Pinnacle®
Midlands Health Network

Sections 1-3

Te Manawa Taki

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

Pinnacle Incorporated
PO Box 983
Hamilton 3240
www.pinnacle.co.nz

Facebook
@PinnacleHealthNZ

Linkedin
pinnacle-health

Sections 1-3

1 Pinnacle's population health and wellbeing framework

2 Health and wellbeing: Summary report

3 Population change and health service use

Pinnacle®
Midlands Health Network

Contents page

Our population health and wellbeing framework

Our approach to population health and wellbeing

Contents page

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 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.

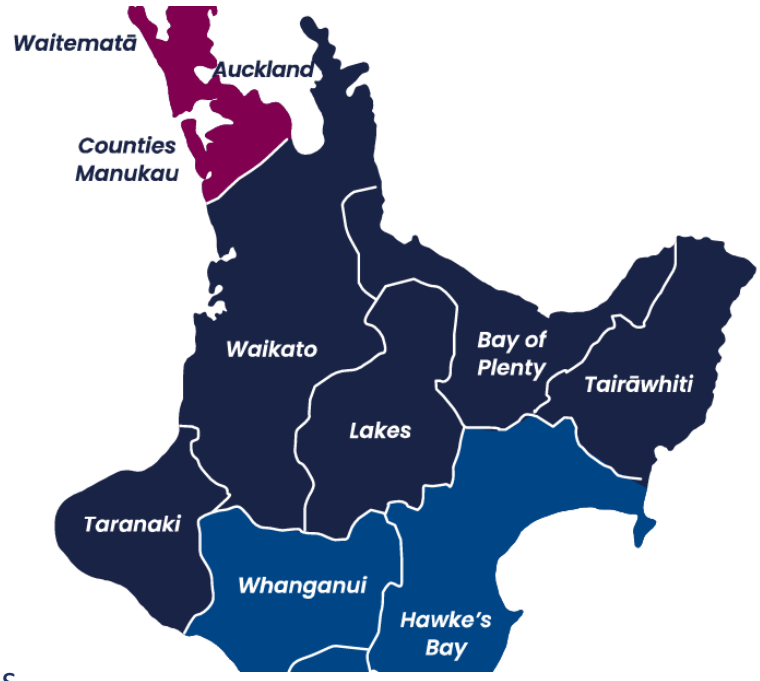
Population health & community wellbeing

Population health & 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 communities.

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

Contents page

Defining population health & 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 improve population health by reducing the burden of disease, improving health outcomes, and promoting equity in health and wellbeing.

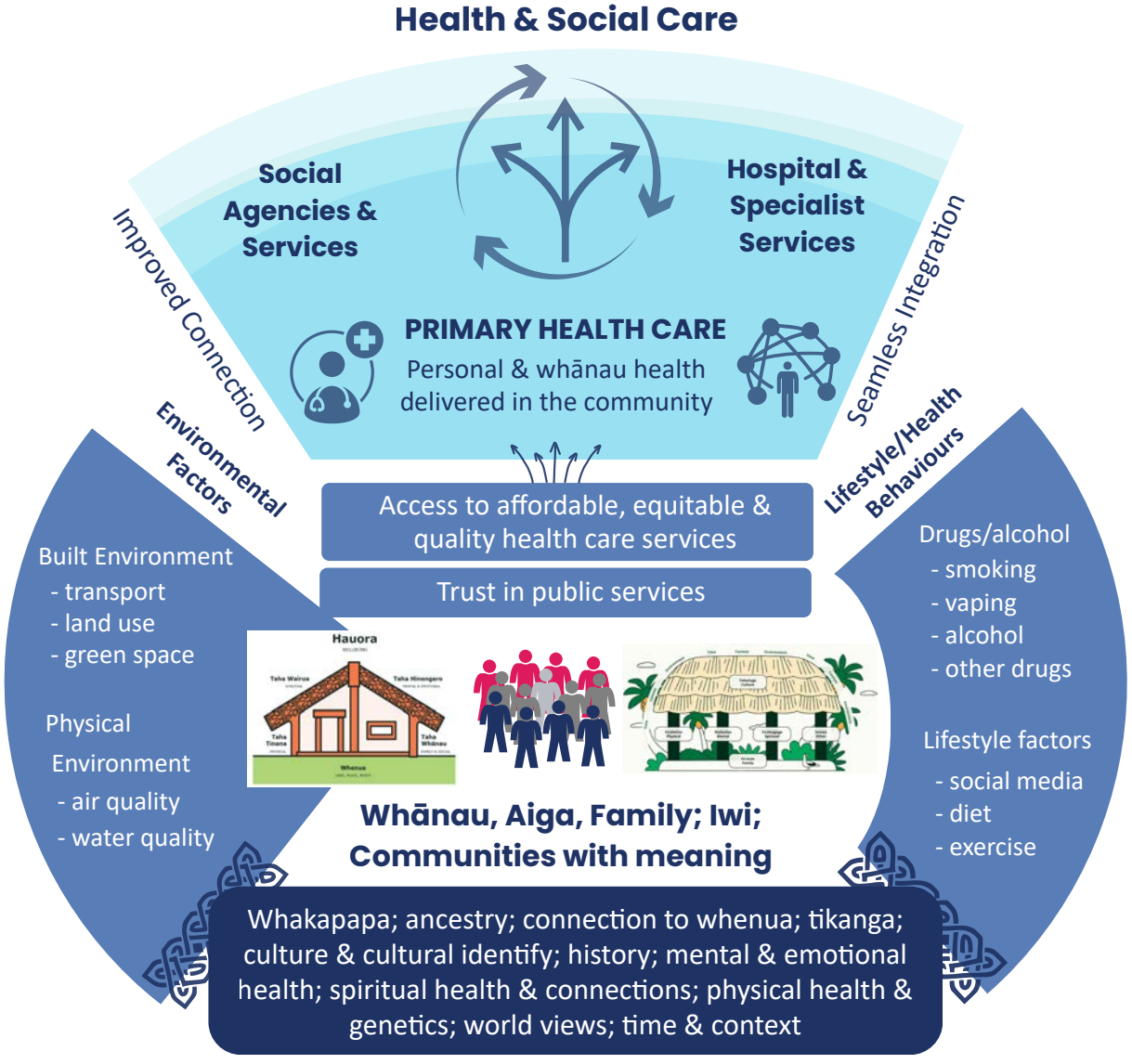
How we will measure this:

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

Integrated model of health and wellbeing

Contents page

Health and well-being 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 well-being 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

Contents page

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

Pinnacle®
Midlands Health Network

Contents page

Te Manawa Taki health and wellbeing summary

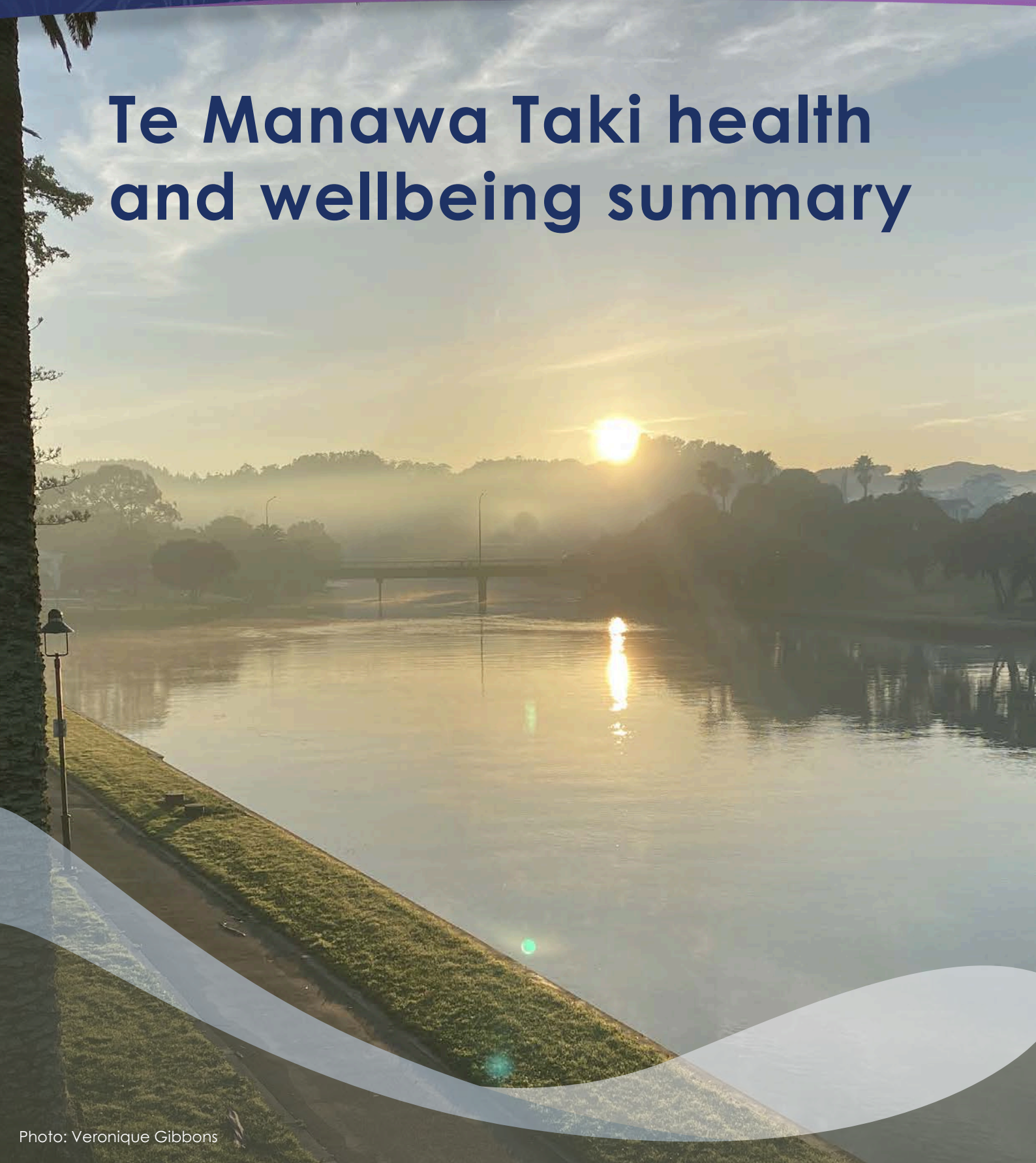


Photo: Veronique Gibbons

Health and wellbeing in Te Manawa Taki

Contents page

The Pae Ora (Healthy Futures) Act 2022

The Act replaced the Public Health and Disability Act 2000 and established a more centralised healthcare system. It aims to create a more cohesive, efficient, and equitable health system.

