Pinnacle®
Midlands Health Network

Sections 1-3

Waikato 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

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

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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.

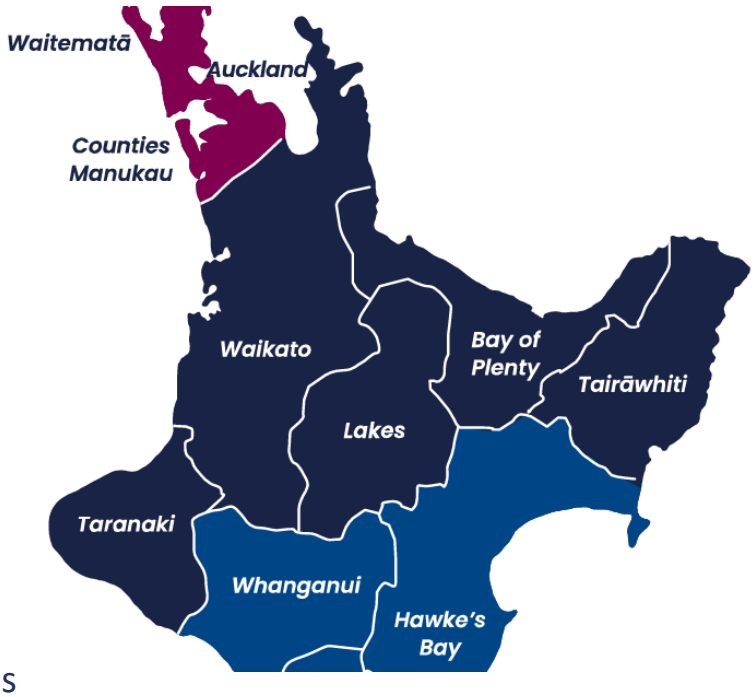
Population health & community wellbeing

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 & 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. Collaboration with iwi, kaupapa Māori providers, and health and social services is crucial for pae ora. 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 the 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

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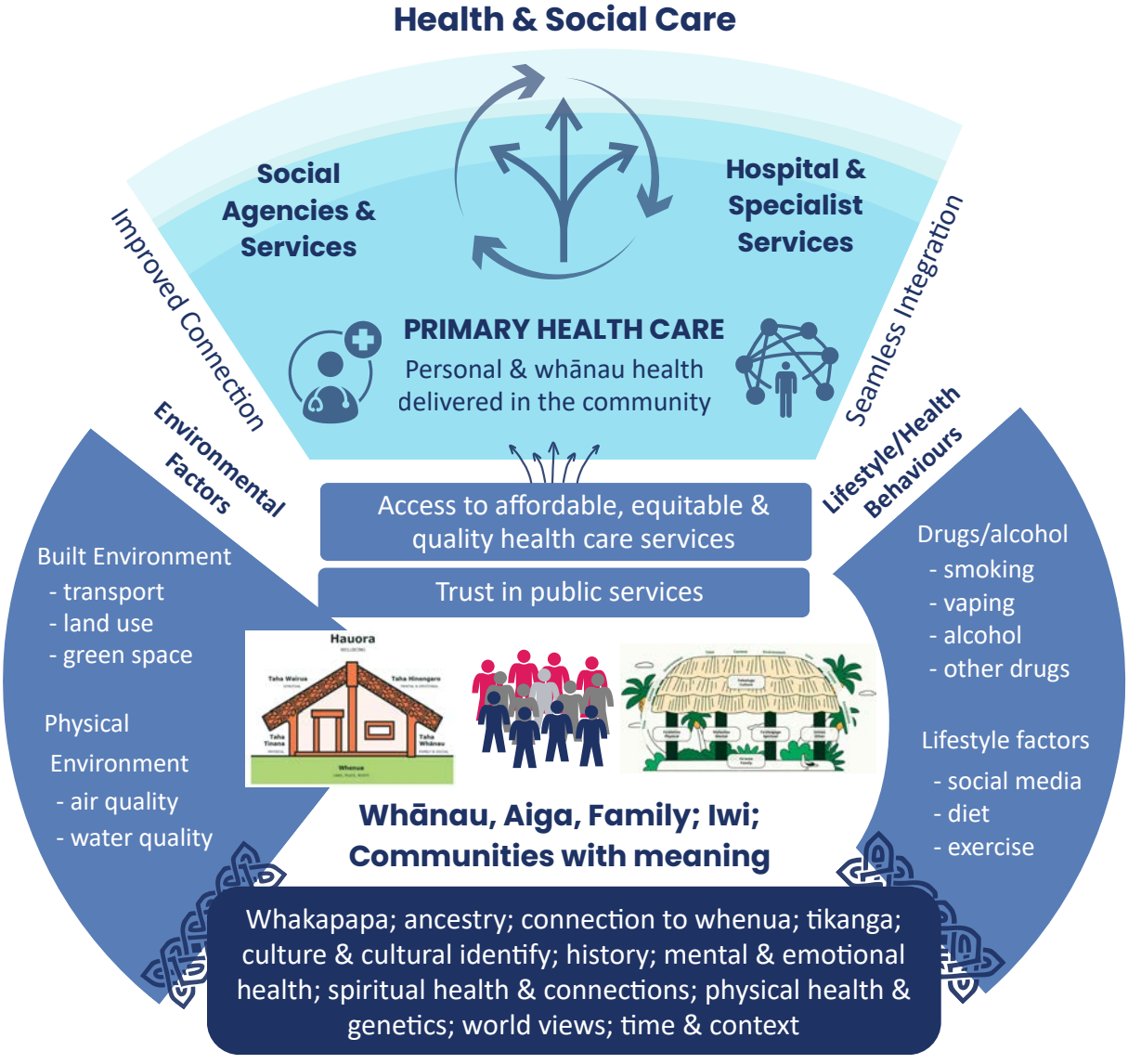
Health and wellbeing are shaped by the conditions in which people are born, grow, live their daily lives, work and age. These determinants are influenced by the distribution of power, resources, and policies at national and local levels. Factors such as income, housing, education, cultural identity and 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 well-being.

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

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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 & 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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Waikato health and wellbeing summary

