Other expectations of providers will be that all clinical staff are NZ registered and fully authorised to practice in New Zealand and that all consultations are coded using SNOMED CT. Clinicians may be GP or Nurse Prescribers or other appropriate prescribing clinicians.

3.1.2 Funding model

This service will be funded by a mixture of Health NZ subsidies and patient co-payments. Health NZ will not pay for patients that are enrolled with the telehealth service provider. Clawback from capitation will not be a feature of the model initially but may be considered in later stages.

Provisional fees and subsidies for the service are set out in Table below. These will be finalised after negotiations with interested parties and further assessment of the price elasticity of demand. A placeholder payment for general adults is included to provide a compliance payment recognising the requirement to meet standards. This amount can be used to boost or reduce global demand.

Cohort	CSC	Subsidy*	Max Copay*
Under 14	Y	$75	$0
Under 14	N	$75	$0
Youth (14-18)	Y	$55	$20
Youth (14-18)	N	$19	$56
Adult	Y	$55	$20
Adult	N	$2	$73
**Overnight (between the hours of 10 pm – 8 am) we anticipate an additional premium to apply. We foresee this being paid as an additional $10 subsidy from Health NZ plus a $10 copayment from the patient.*			

Table: GP Direct subsidy

3.1.3 Timeline

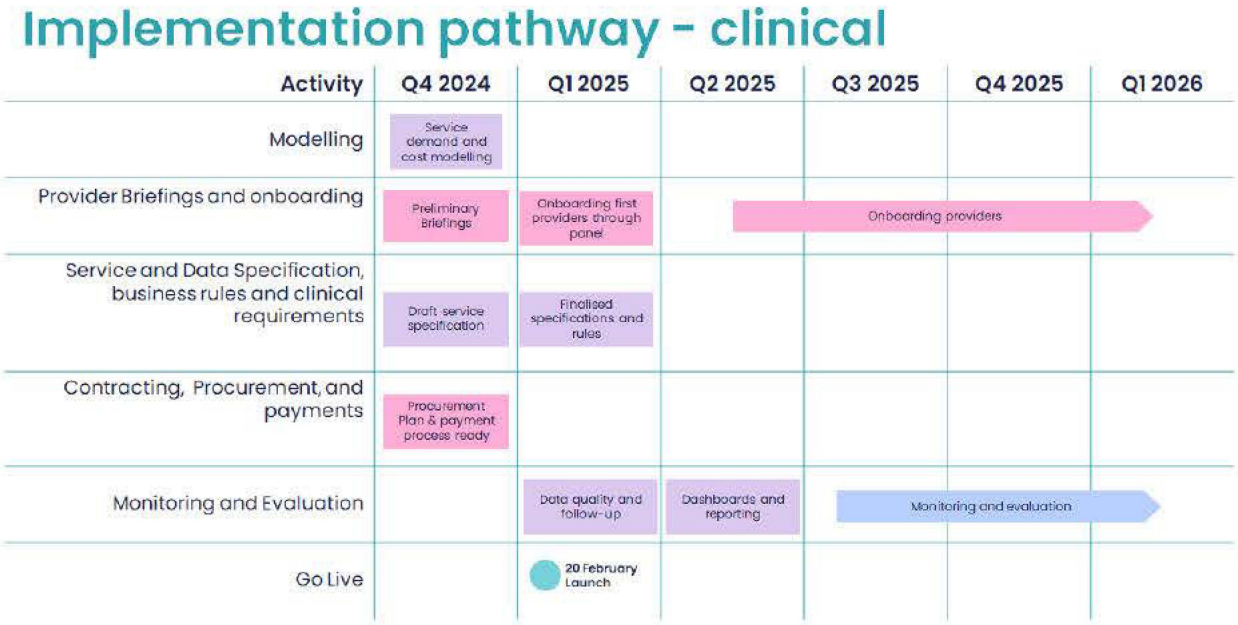


Diagram: Implementation pathway - clinical

3.1.4 Risk Management

Risk	Mitigations
Demand exceeds supply initially – resulting in a poor brand image.	s 9(2)(g)(i) [redacted] To manage demand as service launches: Good pre-consultation protocols will be in place including navigation on the landing page, and support through Healthline when people are not sure, so that people are matched to the right service the first time. s 9(2)(g)(i) [redacted]
Demand for the service over time exceeds the modelled volumes and costs of operation exceed budget (excess demand)	Options to reduce subsidies to impact on cost and demand. Begin with lower subsidies. Independent party checking model.
Lack of a consistent summary care record across NZ impacts on clinical safety	Expedite already planned programme to rollout a consistent summary care record across NZ.
Service may be seen as a competitor to GPs, providing services to those with lower complexity	Effective communications to outline how Urgent Care Direct is intended to complement general practice. Link to revised urgent care framework development which frees up GPs to focus on daytime care
May create a shift away from people enrolling with a general practice, reducing continuity of care and negatively impacting health outcomes.	Continue to encourage enrolment and use of regular GP. Provide informational continuity of care through shared care record. Continue to encourage providers to stand up digital services and join the panel of providers so that enrolled patients can use their provider of choice.