Key aspects of the legislation include:

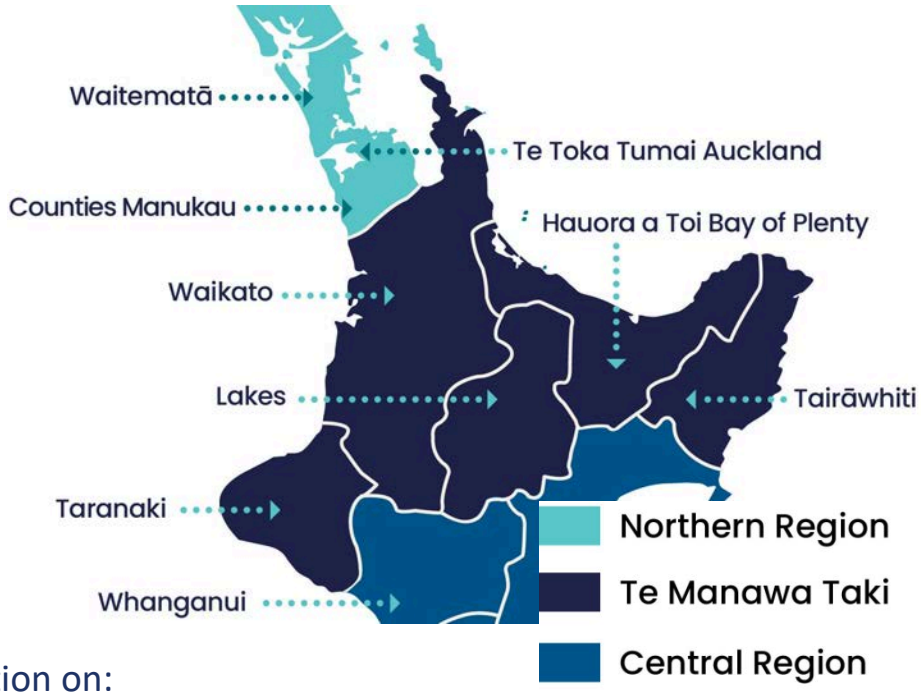
- Health system restructuring, including creating Te Whatu Ora (from District Health Boards) to manage hospital and specialist services at a national level.
- A greater emphasis on reducing health disparities, particularly for Māori, Pacific peoples, and rural communities.
- A renewed population health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

Health regions and across sector information

Te Manawa Taki is one of four health regions, covering the Waikato, Bay of Plenty, Lakes, Taranaki, and Tairāwhiti districts. The regions were established under the health reforms to improve coordination and delivery of healthcare.

Other organisations have released health and wellbeing information relating to the region, including Manatū Hauora, Te Whatu Ora, Te Aka Whai Ora, iwi and Iwi Māori Partnership Boards (IMPBs) and Hauora Taiwhenua.

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



This section covers selected information on:

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

About the Pinnacle 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, other priority populations and clinicians, is central to our work.

Network Snapshot: March 2025

	Taranaki	Lakes	Waikato	Tairāwhiti
Practices	28	6	46	5
Total patients	120,353	46,169	268,498	41,570
Māori patients	23,215	17,704	46,427	17,704
GP FTE	81.3	23.5	204.1	23.5
Nurse FTE	95.0	33.7	188.1	33.7

Network Workforce

1,438
GP/patient ratio

331.3
GP FTE

357.3
Nurse FTE

Primary Health Care Limited (PHCL)

owned by Pinnacle Inc

7 General practices

GP/patient ratio **1,978.8**

35
Rural practices
(inc. 2 non-funded)

142,645
Rural patients

24.7%
Māori

Consults delivered by the Pinnacle network in 2024

Consults with GPs **1.1 million**

\+ **306 thousand** Nurse consults

\+ **232 thousand** Consults with other clinicians

 # Includes medical consults and other claim types

plus Community health care outside general practice

27,240
Practice Plus booked consults

3,273
Ka Ora calls (for rural GPs)

5,038
after hours consults via Whakarongorau Aotearoa

Contents page

PINNACLE identified RISKS & ISSUES

01 Workforce sustainability

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

02 Increased health complexity

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

03 Changing models of care

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

04 Health inequities

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

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

05 Funding models & strategy

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

06 Fragmented IT systems

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

07 Integrating siloed workforces

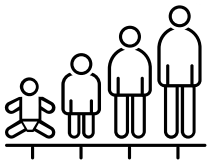
Primary care has limited integration with community & secondary care providers.

People
Now & future

Contents page

20% of New Zealand's population live in Te Manawa Taki.

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



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

18%
are 65+ years now

23%
65+ years in 2043

12,564 Babies born in 2024*

excluding Ruapehu District

In 2023

28% Māori
3% Pacific
60% Other
9% Asian

Population projections

2023 **1.03 million** → 2043 **1.17 million**

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

Māori in Te Manawa Taki

288,160 live in the rohe now

47% are under 25 years

The Māori population has a young age structure

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

7.7% Māori are aged 65+

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

Projected population change

8% Māori in 2023 aged 65+ increasing to **11%** in 2043

23% non-Māori in 2023 aged 65+ increasing to **29%** in 2043

Where people live

Urban compared to Rural

62% Māori **38%**

66% non-Māori **32%**

Contents page

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 with a practice & make appointments to see the GP or nurse when needed

Clinician communication

Better communication between GPs & 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.

Iwi Māori Partnership Boards: Identified Priorities

Primary & Community Care

Contents page

Te Manawa Taki currently has six IMPBs (five across the Pinnacle Network area). These boards represent local Māori perspectives on the needs and aspiration of Māori in relation to hauora Māori outcomes.

The priorities summarised here are from the IMPB community health plans. These interconnected elements provide a framework for health that aligns with Māori values, promotes equity, and supports a future where all people can achieve their fullest health potential.

Te Punanga Ora

Maternity & child health; Child & youth health; Oral health; Primary mental health & addictions; GP services; Pharmacy; Rongoā Māori; Needs assessment & coordination (NASC); Aged residential care (ARC); Audiology; Tane ora services.

Tūwharetoa

Maternal & pepi health (midwives, breast feeding); Immunisation; General practice (access, use of ED, unenrolled); Pharmacy (medicine access); Oral health; NASC & ARC (availability, respite care); Primary mental health & addictions)

Te Tiratū

Primary care (enrolment, access & options, wait times, Tane health care); Maternity; Immunisation; Long-term conditions; Oral/dental health; NASC & ARC; Palliative care Primary mental health & addictions; Rongoā Māori.

Tairāwhiti Toitū Te Ora

Equity & kaupapa Māori services; mental health & addictions; maternal & child health; preventative and chronic disease management; community-based healthcare; health systems reforms. hauoraTairāwhiti.org.nz

Te Taura Ora o Waiariki

Maternal & pepi health (midwives, perinatal mental health, immunisation); General practice (access, costs, transport/distance, afterhours care); Pharmacy - medicine access); Oral health; NASC, home support and ARC; Primary mental health & addictions; Rongoā Māori & Mātauranga Māori.

Determinants of Health & Wellbeing

Contents page

IMPB Priorities

Housing, tobacco & vaping, gambling, food security, alcohol & climate change are priority determinants

Household Crowding

79% of Māori live in un-crowded homes

along with

60% of Pacific people

Housing in the rohe

DAMP & MOULD

1 in 4 report their home is damp and 1 in 5 has mould

THE COST OF HOUSING

15% of households spend 40% + of their income on housing

HOME OWNERSHIP

58% European; 31% Māori & 21% Pasifika own their own home

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 & collaboration between many agencies.