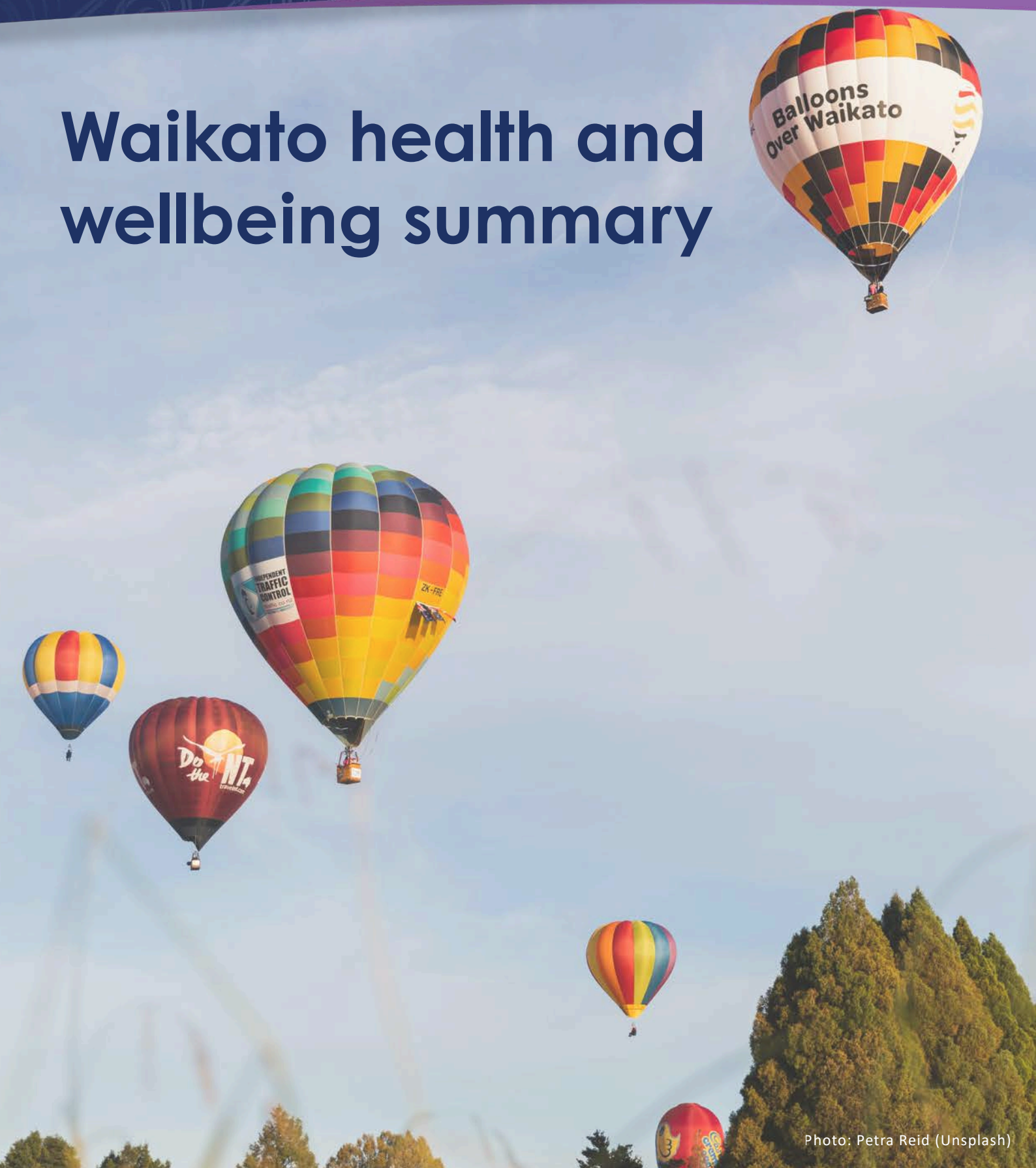

Photo: Petra Reid (Unsplash)

Health and wellbeing in Waikato District

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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 health system.

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

- Health system restructuring, including creating Te Whatu Ora (from District Health Boards) to manage hospital and specialist services at a national level.
- A greater 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 Waikato 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 Waikato area covers the same geographical area of Te Whatu Ora Waikato.

Other organisations have released health and wellbeing information relating to the Waikato, including Manatū Hauora, Te Whatu Ora, Te Aka Whai Ora, Waikato Tainui, Hauraki Māori Trust Board, the Te Tiratū Iwi Māori Partnership Board and Hauora Taiwhenua.

Selected information is summarised here. This report, along with other 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
- 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

Te Tiratū Iwi Māori Partnership Board

Following health sector restructuring, Te Tiratū IMPB is one of six in the rohe that plays a crucial role in the shaping of health services. Alongside long-standing Iwi organisations, they represent local perspectives on the needs and aspiration of Māori in relation to hauora Māori outcomes, ensuring Te Whatu Ora knows and understands their priorities.

About our Waikato 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 in total. 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.

Snapshot (March 2025)

	Waikato
Practices	46
Total patients	268,498
Māori patients	46,427
All < 14 yrs	18.1%
All 65+ yrs	19.4%

Enrolled Patients

17% Māori

3% Pacific people

13% Asian

66% Other

Practice Workforce

1,438 GP/patient ratio

331.3 GP FTE

357.3 Nurse FTE

Rural Waikato

21 General practices

Enrolled patients **95,232**

64.7 GP FTE

73.2 Nurse FTE

1,472 GP to patient ratio

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

Consults delivered in each calendar year

324,853 (2024)

303,947 (2023)

292,998 (2022)

 # Includes medical consults and other claim types

Primary Health Care Ltd (PHCL)

PHCL (owned by Pinnacle Inc) is the largest not-for-profit operator of general practice in Aotearoa

5 General practices

GP/patient ratio **2,001**

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 & secondary care providers.

People
Now & future

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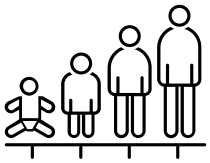
About **9%** of New Zealand's population live in the Te Whatu Ora Waikato District

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



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

17%
are 65+ years now

22%
65+ years in 2043

Ethnicity in 2023

25% Māori

5% Pacific

70% Other

10% Asian

Total responses >100%

Population projections

2023 **459 thousand** → 2043 **539 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 Te Tiratū

114,900 live in the rohe now

48% are under 25 years

7% 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

7% Māori in 2023 → increasing to **10%** in 2043

21% non-Māori in 2023 → increasing to **27%** in 2043

Where people live

Urban compared to Rural

62% Māori **38%**

66% non-Māori **34%**

Community Identifed Issues

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Te Tiratū summary

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

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, when needed

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.

Te Tiratū IMPB: Identified Priorities

Primary & Community Care

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Six priority areas

Primary Care

Different approaches to the issues of unenrolled whānau and whānau who are enrolled, but who are not getting regular health checks and screening are needed. Should explore models of care that can ensure access and better options for whānau (nurse-led care, mobile services) to help mitigate the shortage of GPs, and wait times for appointments. Also need to improve communication with specialists.

Long term conditions

Support the focus on CVD, diabetes, respiratory disease, & mental health. Gout should be added as a priority - in particular improving access to prescribed medicine. The barriers of GP and prescription fees prevent Māori from getting good access to care. Making greater use of nurse prescribers to address this is seen as one solution.

Rongoā Māori

It is a priority to increase investment in rongoā Māori services across the district, and promotion / awareness to have rongoā Māori working in a more integrated way with western medical services.

Oral / dental health

Want a great focus on raising awareness (sugar) among tamariki and their whānau by highlighting impacts on children's teeth later in life. Also people would like to see more mobile dental services going into rural communities regularly.

Primary mental health

More support is needed for children who are experiencing anxiety at younger ages – from events in the home as well as environmental events. School programmes are supported that provide a Kaupapa Māori approach to mental wellbeing for tamariki. Concern that community services are under increasing pressure. Kaupapa Māori services are seeing more complex and challenging clients and need more capacity.

NASC / home care

The growing number of Kaumātua over the next 20 years highlights that there will be an increased need for home care, access to aged care, and a greater need for bringing services to communities through mobile services and home visiting (so Kaumātua can stay in their homes as long as possible). There needs to be more Kaupapa Māori models of rest home care, requiring a need to build a carer workforce.

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, central and local government and non-government organisations.

Housing in the Waikato/ Te Tiratū rohe

HOUSEHOLD CROWDING

Requiring at least 1+ bedroom

Māori **23.6%**

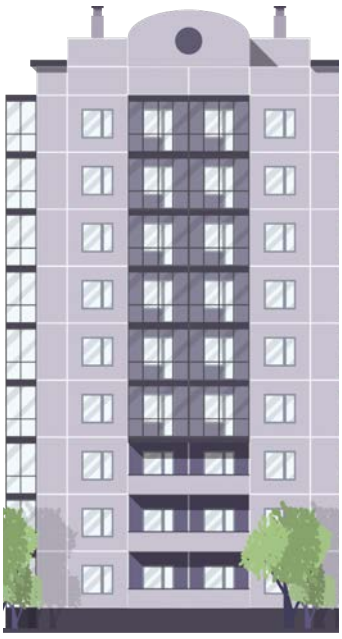
non-Māori **8.8%**

HOUSEHOLD HEATING

Living in households where there is no source of heating

Māori **3.9%**

non-Māori **2.7%**



DAMP HOUSING

45.0% of Māori lived in a home that was sometimes or always damp; compared to 25.7% of non-Māori

MOULD IS PRESENT

37.2% of Māori lived in a house that sometimes or always had mould; compared to 21.1% of non-Māori

HOME OWNERSHIP

27.1% of Māori owned or partly owned their own home, compared 40.0% of non-Māori

2018 Census age-standardised

EAT healthy

29% Taranaki

35% Tairawhiti, Lakes, Waikato

Adults eating 3+ serves of fruit & vegetables each day

Towards Equity

Differences in outcomes persist, particularly for Māori and Pasifika.

Addressing the determinants of health requires planning, investment & 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

Waikato
Health Status & Wellbeing Measures

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76.8 years — Māori life expectancy

72.8 years

84.7 years — non-Māori life expectancy

81.8 years

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

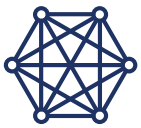
Issues include the workforce crisis, equitable access & outcomes for rural residents, rural funding, services for rural Māori, and an older population (compared to urban areas)

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

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.

