An evaluation of

Extended Primary Care

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Karakia

Tutawa mai i runga

Tutawa mai i raro

Tutawa mai i roto

Tutawa mai i waho

Kia tau ai

Te mauri tū

Te mauri ora

Ki te katoa

Haumi e

Hui e

Tāiki e

Come forth from above, below, within, and from the environment

Vitality and wellbeing for all

Strengthened in unity

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EXECUTIVE SUMMARY

This evaluation explores the experience and early outcomes of the Extended Primary Care (EPC) programme in Otago and Southland (Southern). Using a mixed-methods approach, including a practice survey, interviews, quantitative analysis, and cost modelling, it examines how EPC has been implemented, how it has been experienced by practices, and its early impacts on patients, practices, and the wider health system.

EPC has been widely adopted, particularly in rural areas. All practices recognise the need for additional funding to support acute care in the community. Rural practices, especially those operating with urgent care models of care, used EPC extensively, often delivering care out of hours and to an extended catchment of patients. This reflects local need and limited access to secondary services. In contrast, urban practices used EPC more selectively, often to support Māori and people living in high deprivation areas. These differences highlight the influence of local context in shaping programme use.

Practice experience is mostly positive, though varies by context and use. Urban and lower-use practices see EPC as a more flexible alternative to the Primary Options for Acute Care (POAC) programme. They particularly value the fee-for-time approach and the ability to fund previously unfunded care. High-use rural practices report challenges, including capped funding, administrative burden, and limited impact on overall revenue. These issues lead to rationing of claims and early funding exhaustion. EPC funding is substantially higher than POAC. However, this is often used to offset patient costs, so the additional funding is not always perceived by practices. Practices also called for clearer communication and better sharing of approaches used across the region.

EPC's impact on acute healthcare utilisation is still emerging. Although it often funds care that was already being delivered at either the practice's or patient's cost, there is some evidence of improved access, continuity, and affordability. Some practices report providing additional clinical work-up and having a higher threshold for referring patients to emergency departments. Among high-use rural practices, a small but statistically significant reduction in emergency department presentations was observed. These early findings suggest EPC could help reduce hospital demand and support system efficiency if backed by stable funding and sustained support.

The most immediate benefit has been reduced out-of-pocket costs for patients, especially where acute care costs were previously passed on. However, short-term, claim-based funding limits practice's ability to plan or develop acute care services. To support lasting changes in models of care, EPC needs longer-term, more equitable funding and additional wraparound supports. EPC also shows potential cost-effectiveness, with break-even modelling suggesting that avoiding secondary care for just 6% of EPC patients would offset programme costs.

Key recommendations include advocating for increased funding with a long-term view, refining the allocation model to better reflect local needs and rurality, improving WellSouth's support and transparency, and enabling capability building. These changes would help ensure more sustainable, equitable delivery of acute care in the community and support wider system goals.

BACKGROUND

Acute care

Acute care is defined as any urgent health care that, without prompt treatment, may result in death or long-term disability.[1] Primary care plays a crucial role in managing acute care, frequently managing presentations that would otherwise require secondary care services.[2] Providing acute care in general practice has several benefits, including delivering patient care closer to home, thereby avoiding the inconvenience of travel and other hidden costs for patients, and avoiding costs to the broader health system incurred by utilisation of secondary care.[3] The scope of acute care within primary care is narrower than in secondary care, where advanced testing and specialised services are available. Ultimately, some acute hospitalisations are unavoidable. Nonetheless, when sufficiently resourced, primary care can manage a broad range of presentations that present to secondary care services.[4]

WellSouth, the Primary Health Organisation (PHO) for Otago and Southland (Southern), supports primary care to deliver services across a geographically dispersed population. Almost half of the 330,000 people enrolled in Southern are enrolled in a rural general practice, which makes the delivery of acute care particularly challenging, but necessary. Long wait times for ambulances in rural areas mean that rural general practices often deliver prolonged pre-hospital stabilisation care to patients, sometimes extending into out-of-hours care provision.

Rurality has been associated with an approximately 15% to 30% lower ambulatory sensitive hospitalisation (ASH)[a] rate compared to urban populations among both Māori and non-Māori.[3] This gap is likely due to the relative inaccessibility of secondary care, which is met by rural General Practices acting out of a duty of care to deliver acute services.

Funding acute care in Southern

The Primary Options for Acute Care programme (POAC) has been available to general practices, in various forms, for more than a decade across Te Waipounamu. Originally established to fund a limited number of acute services in general practice, POAC has evolved to include a mix of acute and non-acute services. However, if a patient's presentation didn't align with a listed POAC service, general practices had limited options. Practices could provide the necessary care and charge the patient; deliver the care and absorb some or all of the cost; or refer the patient to secondary care. In rural areas, this could include stabilising the patient while awaiting ambulance transfer, which was not covered by POAC, so rural practices generally absorbed the true cost of providing this care.

Central government funding for acute care services has varied widely. For example, Canterbury receives $11 per Enrolled Service User (ESU) to deliver wrap-around support services through the

[a]ASH presentations "are acute admissions that are considered potentially reducible through interventions deliverable in a primary care setting".[5]

Acute Demand Management Service (ADMS).[b] In comparison, other parts of Te Waipounamu, including Southern, historically received $0.70 per ESU to deliver POAC. In response, WellSouth advocated for increased acute care funding to achieve greater parity across Te Waipounamu. Extended Primary Care (EPC), now being delivered across Te Waipounamu, excluding Canterbury, marks a step toward parity with Canterbury, with a funding increase to $5 per ESU.

Extended Primary Care

EPC is a primary care-based programme delivered by WellSouth and funded by Te Whatu Ora (TWO). EPC was made available to general practices in Southern in August 2024. EPC includes two distinct pathways: a rural stabilisation pathway and an acute care pathway. While most acute presentations to secondary care are appropriate,[6] EPC aims to promote the provision of extended care that is within the clinical scope of general practice clinicians but may fall outside their usual model of care. The acute care pathway enables general practices to manage a range of acute conditions within the primary care setting, with the intention to reduce the need for hospital care when it is safe to do so. Of note, accidents and injuries are excluded from EPC, as they are otherwise funded through ACC.

While the contractual objective of the EPC acute care pathway is to reduce secondary care utilisation, both TWO and WellSouth acknowledge that, particularly for rural practices, EPC may fund care that was already being provided by general practices unfunded. Indeed, the rural stabilisation pathway, available only to rural practices, is intended to fund the observation and management of patients while they await ambulance transfer, that has often been unfunded historically.

Both EPC pathways are funded through a fee-for-time model. Details of claimable conditions, intervention types, claim categories, and the full claiming schedule are provided in Appendix 1. EPC is designed to complement POAC, which continues to provide fee-for-service funding for a smaller range of planned care services. An updated list of POAC services is also included in Appendix 1.

TWO provided WellSouth with the flexibility to determine how EPC funding would be allocated across practices. However, the total amount of funding available and service specifications were determined by TWO to maintain consistency across PHOs in Te Waipounamu, excluding Canterbury. An allocation model was developed collaboratively by WellSouth's Data and Digital team, Clinical Director, and project implementation team. This model, outlined in Appendix 1, was designed to be needs-based, with priority given to patient populations with high ASH rates and rural practices facing a high burden of acute care delivery and patient stabilisation. A "rural" designation was used for practices located 30 to 45 minutes by road from secondary care services, while an "extra rural" weighting was applied to practices located more than 45 minutes away.

[b] The ADMS was introduced to reduce ED visits and acute hospitalisations by providing access to community-based services, including diagnostic, treatment, and support services, provided by extended general practice teams. It has demonstrated effectiveness: In its first 2 years, ED presentations fell by 4.6% in ADMS-aligned practices, compared with a 7% increase in other practices.[7]

The need for evaluation

The TWO contract to deliver EPC initially guaranteed funding until the end of September 2025. TWO has provided assurances that funding will continue, and the contract duration provides a natural opportunity to understand the early impact of EPC. In addition, feedback from practices, particularly rural practices, has highlighted concerns about both the funding amounts and the allocation process. Therefore, WellSouth's Senior Leadership Team (SLT) requested this evaluation to support WellSouth's ongoing refinement of EPC, particularly related to General Practices' uptake of the programme, how best to manage the funding allocation, and understanding the impact EPC is having on patients, general practices, and the wider health system.

EVALUATION METHODOLOGY

Key evaluation questions

To support the evaluation, four key evaluation questions (KEQs) were identified. A mixed-methods early outcome evaluation has been developed to answer these key evaluation questions.

1. How has the EPC programme been utilised by WellSouth General Practices?
2. What have been the General Practices' experiences of the EPC programme for acute care and rural stabilisation?
3. What impact has EPC had on acute healthcare utilisation?
4. What impact has the EPC programme had on the cost of delivering acute healthcare for patients and across the system?

Qualitative methods

Survey

A 15-question survey was developed using Microsoft Forms to explore General Practices' experiences with the EPC programme and their perceptions of its impact on acute care within their practices. The survey questions are presented in Appendix 2. The survey was distributed to all General Practices in the Southern district (n=79), and responses were collected over 5 weeks during April and May 2025. All practice staff, including clinical and non-clinical team members, were invited to participate. Reminders were sent weekly to maximise participation. Survey responses were identifiable at the practice level but anonymous at the individual level, and participants were invited but not required to indicate their role. Summary descriptive statistics were produced. Where multiple responses for the same practice were received, the mean response was reported.

Interviews

Semi-structured interviews were conducted with several key staff within WellSouth, and with general practices in Southern. A range of practices from high (≥80% utilisation), moderate (20%–80%), and low (≤20% utilisation) users of EPC, based on utilisation in quarter 3 (1 January to 31 March 2025), from across the Southern district, were invited to interview. Clinical and non-clinical staff were invited to participate to capture a range of perspectives. Both semi-structured interview guides are presented in Appendix 2. Invitation and information sheets were provided to all participants, and written consent was obtained. Interviews were conducted in person where possible. Interviews were recorded and transcribed, and transcripts were analysed using an abductive approach, according to the framework outlined in Appendix 3[8]. Survey free-text responses were analysed using the same framework and are included in the interview results. Coding, analysis, and peer review were conducted by two evaluators.

Document review

WellSouth received and documented feedback from general practices during the first two allocation

periods of the EPC programme from 11 August 2024 to 31 December 2024. The evaluation team reviewed this feedback and compared it to the survey and interview data to broadly indicate whether general practices experience of EPC had changed over time.

Quantitative methods

Quantitative data analyses were conducted using Microsoft Excel and R version 4.4.0.

