Evidence Summary - Hardship Fund

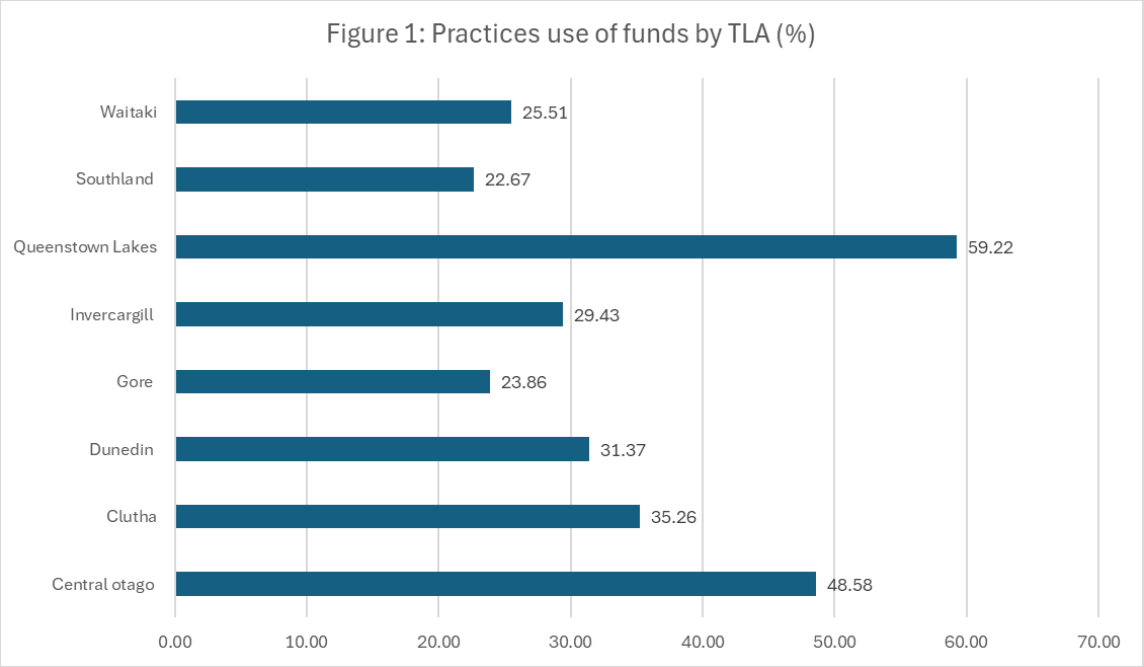
Background

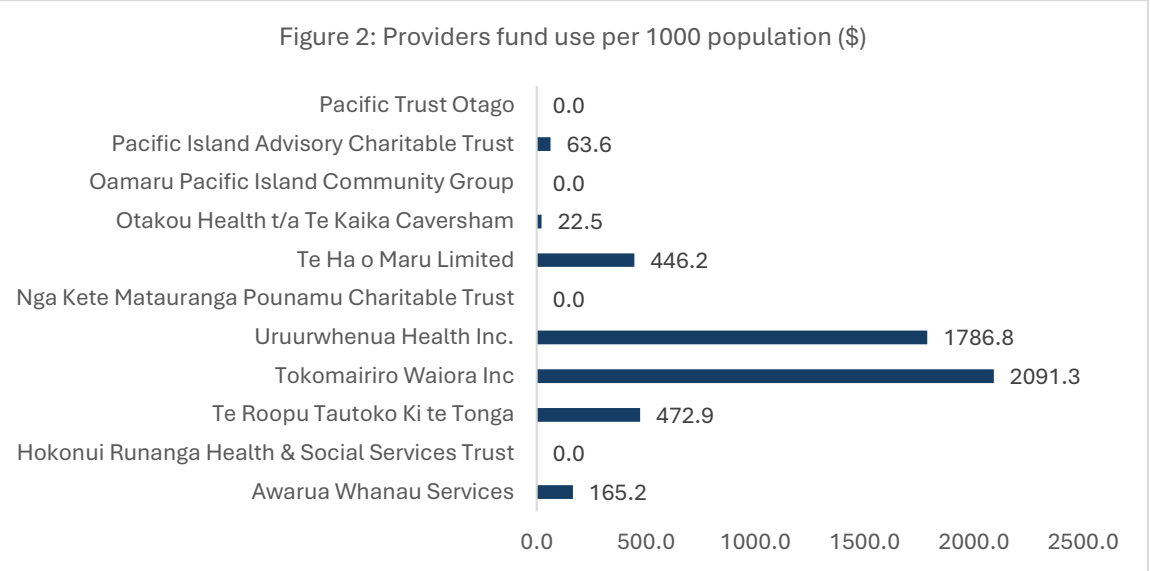
The Hardship Fund was established by WellSouth to reduce financial barriers to accessing primary health care for people experiencing both financial hardship and clinical need. The programme provides general practices, Māori providers, and Pacific providers (collectively referred to as Providers) with an allocation to support patients who would otherwise be unable to afford healthcare. The fund aligns with WellSouth's strategic priority of improving equity in healthcare access and with Government Policy Statement Indicator 1.10, "Reduced unmet need due to cost." The funding can be used to cover costs such as co-payments, prescriptions, in-practice tests, transport, and payments to external healthcare providers, but it cannot be used for patient debt, secondary care, or dental care.