+155,962 medical consults in 2043

The Waikato will need to provide an additional 156,000 medical consults (if 2023 rates remain). 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

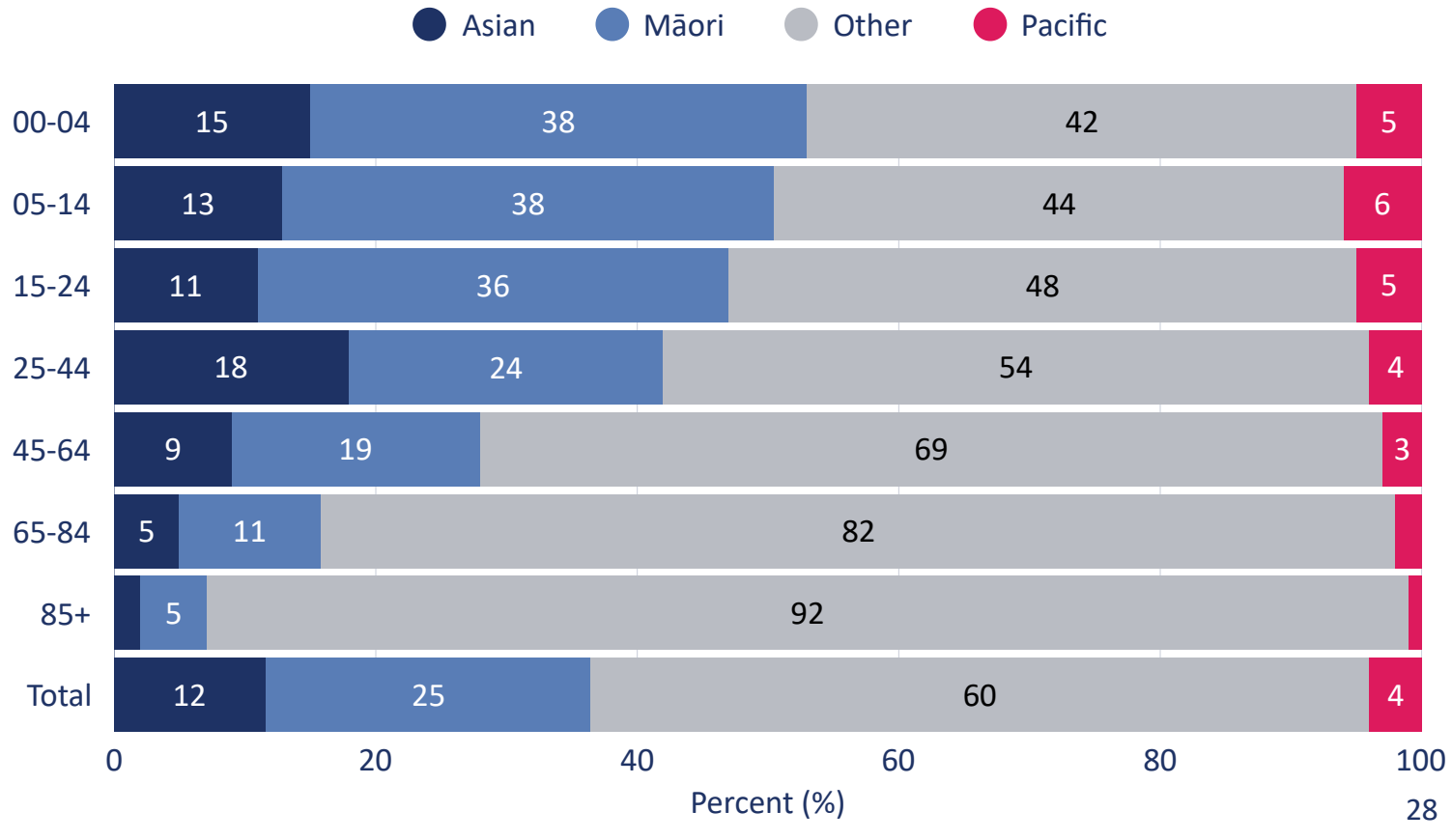
Table 1: ERP, by age and ethnicity, 2023

	Asian	Māori	Other	Pacific	Total
00-04	4,500	11,140	12,140	1,460	29,240
05-14	7,910	23,620	27,240	3,430	62,200
15-24	6,670	20,940	27,910	2,950	58,470
25-44	21,680	29,550	64,620	4,830	120,680
45-64	9,290	20,860	75,090	3,130	108,370
65-84	3,380	7,530	58,920	1,190	71,020
85+	200	410	7,480	100	8,190
Total	53,630	114,050	275,400	17,090	458,170

Key Points

- Over 458,000 people were resident in the Waikato district in 2023 (using Health NZ boundaries).
- Overall, 25% of people were Māori, with 4% and 12% 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

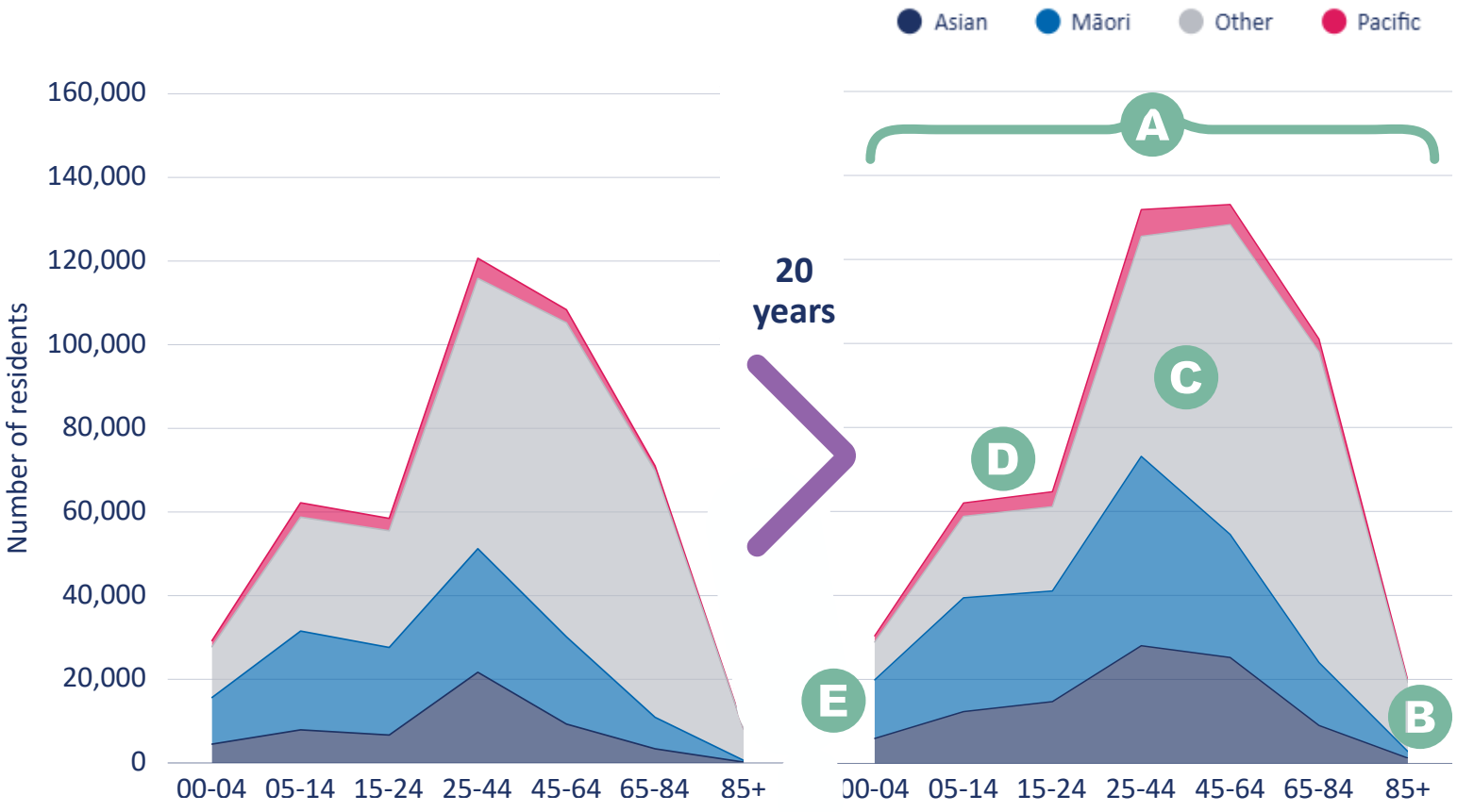
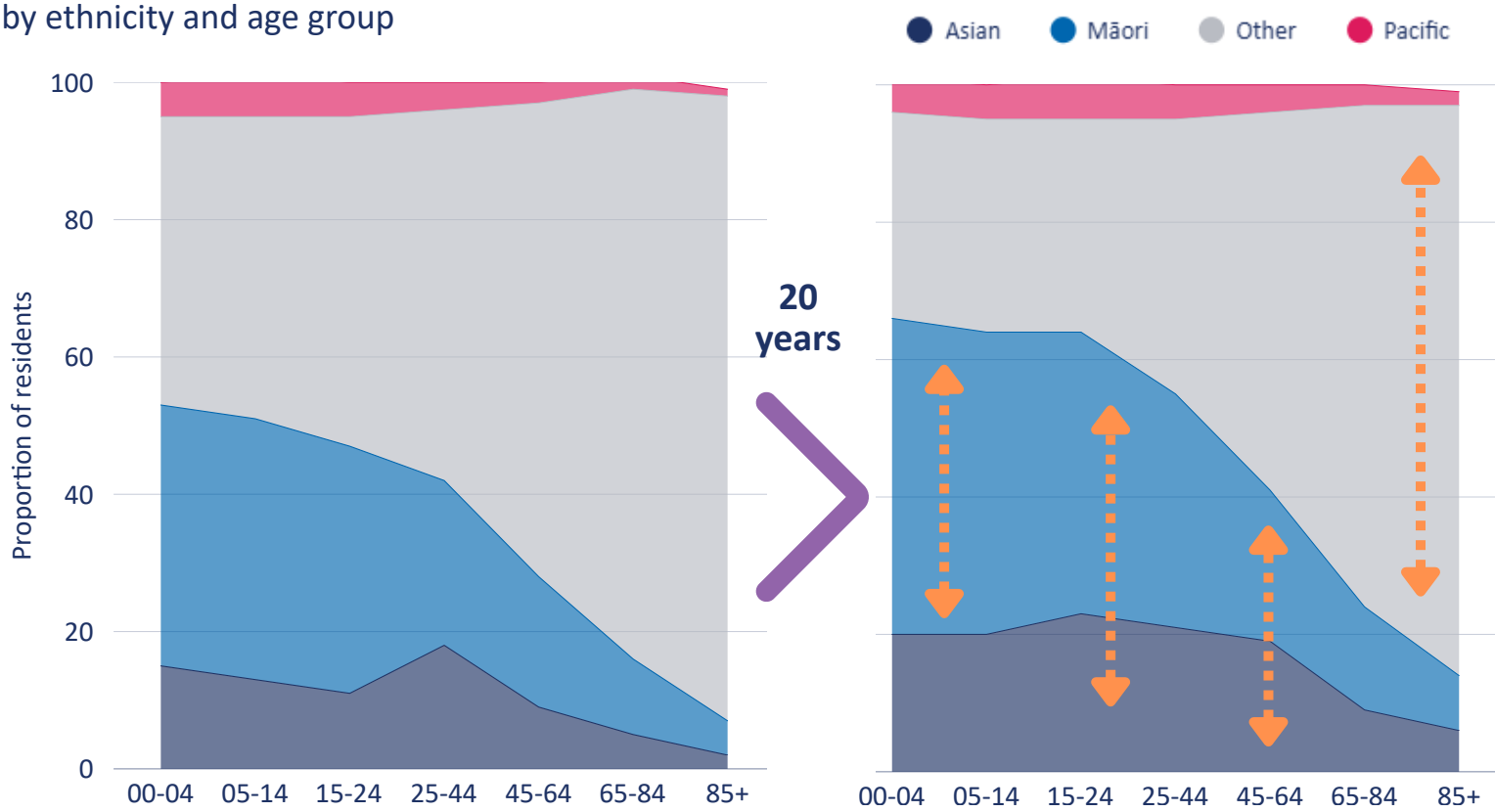


