Priority 7 Key Insights | Page 1

Pakeke accessing primary and community care relating to Diabetes and Cardiovascular disease

What measures and why we are looking at them

The lead measures for this priority provide insight into how pakeke Māori interact with general practices. Lead measures include PHO enrolment, the type of GP practices where Māori are enrolled, and their experiences when in contact with their health care professional. The other lead measure for this priority monitors pakeke Māori access to hypoglycaemic medication, the indicators of medication use are not intended to suggest an 'ideal' rate of use, rather they provide a high-level view.

This priority investigates the impacts primary care access has on preventing and managing diabetes and cardiovascular disease. Supplementary measures provide further context, including the average number of GP contacts over 12 month and barriers to accessing general practices. Complications of these conditions are explored through hospitalisations.

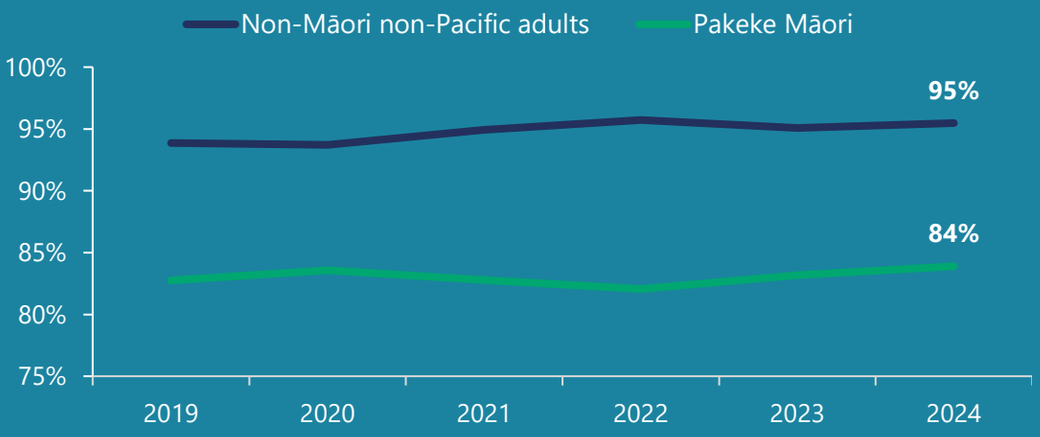
In 2023, 9.9**%** of Māori adults 15+ years had diabetes

Māori are **2.2x as likely** to have diabetes, compared to European/other

The number of Māori with diabetes **has increased by 12,183,** from 41,970 in 2018 to 54,153 in 2023.

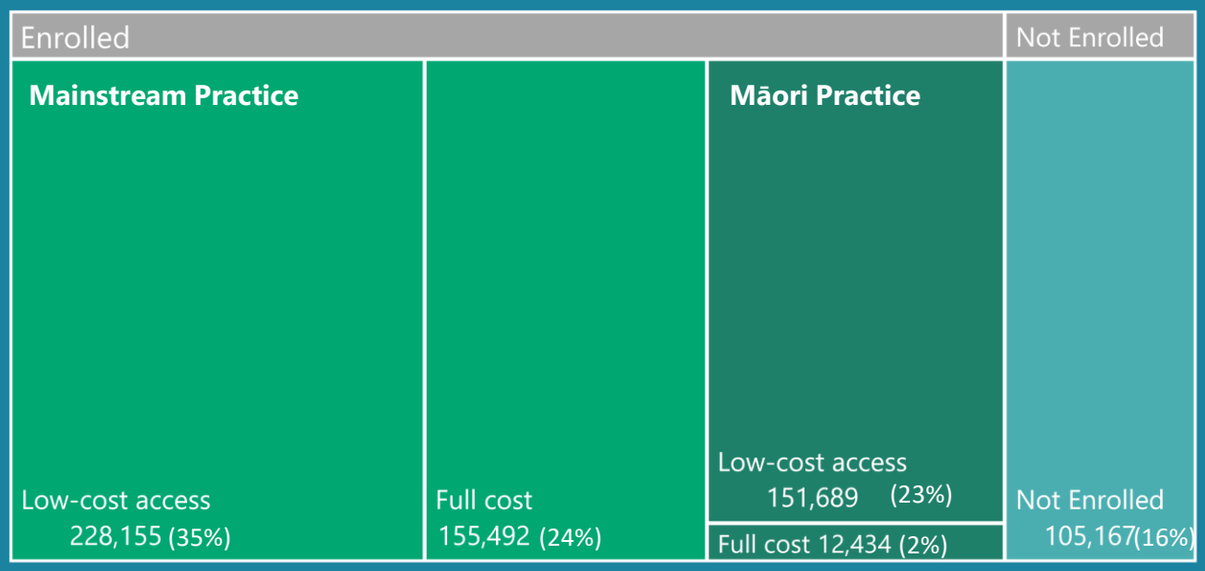
2.5% of Māori aged 35+ years were hospitalised for CVD in 2020-22

