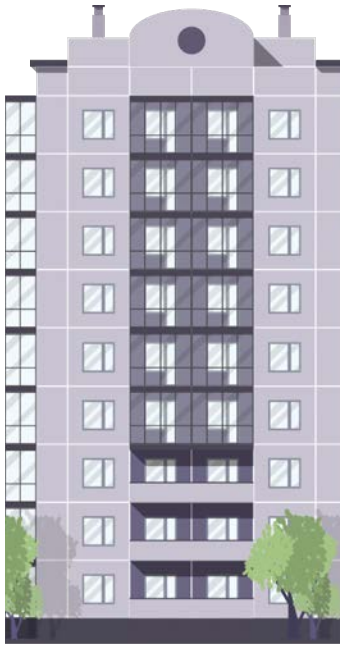
non-Māori **8.5%**

HOUSEHOLD HEATING

Living in households where there is no source of heating

Māori **3.1%**

non-Māori **1.6%**



DAMP HOUSING

44.0% of Māori lived in a home that was sometimes or always damp; compared to 25.1% of non-Māori

MOULD IS PRESENT

39.5% of Māori lived in a house that sometimes or always had mould; compared to 21.3% of non-Māori

HOME OWNERSHIP

25.7% of Māori owned or partly owned their own home, compared 44.5% of non-Māori

2018 Census age-standardised

EAT healthy

29% Taranaki

35% Tairāwhiti 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

Tairāwhiti

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Health Status & Wellbeing Measures

78.1 years — **72.1 years**

Māori life expectancy

83.6 years — **80.3 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

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Midlands Health Network

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Population change and health service use

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.

+ 12,180 medical consults in 2043

The network may need to provide an additional 12,000 medical 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.

Ethnicity and age summary

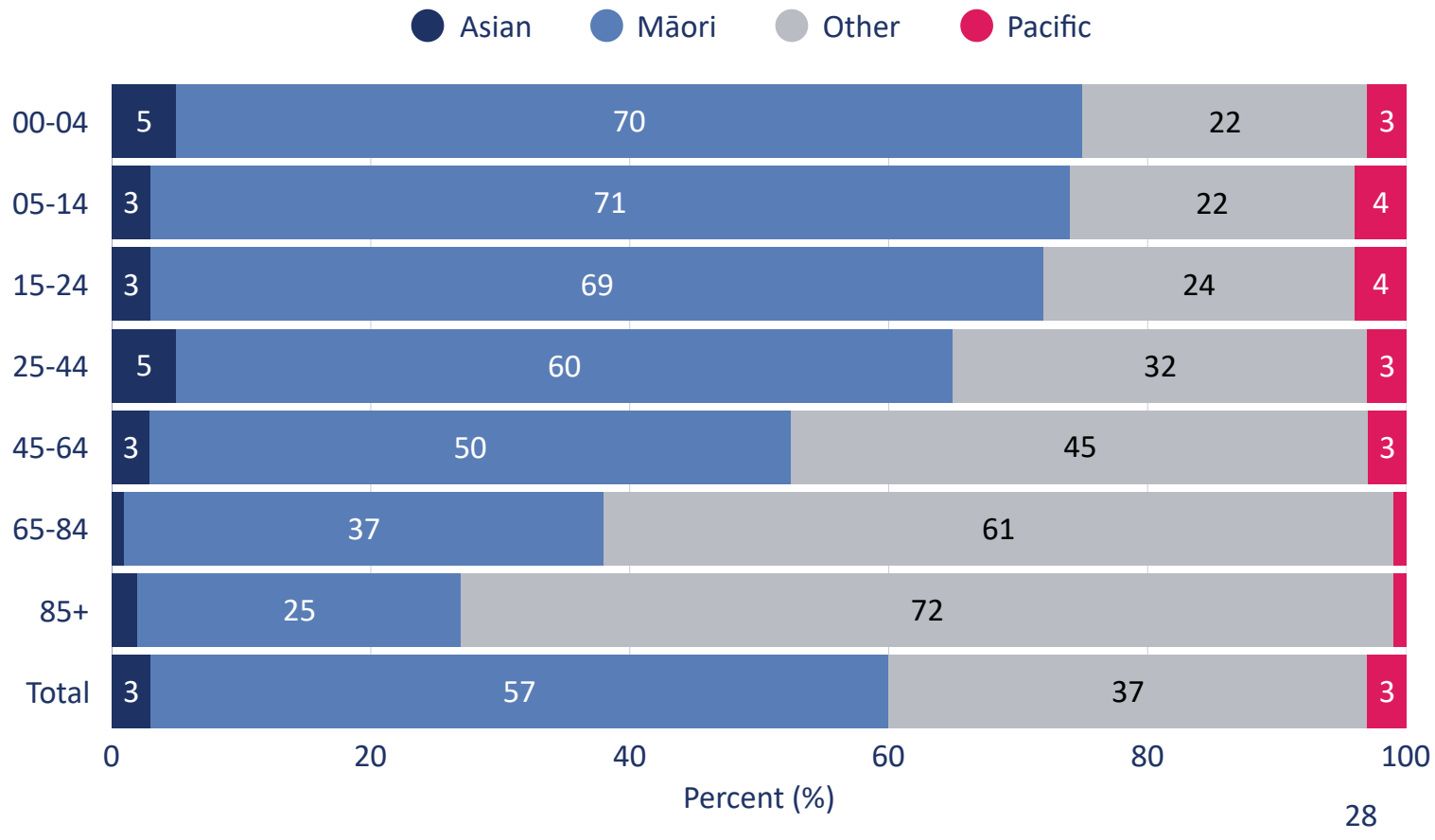
Table 1: ERP, by age and ethnicity, 2023

	Asian	Māori	Other	Pacific	Total
00-04	175	2,500	780	125	3,580
05-14	240	5,540	1,700	330	7,810
15-24	180	4,390	1,540	245	6,355
25-44	570	7,570	4,050	395	12,585
45-64	340	6,370	5,790	335	12,835
65-84	85	2,960	4,860	100	8,005
85+	20	210	600	5	835
Total	1,610	29,540	19,320	1,535	52,005

Key Points

- Some 52,000 people were resident in the Tairāwhiti district in 2023.
- Overall, 57% of people were Māori, with 3% for both Pacific people and Asian.
- Figure 1 shows the difference in the age structure by ethnicity, with a high 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