Descriptive analyses

Routinely collected datasets, including WellSouth portal claims, Thalamus dashboards, and secondary care presentation data[c], were used in this analysis. WellSouth portal claims and Thalamus dashboards used the start of the programme, 9 August 2024, until 31 March 2025 as the analysis timeframe. Secondary care presentation data were obtained for 9 months before and after the launch of EPC in August 2024 (1 December 2023 to 31 March 2025). A 6-week window after the end of the data capture was allowed to optimise the completeness of these datasets. Due to an unexpected issue with data quality arising from incomplete data, analysis of hospitalisation data has been limited to 1 December 2023 to 31 January 2025. Portal and hospitalisation data were provided in Excel format by WellSouth's Data & Digital team.

Data were used to describe the proportion of practices engaging with EPC and patterns of utilisation over time. Demographics of the population for whom an EPC claim was made were described by rurality, claim type, age, gender, ethnicity and socioeconomic deprivation (NZDep quintile). Secondary care events excluding injuries and accidents were linked to a patient's general practice. ED presentations and acute hospitalisations within 3 days of an EPC acute initial or acute follow-up claim were described. The ED presentation dataset contains limited information on the presenting condition, limiting direct comparisons between EPC and secondary care datasets. It was considered reasonable to assume that most people with a secondary care visit within 3 days of an EPC claim were presenting with the same condition. A sensitivity analysis at 7 days was also conducted.

Cost-based analyses

The Thalamus 'claim monitoring' dashboard was used to determine changes in funding for acute care, including EPC and acute POAC claims, both for practices and the PHO, before and after the introduction of EPC. The 9 months preceding the start of EPC (August 2023 to April 2024) were compared to the first 9 months of EPC (August 2024 to April 2025) to reduce the impact of seasonal variation.

The cost-effectiveness of the EPC acute care pathway was estimated by comparing the total cost of delivering EPC to the potential reduction in costs to secondary care due to estimated avoided presentations. The average cost of an ED visit and hospitalisation were based on estimations presented in Treasury's cost-benefit analysis (CBAx) tool, and a break-even analysis was conducted.

[c] Acute admission data were sourced from the National Minimum Dataset (NMDS), while ED visit data was sourced from the National Non-Admitted Patient Collection (NNPAC).

Inferential analyses

Inferential analyses compared secondary care utilisation before and after the introduction of EPC. Difference-in-differences analyses were conducted to explore the effect of EPC on secondary care utilisation. ED visits were the primary analysis. Supplementary analyses of acute hospitalisations and ASH rates was not possible due to the limitations of these datasets. Rural and urban practices with high (>80%) and low (<20%) utilisation of their EPC allocation were compared.

Strengths, limitations and ethics

The evaluation utilised a mixed methods approach to triangulate findings and strengthen the robustness of the conclusions drawn. Integrating different types of data on the same topic can help to offset the limitations of each method and enable a more comprehensive understanding of the evaluation subject.[9]

There was a high level of engagement from staff working in general practice, both in survey responses and interviews. Clinical staff, in particular, were well represented. This is a strength of this evaluation, given that engaging clinical staff can be a challenge, given their time constraints. The risk of low participation in the survey and interviews was mitigated by support from WellSouth Primary Care Relationship Managers and utilising WellSouth communication channels to circulate weekly reminders.

There is potential for respondent bias, particularly from respondents who had engaged in EPC and had strong views about the programme. This is highlighted by the low numbers of low users of EPC interviewed, potentially limiting insights from this group. Interviews were conducted prior to quantitative analysis, enabling an exploratory and naïve approach to understanding. Qualitative data saturation was achieved for high and medium users, but likely not for low users of EPC. As there are many different approaches to acute care delivery, it is possible that the 3 acute care delivery models described in this evaluation do not fully capture the variety of models used in Southern.

The short time EPC has been in place limits the ability to draw confident conclusions about its outcomes, particularly regarding its impact on secondary care utilisation. This challenge is compounded by the need to further restrict the analysis window due to an unexpected issue in the availability of the hospitalisation data. Several assumptions were necessary to estimate the cost-effectiveness of EPC, particularly regarding its impact on avoiding secondary care visits.

The evaluation team has completed the WellSouth ethics checklist and determined that this evaluation does not require feedback from the ethical guidance committee, as the data used is routinely collected and there was no patient participation.

EVALUATION FINDINGS

Descriptive statistics

Overview of EPC claiming behaviour across practices

Between 11 August 2024 and 31 March 2025, there were 3233 EPC claims made by practices in Southern. Of these, 151 claims were rejected and 3082 were accepted.[d] Most practices (76/79, 96%) have engaged in EPC with at least 1 claim (Figure 1).

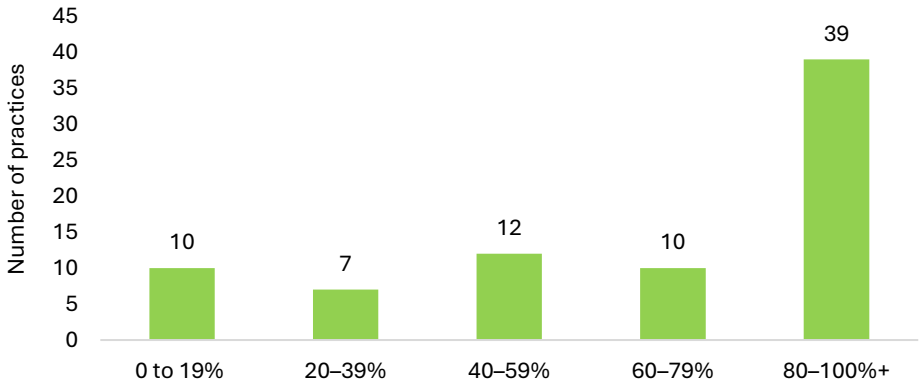

Figure 1. Percent utilisation of EPC allocation over quarter 1-3.

Almost half of practices (49.3%) had used at least 80% of their total funding allocation over quarters 1 to 3. In fact, 30 practices (38%) had used at least 95% of their allocation. At the other end of the spectrum,10 practices had used less than 20% of their allocation. Of the 3 practices with no claims, 2 primarily serve residents in aged care facilities, and the third indicated an intention to start using EPC in the near future.

Acute initial claims were the most common claim type for both urban (1336, 94.4%) and rural (1184, 72.5%) patients. Rural stabilisation claims made up nearly a quarter of claims for rural patients (22.5%), and 0.6% of urban patients (who were seen in a rural practice), while acute follow-up claims accounted for approximately 5% of claims among both urban and rural patients (Appendix 4).

The vast majority of claims (2968, 96.3%) were for the practice's own enrolled patients. Twenty-six practices made claims for patients enrolled in other WellSouth practices (114, 3.7%), and the majority of these were rural practices in domestic tourism centres.

[d] The primary reason claims were rejected was because the practice's allocation had been fully utilised. Other reasons included when an acute care initial claim had already been made in the last 5 days, the claim was made outside the allowable window (5 days for follow-up, 60 days for acute initial), and a small number of duplicated or incorrectly completed claims.

EPC claims use a fee-for-time approach. The mean dollar amount claimed for rural patients (all claim types) was 30% higher ($320 [range $11.5–$1350] than urban practices ($202 [range $11.5–$897]).[e] GP/NP and/or nurse and/or admin/observation time in is accounted for in 15-minute increments. Urban practices were able to claim up to 90 minutes, while rural practices could claim up to 180 minutes under the rural stabilisation pathway. 15-minute claims were most common for all staff roles, except rural GP/NP, who most often claimed 30 minutes. There were very few claims greater than 60 minutes made by either rural or urban practices. The distribution of time claimed by rurality and staff role is presented in Appendix 4.

EPC claims also note whether most of the care provided occurred in- or out-of-hours. Rural practices were 4.5 times more likely to claim for care delivered out-of-hours than urban practices (219, 13.4% of rural claims, versus 43, 3.0% of urban claims).

Demographic characteristics of EPC recipients

Of the 3082 accepted claims, 1633 (53%) were for rural patients, and 1415 (47%) were made for urban patients. Patient rurality was unknown for 34 patients, and these were excluded from this comparative analysis.

Table 1 presents the demographic characteristics of patients for whom EPC was claimed and the total WellSouth population, stratified by rurality. The highest number of EPC claims occurred among those aged 60 to 84 years, with a smaller secondary peak in children aged under 5 years (Appendix 4). The proportion of Māori patients was similar between rural EPC claims and the enrolled population, while in urban areas, Māori were overrepresented among those with EPC claims. Pacific peoples for whom EPC was claimed resembled the total enrolled population in both rural and urban areas. In rural areas, patients with an EPC claim were more likely to live in lower deprivation areas (Q1 and Q2), whereas urban EPC patients were more concentrated in the higher deprivation areas (Q4 and Q5) compared to their respective enrolled populations. This suggests that the approach to claiming may differ by rurality, with urban practices potentially using EPC for patients with affordability issues more so than in rural practices. In rural areas, patients with an EPC claim were more rural (R2 and R3) compared to the distribution of rural WellSouth practices.

[e] The highest-value claims were for the management of a 1-year-old with an acute asthma exacerbation requiring prolonged care while awaiting helicopter evacuation, and an 85-year-old with sepsis resulting from an animal bite requiring management and observation.

Table 1. Demographics of patients accessing EPC and the total WellSouth enrolled population, by rurality.

		EPC rural, n (%)	WellSouth rural, n (%)	EPC urban, n (%)	WellSouth urban, n (%)
Age	Mean (range)	53.8 (0–99)	40.2[a]	49.8 (0–99)	40.7[a]
Gender	Female	862 (52.8)	74998 (50.0)	811 (57.3)	96333 (51.3)
	Male	711 (47.2)	74976 (50.0)	604 (42.7)	91279 (48.7)
Ethnicity	Māori	143 (8.8)	13003 (8.6)	219 (15.5)	22316 (12.0)
	Pacific Peoples	31 (1.9)	3059 (2.0)	46 (3.3)	6436 (3.5)
	Non-Māori Non-Pacific	1453 (89.0)	135329 (89.4)	1150 (81.3)	157675 (84.6)
Deprivation[b]	Q1	614 (37.6)	53146 (35.1)	231 (16.3)	39644 (21.3)
	Q2	404 (24.7)	36185 (23.9)	225 (15.9)	3792 (20.3)
	Q3	307 (18.8)	31889 (21.1)	244 (17.2)	32265 (17.3)
	Q4	222 (13.6)	19405 (12.8)	371 (26.5)	43812 (23.5)
	Q5	86 (5.3)	8942 (5.9)	342 (24.3)	31528 (16.9)
Rurality[c]	GCH	R1 570 (34.9)	R1 78256 (51.7)	U1 785 (55.5)	U1 121010 (64.9)
		R2 973 (59.6)	R2 71280 (47.1)	U2 630 (44.5)	U2 65417 (35.1)
		R3 90 (5.5)	R3 1855 (1.2)		
Total		1633	151391	1415	186427

[a] Mean age of WellSouth enrolled populations estimated from weighted averages of 5-year age bands.
[b] NZDep Quintile; Q1 represents those that are least socioeconomically deprived.
[c] GCH, Geographic Classification of Health, defined rurality according to proximity to a larger urban area with respect to health; based on patient address for EPC, and practice address for WellSouth practices.