Proportion of Māori and non-Māori non-Pacific adults (15+ years) enrolled in primary care



In July 2024, **84% of pakeke Māori** were enrolled in primary care, compared to **95% of non-Māori non-Pacific adults.**

Number and proportion of pakeke Māori (15+ years) enrolled in primary care



25%

of all pakeke Māori were enrolled at a Māori practice

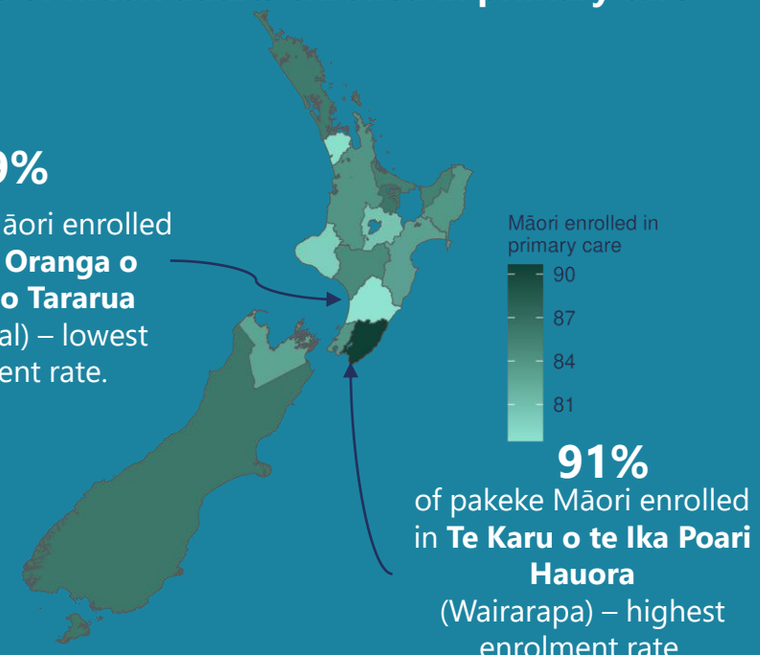
58%

of all pakeke Māori have low-cost access to primary care

Percentage of Māori adults enrolled in primary care by IMPB

79%

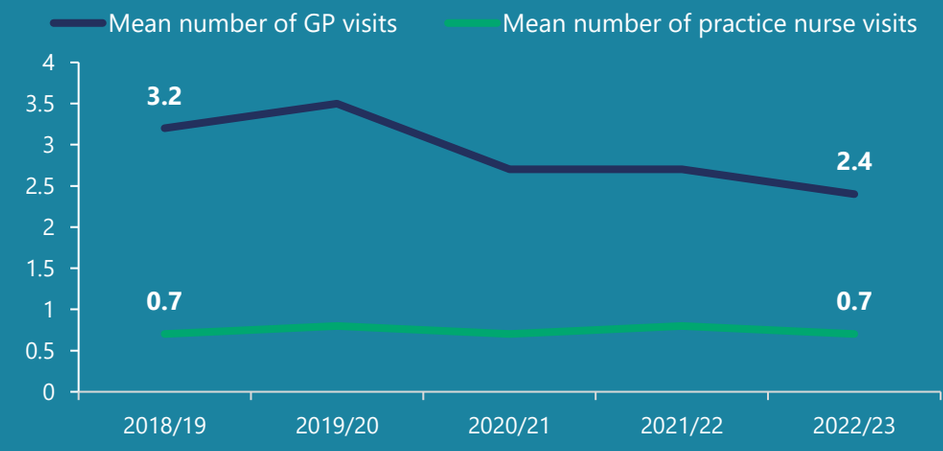
of pakeke Māori enrolled in **Te Pae Oranga o Ruahine o Tararua** (MidCentral) – lowest enrolment rate.