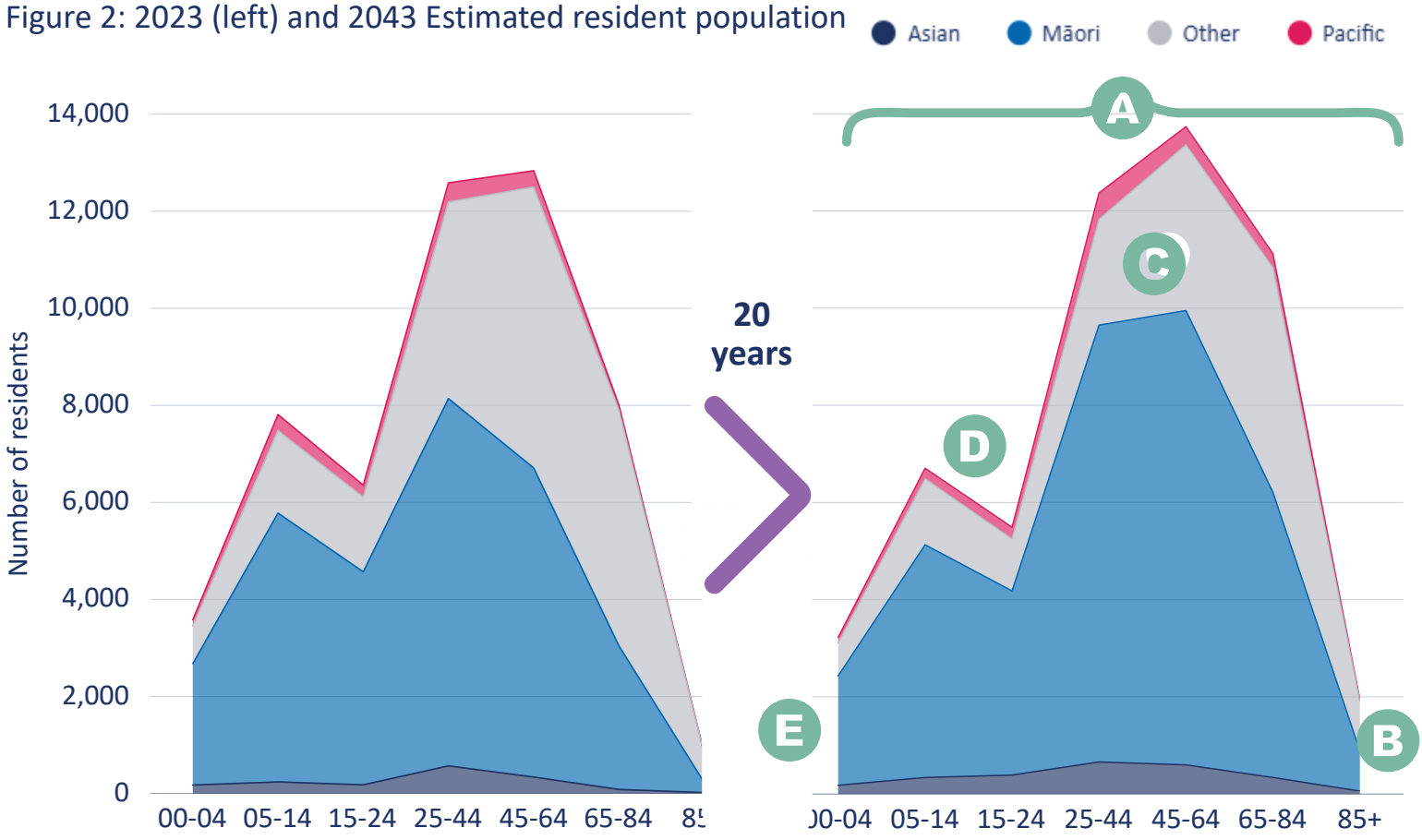
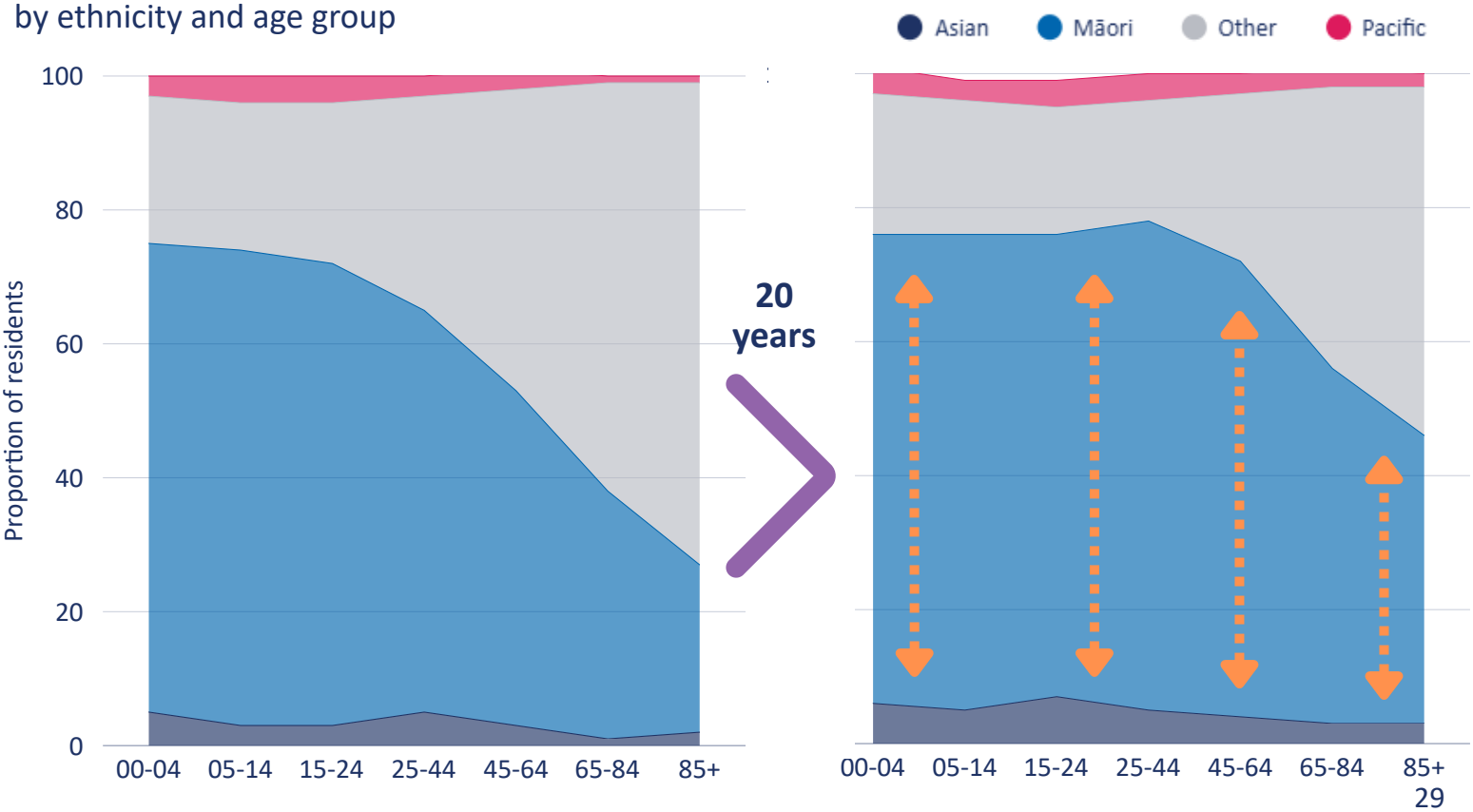