There is a large shift to fee for service funding of episodic care for primary care services.	The funding and co-payment structure for this service will be a balance of enabling access to urgent care, but also ensuring people are incentivised to seek care from their general practice team. s 9(2)(f)(iv) [redacted]
Limited window for implementation	Work with existing providers and allow for ramp-up time.
Service providers fail to provide a clinically safe / high quality service	Explicit clinical quality standards and Clinical governance arrangements required
There may be some people who use the teleconsultation service, that actually need to see an in-person clinician for their health care needs.	Protocols with the selected providers will be established to ensure that people are directed to the best clinical option for in-person services that are available at the time – this may be to the enrolling primary care practice, an urgent care clinic or if needed the closest emergency care department.
Service providers and general practices may be vying for the same workforce	Limited subsidies will reduce demand for the service to a manageable level and minimise the impact on

Risk	Mitigations
	the GP workforce. Use of other clinical roles (e.g. Nurse Practitioners and prescribing pharmacists) to deliver the service will reduce the impact on scarce GP workforce. Estimate the service will require about 4% of primary medical workforce.
Limited access for patients lacking digital literacy or internet connectivity (negative equity impacts)	s 9(2)(g)(i) Subsidies are targeted at lower income and younger populations, benefiting more deprived populations.

Table: Risk management – clinical

3.1.5 Scope inclusions/exclusions

The following table outlines initiative inclusions and exclusions.

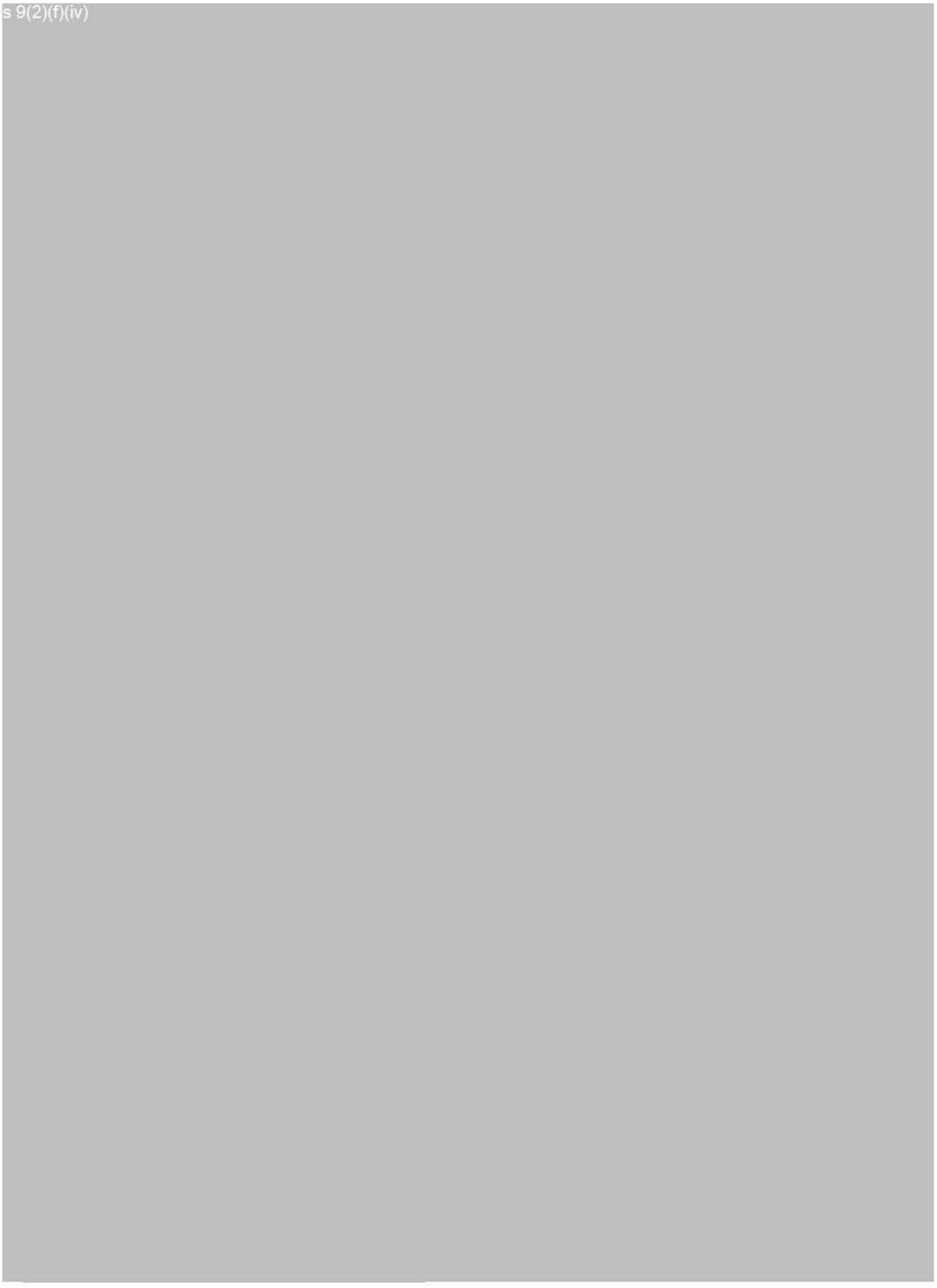
Inclusions	Exclusions
Delivery of fit-for-purpose complete telehealth consultation services by a NZ Registered GP and/or Nurse Practitioner.	The service will not be an enrolment service, and its core focus is not to providing ongoing care for people. s 9(2)(g)(i)
Targeted subsidies for selected populations to reduce the cost to access the service	The service will not provide the full range of services as delivered for people who are enrolled with a general practice teams e.g. recall for screening, immunisation.
Efficient on-line booking and payment systems.	People who are not eligible for health care in New Zealand
Effective clinical governance, cybersecurity and patient experiences monitoring as key service components.	People with clinical requirements that may not be able to be managed through a telehealth mode of care. e.g. large wound management.
Service components that ensure continuity of patient information, with links to national health systems, appropriate recording of notes and transfer of information back to a persons enrolled general practice where applicable.	