This evaluation examines how effectively the fund has improved equity of access, noting that preliminary data, pre-evaluation, showed wide variation in utilisation across practices and providers. The evaluation uses a mixed-methods approach, combining utilisation data with qualitative insights to inform future funding decisions and programme refinement.

Findings from Quantitative Data

Quantitative analysis of fund usage reveals geographical variation in uptake. Figure 1 shows regional variation in Hardship Fund utilisation, with usage ranging from 22.67% of total allocation in Southland to 59.22% in Queenstown-Lakes. This disparity suggests that factors such as practice engagement or specific socio-economic pressures may be influencing fund uptake. Notably higher usage in high-cost areas like Queenstown-Lakes and Central Otago likely reflects greater financial barriers to healthcare experienced by populations in these areas. In contrast, lower usage in several regions may indicate administrative barriers or a lack of integration into practice workflows. Figure 2, showing fund use per 1000 population for Māori and Pacific providers, indicates substantial differences in utilisation. While some providers demonstrate high rates of fund usage, a notable number report no usage at all. This variation points to differing levels of fund promotion or administrative capacity within the providers, a factor later explored in the qualitative findings. However, caution is required when interpreting this data. Given that the data was collected through self-reported spreadsheets, the reported zero usage may reflect under-reporting rather than an absence of fund usage.





Fund usage by service users' socioeconomic and demographic profile

The Hardship Fund's reach across different population groups reveals important patterns in equity and need. Practice data shows that Māori service users received 19.5% of fund allocations,1.8 times their share of the regional population (10.6%), indicating effective targeting of this priority group. Interestingly, low-use practices (0-10% of allocation used), allocated 40% of their funding to Māori patients (see figure 3). Pacific service users, however, received only 2.5% of allocations, despite being 2.8% of the population. Further engagement may be required to ensure equitable access to the fund for Pasiifka populations. Non-Māori, non-Pacific (NMNP) ethnic groups comprised 78.0% of fund use and are 86.5% of the population.

Analysis by deprivation quintile and Community Services Card (CSC) status shows that overall, the majority of funding (57%) went to individuals with a CSC. Notably, the proportion of fund users with a CSC increases with deprivation, rising to over three-quarters (77%) in the most deprived quintile (Q5). This indicates the fund is reaching CSC holders in areas of highest need. Concurrently, a substantial portion of the fund (43% overall) supports individuals without a CSC. Qualitative data suggests this is a group likely facing acute financial barriers but are ineligible for this form of subsidy. This overall pattern, where the fund supports both CSC holders and non-subsidised individuals, aligns with the age data showing the primary beneficiaries are working-age adults (31–60 years), a demographic often under significant financial pressure.