Smoking

8.8% of all TMT residents

Across Aotearoa

17.2% of Māori

14.7% Pasifika

5.0% Asian

7.4% European/Other

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

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

1 in 5 adults engage in hazardous drinking patterns

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)

Te Manawa Taki
Health Status & Wellbeing Measures

Contents page

75–78 years
71–74 years

Life expectancy

Ffrom 74 in the most deprived areas to 87 in the least deprived areas

85.5%
Estimated adults
771,000

Self-rated health

Said **their own** health was good, very good or excellent

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)

2.0% Diagnosed with heart failure (est. 18,000 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**

14.7% engage in **little or no physical activity** (<30 minutes of physical activity in the past seven days)

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

Contents page

Key Health System Risks & Pressures

Workforce shortages

01

Medical, nursing, allied health & support roles

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

Health equity

02

Culturally responsive & equitable care

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

Access to health care

03

Unmet need, the cost of care, afterhours care

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

Rural health

04

There are health inequalities for rural residents

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

Funding models

05

Sustainable & equitable funding models are needed

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

Health complexity

06

Health complexity is increasing

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

Technology

07

IT systems & infrastructure are not fit for purpose

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

Secondary backlog

08

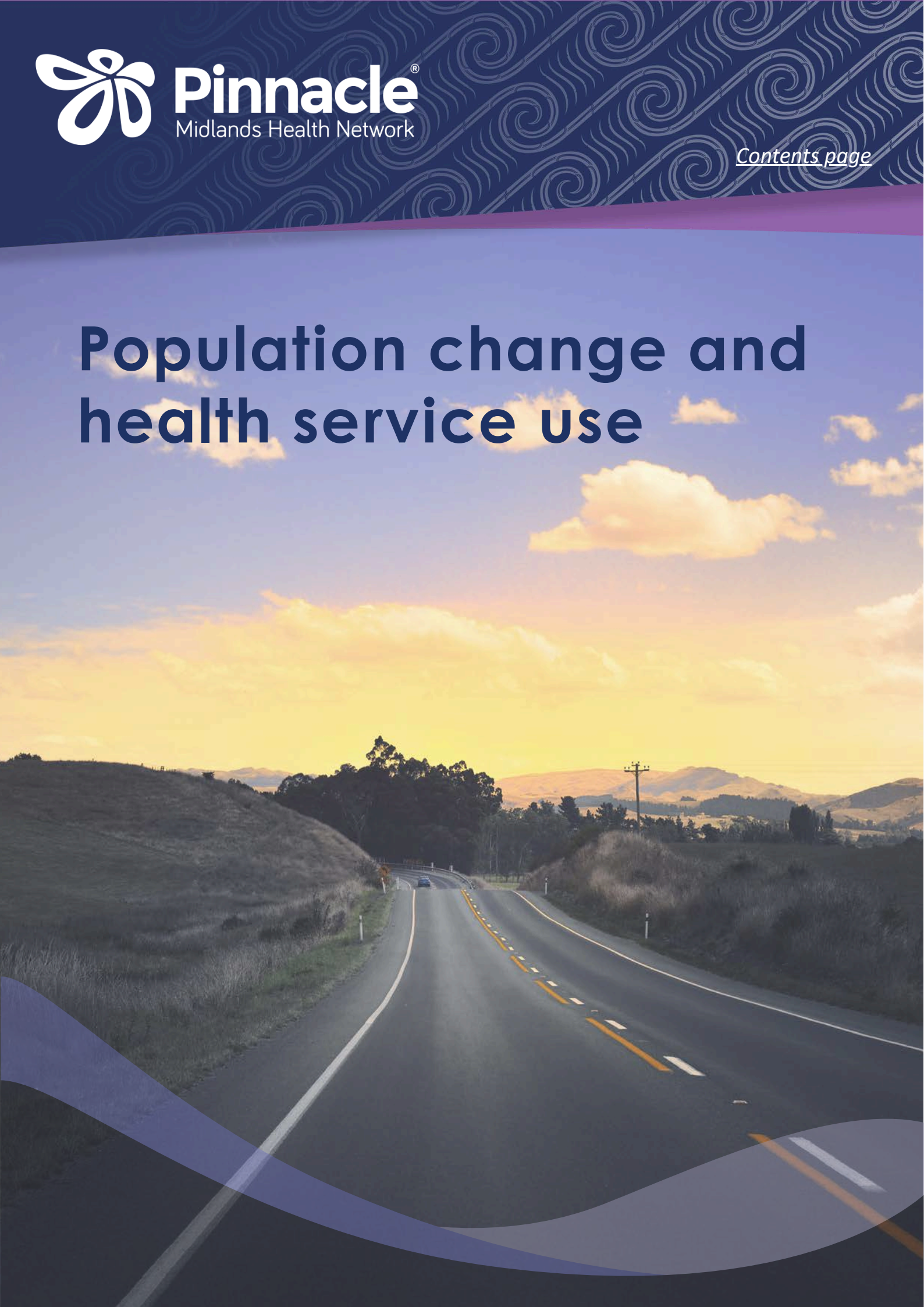
Delays in accessing secondary care are growing

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

Pinnacle®
Midlands Health Network

Contents page

Population change and health service use



Summary: Population change

Contents page

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

Contents page

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.

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

The 2023 estimated resident population (ERP)

Contents page

Ethnicity and age summary

Unless stated, data about the estimated resident population (ERP), current and projected, excludes the Bay of Plenty.

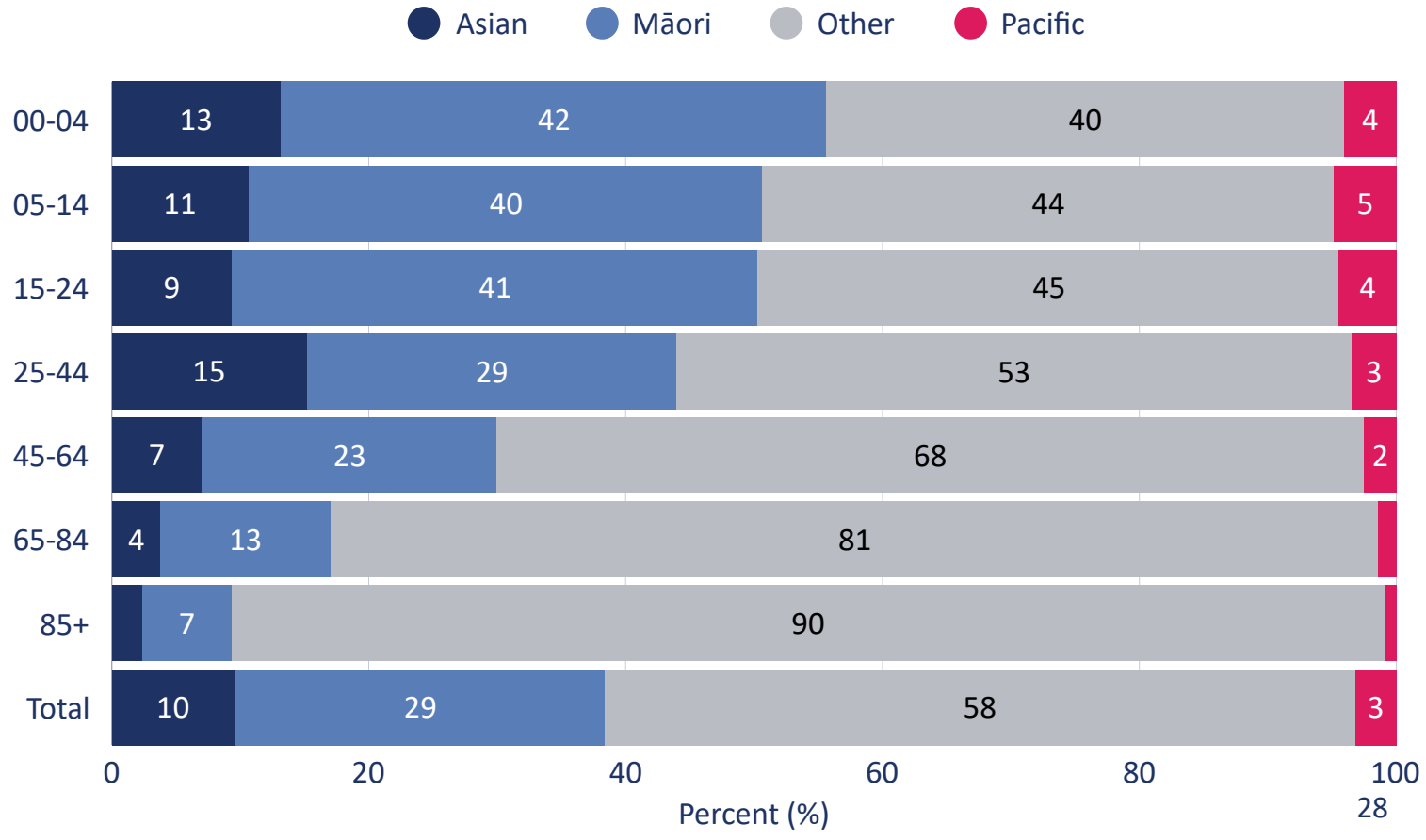
Table 1: ERP, by age and ethnicity, 2023

	Asian	Māori	Other	Pacific	Total
00-04	6,395	20,530	19,510	1,965	48,400
05-14	10,740	40,000	44,580	4,860	104,180
15-24	8,670	38,050	41,970	4,155	92,845
25-44	29,610	55,870	102,230	6,715	194,425
45-64	12,950	42,150	124,110	4,545	183,755
65-84	4,550	15,880	97,370	1,690	119,495
85+	330	960	12,380	125	13,795
Total	73,250	217,440	442,150	24,055	756,895

Key Points

- Almost 757,000 people were resident in the four districts of Waikato, Lakes, Tairāwhiti and Taranaki in 2023.
- Overall, 29% of people were Māori, with 3% and 10% for Pacific people and Asian respectively.
- Figure 1 shows the difference in the age structure by ethnicity, with a significant proportion of young people (<25 years) being Māori.
- The older age structure of the Other population (mostly Pākehā) is also very clear.