The most common presenting conditions have been grouped and are summarised in Appendix 4. Combined, these conditions make up over 80% of all presenting conditions. Chest pain or cardiac presentations account for over 25% of all presentations alone.

Survey results

Thirty-nine responses were received from 30 of the 79 practices in Southern, resulting in a 38% survey response rate. Responding practices had a relatively even rural-urban split (14 rural, 16 urban), and almost two-thirds of respondents were clinicians. The majority of practices (80%, 24/30) described their overall experience with EPC as “good” or “excellent”. Two practices described their experience of EPC as “poor” or “very poor”, mainly due to the time required to administer the programme. This will be discussed in more detail throughout the evaluation. Despite this, survey results indicate that practices in Southern have on the whole had a positive experience of EPC.

Further survey results indicate that EPC has had a substantial positive impact on a practice’s ability to provide both acute care and rural stabilisation care. Respondents felt that EPC had the greatest impact on reducing out-of-pocket costs for patients and supporting patients to receive care closer to

home. However, the impact of EPC on the practice's own experience was mixed. EPC had a limited impact on skill mix, equipment, and workflow (mean score 2.7–2.9/5), and there was a clear indication from practices that demand is exceeding funding.

The majority of practices report they have used all the available funding and/or are rationing to make the funding last longer. The purpose of rationing is to extend the number of patients who access funded acute care. Likely because of these funding limitations, EPC was perceived as not fully meeting the needs of practices to deliver acute care. There was positivity for the fee-for-time model and claiming form (mean score 3.9–4.2/5), while the quarterly allocation and variability in the allocation amounts each quarter were less well-received (mean score 2.9–3.0/5). Support received from WellSouth was perceived as adequate (mean score 3.5/5).

Interview findings

Eighteen interviews were conducted with general practices. The majority of practices interviewed were rural, and practices were skewed towards high users[f] of EPC. Thirty-nine practice staff were interviewed, the majority of whom were clinicians. A breakdown of interviewees is provided in Appendix 3. Seven key themes were identified through abductive analysis and are presented below.

Acute care: models of delivery

Different models of managing acute demand in primary care exist across Southern. A key finding from practice interviews is that the model of acute care strongly influences how EPC is perceived, utilised, and experienced. Understanding these models is therefore essential before examining the EPC programme. Three distinct models of acute care were identified: the urgent care model, the hybrid model, and the traditional model, detailed in Figure 2.

Rural practices often provide extensive acute care due to limited access to secondary services in rural communities.[10] To address this inequity, some practices have developed an urgent care (UC) model. This model requires significant investment in dedicated staff, space, beds, and equipment to meet acute needs within the community. UC model practices see themselves as serving a wider catchment area that includes their enrolled patients, other locally enrolled patients, Southern-enrolled patients, domestic visitors, and international tourists. These practices are often located in areas with seasonal peaks in visitor and seasonal workers, which adds complexity to acute care delivery. Domestic visitors may also expect funded acute care, as is available elsewhere in the New Zealand health system.

> *"I think it [EPC] works well if you're a little general practice that doesn't have the same acuity that comes through a big rural practice that also does an after-hours service as well as weekend service."*
> UC model practice

While rural hybrid and UC practices have made investments into their model of care, it should be noted that other funding streams are available to these practices, such as rural capitation funding and

[f] High users are defined as those who used >80% of their total allocation during 11 August 2024 to 31 March 2025 (quarters 1 to 3).

other bespoke TWO contracts. Understanding this complex funding landscape is beyond the scope of this evaluation, but it is important to acknowledge.

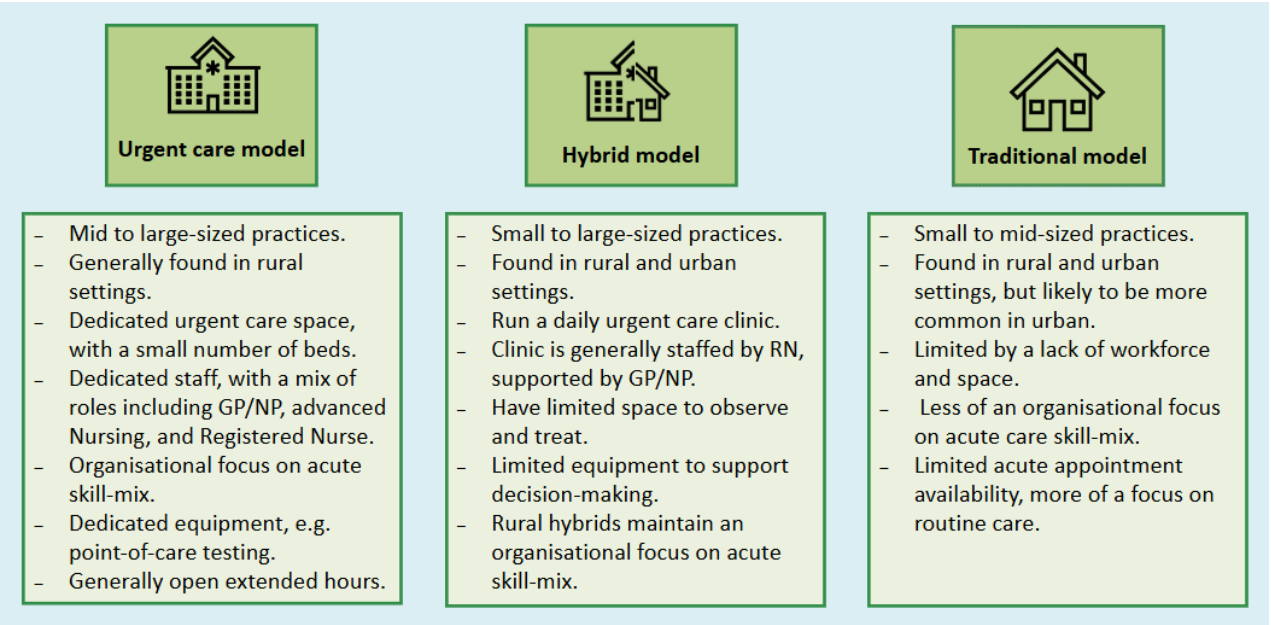

Figure 2. Models of acute care delivery in WellSouth general practices.

Factors influencing uptake of EPC

Additional funding to support acute care is considered highly relevant to general practices, and most practices report a growing demand for acute services. Traditional and hybrid model practices were generally positive about EPC, viewing it as 'nice to have' when needed. In contrast, UC model practices saw EPC as a core part of their business model.

> *"We found it fantastic. It has been very helpful, and very handy, actually, just having a little pot of something that makes it a little bit easier."*
> Traditional model practice

Practices reported mixed enthusiasm about engaging with EPC initially. Traditional and hybrid model practices were reluctant to engage with EPC until they could understand the programme and see its applicability. Some of these practices had been made wary by previous experiences of adopting a new programme only for it to be discontinued or changed. However, UC model practices were proactive in engaging early and ensuring their allocation was utilised.

> *"To be honest, when we first got it, it was like all these new initiatives, you thought, how hard is this going to be? How many forms are we going to have to fill in? Is it worth it?"*
> Traditional model practice

Conversely, some practices, particularly traditional and hybrid models, said they lacked clarity on how to apply EPC in practice. Written materials, including programme sheets and email updates, were often seen as insufficient to make them feel informed. Following the initial promotion and written materials, the role of Primary Care Relationship Managers (PRMs) was to encourage practices to engage and assist them in establishing the programme. The value of this multi-pronged approach was borne out, as many practices relied on their PRM and conversations with other practices for guidance and specific use cases. PRMs often played a key role in reminding practices that unutilised funding could be withdrawn.

> *"I actually needed something practical, like, how can we do it? Because if you look at this [programme sheet], you don't always see ... ways to do it."*
> Traditional model practice

Practices often discussed missed opportunities to claim EPC. For example, in UC model practices, claimable events were often missed during busy periods as the clinical team was focused on delivering patient care rather than claiming. Conversely, traditional model practices that have fewer opportunities to utilise EPC find it more difficult to keep the programme front of mind and therefore missed out on claims. Many reported increased use of EPC when a staff member, usually a practice manager or nurse, championed the programme.

Lower-using practices expressed interest in learning from high users, asking, for example: "Who uses the most funding, and how do they do it?" and "What can we learn from them?" There is an opportunity for WellSouth to better support implementation by facilitating knowledge sharing between high and low users of EPC and including nominated practice champions in the initial rollout.

Limited allocations and rationing

EPC funding is well-received, but running out of allocation is a major frustration. Many, mostly rural, practices reported they could use their entire allocation within days or weeks if they claimed for all eligible patients without rationing. Most practices lacked clarity on how allocations were calculated and called for greater transparency of this process. UC model practices in particular perceive inequities in allocation based on differences in model of care and local context, which are not fully accounted for in the model. Quarterly allocations were generally preferred for ease of management, though six-monthly allocations were also considered acceptable. Practices emphasised that longer term certainty of funding would be the most impactful improvement. Most practices had an approach to rationing the available funding within the quarter. Common approaches are described below. Practices may use multiple approaches and/or change approaches within a quarter.

1. *Restricting patient eligibility criteria*

> *"Depending on how it's going, we take it down to away from visitors, just to enrolled people or New Zealand and enrolled, or just enrolled patients, or just chest pain."*
> UC model practice

Although EPC is available to anyone eligible for funded care in New Zealand, practices define their own eligibility criteria. Some changed eligibility rules throughout the quarter, leading to confusion and discomfort for staff and concerns about a "postcode lottery" effect.

2. *Underclaiming time spent*

Many practices intentionally underclaimed the actual time spent in a variety of ways to stretch their allocation. For instance, some traditional and hybrid practices applied a standardised claim amount (e.g. 15 minutes each for GP/NP and nurse) regardless of the presentation. Practices expressed a desire for real-time visibility of the claim value to better manage their allocation as the form is completed.

> *"If the patient was in the practice for two hours, they would only claim for an hour, just to spread it out."*
> Hybrid model practice

3. *Selective claiming*

Practices selectively claim, based on patient type or presentation. An UC model practice, for example, prioritised acute care claims over rural stabilisation, while others reserved claims for patients requiring particularly lengthy treatment. Practices that previously did not pass costs on to patients were less likely to ration. These practices were generally more accurate with time claimed to better reflect actual need and to reduce administrative burden by using up their allocation in fewer, larger claims.

> *Compared to POAC, where we would try and mash people into these certain areas, yeah, [EPC works well]"*
> UC model practice

EPC was generally viewed as more appropriate for supporting acute care than POAC due to its broader eligibility. However, practices stressed that EPC is only useful while funding lasts. Unlike EPC, POAC was perceived as uncapped, and although a cap existed, practices rarely felt its impact. UC model practices noted that items like IV fluids, once effectively unlimited under POAC, now consume a significant portion of EPC funds. There is interest in reinstating certain POAC items as separate fee-for-service claims. Some traditional practices felt that POAC had a greater financial impact for specific treatments, as the fee-for-service amount was greater than the practice had chosen to claim via EPC.