Figure 3: 2023 (left) and 2043 (right) proportion of ERP by ethnicity and age group



Five Summary points [points A-E on Figure 2]

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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 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 while the proportion of Māori and Asian increases.

D **Young people (05-14 and 15-24 years):** Numerically a decease, but the proportion of Māori and Asian increase significantly.

E **The first years of life:** Numerically a decline projected overall, with the proportions by ethnicity remaining about the same (compared to 2023).

Photo: Veronique Gibbons

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.

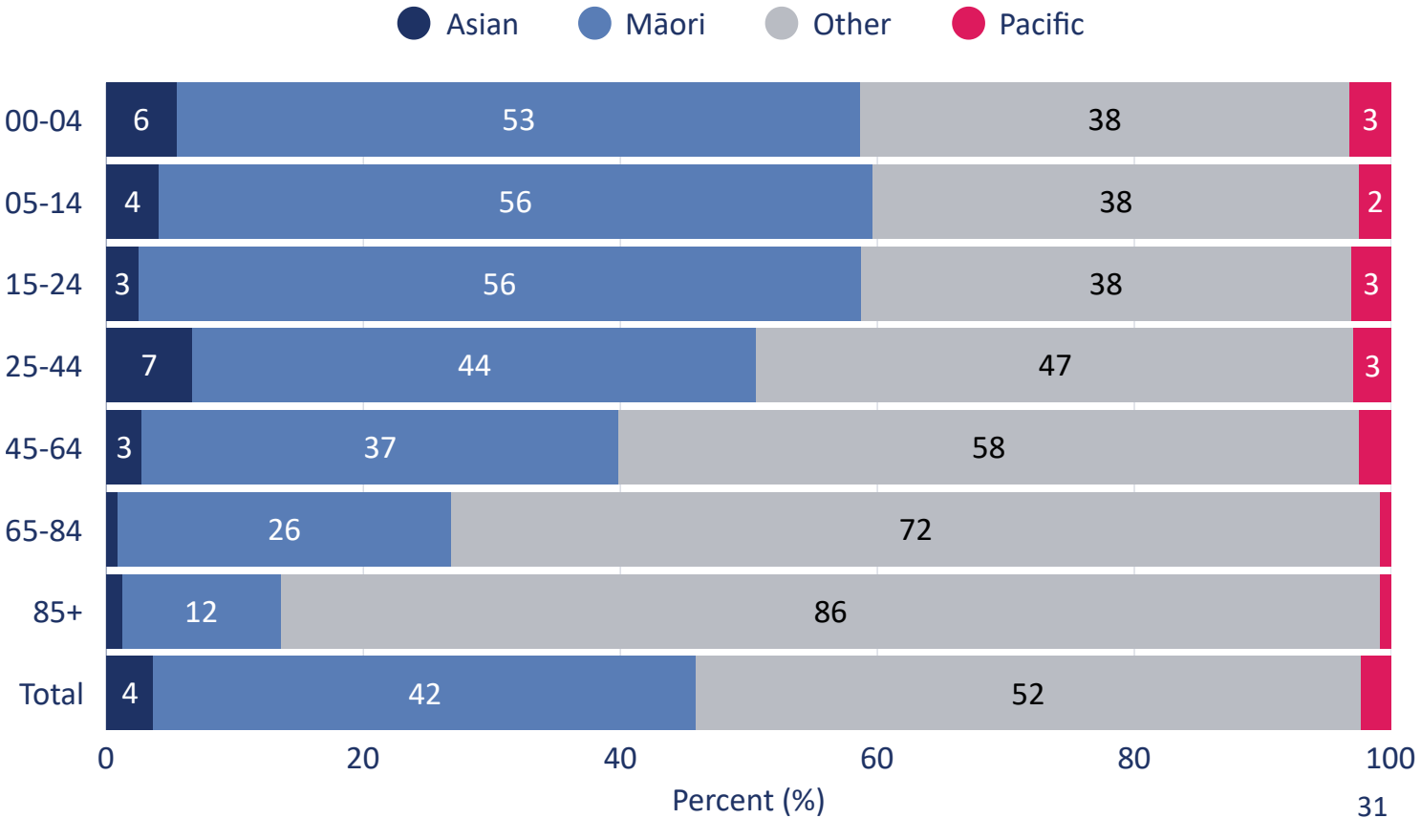
Table 2: Enrolled people, by ethnicity and age group

	Asian	Māori	Other	Pacific	Total
00-04	123	1,183	847	72	2,225
05-14	228	3,110	2,117	138	5,593
15-24	122	2,713	1,841	149	4,825
25-44	623	4,056	4,303	270	9,252
45-64	265	3,511	5,462	233	9,471
65-84	63	1,729	4,830	55	6,677
85+	11	103	717	7	838
Total	1,435	16,405	20,117	924	38,881

Key Points

- 38,881 people were enrolled for the entire 2023/24 year.
- 4% were of Asian ethnicity, 42% Māori, 2% Pacific People and 52% 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