Figure 3: Practices fund usage by ethnicity of service users

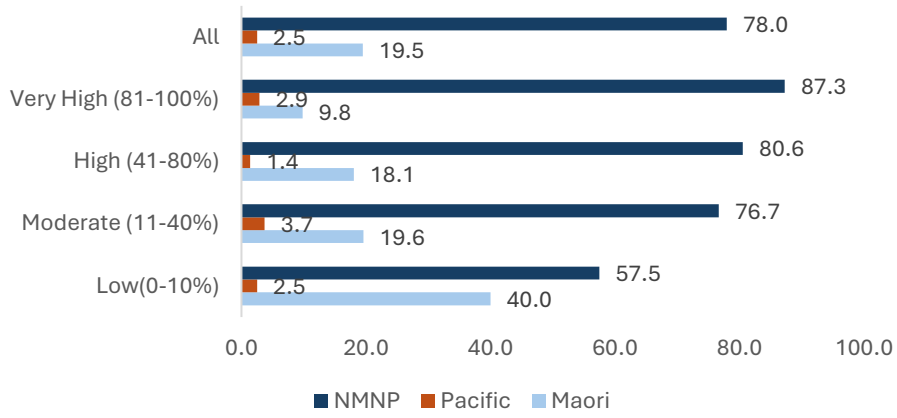
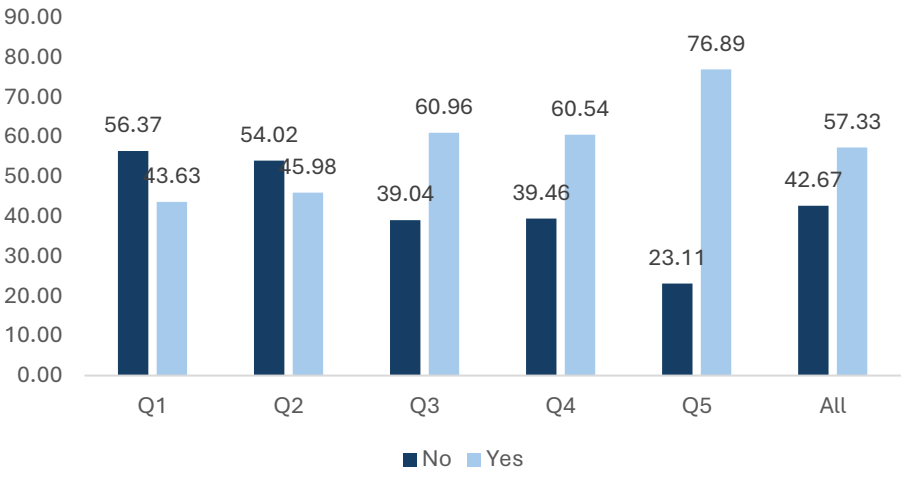


Figure 4: Fund usage by service user's CSC status and quintile



Analysis of hardship fund use by practices and providers

Practices and providers documented the reasons for using the Hardship Fund; the most frequent applications are acute and complex GP consultations, blood tests, mental health

support, prescription costs, and podiatry services. Moderate fund use includes procedures like iron infusions, minor surgeries, and rehabilitation for specific health conditions or post-surgical recovery. The fund is also applied to transport and accessibility support. Less frequently, the fund addresses intersecting social and health crises such as homelessness, job loss, or urgent ambulance costs, highlighting its critical role in mitigating hardship where financial stress and health needs converge.

Findings from the Qualitative Data

The analysis of interviews with nine practices and six providers identified five key themes.

1. **Local discretion as the key to equity**

Both practices and providers expressed that the most valued feature of the Hardship Fund is its discretionary nature. Local decision-making is seen as essential for equity, as it allows clinicians and practice staff to respond to individual circumstances using their direct knowledge of service users.

You've allowed us the ability to decide how to maximise the benefit of it, and you seem to respect that we know our whānau… you're trusting us to make the best use of it" (Provider)

Some practices reported avoiding the term "hardship", as it may discourage service users, instead reframing the fund in more neutral language to improve acceptability.

2. **Use of the fund reveals system gaps**

Patterns in how the fund is used highlight persistent gaps in the wider health system. The fund is commonly applied to cover GP visits, follow-up appointments, and diagnostic procedures that service users would otherwise delay due to cost. A repeated finding was the use of the fund for podiatry services, especially for older adults and people with diabetes, where early intervention can prevent serious complications. Some practices also used the fund creatively for preventative tools, such as blood pressure monitors, or to enable timely diagnostics.