Operational experience and perceptions of EPC

The fee-for-time (FFT) model was generally appreciated for capturing the variability in acute care delivery. However, the hourly rate of the FFT model was perceived as "very generous".[g] Combined with limited funding, the FFT model and high hourly rate are contributing to rationing behaviours. Practices suggested a larger total allocation and a lower in-hours rate, enabling more patients the opportunity

> *"It's generous in terms of what we've got in terms of the pot. But because the pot is quite small, yeah, we're pulling out a big chunk of that."*
> UC model practice

[g] The hourly rate was standardised across PHOs in Te Waipounamu, excluding Canterbury, and was intended to also cover provision for consumables and other incidental costs.

to receive funded care. There was also interest in an out-of-hours rate or call-out fee, and the ability to part-charge patients to spread funding further[h].

The EPC claim form itself was described as easy to use. However, practices had mixed views of the total administrative workload required for EPC. In practices with high claiming rates, the coordination required to track time spent by each staff member involved is time-consuming. In low-use traditional practices, claims were typically completed by the practice manager. By contrast, in larger practices, nurses or sometimes GPs took the lead, creating a perception that the administration is encroaching on clinical time.

Clinicians now see the dollar value of claims and the allocation remaining, which adds stress and cognitive load, and is seen as beyond their usual role. Some practices suggested a return to a fee-for-service model that removes clinician decision-making in the claiming process.

> *"They've added another layer of stress on the team now, because we're all so conscious of that dollar amount."*
> UC model practice

Additionally, more broadly, many practices expressed a desire for WellSouth to only collect essential data and provide a clear rationale for why it is required. Many practices described the WellSouth programme ecosystem as overly complex, making it difficult to determine which programme to use. High-use practices often used EPC as a last resort after exhausting other funded programme options.

Rural practices recognised the value of continuing to develop an acute care model and expressed a strong desire to invest, particularly in workforce, skill-mix, and equipment. This investment is hindered by a lack of funding certainty. While UC model practices have made substantial investments, the ongoing staffing costs present sustainability challenges. However, these practices remain committed to overcoming the rural inequity of patients having to pay for a service that would be freely available if there was a local ED. Rural hybrid practices are similarly wanting to invest but would require more investment as they have less space, skillsets and equipment currently. Urban practices' opinions were more mixed. Some saw potential in expanding acute care if the funding 'bucket' was bigger, while others felt that, due to proximity to hospital services, investment in acute care was unlikely to significantly reduce ED use, even in an unconstrained funding environment.

> *"You know, we could change our model of our staffing if we had more funding, but we have to have our staffing to what we can actually budget. And EPC doesn't really factor into that, it's just more patient focussed."*
> UC model practice

Impact of EPC on patients

Practices consistently identified the financial benefit to patients as the most impactful aspect of EPC. Most charge a standard consult fee alongside an EPC claim. A few, serving low-income populations, intentionally choose not to charge, while one urban traditional model practice was unaware that charging was permitted alongside this programme. Although EPC is not actively promoted to patients,

[h] Out-of-hours rates and part-charging of patients were exclusions in the service specifications defined by TWO.

practices report that EPC enables them to reassure patients who express cost concerns, thereby helping to reduce financial barriers to care. In practices that previously passed additional acute care costs on to patients, EPC has significantly reduced out-of-pocket expenses, beyond what was possible under POAC, for a broader range of presenting conditions. Conversely, in the small number of practices that previously absorbed most of those costs, the financial impact on patients has likely been minimal.

The limited nature of EPC funding leads to fluctuating costs for patients, even within the same quarter. Because demand is difficult to predict, most practices prioritise claims for enrolled patients rather than basing decisions solely on clinical acuity or the potential to prevent ambulatory sensitive admissions. Once the allocation is exhausted, additional costs may be passed on to patients, particularly in hybrid and traditional model practices, who highlight the inequity this causes for their patients. In some cases, EPC has resulted in less equitable access than POAC. For example, a patient receiving IV fluids for hyperemesis might have some visits covered early in pregnancy, only to be charged later once the allocation runs out, causing confusion for patients and discomfort for staff.

> *"It is inequitable even for our registered patients, because if you're later in the quarter, you're going to get charged, but you might [know someone else] down the road, and last week, and they didn't get charged"*
> UC model practice

All practices were consistent in their initial response that EPC funding has not significantly changed clinical decision making. However, many shared examples where it had influenced care delivery. Some traditional model practices noted a slightly higher threshold for ED referral and an increased willingness to perform additional investigations, thereby providing "more care closer to home" for the patient. Practices reported that the rural stabilisation pathway has not significantly changed how patients are clinically managed while awaiting ambulance transfer. However, some UC model practices noted that EPC allows additional patient workup, such as point-of-care testing, without passing the cost to the patient. This can improve patient experience and flow through the hospital.

> *"Probably hasn't put a lot of impact on the patient, quality of care, or anything that we do different. It's just another bit of money we've got to think about in our heads."*
> Hybrid model practice

Practices serving low-income populations reported that EPC made it easier for patients to agree to treatment they might otherwise decline due to the cost barrier. Previously, the prospect of fees beyond a standard consult sometimes resulted in patients leaving without treatment. The acute follow-up pathway was less used but valued, as it enabled additional consultation that may otherwise have been declined, supporting better continuity of care and patient safety. In both rural and urban settings, several practices said EPC allowed clinicians to make decisions based solely on clinical need, without compromising care when patients experienced a cost barrier.

> *"Some might choose not to go to ED because of the wait times, and they don't want to come here because of the bill, so they just stay home and what happens to them? We don't know."*
> Hybrid model practice

Financial impacts of EPC on practices

While practices appreciate EPC funding, particularly in reducing patient cost barriers and supporting some aspects of acute care delivery, EPC is widely seen as having a limited impact on overall financial sustainability. Practices view EPC as not enabling them to build capability or plan long-term service delivery improvements.

High-using rural practices, especially UC model practices, described the funding as "inadequate to meet actual need", while some reported being "financially worse off" using EPC compared to POAC. Several practices indicated they may need to scale back services or increase fees if no changes are made, and one practice described itself as being at "breaking point".

> *"It's definitely we're worse off, and the patients are worse off."*
> UC model practice

Hybrid practices particularly appreciated EPC funding as "every little bit counts." For traditional model practices, EPC is typically seen as a bonus, with less emphasis on utilising consistently. In contrast, UC model practices view EPC as essential to delivering a "core capability for the region", which they do not feel has been valued. Issues such as variation in quarterly allocations, lack of long-term certainty, and frequently running out of funding mean that EPC is not seen as impacting practice sustainability. Furthermore, in several practices in which costs would otherwise be passed on to patients, EPC merely shifts the financial cost from the patient to WellSouth without changing the overall finances of the practice. This limits the practice's ability to invest in new approaches to acute care. Ultimately, like other WellSouth programmes, EPC is seen by both rural and urban practices as a "sticking plaster" to cover the underfunding of primary care.

> *"I'm hesitant to invest for the long term, if it's just short-term money."*
> UC model practice

All practices agreed that longer-term funding certainty is preferred. UC model practices, in particular, having already invested in acute care infrastructure, said that a 12–36 months funding horizon would allow for better planning, changes to workflows, and workforce development without affecting routine care. An increase in funding, particularly if not tied to individual claims, would contribute to sustainability over the longer term, and provide capacity to consider changes in models of care. Rather than individual claims, UC model practices expressed a desire for an extended capitation funding model to better align with their model of care and the local context of their practice.

> *"To me it's a capability fund type of thing as opposed to a we occasionally do this, we'll apply for it."*
> UC model practice

Lower-use practices were particularly frustrated by the pressure to spend allocations each quarter, and the threat of clawbacks. As acute care demand is unpredictable, this approach was perceived as being punitive. Many practices recommended allowing unspent funds to roll over into future quarters or to be reinvested in acute care capacity or capability.

Impacts on the broader health system

Most practices, particularly in rural areas, felt that EPC has likely not led to measurable changes in secondary care presentations, as there has been no significant shift in the volume or nature of acute care delivered compared to before EPC. However, rural UC practices noted that if their services were discontinued, EDs would likely be "overrun".

Some practices suggested EPC may improve system efficiency for individual patients referred to ED, as they are now more likely to arrive having received initial investigations or management. Rural practices also observed that secondary care is increasingly asking more of primary care. UC model practices, in particular, reported being expected to do more, given their facilities and capabilities. Other practices noted that they are now being asked to hold patients for longer and perform additional investigations to determine the need for secondary care.

> *"Are we holding someone for that second Troponin? That's the conversation that'll happen every other day with [secondary care] and they would really like us to do that."*
> UC model practice

Document review

Feedback from WellSouth practices received during the first six months of EPC reflected consistent themes with those identified through the survey and interviews. Most practices that shared feedback valued the programme and found the claiming form easy to use. High-use practices, particularly in rural areas, engaged quickly but expressed frustration at the limited funding available and associated concerns about running out of funding. Several practices supported retaining IV fluids and IV antibiotics as standalone fee-for-service items outside of the fee-for-time approach to claiming.

Among moderate-use practices, concerns centred on utilising the allocated budget given the unpredictable nature of acute demand and ensuring equitable access to funded care, limitations they had not experienced under POAC. Many indicated they could deliver more acute care if additional funding were available. Some practices found it challenging to determine when making an EPC claim was appropriate. Practices noted inconsistent use between their clinicians, and practice managers often needed to remind staff to ensure EPC was considered. Low or non-using practices expressed a need for further information and clearer examples of how EPC could be applied, including real-world claiming examples. Several practices also cited other pressures, including staff shortages, PMS changes, and onboarding of new staff, as barriers to early adoption.

WellSouth staff interviews

WellSouth leadership described EPC as an important first step toward achieving parity in acute care funding across Te Waipounamu. They acknowledged that the current funding environment is "transactionally complex" and emphasised the need for long-term, stable funding to support shifts in models of care. They reinforced the dual purpose of EPC: first, to enable practices to deliver more

care closer to home and reduce secondary care presentations; and second, to recognise the acute care that practices, particularly in rural areas, have historically provided without funding.

Staff involved in the design and administration of EPC echoed practices' frustrations with the complexity of the allocation model. They highlighted the significant time burden involved in regularly adjusting allocations to respond to emerging patterns of use. These adjustments were intended to balance equitable access to funding across practices with the need to ensure full utilisation within the contracted funding period.