Figure 3: 2023 (left) and 2043 (right) proportion of ERP by ethnicity and age group



Five Summary points

Contents page

[points A-E on Figure 2]

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.

C **Middle aged people (45-64 years):** Numerical increase (+13k overall). 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 static for those aged 4-14 years with growth for the 15-24 age group. The number and proportion of Other people in this age group decreases.

E **The first years of life:** Numerically a small increase expected overall, with the decline in Other children offset by increases in the number of Asian and Māori children.

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.

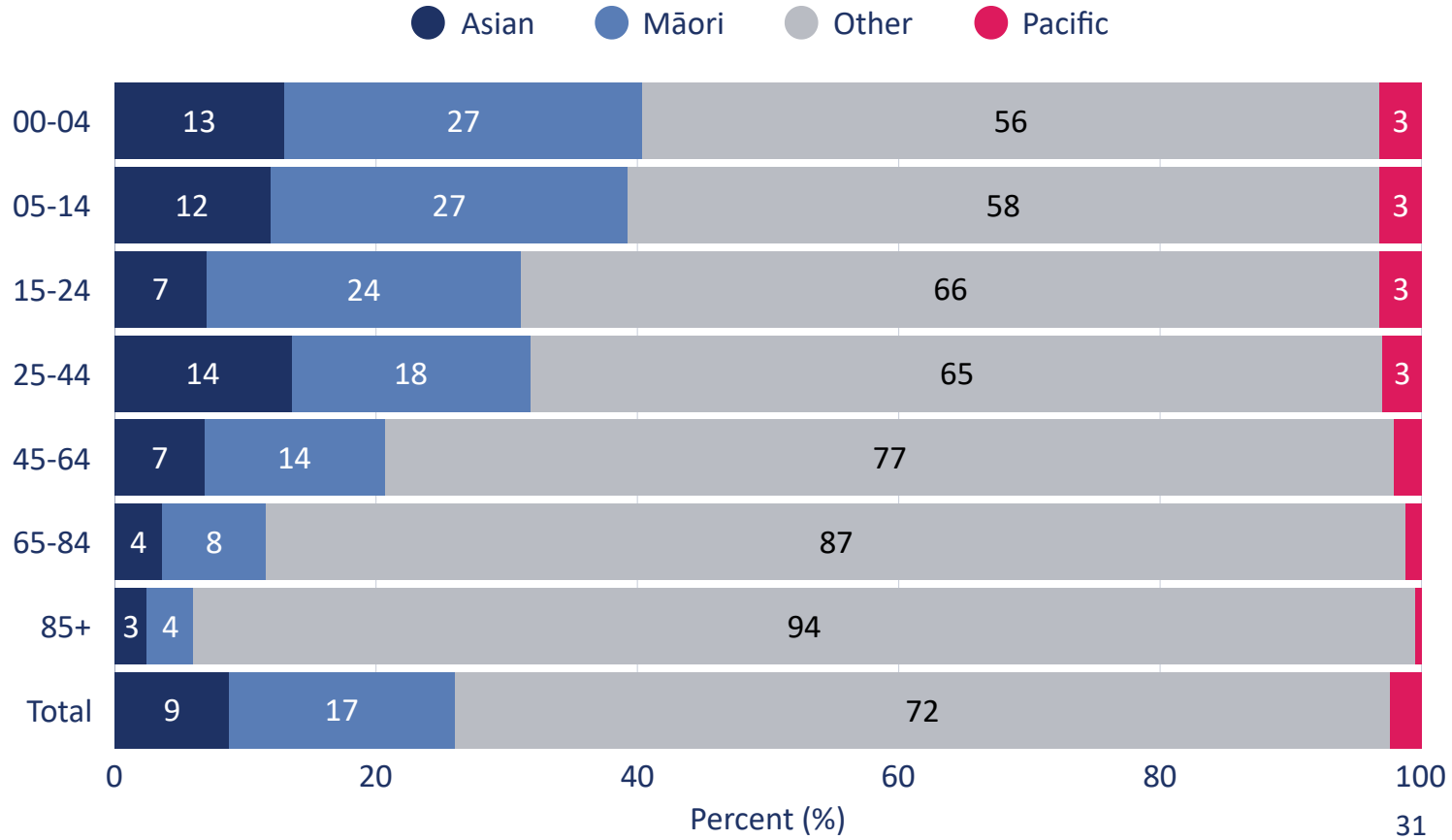
Table 2: Enrolled people, by ethnicity and age group

	Asian	Māori	Other	Pacific	Total
00-04	1,582	3,333	6,858	388	12,161
05-14	3,868	8,854	18,630	1,037	32,389
15-24	2,035	6,970	18,978	913	28,905
25-44	7,842	10,484	37,527	1,689	57,542
45-64	4,201	8,321	46,685	1,241	60,448
65-84	1,637	3,593	39,253	537	45,020
85+	137	193	5,120	25	5,475
Total	21,302	41,748	173,060	5,830	241,940