91%

of pakeke Māori enrolled in **Te Karu o te Ika Poari Hauora** (Wairarapa) – highest enrolment rate.

Average number of GP and Nurse visits for Māori adults (15+ years)



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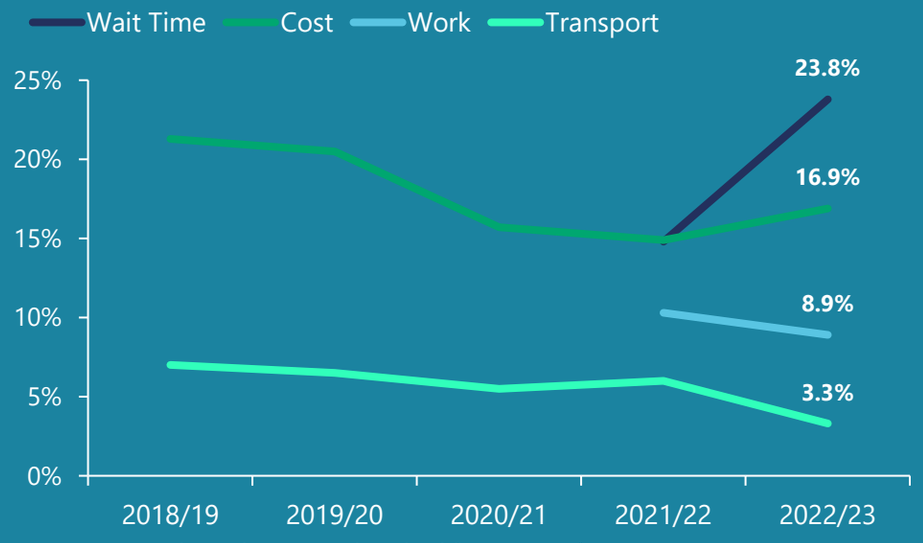
Pakeke accessing primary and community care relating to Diabetes and Cardiovascular disease

18% of medical students that graduated in 2022 were Māori.

Māori aged 35+ are **2.3x as likely** to die from CVD, compared to non-Māori

Barriers to accessing primary care for pakeke Māori

Unmet need for GP due to:



Wait time and Work were only asked from 2021/22.

Most recent primary care experience for Māori

% of Māori who had a shared treatment or care plan agreed with a health care professional to manage their long-term condition(s):

41%

% of Māori confident the health care professional knew enough about their medical history:

77%

% of Māori who felt their spiritual needs were met:

81%

% Māori who had trust and confidence in the health care professional:

86%

% of Māori who felt the health care professional informed them as much as they wanted about their health condition, treatment or care:

87%

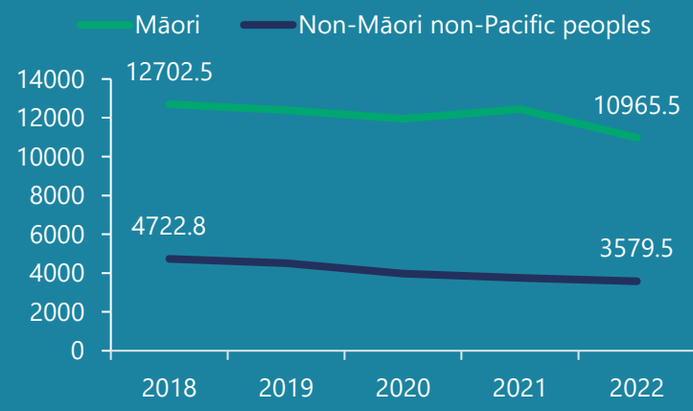
% Māori who felt they were involved in decisions about their treatment and care:

89%

Diabetes complications

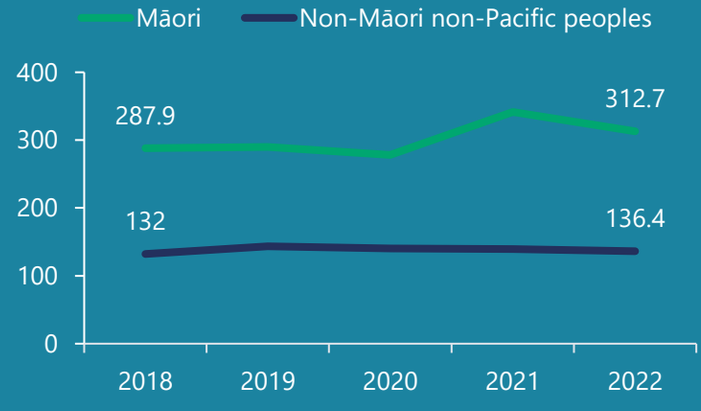
The rate of renal failure hospitalisations for Māori with diabetes is decreasing, but at a slower rate than non-Māori non-Pacific peoples. In 2022, Māori with diabetes were 3.1 times as likely to be hospitalised with renal failure.

Renal failure-related hospitalisations per 100,000 Māori with diabetes

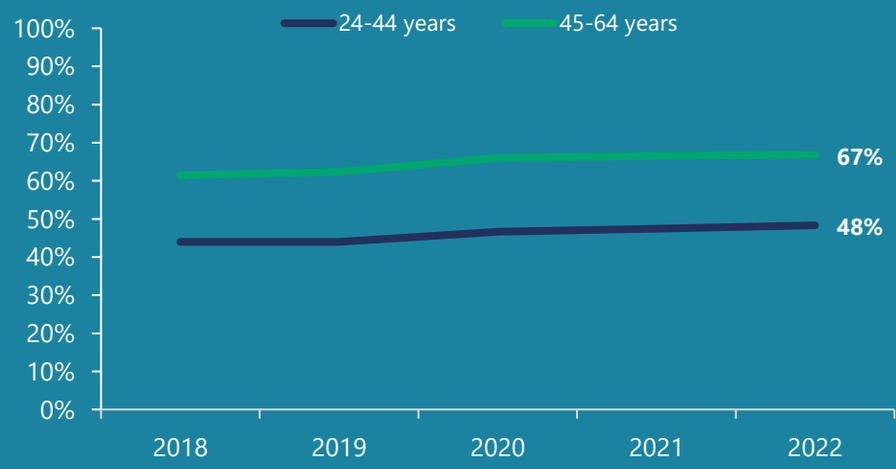


The rate of limb amputations for Māori with diabetes are increasing and the equity gap has remained consistent.
In 2022, Māori with diabetes were 3.1 times as likely to have a limb amputation hospitalisation.

Hospitalisations including a limb amputation per 100,000 Māori with diabetes



Proportion of Māori with diabetes regularly receiving any hypoglycaemic medication



*Regular use was defined as hypoglycaemic medication dispensed in 3 or more quarters of the year.

In 2022, 16,344 Māori aged 45-64 years with diabetes regularly received hypoglycaemic medication, and 4,280 Māori aged 24-44 years.

Māori aged 45-64 years **with diabetes have a lower rate of regular hypoglycaemic use than European/Other** (67% vs 72% in 2022).