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



Key changes: Numbers and proportion

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

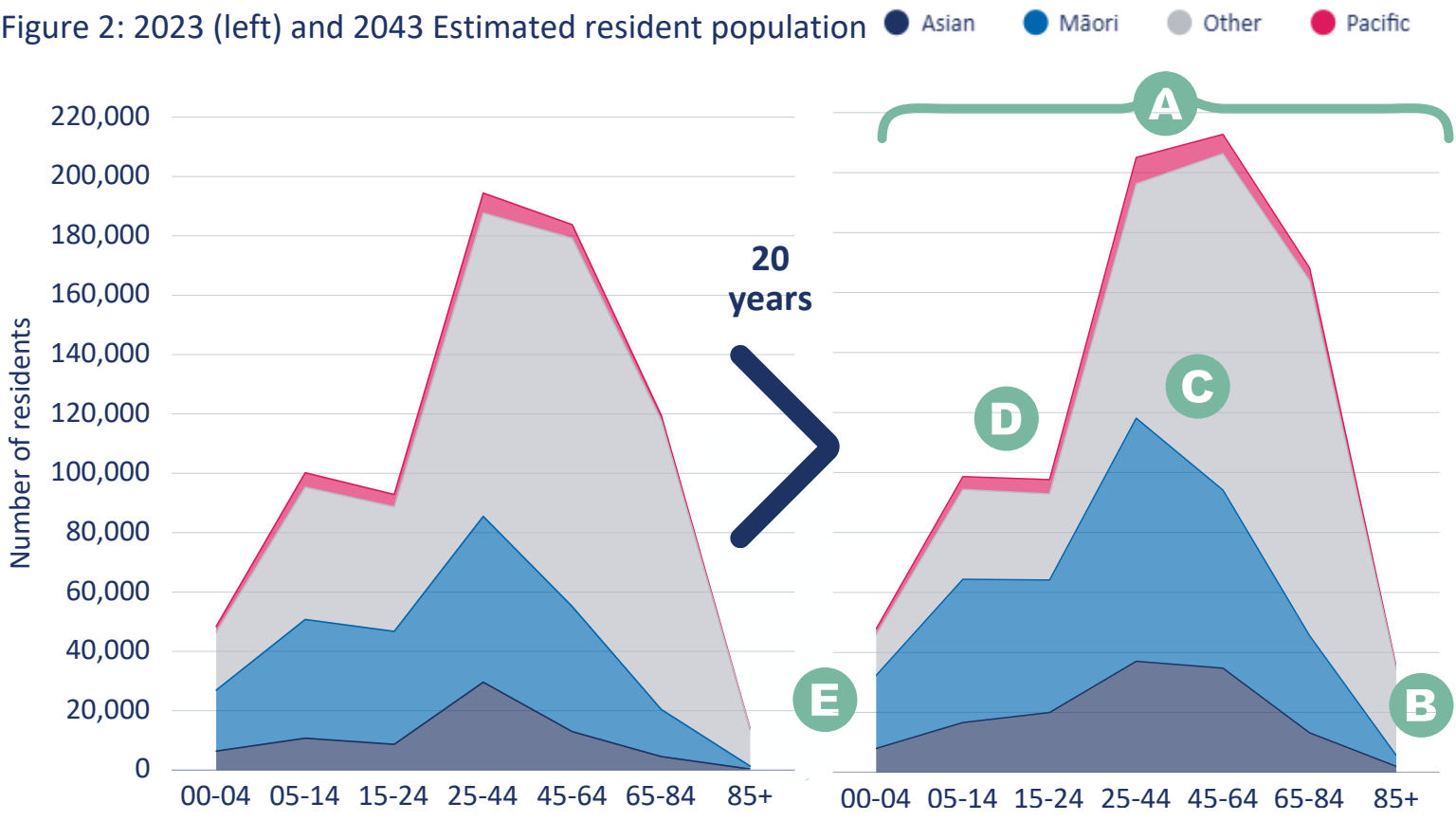
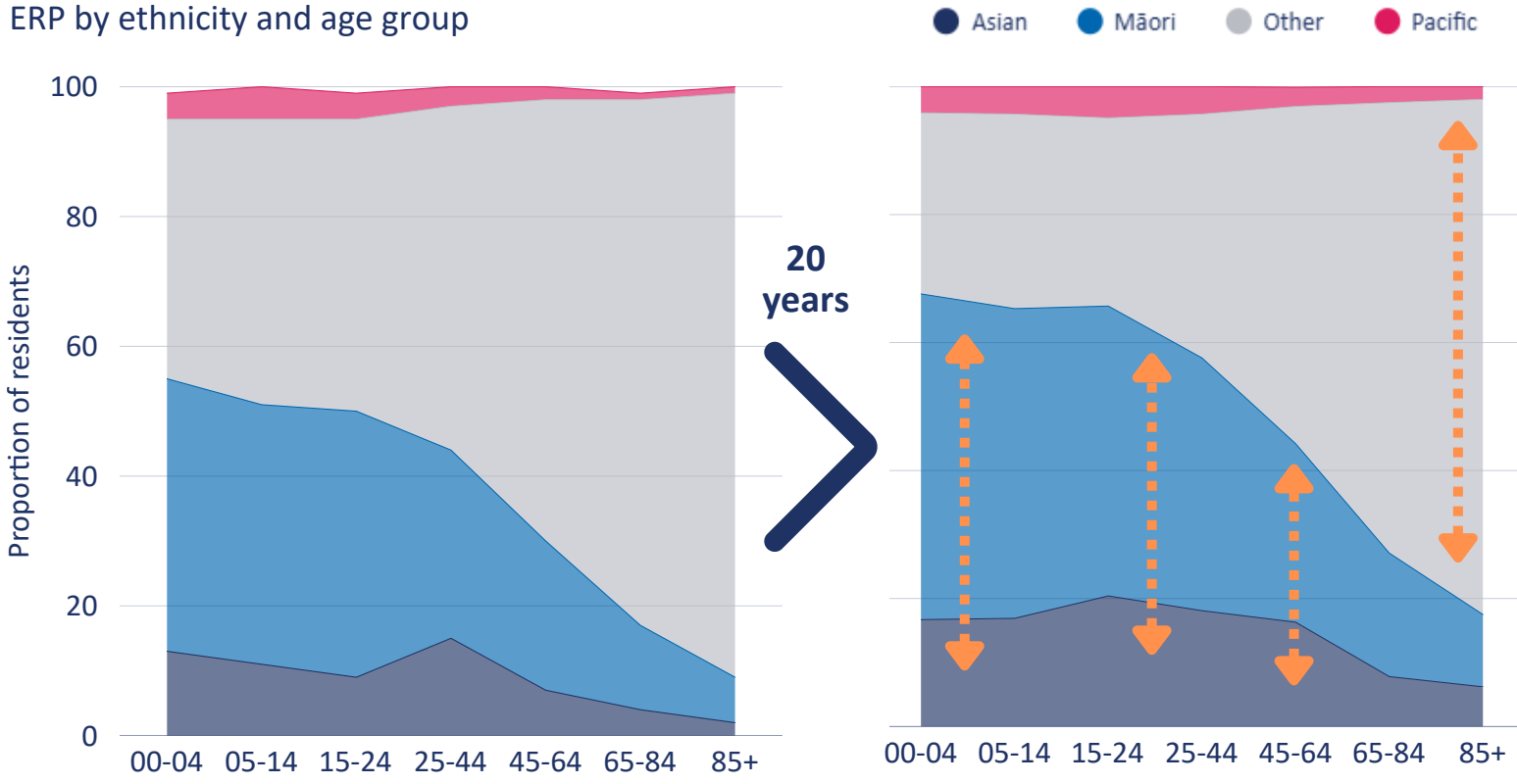


Figure 3: 2023 (left) and 2043 (right) proportion of ERP by ethnicity and age group



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

Contents page

A **Overall change:** Numerical and structural ageing differs between ethnic groups over the 20 year time period.

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. Proportion of 85+ Other declines from 90% to 81%.

C **Middle aged people (45-64 years):** Numerical increase. The proportion of Other people in this age group falls from 68% to 53% in 2043. Proportion of Māori and Asian grows.

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

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

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.