Medical consults in general practice, 2023/24

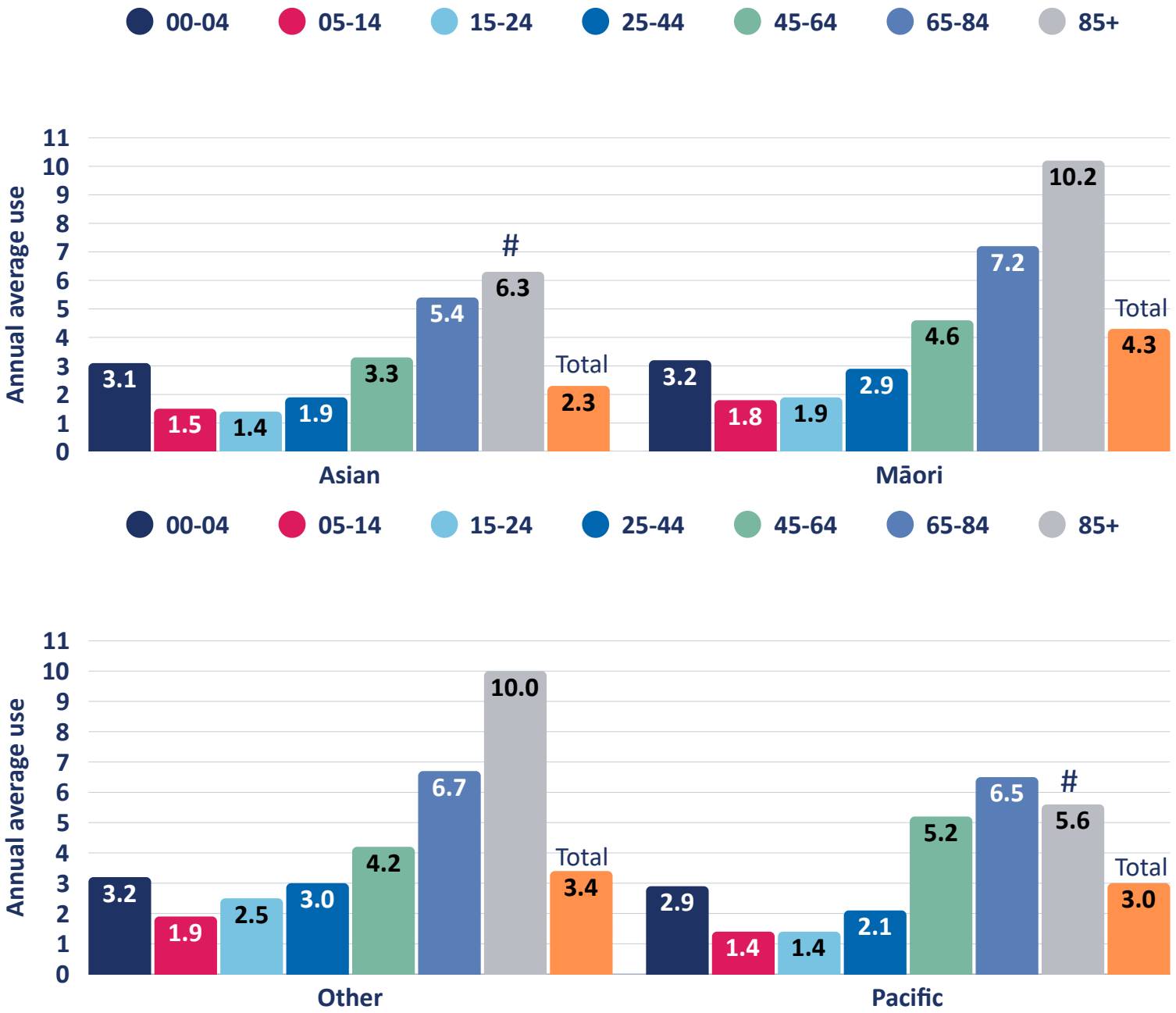
Contents page

All network practices

Key Points

- 148,939 medical consults were recorded for the 38,881 people enrolled in all four quarters of this year.
- The annual average use of medical consult services differs by age, with higher service use for those aged 0-4 years, 65-84 and 85+ years across ethnic groups.
- Those aged 85+ years were a numerically smaller group (n=838), but had the highest average use, with 10.2 for Māori and 10. 0 for Others (note small numbers of Asian and Pacific #).

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.

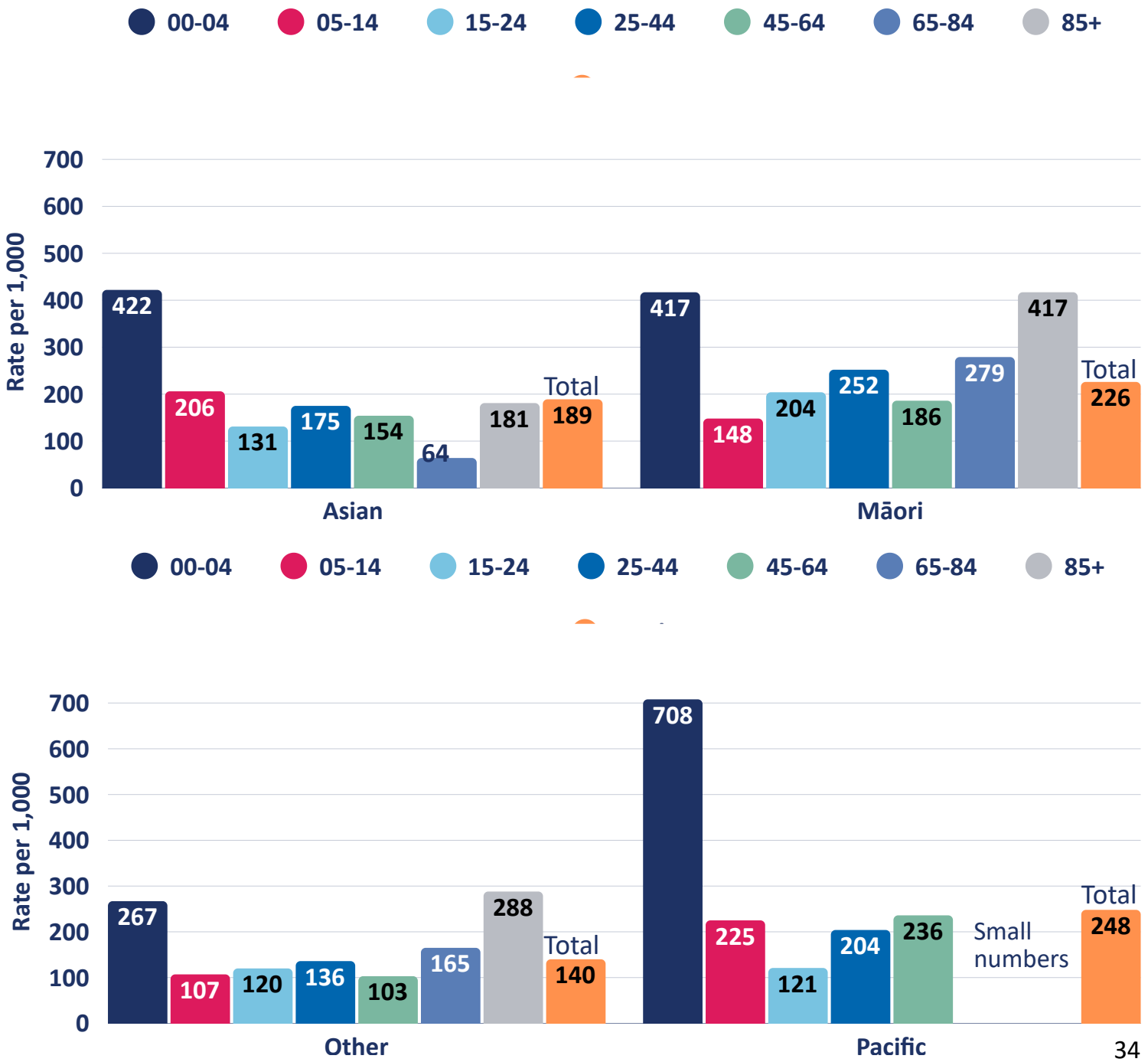
The "unders and overs" in capitation highlight the tension between population-based funding and the reality of individual and community health needs.