Key Points

- 241,940 people were enrolled for the entire 2023/24 year.
- 9% were of Asian ethnicity, 17% Māori, 2% Pacific People and 72% Other (majority Pākehā).
- Like the resident population, the enrolled population shows very different age structures by ethnicity (Fig. 4).
- The network population is never static, with people joining and leaving the network - 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

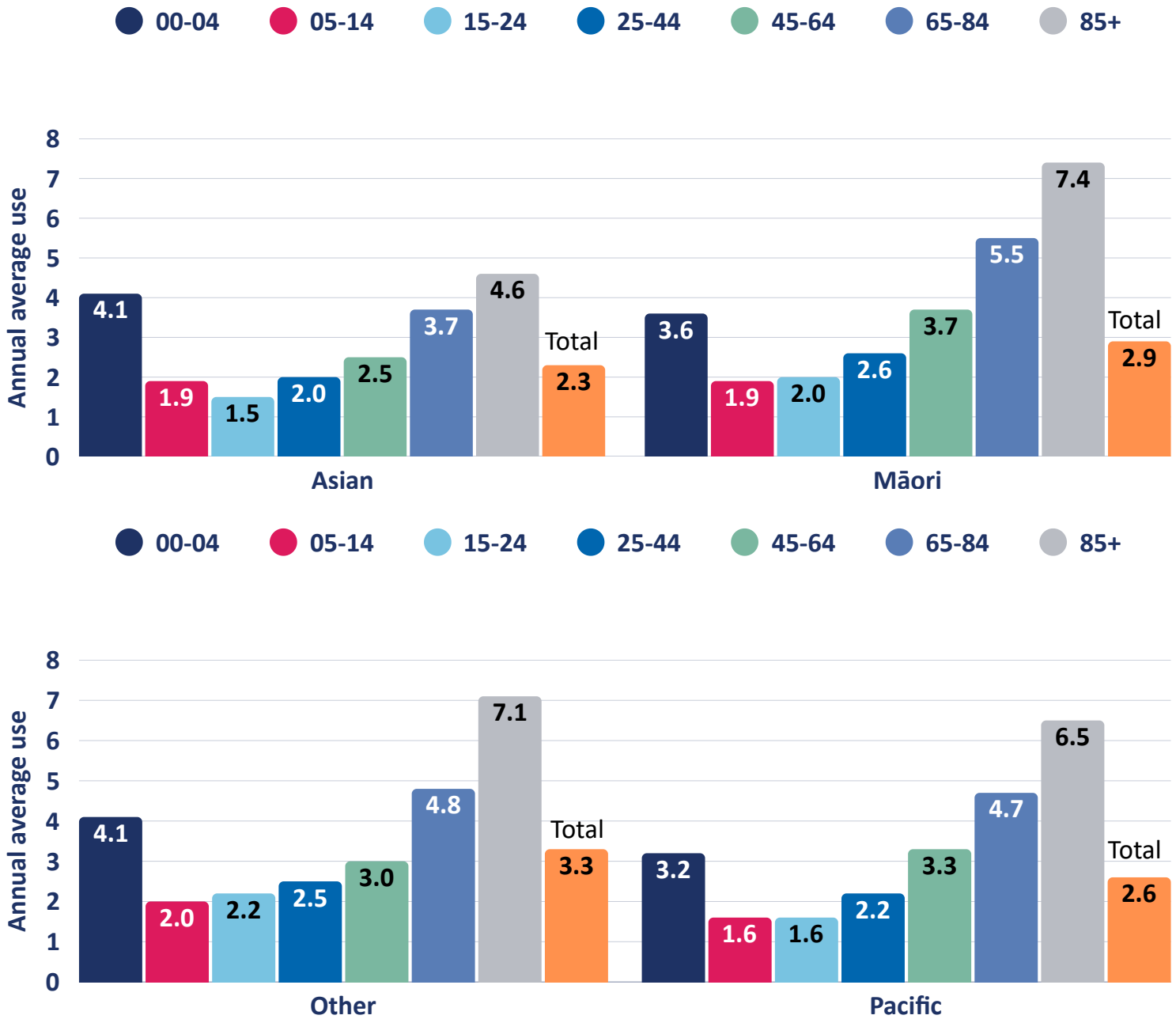
Contents page

All network practices

Key Points

- 752,165 medical consults were recorded for the 241,940 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=5,475), but had the highest average use, ranging from 4.6 for those recorded as Asian to 7.4 for Māori.

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



Data note: These are 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.

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 while those with high need or underserved groups face sustainability challenges.

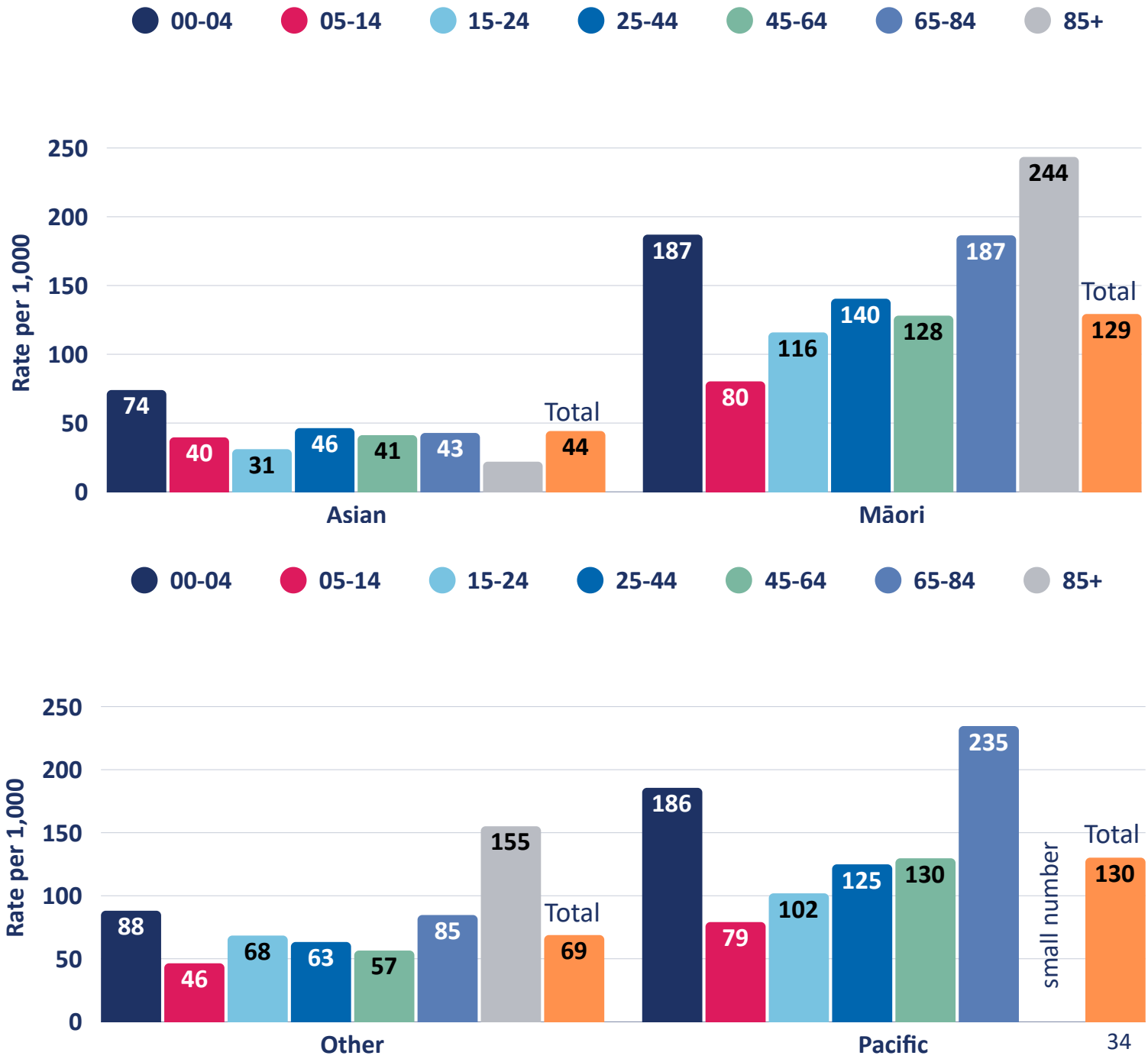
The "unders and overs" in capitation highlight the tension between population-based funding and the reality of individual and community health needs.