Acute care pathway outcomes

To explore the effectiveness of EPC in avoiding presentations to secondary care, patient outcomes were analysed immediately following, and three days after, an EPC claim. Immediately following an EPC acute care visit (initial or follow-up), 88.0% of patients returned home, while 12.0% were referred directly to secondary care (8.5% to ED, and 3.5% to hospital via ED, Table 2). In the subsequent three days, a further 12.0% of patients presented to secondary care, resulting in 76.0% of patients who presented to primary care with an acute issue and had an EPC claim ultimately remaining in the community. A sensitivity analysis using a 7-day window did not identify a meaningful increase in secondary care presentations.

Table 2. Outcome of treatment both immediately and within 3 days following an EPC acute care claim (n=1770).

		Immediate outcome after EPC visit,[a] n (%)	Further secondary care visits within 3 days,[b] n (%)	Overall outcome 3 days after EPC visit,[c] n (%)
Community		1558 (88.0)	-	1346 (76.0)
Secondary[d] care	ED	150 (8.5)	74 (4.2)	224 (12.7)
	Hospital	62 (3.5)	138 (7.8)	200 (11.3)

[a] Per EPC claim form.
[b] based on nationally collected datasets (NNPAC and NDMS).
[c] Note, this estimate assumes that people attending secondary care within 3 days of an EPC visit are very likely to present with the same condition as the EPC visit. Beyond 3 days, this assumption is likely to be less reliable. Additionally, a sensitivity analysis at 7 days did not suggest a significant increase in presentations.
[d] Hospitalisation data, including ED, was complete only until 31 January 2025, EPC claims and events after this date were excluded from this analysis.

Impact of EPC on secondary care presentations

In the period from 1 December 2023 to 31 March 2025, there were 88,489 ED visits and 842,013 visits to general practices across Southern.[i] Figure 3 shows the trend in ED presentations over time in high and low EPC-using practices, stratified by rurality. All cohorts show signs of seasonality, with increased ED presentations during winter. Urban practices with high EPC utilisation have a higher

[i] Presentations to EDs outside of the Southern district, follow-up visits to ED and visits eligible for ACC were excluded.

mean ED presentation rate per 1000 ESU than urban practices with a low EPC utilisation. This trend is inverted for rural practices, with low users of EPC practices having the highest ED presentation rate, and high using rural practices the lowest. The
observed differences in practices may be influenced by underlying models of care within the practice and population demographics.

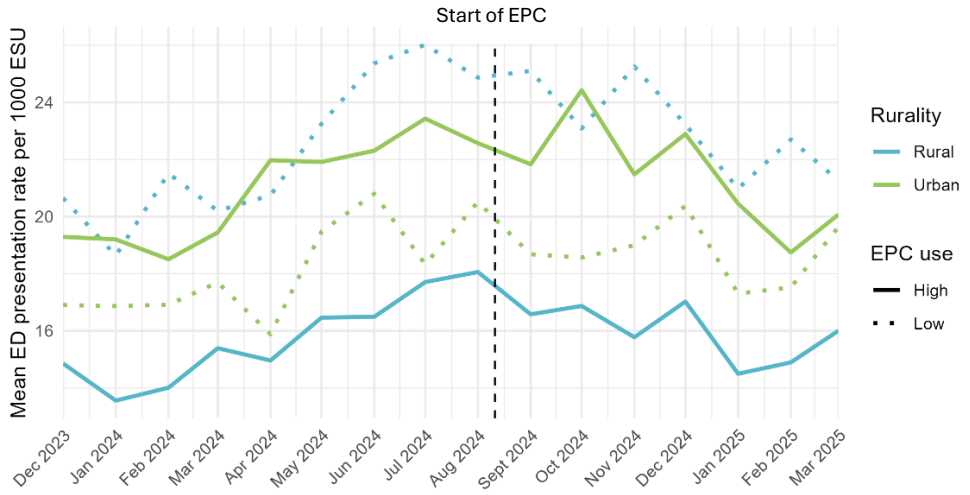

Figure 3. Monthly ED presentation rate per 1000 ESU by practice, EPC usage, and rurality.

Difference-in-differences regression models (Figure 4) were fitted to estimate the impact of EPC on ED presentations in rural and urban practices. The models compare ED visit rates before and after the introduction of EPC, and between low-using and high-using practices. Analysis is further split into urban and rural practices. Variation between practices and seasonality has been accounted for in the models. Robust standard errors have been used to avoid overestimating the effect of EPC.

Before EPC, rural low-using practices averaged 22.2 ED visits per 1000 ESU per month, compared to 15.9 in rural high-usage practices. In the post-EPC period, after accounting for baseline differences, high-using rural practices recorded a small reduction of 0.36 ED visits per 1000 ESU per month relative to the change in low-using practices (p<0.001). Among urban practices, low-using practices averaged 18.3 ED visits per 1000 ESU per month before EPC, compared to 21.1 in high-using practices.

Following EPC, accounting for baseline differences, high-using urban practices showed a very small increase of 0.15 visits per 1000 ESU per month compared to low EPC-using practices (p=0.045). Given the short time that EPC has been operational, it is important not to over-interpret these results. This analysis should likely be repeated in 12–36 months when EPC use has normalised.

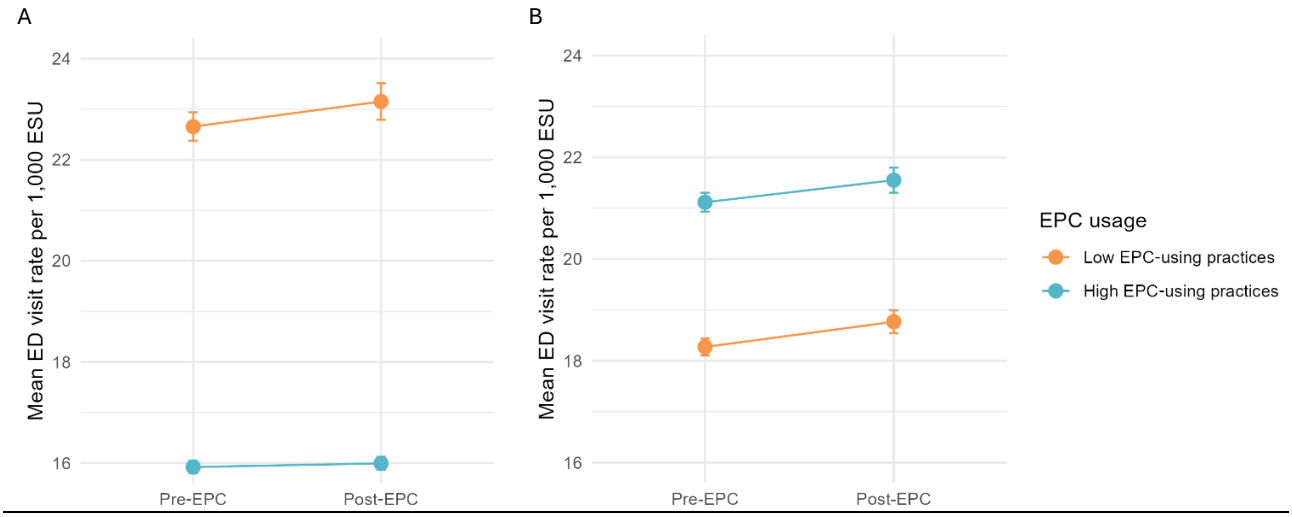

Figure 4. Difference-in-differences analysis comparing mean ED presentation rates by EPC usage level in (A) rural and (B) urban practices.

Cost-based analyses

Comparison of acute care funding from POAC and EPC programmes

Figure 5 presents the total accepted POAC claims (excluding separately funded planned services, e.g. skin lesions) over time among all WellSouth practices, overlaid with total accepted EPC claims. Total funding for acute care has increased substantially. The monthly amounts claimed through POAC have decreased since EPC was introduced, but this has been offset by an increase in EPC claiming far beyond that of POAC pre-EPC.

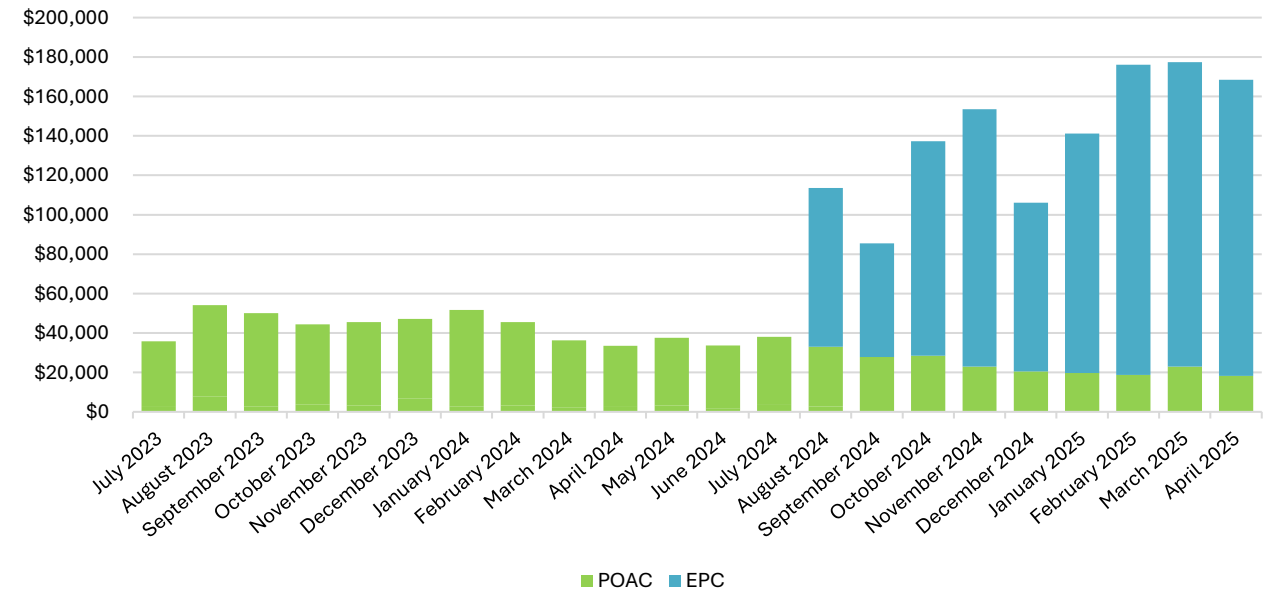

Figure 5. Total amounts claimed for acute care through the POAC and EPC programmes across all WellSouth practices between July 2023 and April 2025.

To account for potential seasonal variation in claiming patterns, the number and dollar value of claims made through the EPC programme from its launch in August 2024 to the end of April 2025 were compared with the corresponding nine-month period in the previous financial year (Table 3). Following the introduction of EPC, the total number of claims nearly doubled, while the total dollar amount distributed to practices more than tripled. Similarly, the average dollar amount claimed per EPC claim during this period was twice that of POAC acute care-related claims ($312 versus $143, respectively).