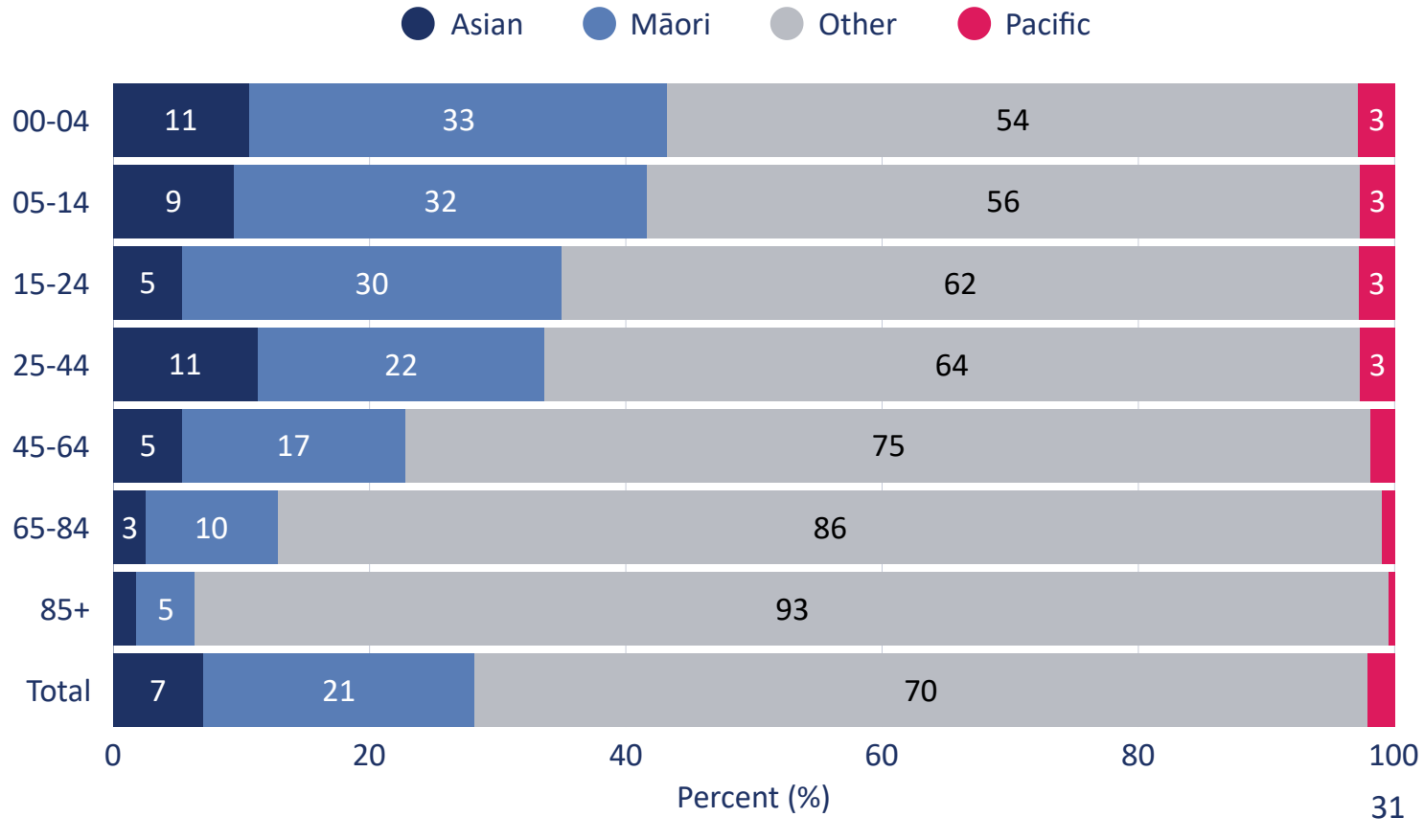
Table 2: Enrolled people, by ethnicity and age group

	Asian	Māori	Other	Pacific	Total
00-04	2,377	7,285	12,036	625	22,323
05-14	5,606	19,190	33,042	1,607	59,445
15-24	2,752	15,124	31,719	1,424	51,019
25-44	11,741	23,154	66,005	2,772	103,663
45-64	5,972	19,194	83,015	2,011	110,192
65-84	2,074	8,302	69,419	774	80,569
85+	179	454	9,224	41	9,898
Total	30,701	92,694	304,460	9,254	437,109

Key Points

- 437,109 people were enrolled for the entire 2023/24 year.
- 7% were of Asian ethnicity, 21% Māori, 2% Pacific People and 70% Other (majority Pākehā).
- Like the resident population, the Pinnacle enrolled population shows very different age structures by ethnicity.
- 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

- 1,310,764 medical consults were recorded for the 437,109 people enrolled in all four quarters of this year.
- The annual average use of medical consult services differs markedly by age, with higher service use for those aged 0-4 years, 65-84 and 85+ years across all ethnic groups.
- Those aged 85+ years were a numerically smaller group (just under 10,000), but had the highest average use, ranging from 4.6 for those recorded as Asian to 7.3 for Māori.

Figure 5: Annual average use of medical consults, by ethnicity and age group, 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.

Contents page

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 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, 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 clinician 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.

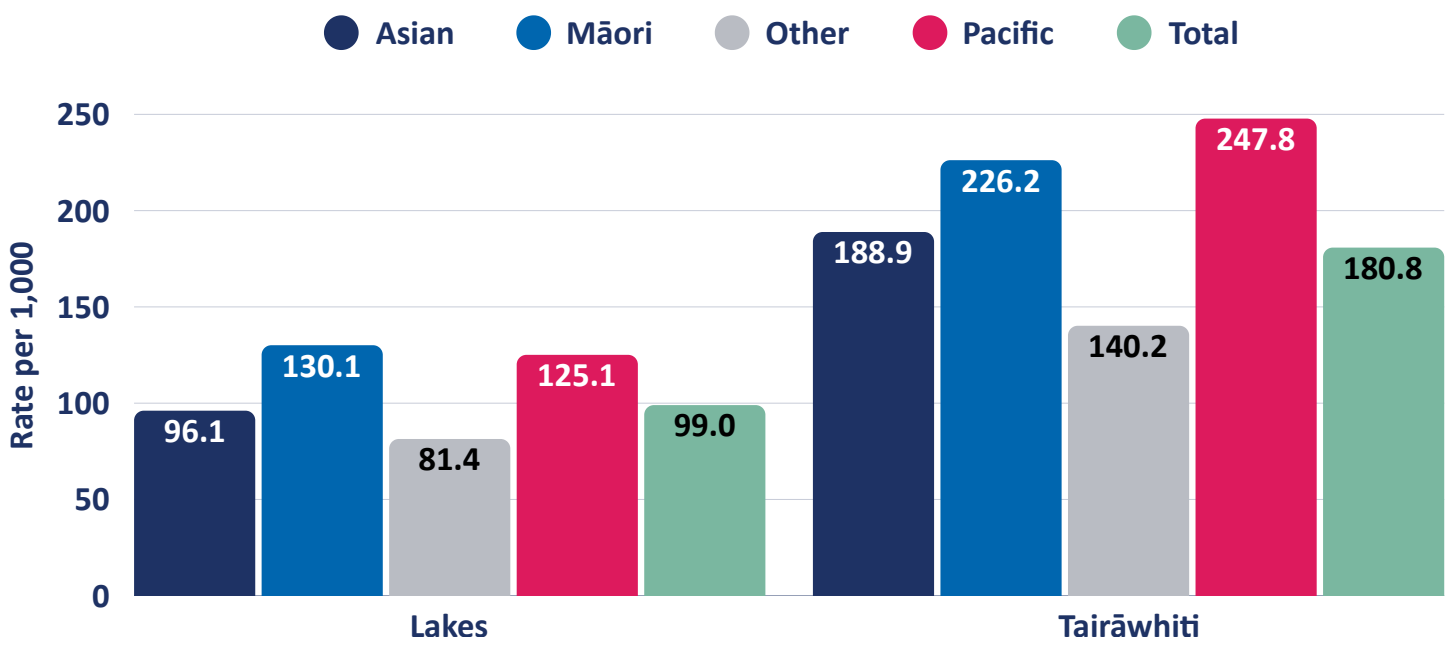
The "unders and overs" in capitation highlight the inherent tension between population-based funding and the reality of individual and community health needs.

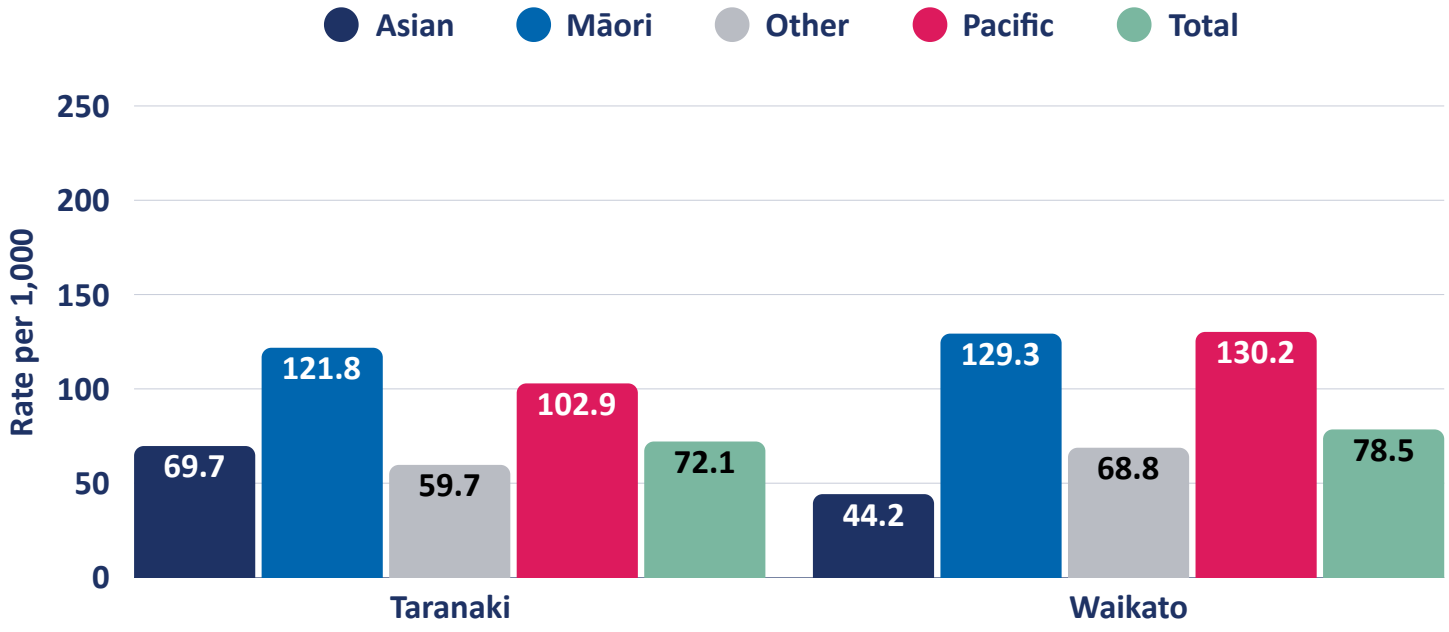
People enrolled for all of 2023/24

Key Points

- Rates for low acuity visits to the ED were highest in Tairāwhiti. The lowest rate of 140 per 1,000 (for Others) was higher than any rate across all ethnic groups in the other three districts.
- Rates for Māori were similar in Lakes, Taranaki and Waikato at 120 - 130 visits per 1,000 enrolled.
- Across district, rates were lowest in the Waikato for Māori (44 per 1,000) and highest for Pacific people in Tairāwhiti (247 per 1,000).