People enrolled for all of 2023/24

Key Points

- Rates for low acuity visits (non-accident) to the ED were highest in Tairāwhiti compared to the districts of Lakes, Taranaki and Waikato.
- There was a wide variation in rates across ethnic groups.
- 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

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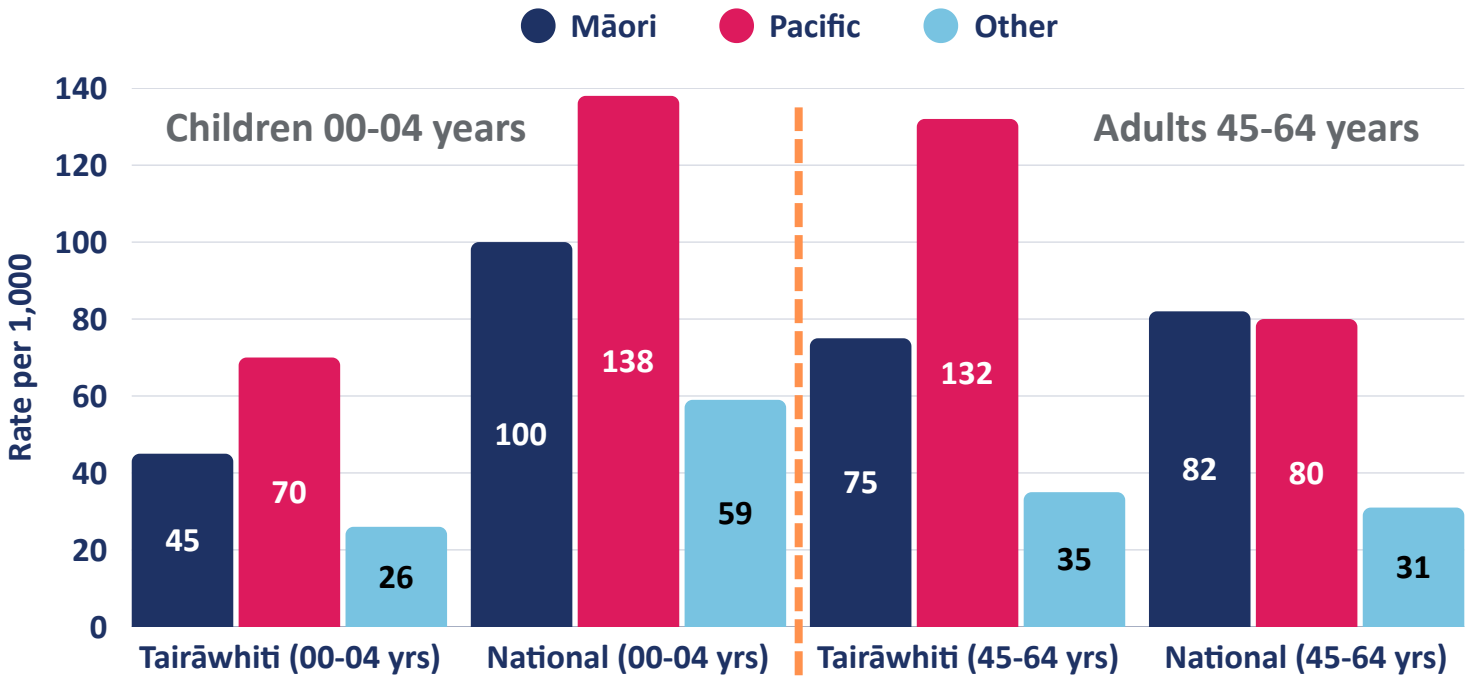
Ambulatory sensitive hospitalisations (ASH) are hospital admissions for conditions that *could potentially* be managed or prevented through primary care interventions. This is considered a partial measure of the effectiveness of the primary and secondary healthcare system interface, it is often used 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 Tairāwhiti 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. Gastroenteritis / dehydration
4. Dental conditions
5. Lower respiratory infections
6. Dermatitis and eczema
7. Pneumonia
8. Constipation

Adults

- Standardised rates for adults were similar for Māori and Others, but higher for Pacific adults (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. Gastroenteritis / dehydration
6. COPD
7. Epilepsy
8. Kidney / urinary infection

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.

Projected Pinnacle enrolled population and service use in 2043

Future population and medical service use

We have taken the projected 2023-2043 percentage change in the resident population (by ethnicity and age group) and applied it to the 2023 Pinnacle enrolled population. 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