Table 3. Comparison of acute care claims made through POAC and through EPC.

	August 2023 – April 2024		August 2024 – April 2025	
	Number of claims	Total $[a]	Number of claims	Total $[b]
POAC	2703	408,072	1465	209,773
EPC	-	-	3791	1,182,839
Total	2703	408,072	5256	1,392,612

[a] Mean $ per claim pre-EPC: POAC $151
[b] Mean $ per claim post-EPC: POAC$143; EPC $312.

Further analysis was undertaken to understand if all practices experienced an increase in funding, or if funding increases were concentrated in a small number of practices. Of the 79 practices, five were excluded from comparison due to data limitations: one is a satellite clinic that does not submit claims directly, while for 4 practices, a comparison was not possible as they had not utilised EPC and/or POAC across the two time periods under analysis. Among the remaining 74 practices, all those that engaged with EPC received more acute care funding in the first 10 months of the programme (11 August 2024 to 11 June 2025) than in the entire previous financial year. Increases in acute care funding ranged from 7% to 1303%. The median percentage increase in acute care funding was 193%.

Avoided secondary care events required for EPC to break even

EPC appears to require only a low level of impact to be cost-neutral (Table 4, Figure 6). For every 1000 patients with an EPC acute care claim, it is assumed that 239 (24%) will utilise secondary care within 3 days, as observed in the 'Acute care pathway outcomes' section of this report. This leaves 761 patients whose outcomes in the absence of EPC are uncertain.

To estimate the minimum level effectiveness required for the EPC programme to break even (i.e. become cost-neutral), the total cost of delivering EPC to 1000 patients was divided by the average cost of a secondary care event.[j] Based on this, the programme would be cost-neutral if just 60 per 1000 patients (6%) avoided a secondary care event as a result of EPC.

[j] Secondary care events are assumed to occur in the same ED:Hospitalisation ratio that was observed in the 'Acute care pathway outcomes' section of this report, Table 2), resulting in 60 presentations consisting of 32 ED visits and 28 hospitalisations.

Given the conservative assumptions used in this estimate, the actual number of avoided events may be higher, suggesting that EPC has the potential to deliver cost savings across the health system (Figure 6).

Table 4. Break-even scenario: number of avoided secondary care events required for EPC to be cost-neutral per 1000 patients with an EPC acute care pathway claim.

Cost of EPC, $	Estimated saving from avoided secondary care visits[a]		Net balance, $
	Number, n	Amount, $	
–$256,000	60[a]	$257,202	$1202

[a] Minimum number of events that need to be avoided for the EPC to break even (number based on the ED:Hospital ratio identified in those 239 patients that we know presented to ED; equivalent to 32 ED visits and 28 hospital stays).
Note, it is assumed that the 239 patients who attend secondary care were unavoidable presentations and would occur with or without the EPC programme.

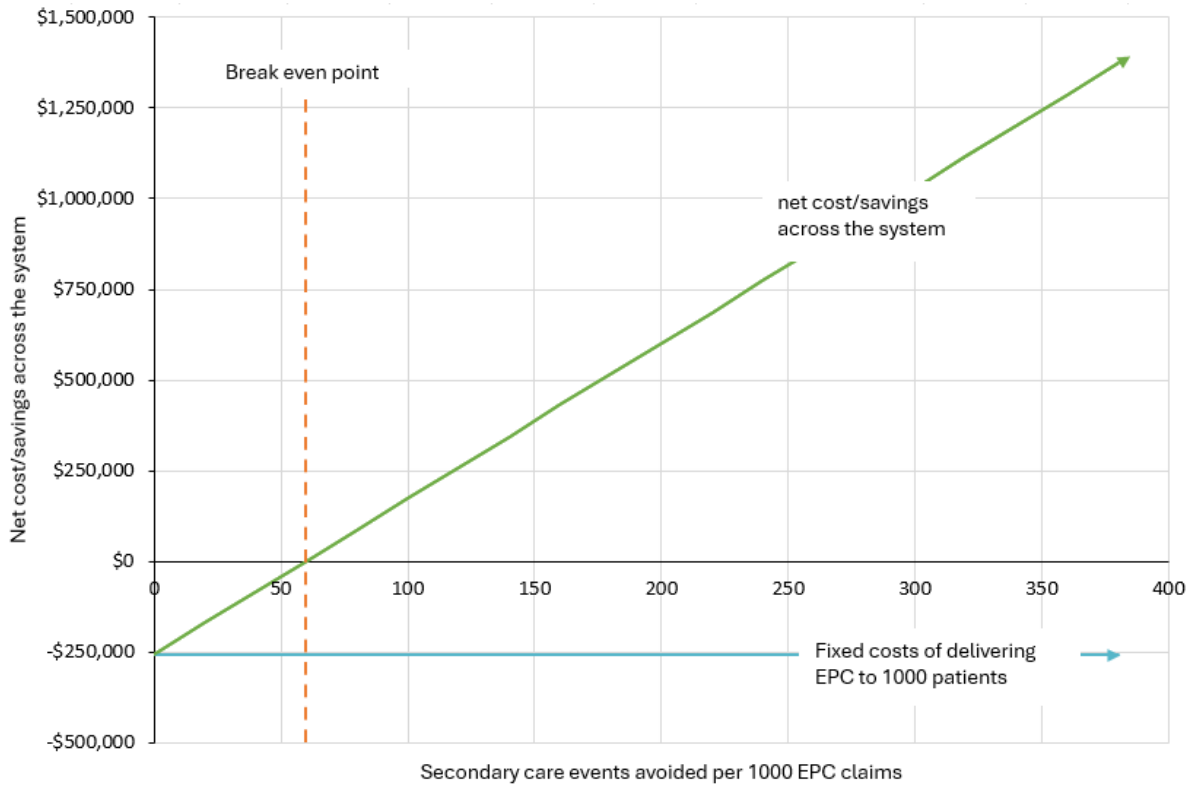

Figure 6. The estimated net cost/savings to the health system as the potential number of secondary care events avoided increases. The break-even point occurs at approximately 60 avoided events per 1000 EPC claims, beyond which the programme becomes increasingly cost saving.

KEY LEARNINGS

Addressing the key evaluation questions

KEQ1: How has the EPC programme been utilised by WellSouth General Practices?

EPC has generally been widely adopted by practices across Southern. Practices recognise the need for additional acute care funding and value a programme of this kind. Rural practices in particular have utilised EPC extensively: Rural practices have made more claims, claimed higher amounts per visit, proportionally used more of their allocation, and were more likely to provide EPC care out of hours. Rural UC model practices were more likely to claim for patients enrolled in other practices in Southern. This suggests rural practices' utilisation of EPC is influenced by their model of care, population demography, and catchment effects.

Urban practices are also influenced by their local context and were more likely to use EPC for Māori patients and those living in higher deprivation areas. This suggests EPC utilisation is different in urban and rural settings, with urban practices using EPC to reduce inequities and barriers to access. When considering EPC moving forward, and other WellSouth programmes, the local context should be recognised as a key influence on adoption and utilisation.

KEQ2: What have been the General Practices' experiences of the EPC programme for acute care and rural stabilisation?

EPC is generally well-regarded by practices. Particularly appreciated were the fee-for-time approach, rural stabilisation pathway, and recognition of the demands of acute care on general practice, especially where this was previously unfunded. However, experience is again influenced by local context. Traditional and hybrid model practices, particularly in urban areas, generally view EPC as a "nice to have" option and an improvement to POAC. Some practices were initially unclear on the purpose of EPC, struggled to optimise their use of the programme, and expressed a desire to understand how others were using the programme well. Nonetheless, because these practices are less likely to run out of funding, their experience has largely been positive.

In contrast, the experience of high-use practices, especially rural UC model practices, has been more mixed. While these practices see the potential of EPC to support the delivery of acute care, the need to ration claims and manage limited allocations has added cognitive load to clinical work and undermined their sense of financial security, and many report consistently running out of funding. Additionally, much of the EPC funding is being used to reduce patients' out-of-pocket costs and therefore has a limited impact on a practice's overall sustainability. These factors have created a perception of being financially worse off compared to POAC, despite data demonstrating that all practices have increased their acute care WellSouth-derived funding from EPC, compared to POAC.

Rural practices have a strong desire to invest in their acute care capability, especially given the increasing demand. However, the short-term, claim-based nature of EPC funding limits their ability to plan and deliver services.

KEQ3: What impact has EPC had on acute healthcare utilisation?

EPC's impact on acute healthcare utilisation appears limited so far, largely because the funding often supports care that practices were already providing, either at their own cost or that of the patient. As a result, the programme has not yet driven widespread changes in practice or patient behaviour. In some cases, EPC has enabled practices to raise the threshold for referring patients to the ED, when clinically safe to do so, and to carry out additional investigations without passing costs on to patients. Access to funded follow-up visits has supported better continuity of care, which many practices see as a tangible benefit for patients. Most practices felt EPC likely hadn't yet meaningfully reduced secondary care demand but saw potential efficiencies by allowing patients to arrive at ED with initial investigations and treatment already underway.

There was a small but statistically significant reduction in ED visits among high-use rural practices following the introduction of EPC. Though modest, these early results suggest that EPC could contribute to reducing demand for secondary care. Funding to strengthen primary care capacity and capability to deliver additional acute care may lead to more impactful changes in the models of acute care delivery, including shifts in patient behaviour and, ultimately, reduced utilisation of secondary healthcare. Beyond secondary care, additional care closer to home, promoting continuity of care, and recognising practices for their significant contribution to acute care management are also benefits of EPC.

KEQ4: What impact has the EPC programme had on the cost of delivering acute healthcare for patients and across the system?

The most significant financial impact of EPC appears to be reducing out-of-pocket costs for patients. This is particularly positive in patients attending practices that would have previously passed costs on, and urban practices where EPC appears to be targeted at those are more likely to experience inequity because of cost barriers.

For practices, EPC has substantially increased their overall WellSouth-derived funding compared to POAC. However, as discussed previously, this has not aligned with practices perception. From a health system perspective, EPC presents an opportunity to support practices in building acute care capacity and capability, particularly in areas that have limited access to secondary care. Estimates based on patient outcomes suggests that EPC has the potential to be cost-effective by shifting additional care into primary care and reducing pressure on hospitals. Some hospitalisations are likely unavoidable, and around a quarter of patients who use EPC still attend secondary care. To break even across the system, just 6% of patients treated through the EPC acute care pathway would need to have avoided a secondary care visit because of the care provided through EPC.

However, the decrease in ED visits that can be attributed to EPC is small and further analysis as the programme becomes embedded and more data becomes available is required. Achieving system-level efficiency gains will depend on increased and equitably distributed funding, coupled with a longer-term funding approach. This would allow practices to plan, build capability, and expand acute care services, ultimately delivering more accessible care for patients while reducing pressure on the wider health system.