People enrolled for all of 2023/24

Key Points

- Rates for low acuity visits (excluding accidents) to the ED were the highest for Māori and Pacific people in the Waikato. Rates per 1,000 were lowest for Asian.
- There was a small number of Pacific people aged 85+ years so that result is not shown.
- 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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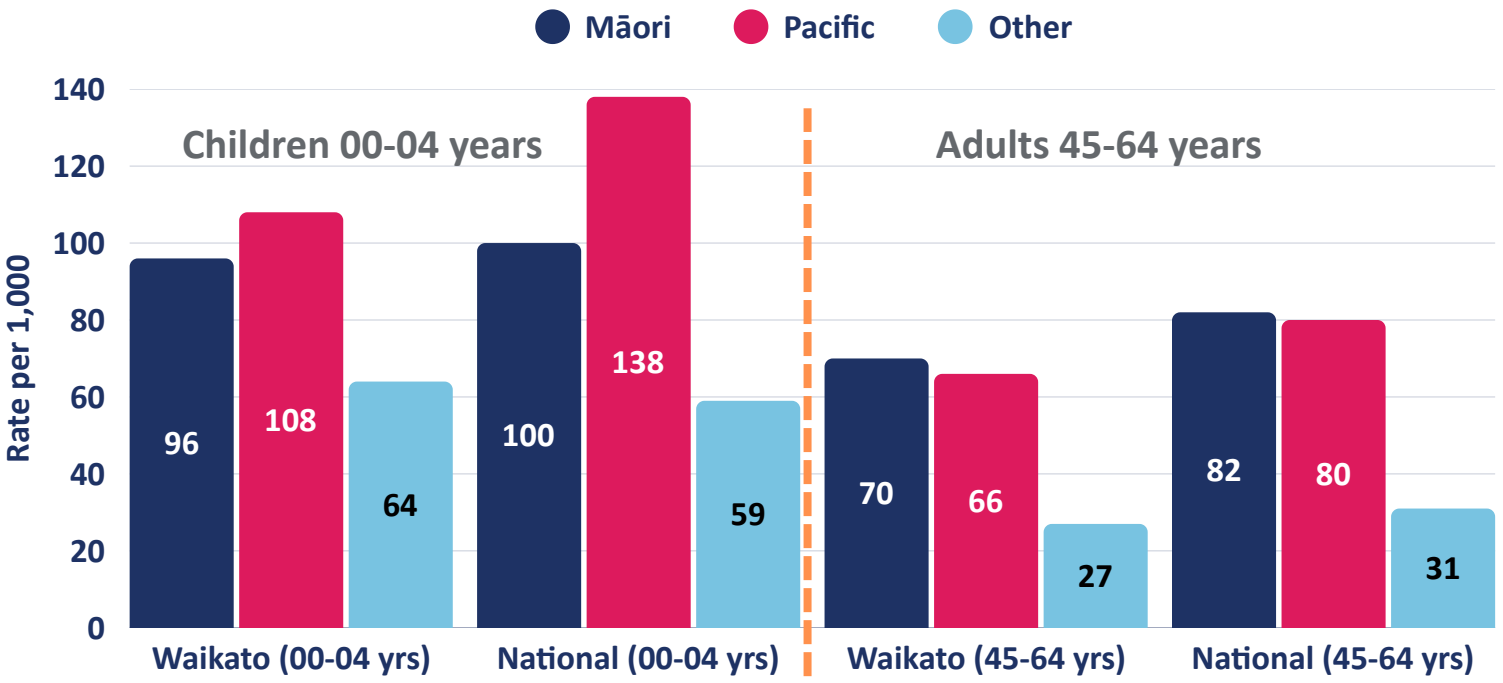
Ambulatory sensitive hospitalisations (ASH) are hospital admissions for conditions that *could potentially* be managed or prevented through primary care interventions. This is considered a partial measure of the effectiveness of the primary and secondary healthcare system interface, it is often used 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 the Waikato were similar to the national level results (in that year), apart from Pacific children where Waikato had a higher rate.
- The top eight ASH conditions were:

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

Adults

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

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

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

Future population and medical service use

We have taken the projected 2023-2043 percentage change in the resident population (by ethnicity and age group) and applied it to the 2023 Pinnacle enrolled population. Figure 9 applies the population change to the pattern of medical consults in 2023 by age and ethnicity.

Figure 8: Projected numerical difference in 2043 (from 2023 base)

Points A-E explained over page

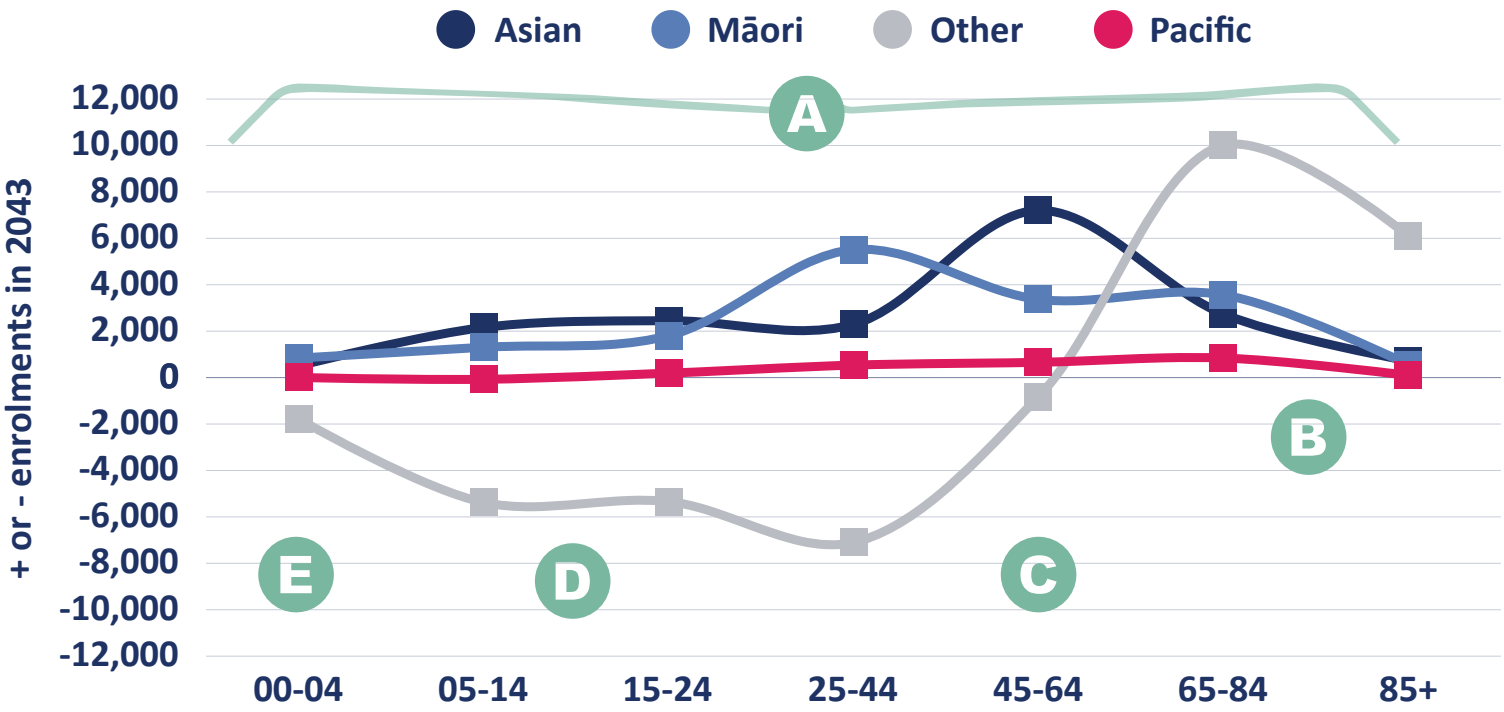
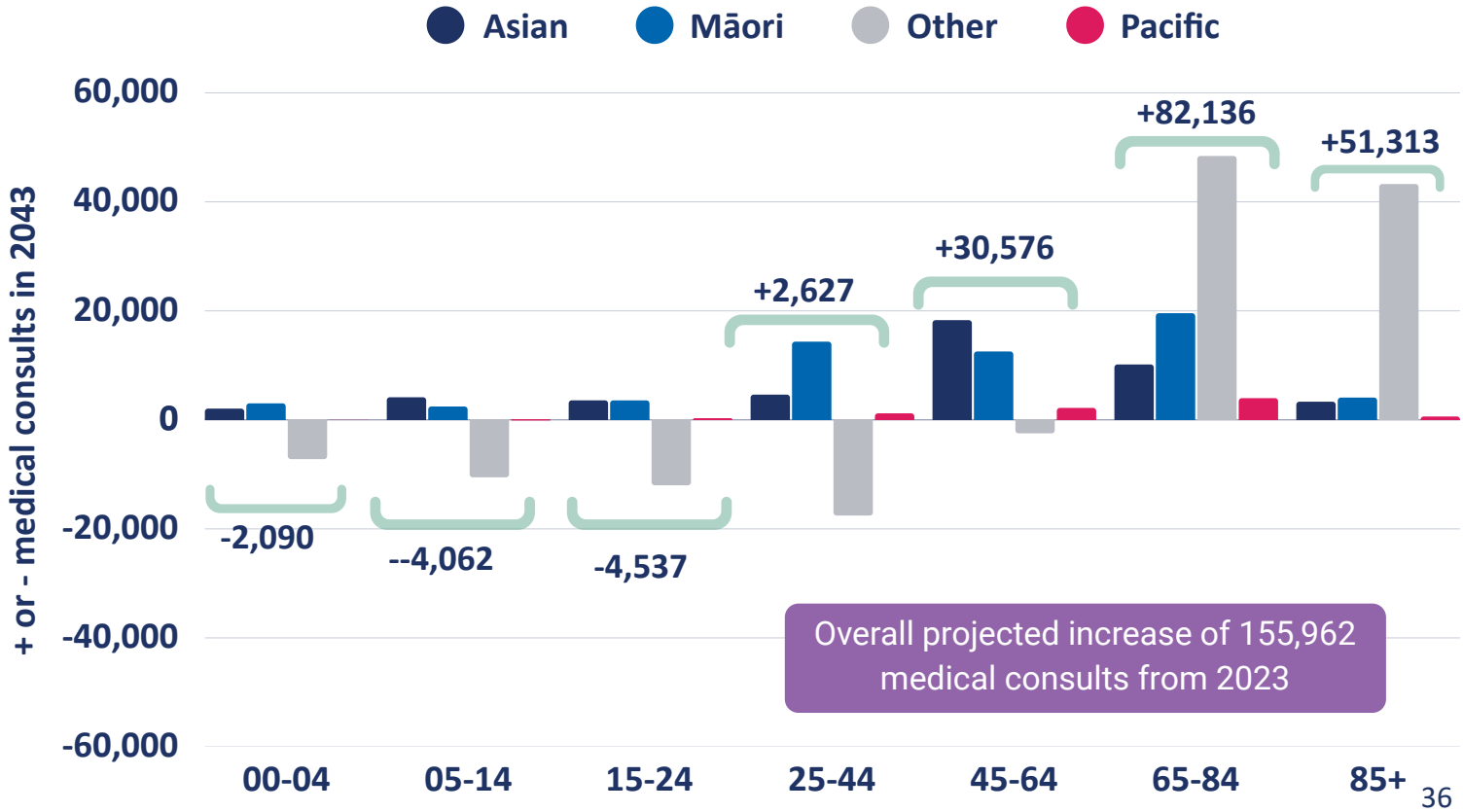