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





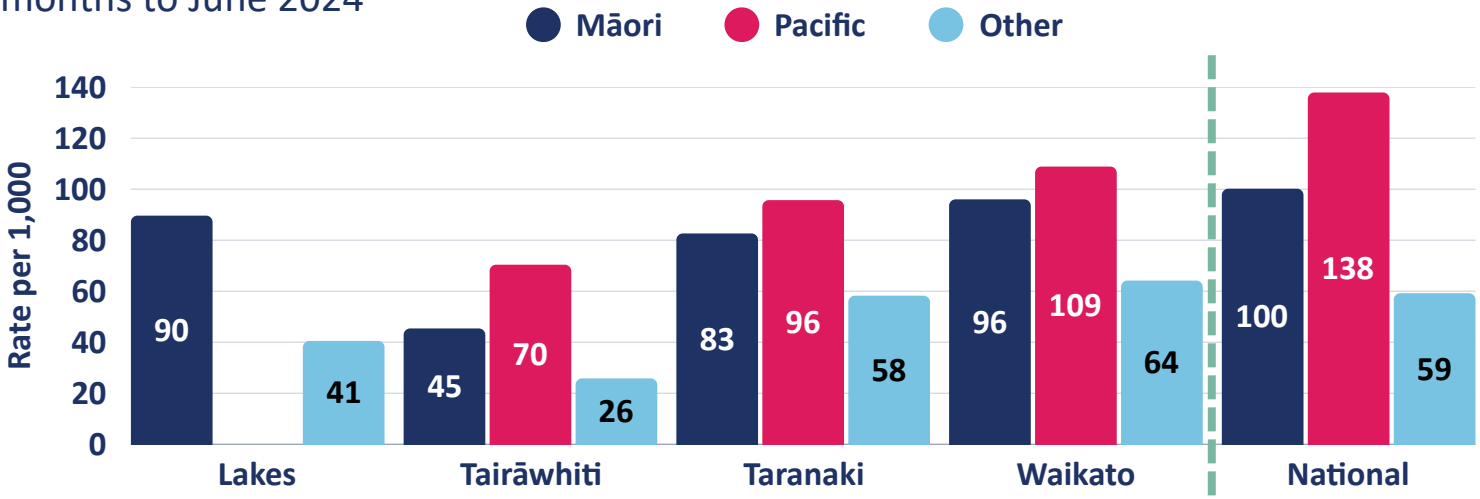
Ambulatory sensitive hospitalisation in 2023/24

Contents page

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

Children aged 0-4 years

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

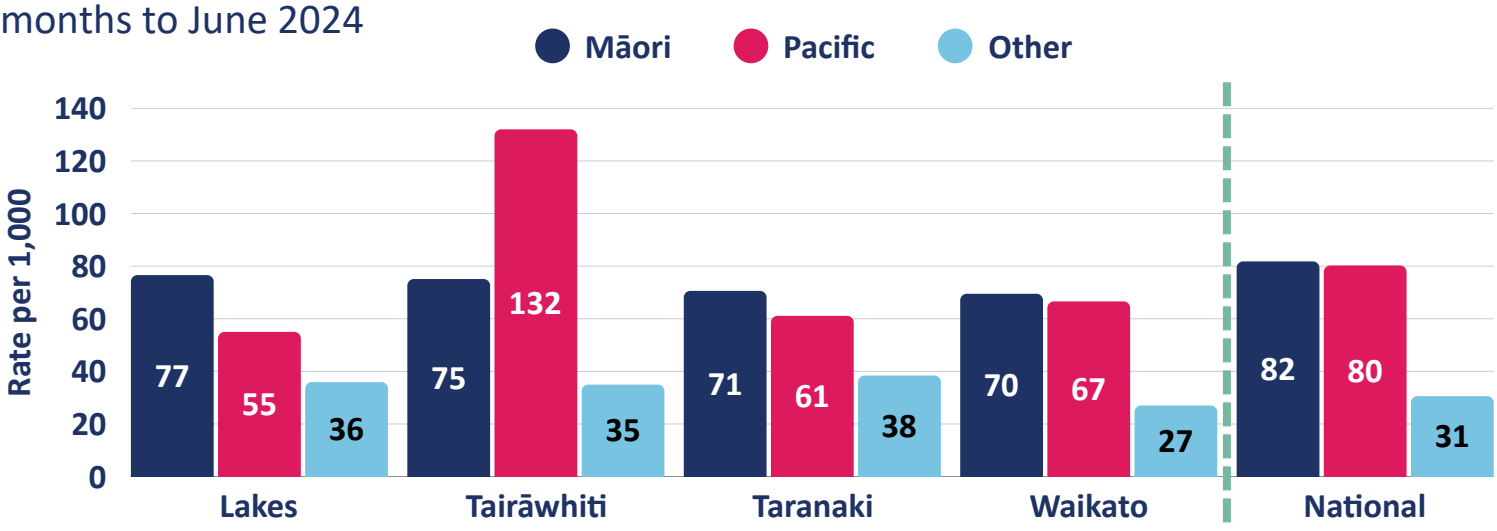


Key Points

- For children, rates across districts are similar to or lower than national levels, with ASH for Other children being lower within districts.
- For adults, highest rate is in Tairāwhiti for Pacific people. Otherwise, rates are similar to or lower than at the national level.

Adults aged 45-64 years

Figure 8: Standardised ASH rate per 1,000 population by district and ethnicity, 12 months to June 2024



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

Contents page

Future population and medical service use

We have taken the projected 2023-2043 percentage change in the resident population (by ethnicity and age) and applied it to the 2023 Pinnacle enrolled population. This was done at the district level and summed. At the network level, from 2023 to 2043 there are a projected 65,258 more people enrolled. Figure 10 applies the population change to the pattern of medical consults in 2023 by age and ethnicity.