Recommendations

1) Advocate to Te Whatu Ora for parity in Te Waipounamu, in relation to:

a) Increased EPC funding.

b) A longer-term contract.

c) Additional wraparound services, similar to those available in Canterbury's Acute Demand Management Service, adapted to Southern's geography.

This is supported by findings that:

i) EPC has the potential to cost-effectively reduce acute presentations to secondary services.
ii) There is strong demand from general practices for reliably accessible acute care funding.
iii) EPC enables patients to access care with reduced cost barriers.
iv) The impact of EPC on secondary care is limited by a lack of wraparound services.

2) Refine the funding allocation model.

a) If an increase in funding is not provided by Te Whatu Ora:

i) Adjustments to the base allocation formula should better reflect local context, including:

(1) Practice rurality.
(2) Extended hours services and wider catchment demands.
(3) Seasonal fluctuations in demand (e.g. due to local tourism).
(4) The practice's acute care model.

ii) Provide practices with annual certainty of funding allocations, paid in quarterly instalments.

iii) Enable funding rollover between quarters, recognising unpredictable acute demand.

b) If an increase in funding and funding surety is provided by Te Whatu Ora, additional funding should be used to:

i) Recognise out-of-hours costs with a higher claim rate or call-out fee.

ii) Recalibrate the hourly rate to enable broader reach and fairer distribution of time-based funding to more patients.

iii) Provide a longer-term view of funding for practices.

3) **Strengthen communication and support for practices.**

   a) Build capability by clarifying the purpose and utility of EPC.

      i) Deliver ongoing EPC training, support, and communications, both face-to-face and virtually, to practices.

      ii) Act as a knowledge broker to share learning between high- and low-use practices.

      iii) Clearly explain the purpose of data collection and how insights are used.

      iv) Increase transparency about the total acute care funding reaching each practice over time.

4) **To build acute care capability, alternative approaches to EPC delivery may be required.**

      i) Further engage with practices to understand capability-building preferences.

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APPENDICES

Appendix 1

During the development of the EPC programme, consensus was built with other PHOs across Te Waipounamu, excluding Canterbury, on which common presenting conditions and associated interventions would be eligible, informed by the ADMS programme in Canterbury. Inclusion/exclusion criteria, dollar amounts for GP/NP, Nurse, and administration time, and reporting structure were co-designed with HNZ/TWO. This resulted in a single claiming form being used across Te Waipounamu practices for EPC services.

Table A1. Claimable conditions and care provision under EPC.

Eligible presenting conditions[a]		
Abscess Abdominal pain Angina Allergy Asthma Cancer Cardiac Chest Pain Congestive Heart Failure COPD COVID Deep Vein Thrombosis Dehydration	Diabetes Dizziness/vertigo ENT Frailty Fever Unknown Foreign Body Gastroenteritis Gynaecological Infection (other) Kidney/Urinary infection Mental Health Musculo-skeletal Neurological	Pleurisy/Pleural Effusion Pneumonia Pneumothorax Post discharge review Psychological/social/acopia Pyelonephritis Renal Colic Respiratory (not COPD, Asthma, Pneumonia) Syncope/collapse/LOC Tonsilitis Urological Viral illness Other
Type of care and interventions		
Ambulance to secondary care/ED Anticoagulant Blood Test (sent to lab for analysis) Bowel Care Catheterisation	Consult - GP/NP Consult - Nurse ECG Equipment IV Therapy Medication by IM or SC Nebuliser	Observation Point of Care testing (immediate results) Phone Call Support Services Ultrasound Wound Care

[a] Accidents and injuries (covered by ACC) are not eligible for EPC.

Table A2. Current POAC services, POAC services stopped, and POAC services transferred to EPC at the launch of EPC.

Current POAC programmes[a]	POAC programmes stopped when EPC commenced	POAC programmes transferred to EPC
IV iron infusion Zoledronic acid Skin lesions Long-acting reversible contraceptives (LARC) Rheumatic fever Pipelle biopsy	POAC: Extended Treatment COPD Hospital Discharge (transferred to CarePlus funding) COPD Ambulance Diversion (discontinued)	IV fluids[b] IV antibiotics[b] Urinary catheterisation

[a] Current POAC programmes include separately funded planned care.

[b] IV Fluids and antibiotics are included in the fee-for-time model within EPC, not as separate fee-for-service items.

Table A3. WellSouth base EPC funding allocation model for practices.

Extra rural weighting	Rural weighting	Māori weighting	Pacific Peoples weighting	Community Services Card weighting	65 years and over weighting	Under 14 years weighting
2	2	1.5	1.5	1.5	1.5	1.5

Note, weightings in each category are multiplicative.

Appendix 2

Survey questions

1. Do you understand the purpose of this survey and give your consent to participate?
2. What is the name of your General Practice?
3. What is your role within your General Practice?
4. Please rate your practice's overall experience with EPC. (with 1 being poor and 5 being excellent)
    A) To what extent has EPC impacted your practice's ability to provide Acute care? (with 1 being "No impact" and 5 being "Significant positive impact")
    B) To what extent has EPC impacted your practice's ability to provide Rural stabilisation care? (with 1 being "No impact" and 5 being "Significant positive impact")
5. How has EPC impacted care for patients? (with 1 being "No impact" and 5 being "Significant positive impact")
    A) More patient care provided closer to home
    B) Reduced out of pocket costs for patients
6. C) Fewer hidden costs for patients (e.g. travel)
7. How has EPC impacted the following? (with 1 being "No impact" and 5 being "Significant positive impact")
    A) Improved practice financial sustainability
    B) Change in staff skill mix towards acute care
    C) Increased investment in equipment/other resources
    D) Changes to workflow/operation (e.g. acute appointments offered)
8. If EPC programme funding continues long term, do you think this will impact your practice in any of the following ways? (Select all that apply)
    - Improved practice sustainability
    - Change in staff skill mix towards acute care
    - Increased investment in equipment/other resources
    - Changes to workflow/operation (e.g. acute appointments offered
    - Unsure/doesn't apply to me
9. Does the EPC funding meet the needs of your practice? (with 1 being "Not at all" and 5 being "Fully meets needs")
10. To what extent has your practice used the allocated funding? (with 1 being "We have used none of the available funding" and 5 being "We have used all of the available funding")
11. Why has your practice more of the funding? (select all that apply)
    - N/A (we have used all the available funding
    - We have not needed to provide extended acute care services
    - We were not aware that EPC funding was available or were unsure how it could be utilised
    - the administrative requirements to claim are too complex or time consuming
    - We have been rationing the allocation to ensure the funding lasts longer
    - The reimbursement rates are not adequate
    - Not sure/this doesn't apply to me
    - Other
12. What has your experience been with the following aspects of EPC within your practice? (with 1 being "Poor" and 5 being "Excellent")
    A) Fee-for-time funding model
    B) the Claiming form
    C) Allocation of funding quarterly
    D) Variation in allocation amount each quarter
    E) Support provided from WellSouth to adopt EPC
13. What changes can you suggest that would improve any of the above aspects?
14. Do you have any other feedback to share with WellSouth about the EPC programme?
15. Would you like to discuss further with the evaluation Team? [Yes/No]

General practice interview prompts

Operational use & integration

1. Can you describe how you use EPC in your practice day-to-day?

   → *What kind of situations/patients typically lead you to use EPC?*

   → *Given that the funding is capped, how do you choose who accesses EPC? I.e., what is your approach to rationing?*

2. Has EPC impacted your existing processes or workflows within the practice, and if so, how?

   → *E.g. acute clinics, additional acute appts.*

   → *Changes to how patients are managed [acute care / rural stabilisation].*

   → Has EPC had any impact on [available space within the practice/changes to staff skill mix/investment in equipment].

   → *Do you foresee that any of these aspects would change in future with sustained EPC funding?*

Financial impact on practice and sustainability

3. How does EPC compare to other WellSouth programmes in terms of?

   → *Claiming requirements i.e. portal form // funding available vs time taken to deliver // fee-for-time vs fee-for-service model.*

   → *Comparison to POAC*

4. Could you describe your experience of the funding allocation process?

   → *And describe how it has impacted your practice?*

5. What impact, if any, has EPC had on the financial sustainability of your practice?

   → *Both holistically and in the context of providing acute care.*

   → *Do you see EPC supporting financial sustainability for your practice in the long term?*

Impact – acute care

6. What difference (if any) has it made for your patients, compared to before EPC?

   → *E.g. more care provided closer to home, reduced out-of-pocket costs for patients, fewer hidden costs for patients (e.g. travel)*

   → *Can you share any patient stories that reflect the impact of EPC on acute care?*

7. Do you think there has been any impact on ambulance services/urgent care/others in wider health system?

Impact – stabilisation care [rural only]

8. What difference (if any) has it made for your patients, compared to before EPC?

   → *Can you share any patient stories that reflect the impact of rural stabilisation?*

9. Do you think there has been any impact on ambulance services/urgent care/others in wider health system?

Reflections & recommendations

10. Thinking about EPC, what do you think is working particularly well?
11. Thinking about EPC, what would you change or improve if you could?
12. What would good like in relation to the method in which EPC funding is allocated to your practice, recognising the constraints around funding.

WellSouth staff interview prompts

1. Let's start with your thoughts on the overall purpose of EPC. From your perspective, what was EPC trying to achieve?

→ To what extent has EPC achieved its goals so far?
→ What barriers have there been to achieving goals? (e.g. limited funding, slow/low uptake by practices, or excess unmet need, meaning additional, but appropriate presentations to secondary care)
→ Is there a tension between the purpose in the contract specs and the purpose from WellSouth's perspective?

2. What are some of your reflections on the development and implementation of EPC?

→ Collaboration with others in TWP to develop programme
→ 'Acute care' and 'rural stabilisation' pathways
→ Fee-for-time model
→ Claim per patient model
→ How it was managed within WellSouth

3. Reflections on the bespoke quarterly funding allocation approach

→ Sustainability of this allocation approach in the longer term: WellSouth time and resources needed to decide allocate each quarter.
→ Thinking broadly about rurality for both patients and practices, and for other populations, including Māori and Pacific Peoples), how do you think EPC has impacted equity?

4. How do you think EPC fits with other programmes WellSouth delivers for practices?

→ Impact of EPC on POAC and other programmes – does EPC fit well within the WellSouth programme "ecosystem"?

5. What impact do you think the new acute care funding will have on EPC?
6. In 12 months, what would good look like for EPC from your perspective?

Appendix 3

Interview data and free-text responses to the survey were analysed using an abductive approach. Transcriptions were first coded in Excel according to pre-defined codes and categories shown in Table A4 below. After initial coding, new codes will be added, if necessary, to capture relevant and important data that does not fit into an existing code. The codes were analysed to identify the key themes. Illustrative direct quotes were also captured.