"There was a lady who wasn't going to have her biopsy done… We did the biopsy and it came back with a basal cell carcinoma. So… if we hadn't been able to utilise that, she would have put that off" (Practice)

3. **Supporting people with hidden or compounded hardship**

The fund plays a vital role for service users who experience substantial financial stress but are not eligible for a Community Services Card. This "working poor" group was frequently described as falling through existing funding systems, despite struggling to afford primary care.

"It's the people without a Community Services Card who have to pay for three times the price of the doctor's consults. They're the ones who this can help, and just because they don't have a community service card doesn't mean they don't have any hardship" (Practice)

Providers also described service users facing layered challenges, including mental health issues, housing insecurity, and food poverty, which often lead to health being deprioritised. Rural practices highlighted additional barriers related to distance, lack of public transport, and absence of funded urgent care services. Practices noted that the hardship fund helped to overcome some of these barriers.

4. **Administration and rules limit use**

Despite strong support for the fund, practices and providers consistently identified administrative processes as a major barrier to fund use. The standalone spreadsheet system was described as "time-consuming", "difficult to access", and "poorly integrated" with existing practice systems. Limited access and lack of real-time visibility meant staff were unaware of remaining funds or found the fund too administratively difficult to access during consultations.

"only one person could have access to that spreadsheet so you could, if they weren't here, you've got no idea how much the funding was left. I mean, I didn't even realise it was finished" (Practice)

In addition, eligibility rules were seen as restrictive. The requirement to exhaust all other funding sources, including other WellSouth funded programmes, and the inability to use the fund for existing clinical debt were viewed as particularly limiting.

5. **Strong impact and clear support for continuation**

Across all interviews, there was an agreement that the Hardship Fund makes a meaningful and sometimes life-changing difference. Providers described the fund as enabling timely care, preventing health deterioration, and reducing the likelihood of hospitalisation. The benefits were also seen to extend beyond individual service users, supporting whānau and wider community networks. Participants expressed a clear desire for the fund to continue and for opportunities to share learning across practices to strengthen its use.

"It's not just helping one person. This man volunteers in the community garden and delivers kai to people. If he didn't have his licence, he couldn't use our vehicle, and all those 40 whānau wouldn't get that support." (Provider)

Synthesis of Findings

The qualitative and quantitative findings form a coherent narrative on the fund's role and reach. Data confirm the fund is effectively reaching priority groups, particularly Māori and CSC holders in high-deprivation quintiles, while also revealing inconsistent uptake across regions and providers. The administrative barriers and eligibility rules likely limit utilisation and may explain some of this variation. Together, the evidence establishes the fund's substantial value in improving equity and identifies where operational improvements are needed, directly informing the subsequent recommendations.

Recommendations

1. **Continue and formalise the Hardship Fund as an ongoing equity programme.**
   Feedback from practices and providers, along with quantitative data, provides strong evidence for making the fund a permanent part of WellSouth's primary care support.

2. **Integrate the fund into the WellSouth claims portal.**
   The current spreadsheet system limits use. Including the fund in the existing claims portal will reduce administrative burden, improve visibility, and fit with normal practice workflows. The current balance should also be provided within the portal.

3. **Review eligibility criteria to better reflect patient need.**
   Some current rules limit the fund's impact. WellSouth could consider allowing Māori and Pacific providers a capped, one-off option to clear general practice clinical debt for service users who are unable to access care due to outstanding balances.

4. **Increase fund visibility and share effective practices.**
   To support the utilisation of the Hardship fund, WellSouth should introduce scheduled communications to practices, including clear guidance and practical examples of appropriate use. Furthermore, the organisation should actively facilitate the sharing of successful practice insights to build consistency and confidence across the network. Increasing utilisation for Pasifika patients should be a particular focus of this knowledge sharing.

5. **Rename the fund to the "Discretionary Equity Fund."**
   The term "hardship" can create stigma and discourage use. A new name would better reflect the fund's purpose and emphasise local clinical discretion.