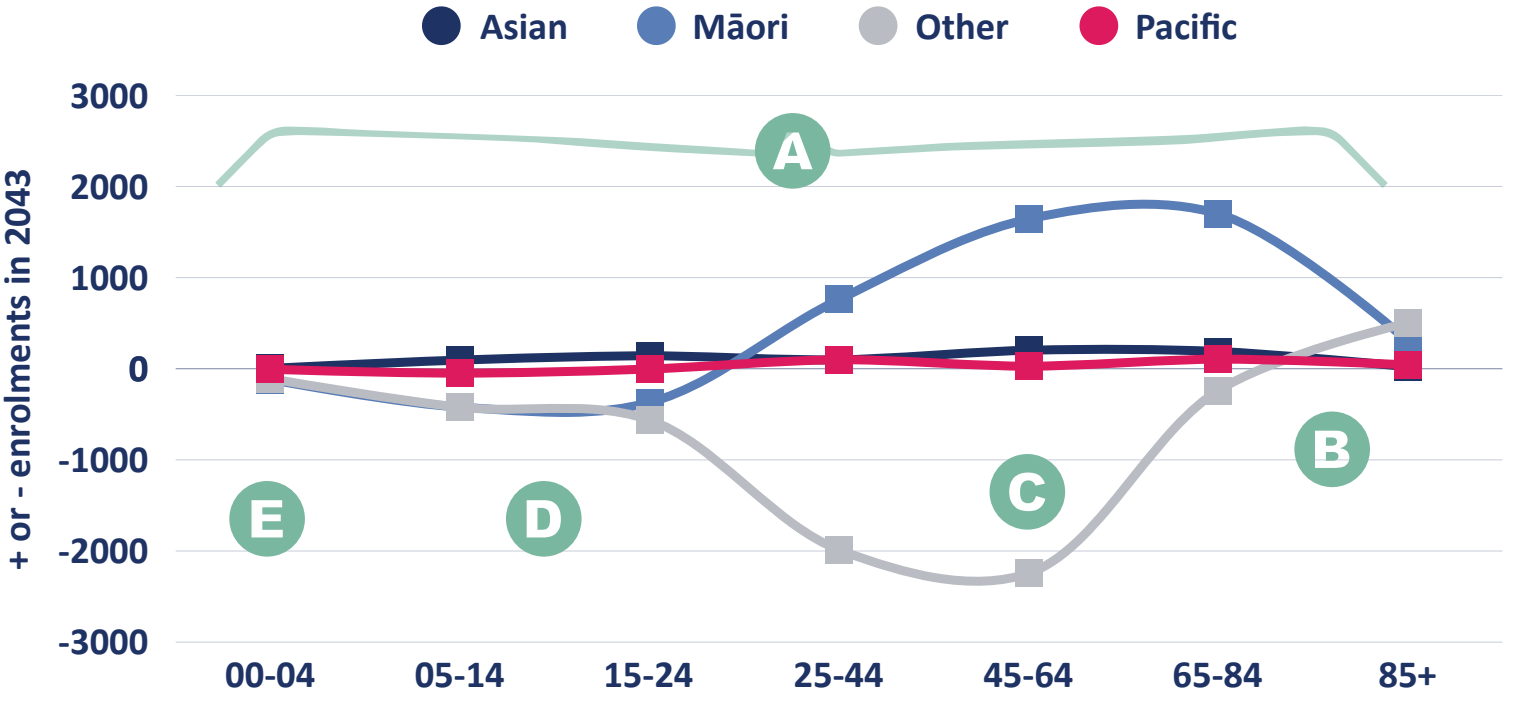
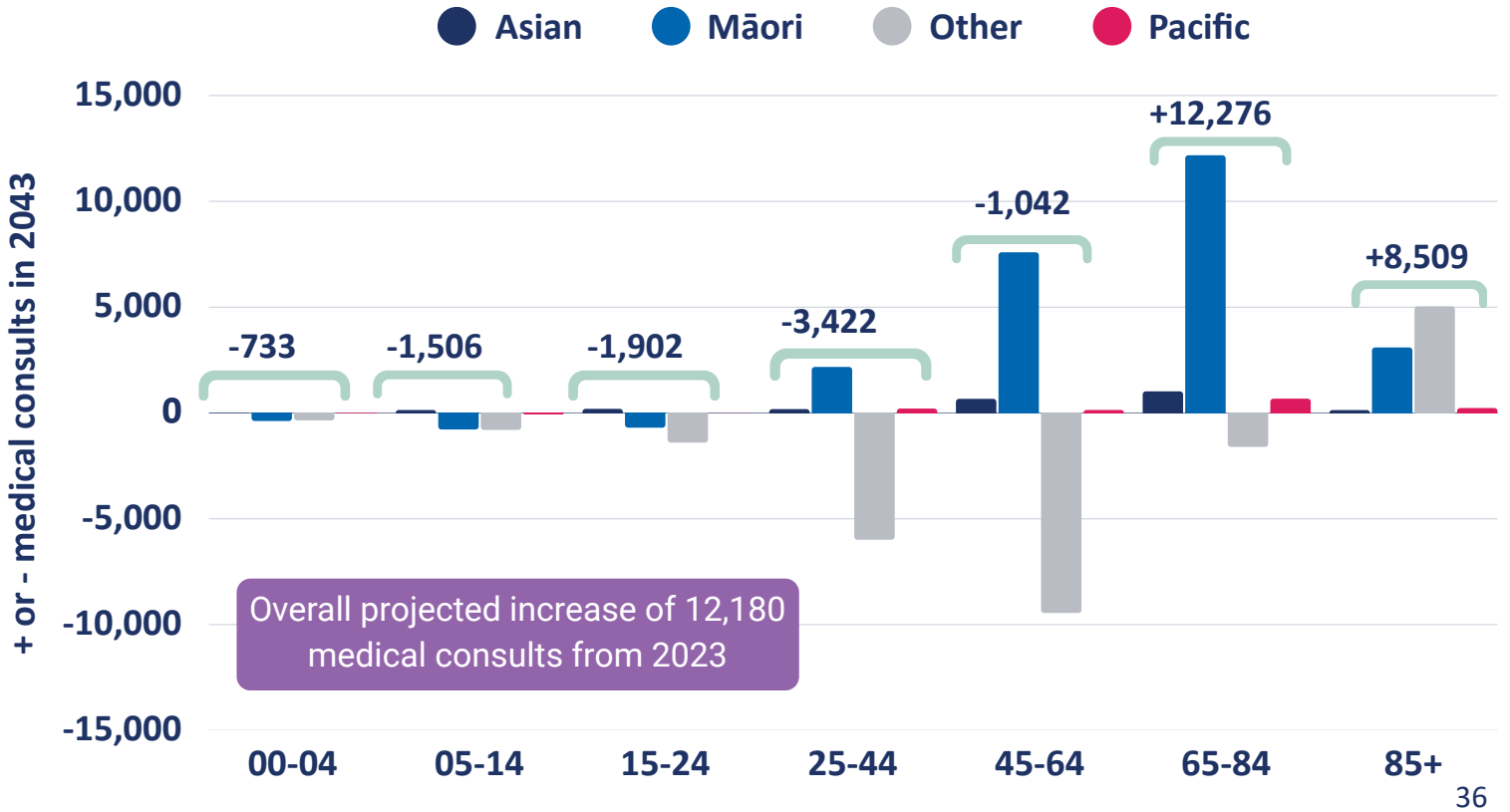


Figure 10: Projected difference in medical consults in 2043 (from 2023 base)



Summary points for Pinnacle

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

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

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

Overall, we are projecting then network may need to provide an additional 12,180 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 hold 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 are the key driver for increased consultations**

65-84 years: There are considerable increases in medical consults projected for Māori (+12,179 from 2023) with a decrease for Other people (-1,604) in 2043. These people are currently aged 45-64 years. The youngest baby boomers will now be in this age group, in 2043 at around 79 years of age (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 8,509 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 consults for Others aged 45-64 years (-9,449) across the network offsets this. The overall decrease in consults for this group is -1,042. These people are mostly in the 25-44 year group in (2023).