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

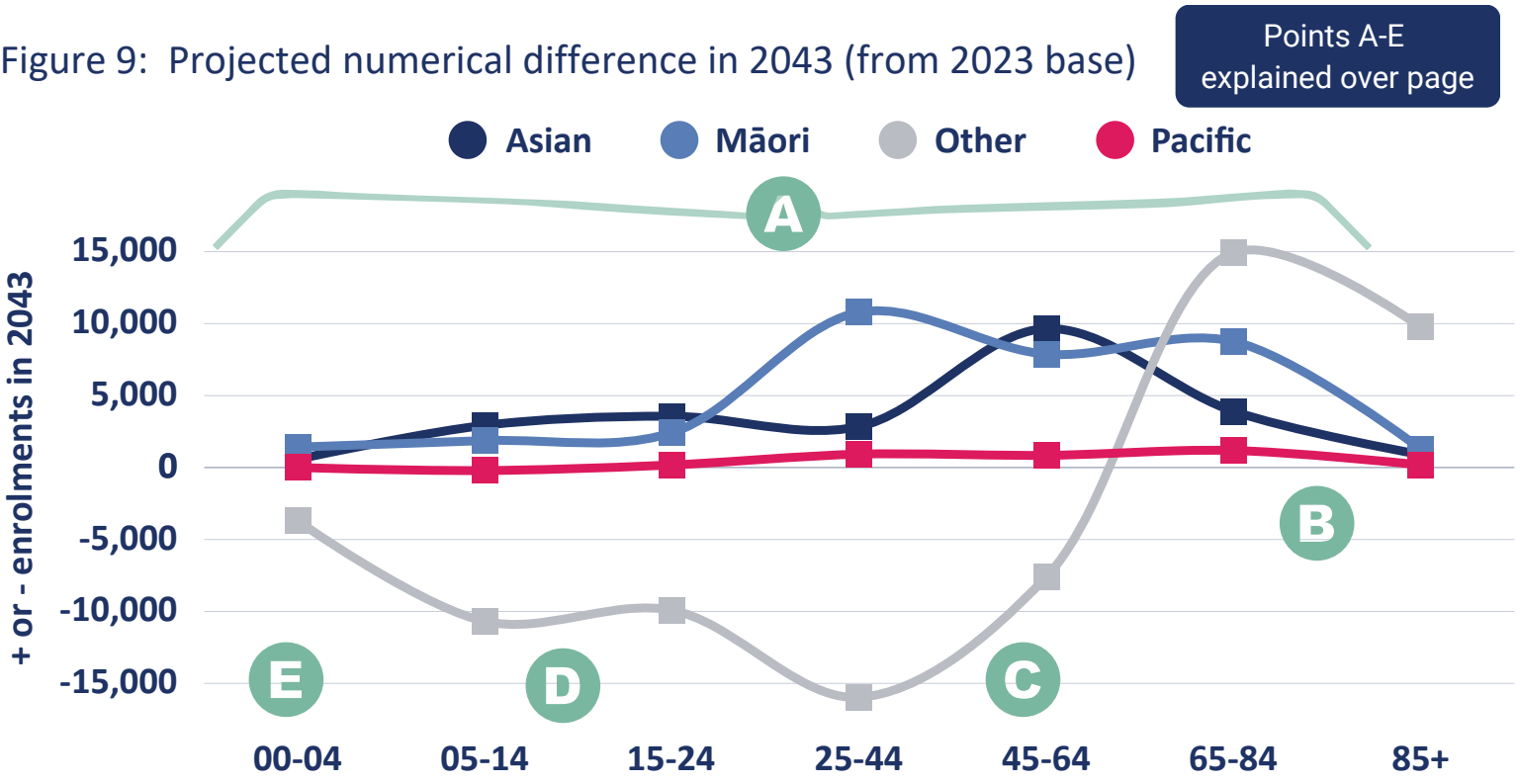
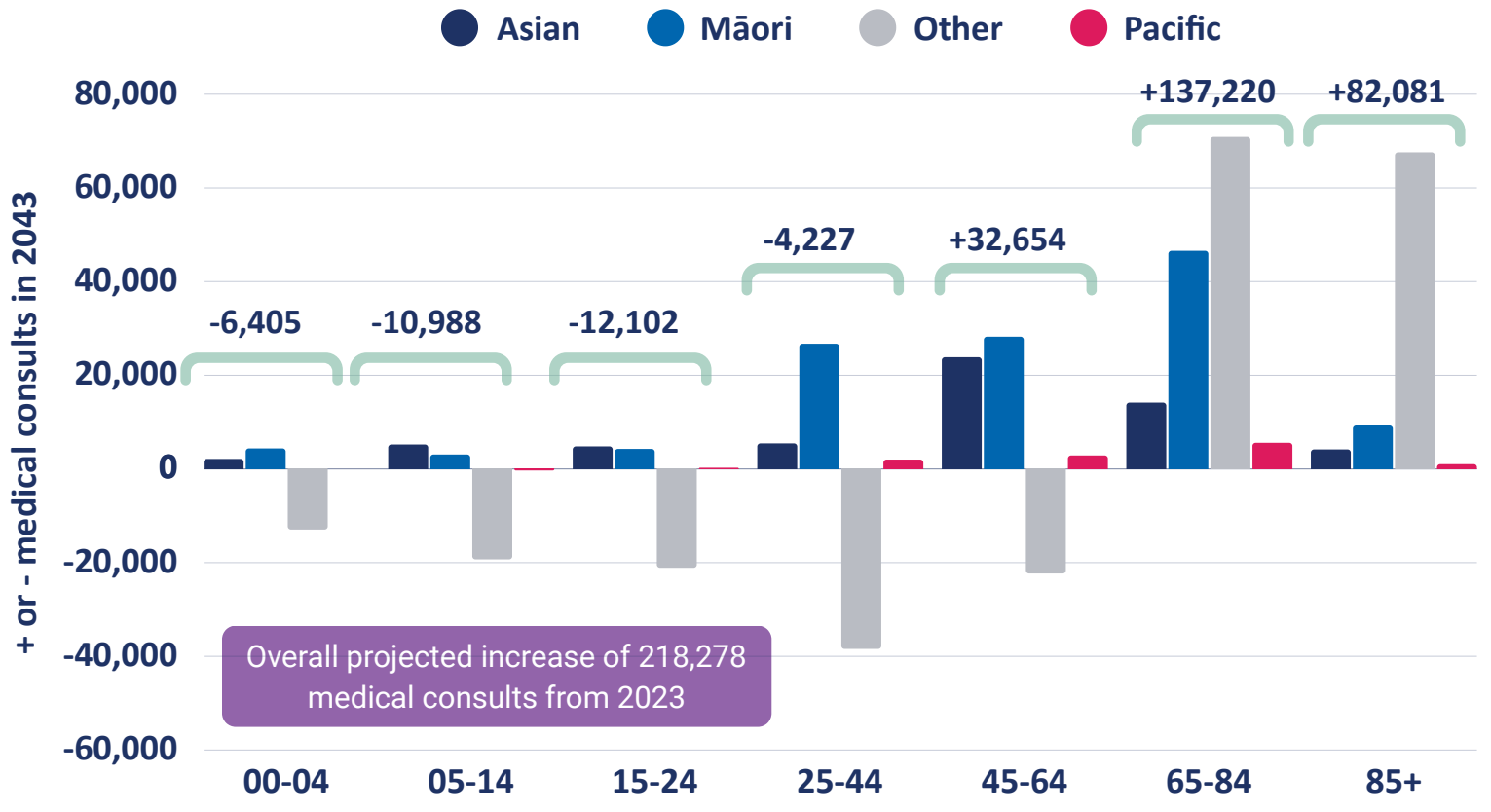


Figure 10: Projected difference in medical consults in 2043 (from 2023 base)



Summary points for Pinnacle

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

Pinnacle's enrolled population at the network level does differ from the 2023 ERP (compare Figure 1 and Figure 4). The network has lower proportions overall of Māori and Asian people, and a higher proportion of Other people (for Pacific People it's very 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 will need to provide an additional 218,000 medical consults in 2043, should the scenario of Pinnacle's enrolled population growing at the medium series rate, and service use (by ethnicity and age) holding true over time. However, as shown, growth and decline in both numbers of people enrolled and the number of medical consults are not uniformly spread.

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

65-84 years: There are considerable increases in medical consults projected for Māori (+46k from 2023) and Other people (+70k) in 2043. These people are currently aged 45-64 years. The youngest baby boomers will now be in this age group, 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 82k medical consults across all ethnic groups. The main drivers of this are the ageing Other (predominately Pākehā) population moving through the life cycle. The oldest baby boomers, if still alive, will now be in their late 90's.

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

Projected increases for Māori, less so for Asian and Pacific people. Projected fewer Others aged 45-64 years (-16k) across the network. The projected decline in numerical consults for Other people (-22k) is offset by projected increases for all other ethnic groups, at around 55k medical consults. These people are mostly in the 25-44 year group now.

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

Projected to be more Māori and Asian people enrolled aged between 5-24 years. This will be offset by fewer Others. It is important to remember that these projections are for medical consults only - there are key lifecycle health care alongside this that will still need to be delivered. There are projected increases in consults for Asian and Māori (+6,526) 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 is driven by fewer Other children. However, within this are smaller increases for Asian (+2k) and Māori (+4k). Immunisation work is not included in this category.

Rural residents: Pinnacle enrolled in 2023/24

Contents page

Rural residents enrolled

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

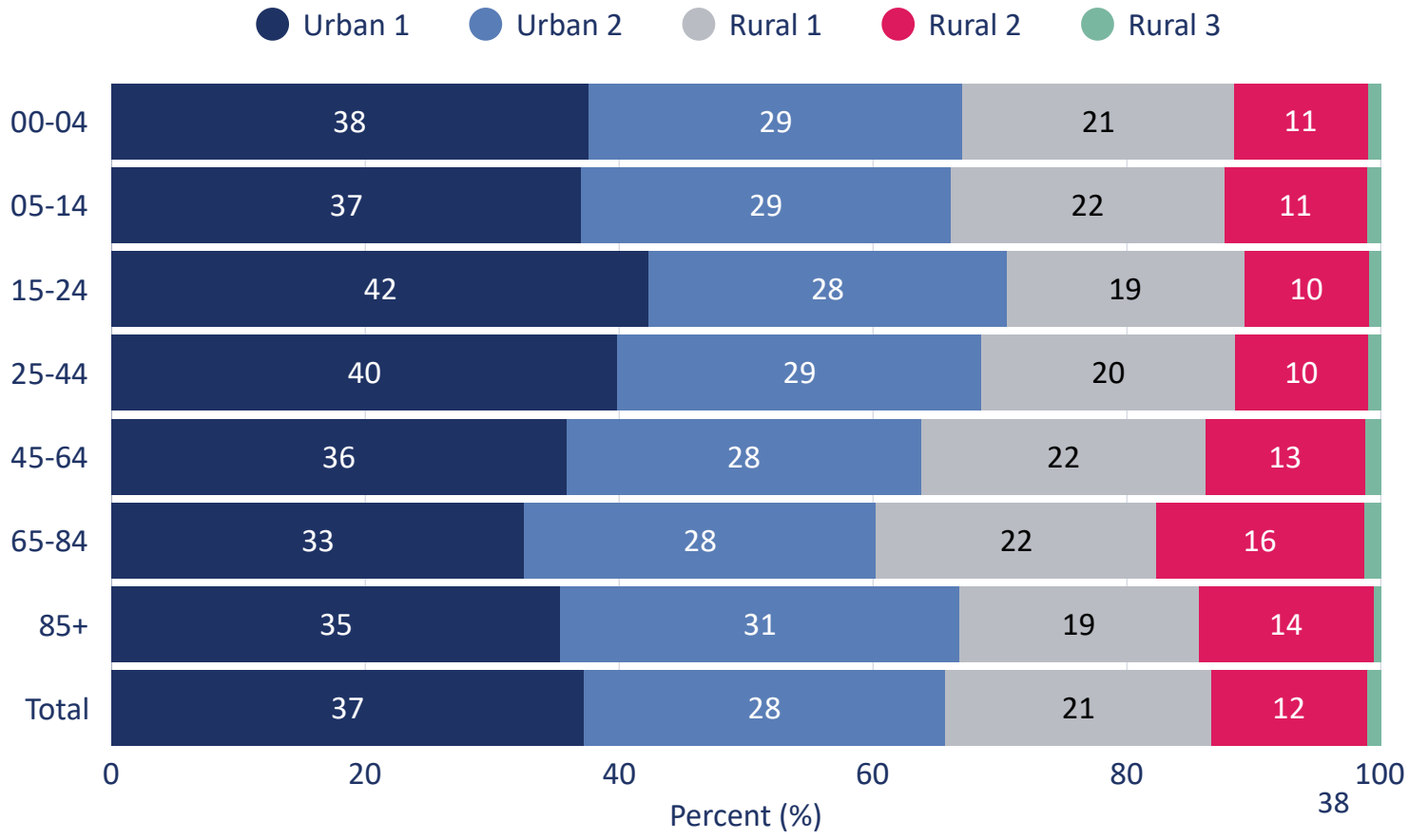
Table 3: Enrolled people, by age group and GCH rurality

	Urban1	Urban2	Rural1	Rural2	Rural3
00-04	8,295	6,501	4,712	2,334	210
05-14	21,579	16,942	12,561	6,556	605
15-24	21,213	14,107	9,389	4,907	444
25-44	40,771	29,359	20,434	10,721	963
45-64	39,021	30,331	24,354	13,645	1,313
65-84	26,007	22,152	17,648	13,080	1,006
85+	3,435	3,047	1,833	1,340	46
Total	160,321	122,439	90,931	52,583	4,587

Key Points

- 34.4% of people enrolled in the Network lived rurally.
- Most rural residents lived in R1 areas, using the geographical classification of health. (61.1% of rural).
- Few people lived in the most remote areas; 3.1% of rural residents, 1.1% of all enrolled.
- The proportion of people by age group living in each rural or urban category are shown in Figure 11.