Priority 7 System actions and delivery reporting

Pakeke accessing primary and community care relating to Diabetes and Cardiovascular disease

GPS 2024-2027 Priorities	Te Whatu Ora Actions	Reporting on actions
Access • Expand access to community-based supports to improve prevention and management of non-communicable diseases, including kaupapa Māori and Pacific-led options. • Work in partnership with IMPBs and local communities to ensure primary and community care services are increasingly tailored to better respond to people's needs, including family and community-based services. • Make health sector information available to local communities and IMPBs to support their role in service design and delivery. • Deliver immunisation services that meet the needs of communities, especially for those with the poorest immunisation rates, including Māori and Pacific peoples. • Implement initiatives that support an increased understanding and uptake of online care and telehealth, particularly in primary and community health care settings, and to equip people, families and whānau to better meet their own mental wellbeing needs	**NZHP Draft (1)** • Improve access to medications for the management of diabetes. • Slow progression of diabetes through proactive interventions. • Timely access to community-led, integrated Te Ao Māori solutions for prevention, early risk detection, diagnosis and self-management solutions for long term conditions that disproportionately affect Māori. • Clinical Service Planning for acute stroke/clot retrieval during 2024/25 to determine future investment to improve consistent access. **Te Pae Tata (2)** • Implement accessible and nationally-consistent clinical pathways for diabetes, cardiovascular diseases, respiratory conditions, stroke and gout, supporting specialist teams to integrate with primary and community care providers to create seamless pathways for whānau. • Prototype admission avoidance, early discharge and home-based care, including remote monitoring pilots; and refocus community nursing, allied health and the Needs Assessment and Service Coordination services to be part of comprehensive primary and community care teams.	**Te Pae Tata Reporting (4)** • The framework to support the implementation of the Comprehensive Primary and Community Care Teams has been developed. Change support to enable the refocus has been planned, aligned with Comprehensive Care Team implementation.
Timeliness • Ensure that people can access general practice services and mental health and addiction services within a reasonable timeframe. • Support strengthened public and population health initiatives for non-communicable diseases to reduce pressure on the health system. • Diversify people's entry points into the primary and community health care system, to ease acute wait times, and support more point of care diagnostic testing for putting people on the care pathway they need sooner.	**NZHP Draft (1)** • Confront the drivers of diabetes (eg nutrition, physical activity).	
Quality • Strengthen clinical and lived experience networks in key service areas to support national and regional leadership, knowledge gaps, and quality improvement. • Improve data on communities, including data collection, reporting, monitoring and sharing for providers and treaty partners and enable outcomes to be monitored by ethnicity, gender, age, rurality, and disability. • Develop system functions and settings to support the rapid adoption of new, evidence-based technologies, research findings, and innovation. • Improve the national approach to gathering feedback and responding to and learning from complaints and health care harm, including the development of culturally-appropriate and accessible feedback channels, as well as restorative practice. • Strengthen public health surveillance to increase the detection and response to communicable and non-communicable diseases, and on information on the distribution of wider determinants of health and wellbeing.	**NZHP Draft (1)** • Establish and implement national pathways for management of complication of diabetes. • Expand and standardise Cardiovascular Disease Risk Assessments (CVDRA) and management. • Community testing and further developments of the Heart Health Plan. • Develop and implement nationally equitable pathways of care endorsed by National Clinical Network - Cardiac for people with cardiovascular disease (CVD) and respiratory diseases. These health pathways will include prevention, self-care, primary care, and community care. **Whakamaua (3)** • Implement an action plan to prevent and manage long term conditions, including gout and diabetes, through a cross-health system approach, including a national communication campaign and extending effective primary health and community models of care.	**Whakamaua Reporting (5)** • Te Whatu Ora are currently developing a new 2024-2027 National Diabetes Action Plan as a coordinated response to diabetes led by Māori and Pacific, with the aim of reducing the burden of diabetes across Aotearoa and eliminating inequities experienced by Māori, Pacific, and other under-served populations. The action plan, which is substantially completed, has been developed with whānau Māori; Pacific people; people with lived experience of diabetes; community, primary care providers; and clinical diabetes experts, and looks to shift the focus to community driven services and strategic prevention, as the best opportunity to eliminate inequities. • Te Whatu Ora are in the early stages of scoping national care pathways for the prevention and management of diabetes-related complications, including foot care, retinal screening, and diabetic kidney disease. This will include new work to strengthen sector guidance on self-management programmes and resources, to help support individuals and whānau with or at risk of chronic health conditions to understand and manage their health and wellbeing on a daily basis.