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

Projected to be fewer Māori, Pacific and Other people enrolled aged between 5-24 years. It is important to remember that these projections are for medical consults only - there are key lifecycle health care alongside this that will still need to be delivered. There are small projected increases in consults for Asian people from 2023 levels.

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

These children will be born around 2039-2043. The overall projected decline (-221) is driven by fewer Māori and Other children. Note: Immunisation work is not included in this category.

Rural residents enrolled

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

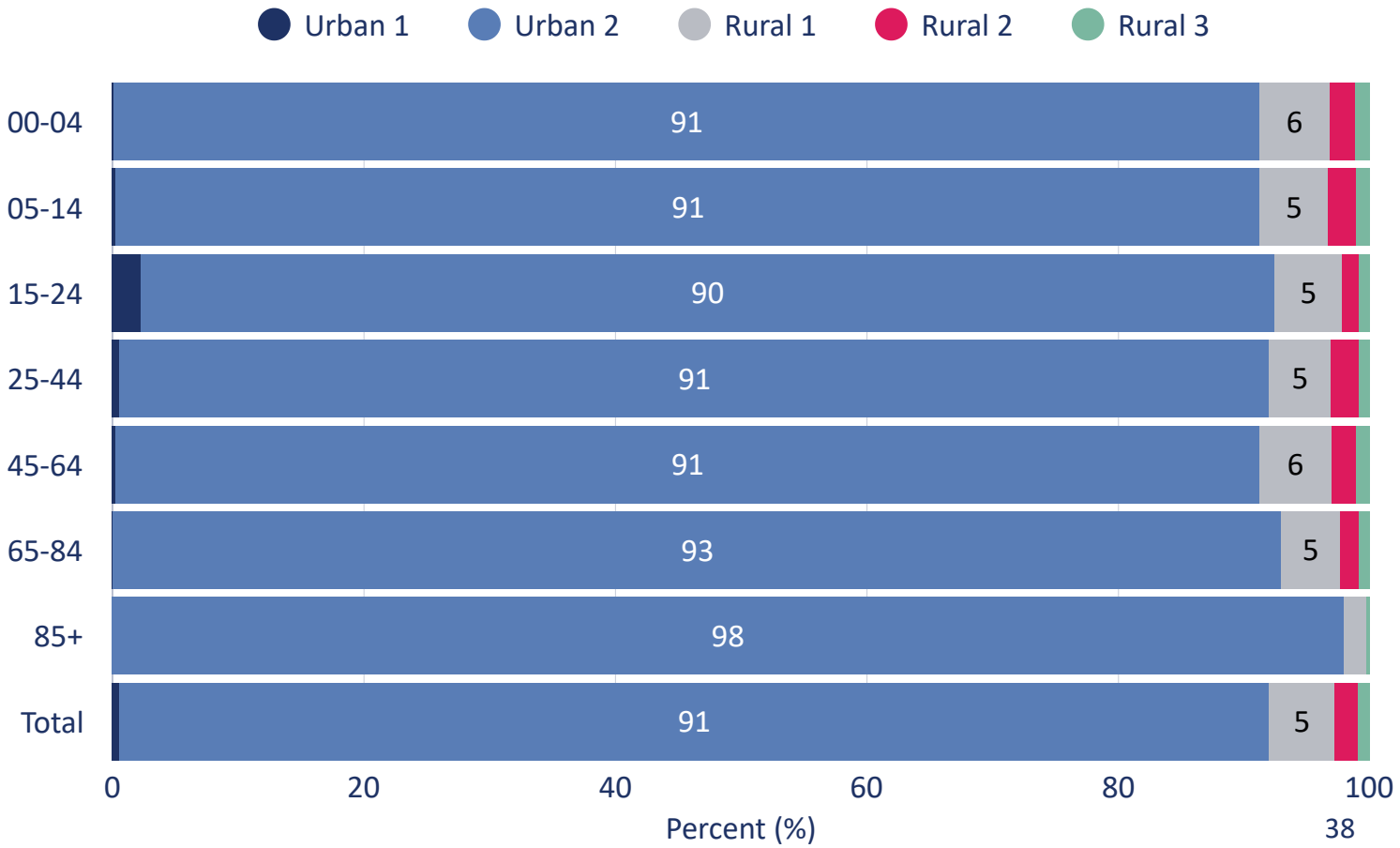
Table 3: Enrolled people, by age and GCH rurality

	Urban 1	Urban 2	Rural 1	Rural 2	Rural 3
00-04	3	2,020	125	45	25
05-14	16	5,021	299	122	61
15-24	108	4,308	256	64	41
25-44	52	8,397	446	209	78
45-64	22	8,536	534	182	103
65-84	5	6,166	312	102	55
85+	0	806	15	0	2
Total	206	35,254	1,987	724	365

Key Points

- Overall, 8.0% of people enrolled in Pinnacle Tairāwhiti lived rurally.
- Most rural residents lived in R1 areas, using the geographical classification of health (66% of all rural).
- Few people lived in the most remote areas (Rural 3).
- 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



Rural residents: Medical service use in 2023/24

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Average service use - by residence category