Figure 9: Projected difference in medical consults in 2043 (from 2023 base)



Summary points for Pinnacle

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

Pinnacle Waikato's enrolled population 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 its 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 the network will need to provide about 156,000 additional medical consults in 2043. This is based on 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 (+19k from 2023) and Other people (+48k) 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 51k 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 and Asian and less so for Pacific people, with a small projected decline for Others. The projected decline in numerical consults for Other people (-2k) is offset by projected increases for all other ethnic groups, at around 33k medical consults. The overall increase is 30k consults. These people were mostly in the 25-44 year group in 2023

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 (+13k) from 2023 levels.

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

These children will be born around 2039-2043. The overall increase is projected to be low, with increases in Asian and Māori offset by a decreasing number of Other children. Overall for this group a projected decline (-2k). Note that immunisation work is not included in this category.

Rural residents: Waikato enrolled in 2023/24

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Rural residents enrolled

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

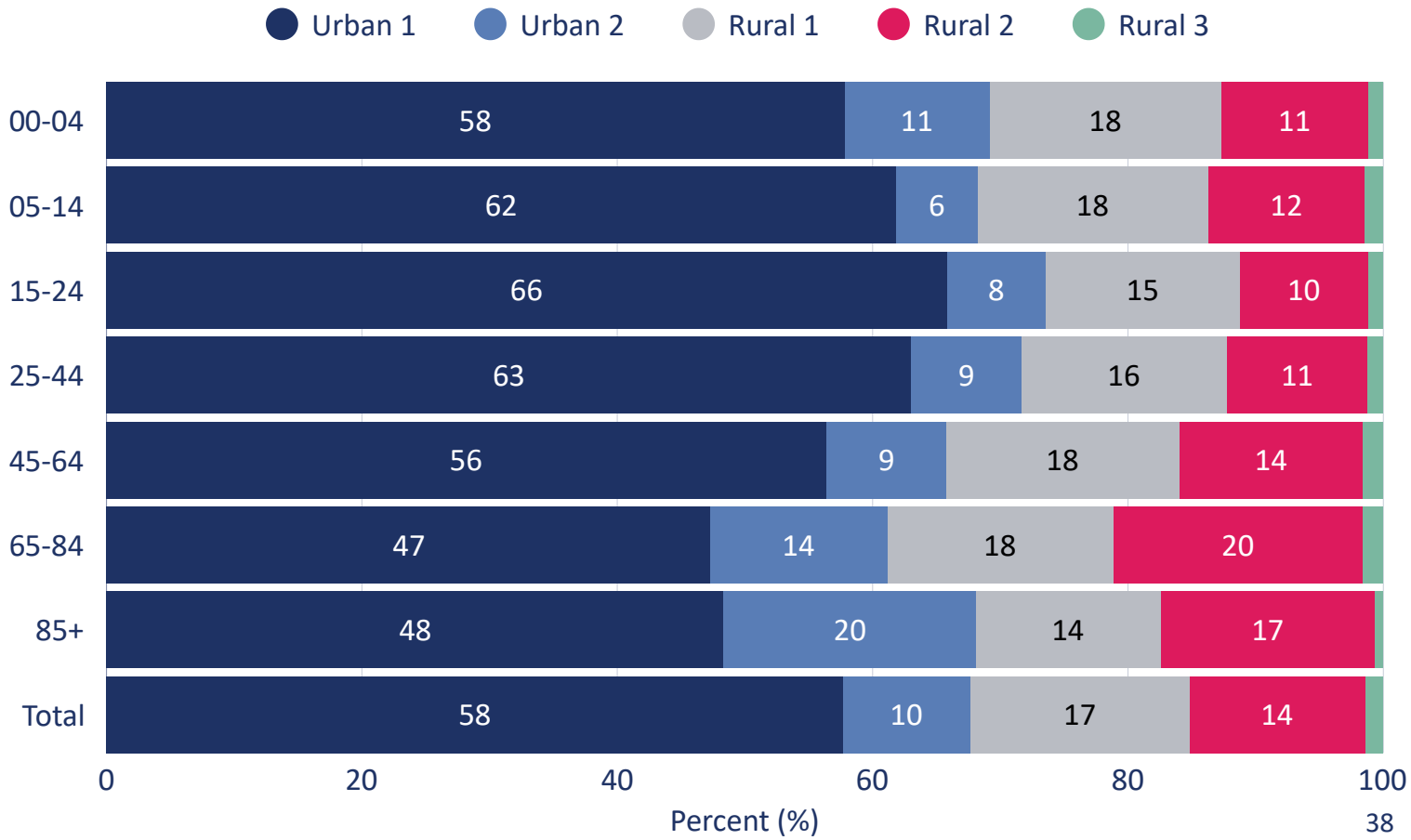
Table 3: Enrolled people, by age and GCH rurality

	Urban 1	Urban 2	Rural 1	Rural 2	Rural 3
00-04	8,222	1,615	2,583	1,627	167
05-14	21,439	2,216	6,276	4,233	495
15-24	20,487	2,402	4,743	3,130	351
25-44	40,198	5,538	10,275	7,008	769
45-64	38,775	6,460	12,599	9,850	1,076
65-84	25,889	7,596	9,661	10,683	874
85+	3,424	1,400	1,024	1,189	43
Total	158,434	27,227	47,161	37,720	3,775