Table A4. Abductive analysis codebook

Category	Code	KEQs	Definition
Overall perception & reflections	Perception of EPC - relevance	2	Whether EPC is a useful programme
	Perception of EPC - effectiveness	2	Whether EPC has been effective to date
	General statements of satisfaction with EPC	2	Practices' opinion of EPC overall (e.g. EPC is great, okay, poor, not useful)
	Suggestions	-	Suggestions for improvement of the programme, funding model or delivery
Adoption & implementation experience	Adoption – factors	2	Reasons for adopting or not adopting EPC
	Implementation - challenges	2	Issues/barriers preventing smooth implementation and adoption
	Utilisation	1,2	The extent and frequency of EPC use: How much funding has been used and changes in use over time
	Equity of EPC delivery	1	Characteristics of patients who are accessing EPC e.g. socioeconomic deprivation or ethnicity.
Operational impacts	Administrative workload	2	Impact of claiming documentation requirements
	Operational strategies/workflow	1,2, 3	How EPC has affected practice workflow (e.g. availability of acute appointments, acute clinics)
	Investment of resources	2	EPC integration into practice (e.g. change in skill mix, equipment, resources (incl. expected future changes)
System-level impacts	Impact on other primary care services	3	Whether EPC has affected other services, e.g. preventive and LTC care
	Impact on wider health services	3	How EPC affects utilisation of ambulances, after-hours clinic, secondary care

Financial impacts	Impact of EPC on overall WellSouth funding revenue	4	How EPC has affected the overall revenue from WellSouth.
	Impact on overall WellSouth-programme funding for practices	4	Whether EPC has affected other WellSouth-funded programmes, e.g. POAC
	Financial viability – acute care	4	Whether the acute care pathway is financially viable for practices (e.g. it covers the costs of delivering care and claiming etc.)
	Financial viability – rural stabilisation	4	Whether the rural stabilisation pathway is financially viable for practices (e.g. it covers the costs of delivering care and claiming etc.)
	Financial sustainability	4	Overall impact of EPC on the overall financial sustainability for practice if sustained at the current level. (e.g. EPC claims will mean we are at least breaking even when delivering acute care/rural stabilisation care)
Patients' experience of acute care (from practices' perspective)	Changes in the management of acute presentations	2,3	Whether EPC has changed how acute care is delivered (e.g. scope of care, threshold for transfer to secondary care etc.)
	Patient experience & outcomes - acute care	2, 3	Whether EPC has impacted patients' access to and experience of care (e.g., care closer to home). Patient-reported impacts and satisfaction (as reported to practices). Example stories of care and outcomes
	Financial impact on patients – acute care	4	Changes in out-of-pocket and hidden costs of care for patients using acute care under EPC
Patients' experience of rural stabilisation care (from practice's perspective)	Changes in the management of rural stabilisation presentations	2,3	Whether EPC has changed how rural stabilisation care is delivered (e.g., scope/threshold for transfer to secondary care etc.)
	Patient experience & outcomes - rural stabilisation	2, 3	Whether EPC has impacted patients' access to and experience of care. Patient-reported impacts and satisfaction (as reported to practices). Example stories of care and outcomes
	Financial impact on patients – rural stabilisation	4	Changes in out-of-pocket and hidden costs of care for patients using rural stabilisation care under EPC
Other	Other	-	Capture interesting insights that do not fit neatly into a code or are not directly relevant to the current evaluation.

Table A5. Number of interviews conducted and number of WellSouth practices by EPC utilisation category.

	Urban interviews, n	Urban WellSouth practices, n	Rural interviews, n	Rural WellSouth practices, n
Low utilisation (<20%)	1	14	1	2
Medium utilisation (20%–80%)	3	20	2	19
High utilisation (>80%)	3	13	8	12

Appendix 4

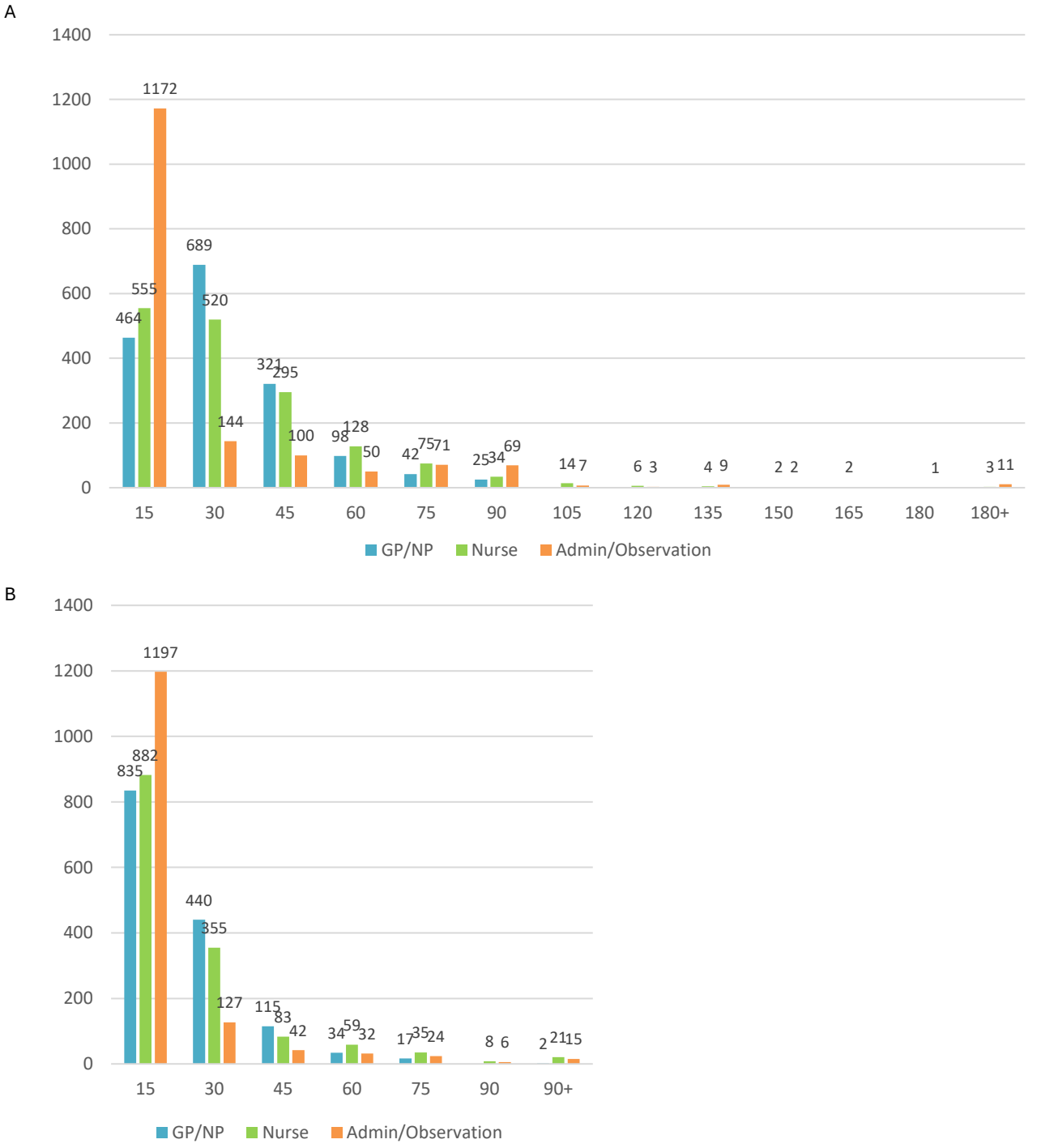

Figure A1. Time claimed by staff role in (A) rural and (B) urban practices.

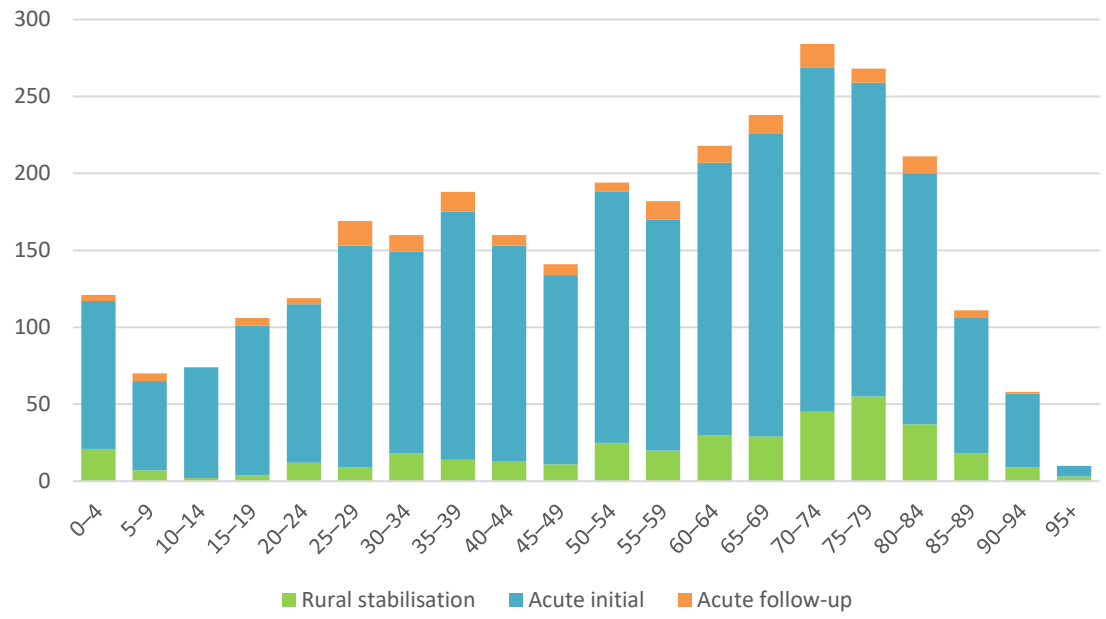

Figure A2. Age distribution of patients with EPC claims.

Table A6. Most common presenting conditions in EPC claims.

	Condition	n (%)
1	Chest Pain / Cardiac / Congestive Heart Failure / Angina / Arrhythmia	805 (26.1)
2	Respiratory / Chronic Obstructive Pulmonary Disease / Asthma / Pneumonia / COVID	376 (21.1)
3	Urological / Renal / Urinary infection	228 (7.4)
4	Abdominal pain	211 (6.8)
5	Infection (other)	191 (6.2)
6	Dehydration / Vomiting / Gastroenteritis	180 (5.8)
7	Dizziness / Vertigo / Syncope / Collapse / Loss of consciousness	151 (4.9)
8	Viral illness	141 (4.6)
9	ENT / Eyes	112 (3.6)
10	Mental health	87 (2.8)

Table A7. EPC claim types by rurality of the patient.

	Rural, n (%)	Urban, n (%)
Acute initial	1184 (72.5)	1336 (94.4)
Acute follow-up	80 (4.9)	71 (5.0)
Rural stabilisation	369 (22.6)	8 (0.6)