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

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

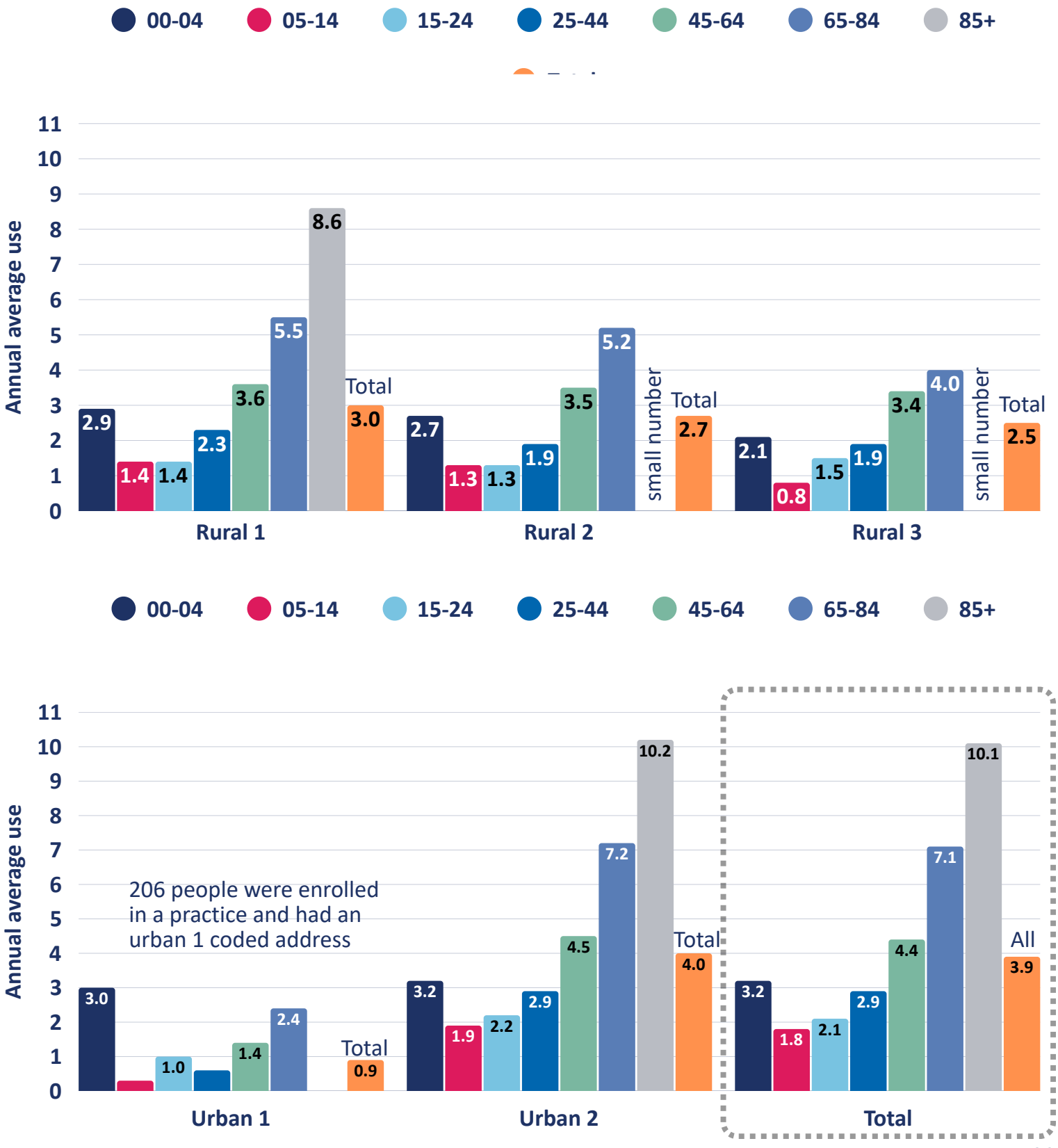
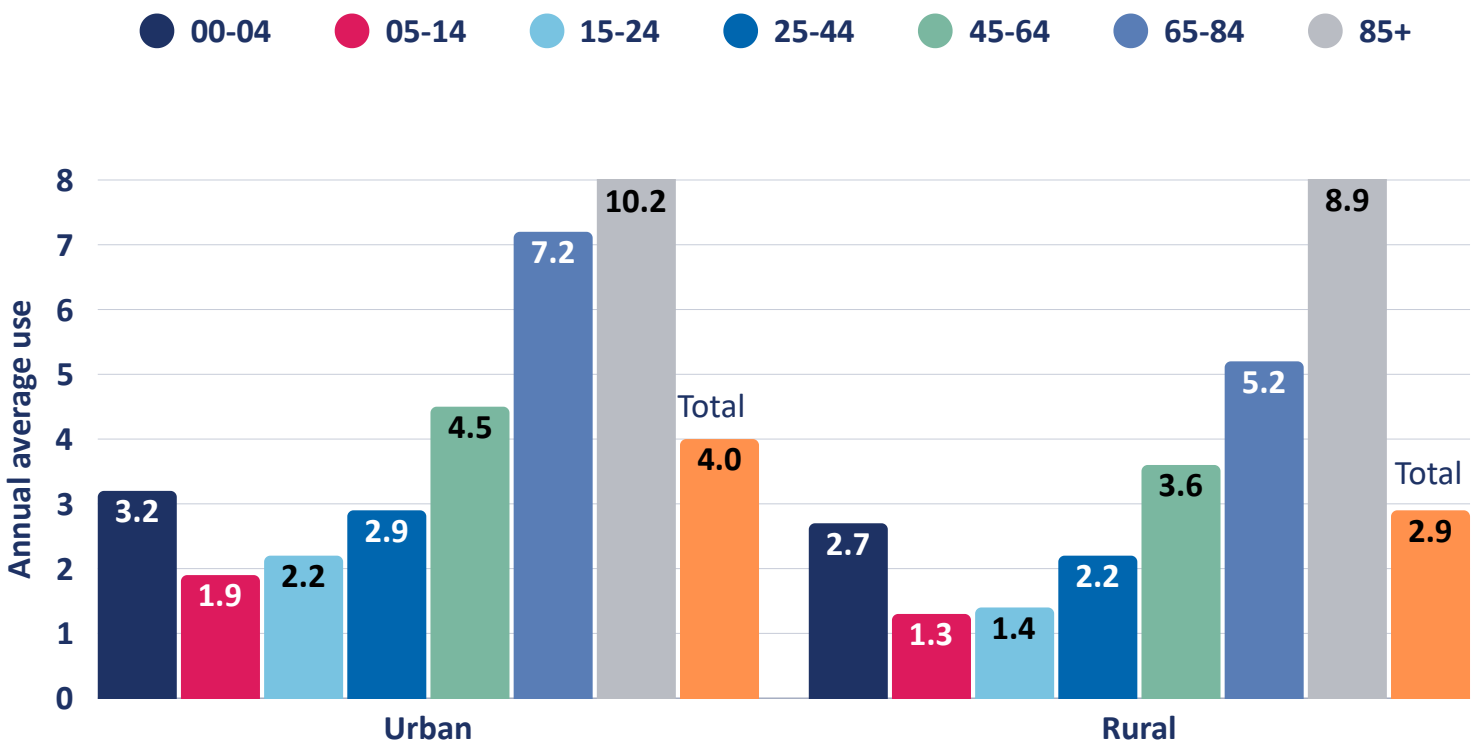


Figure 13: Annual average use of medical consults, by aggregated residence and age



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 six age groups, average use by rural residents is lower than for urban dwellers. At the total level, rural people used on average 2.9 medical consults, compared to 4.0 for urban people.
- Those aged **00-04 years**: There was higher use of medical consults in general practice for urban 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**: A noticeable rural/urban difference is in this age group; 8.9 for all rural residents compared to 10.2 for urban residents