Key Points

- Overall, 32.3% of people enrolled in the Waikato Network lived rurally.
- Most rural residents lived in R1 areas, using the geographical classification of health (53.2% of all rural).
- Fewer people lived in the most remote areas; 1.4% 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

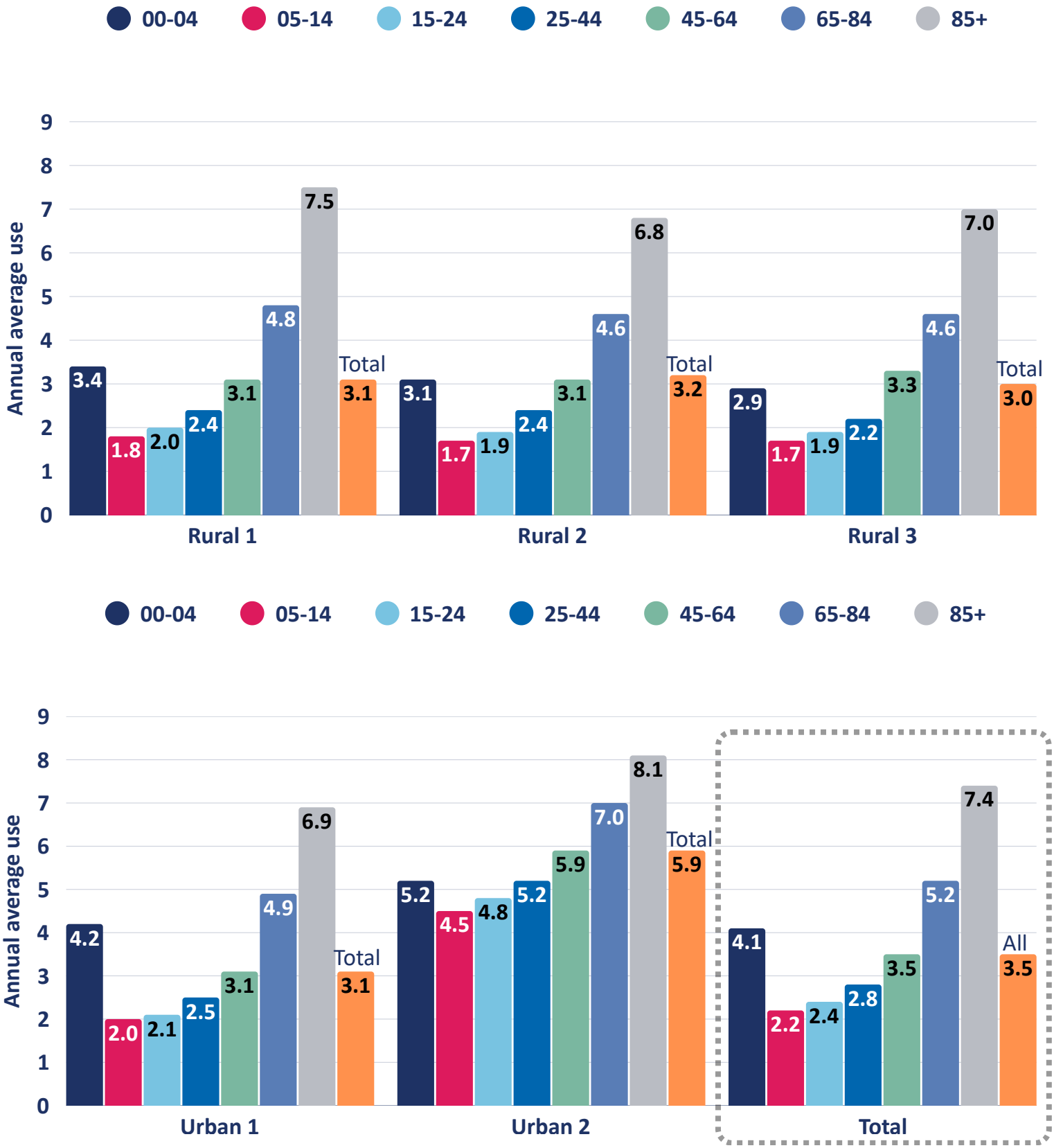
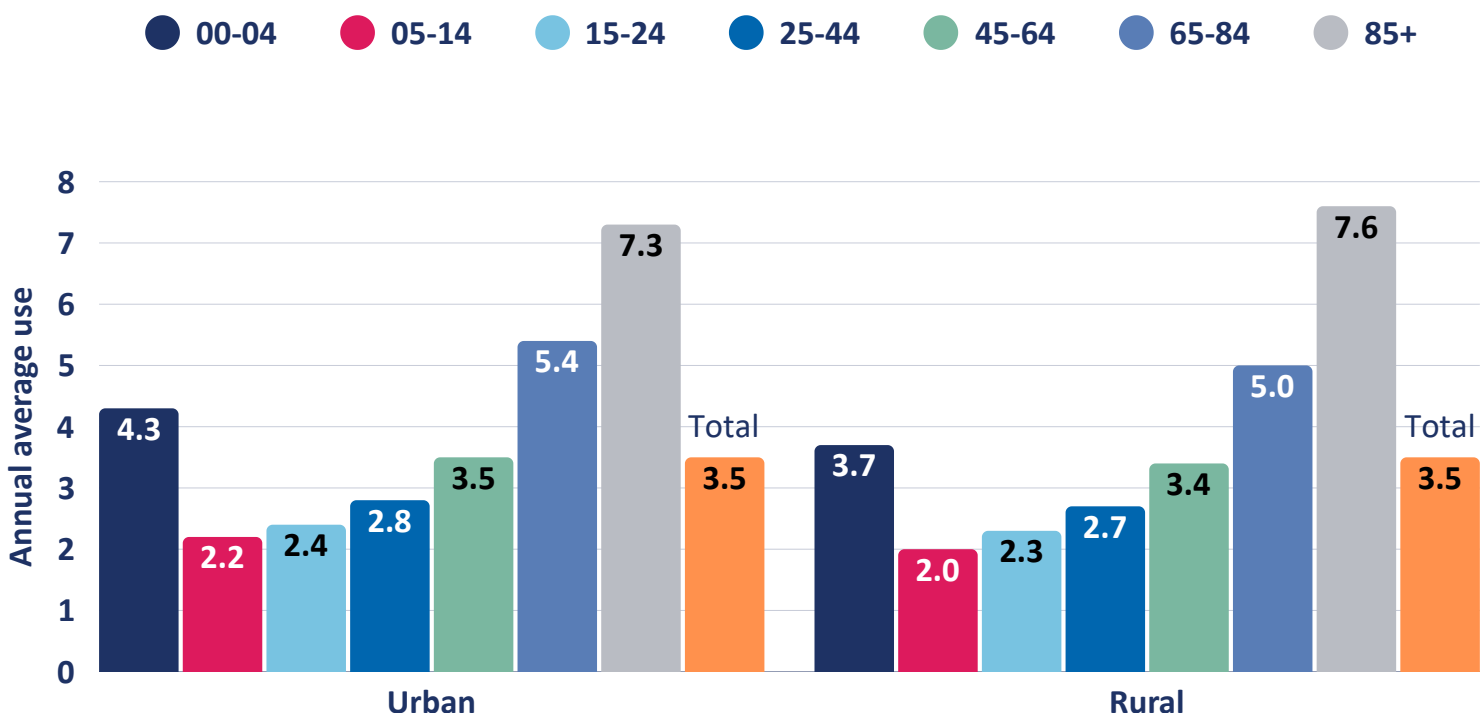


Figure 13: Annual average use of medical consults, by aggregated residence and age



Key Points

- There is a pattern of higher medical service use by the very young and the oldest (65+ years). This is perhaps no surprise.
- While the overall pattern is similar, there is difference in the actual annual average figures by each age group and where they live.
- **Urban vs Rural:** Across each age group (excluding 85+ years), average annual use in 2023/24 was higher among urban residents. At the total level, useage in that year was the same at 3.5 medical consults.
- People **resident in Urban 2 areas** had the highest level of medical consult use in that year, with an overall average of 5.9 consults.
- Those aged **00-04 years**: There was higher use of medical consults in general practice for urban dwellers (particularly those in Urban 2 areas). The lowest level was for Rural 3 residents (with an average of 2.9 medical consults in their enrolled general practice).
- Those aged **85+ years**: Urban 2 residents had on average the highest level of use (8.1 consults) compared to Rural 2 residents (6.8 consults).