Figure 11: Proportion by age group and rurality



Average service use - by residence category

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

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

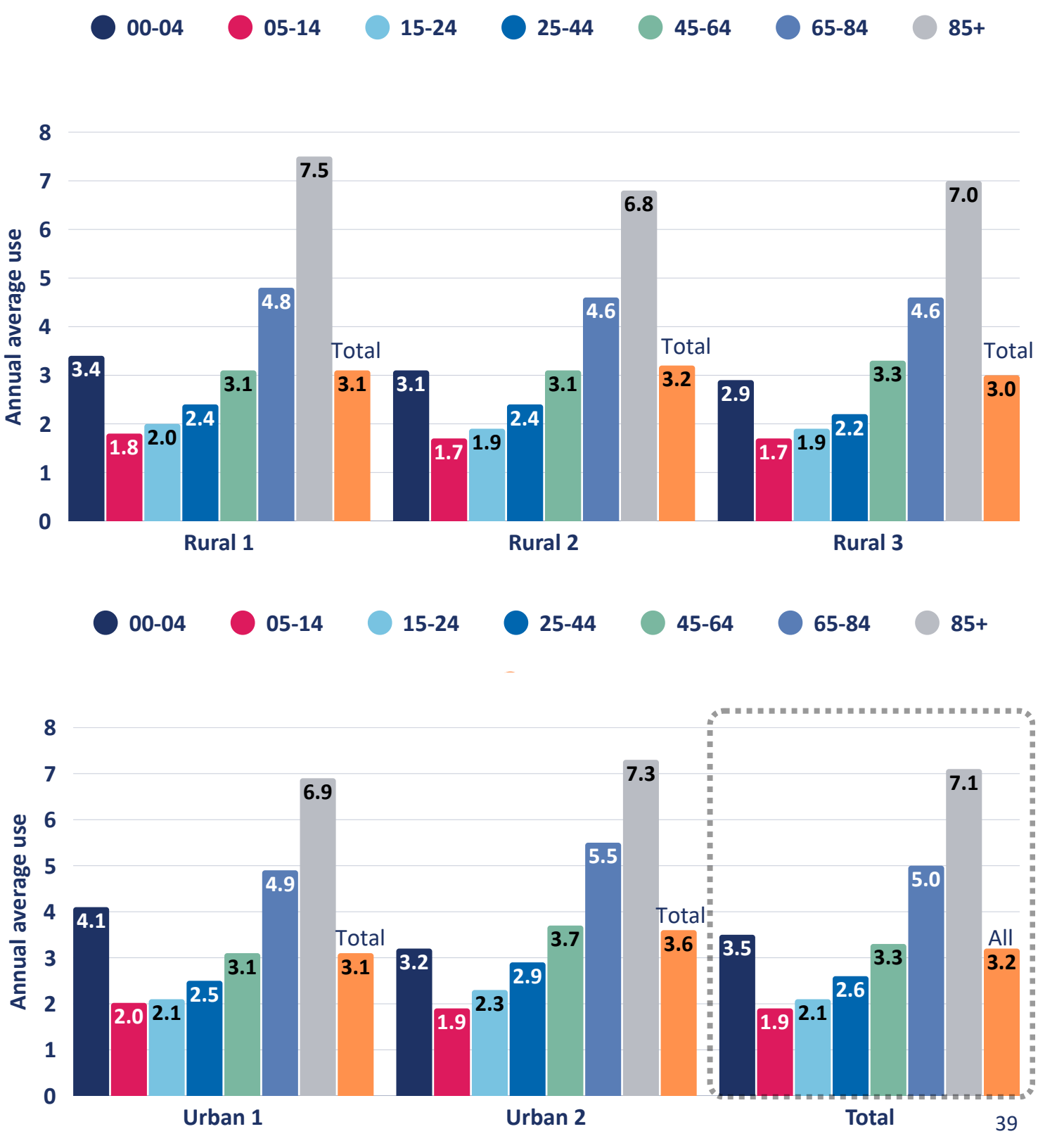
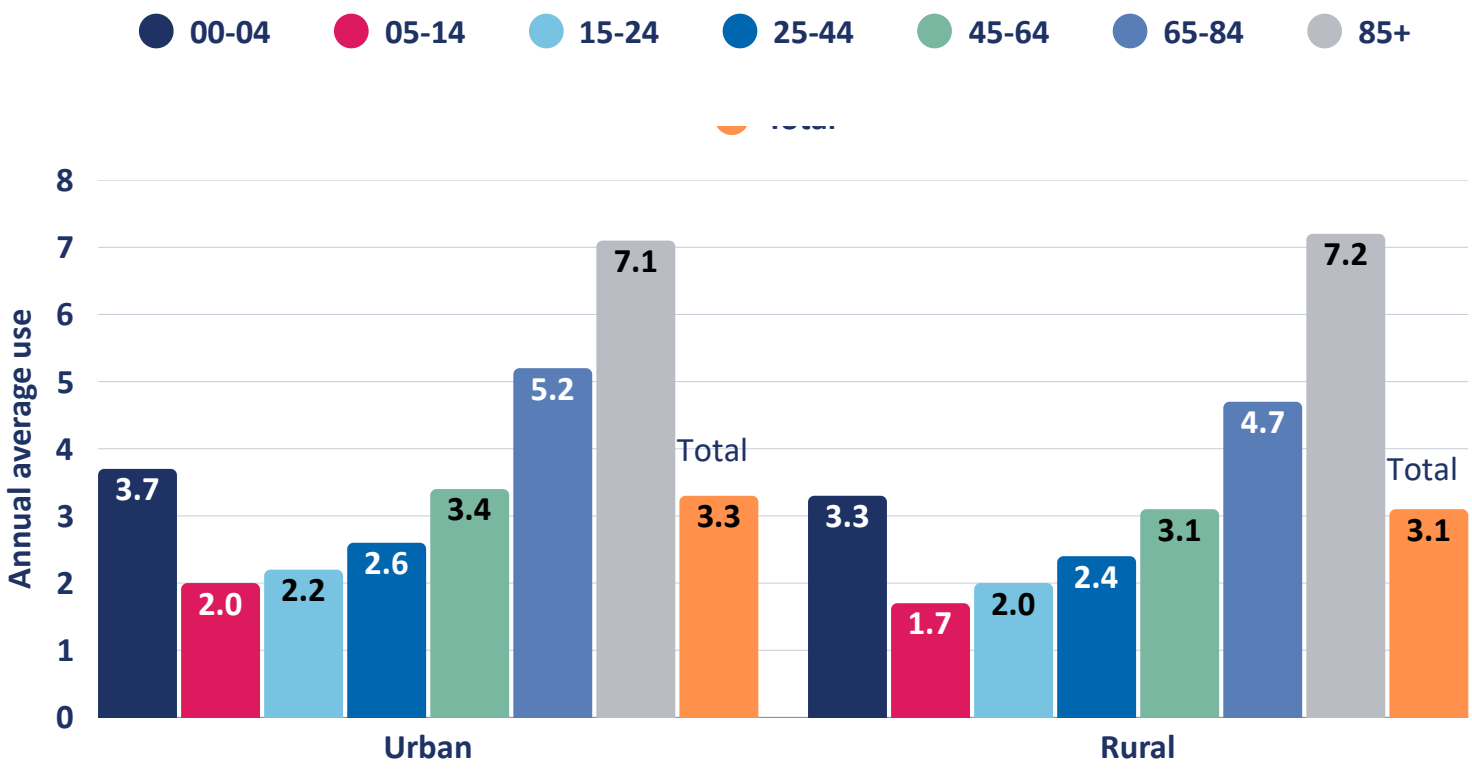


Figure 13: Annual average use of medical consults, by aggregated residence and age



Key Points

- There is a consistent pattern across all figures of higher medical service use by the very young and the older people (particularly those aged 85+ 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:** Up to age 85+ years, those people resident in urban areas on average in that year, used a higher level of medical services in general practice than rural people. Total figures were similar at 3.3 and 3.2 medical appointments for urban and rural respectively.
- Those aged **00-04 years**: those using fewer services (in general practice) in that year (average 2.9) were rural 3 residents, the most remote. This compares to an average of 4.1 consults for those resident in Urban 1 areas.
- Those aged 65-84 years: the highest average use was for those in Urban 2 areas (5.5 consults), compared with the lower average level of in Rural 2 and 3 areas (4.6).