GPS 2024-2027 Priorities	Te Whatu Ora Actions	Reporting on actions
Workforce • Improve access to domestic training pathways to deliver a culturally competent and home-grown workforce that better reflects the population of New Zealand as a whole. • Develop leadership programmes, including investing in aspiring Māori health leaders and rangatahi, as well as Pacific peoples and disabled people. • Ensure public health, primary, and community health care services better enable local leadership in their design, delivery, and integration.	**NZHP Draft (1)** • Strengthening the national diabetes leadership and workforce. **Te Pae Tata (2)** • Commission comprehensive primary and community care models in high Māori populations that address the needs of the community.	**Health System Reform Progress Reporting (6)** • Announcement of the delivery of mātauranga Māori training for the primary and community care health workforce. This is a $4 million investment to 30 June 2025 providing a total of 5,530 training opportunities for 2023/2024 to support kaimahi to incorporate te ao Māori and mātauranga into their practices. **Te Pae Tata Reporting (4)** • The commissioning of primary and community care teams as per action 3.3.6 is being prioritised for Māori. Up to 200 roles are in recruitment across the motu, which includes kaiāwhina in prioritised Māori provider partners.
Infrastructure • Continue to progress digital initiatives to enable care closer to home • Enable flexible and adaptive decision-making on emerging technologies such as precision health, nanotechnology, artificial intelligence and medical devices, for example by updating evaluation frameworks (including the Health Technology Assessment).	**NZHP Draft (1)** • Strengthening the national diabetes technology. **Whakamaua (3)** • Adopt innovative technologies and increase access to telehealth services that streamline patient pathways and provide continuity of care for Māori individuals and their whānau.	**Te Whatu Ora – Digital Enablement Reporting (7)** • A project being delivered from Mid-North services provider Ngāti Hine Health Trust is enabling people with cardiovascular disease (CVD) to monitor their own health remotely. Ngāti Hine will deliver remote patient monitoring and care of patients who have either have CVD or are at risk of developing it. Each person will be given a monitoring plan and device, and will register their daily vital signs and any symptoms of deteriorating health. Patients will receive feedback, access to coordinated treatment, educational material and the ability to communicate virtually with their assigned Whānau Ora navigator. The Ministry is working closely with project teams, sharing learning between participating organisations as a community of practice and looking for opportunities to help others learn from these initiatives as they adopt and promote these or similar services elsewhere

Case Study: Digital Solutions

Piki Te Ora (8)

Piki Te Ora, a Remote Patient Monitoring pilot, is a digital service that partners with four rural communities to co-design and co-develop a better way to improve and support whānau who are living with long-term health conditions including diabetes and cardiovascular disease.

This voluntary project spans two years and aims to collect health information from those who wish to participate. The intent of this pilot is to identify and collect the right health information in a readily consumable, equitable, and accessible way for both users and clinicians. The primary goal of remote patient monitoring, in the context of Piki Te Ora, is to make healthcare more accessible and effective and to empower patients and their whānau to take an active role in their health management.

Ka Ora Telecare (6)

A new rural telehealth contract was awarded in November 2023 to Ka Ora, to provide overnight, weekend and public holiday access to telehealth services for almost 900,000 people. This supports those living in rural areas who may not have easy access to afterhours primary healthcare, to see a kaiāwhina or clinician from the comfort of their own homes. Ka Ora Telecare went live on 8 November 2023. By 15 December 2023, 35% of all eligible rural practices had enrolled in the service. There have been 2,518 nurse appointments and 1,913 GP appointments since the service launched, with 14% of calls made from Māori.