Table: Scope inclusions and exclusions – clinical

3.2 Workstream 1b: Digital Build

s 9(2)(f)(iv)

s 9(2)(f)(iv)



s 9(2)(f)(iv)

s 9(2)(f)(iv)

3.2.2 Timeline

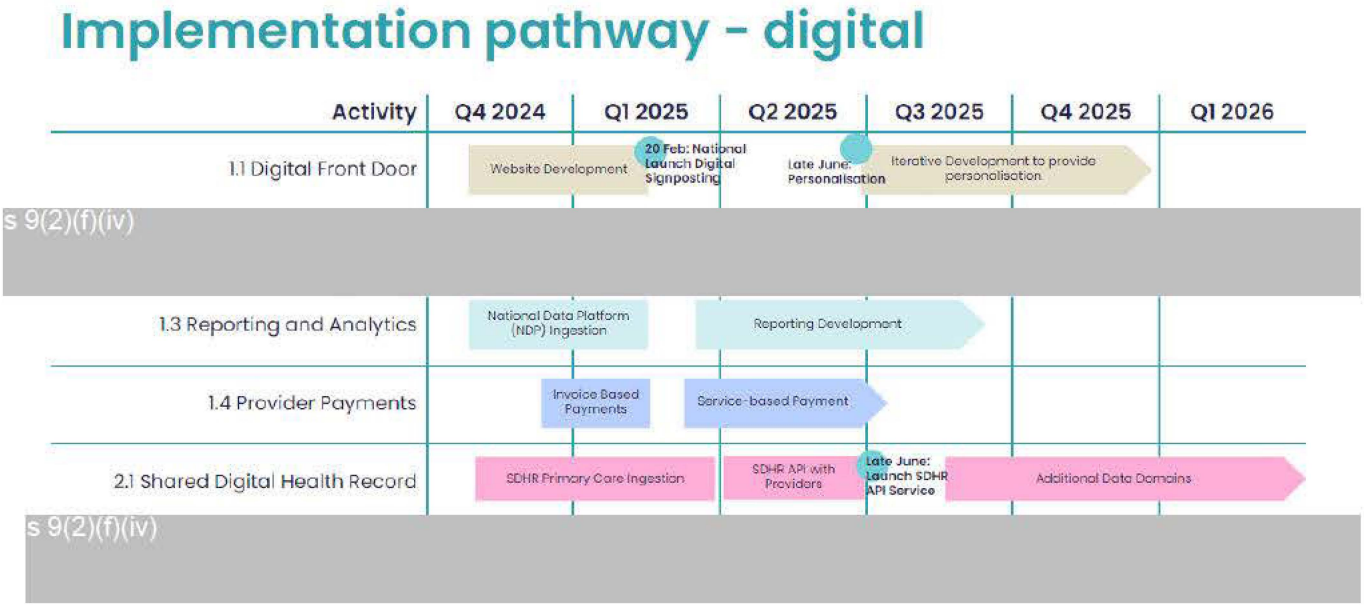


Diagram: Implementation pathway – digital

3.2.3 Risk Management

Risk	Mitigations
Our timeline estimates include assumptions of what our tele-consult providers can deliver and by when. For example, booking and integration. There is risk the providers will not meet our milestones.	Document clear and concise requirements for integration and data in the Services Specification Early engagement with providers to assess capacity to support and deliver to our expectations.

Risk	Mitigations
s 9(2)(g)(i)	

Table: Risk management – digital

3.2.4 Scope inclusions/exclusions

Inclusions	Exclusions
Web and Mobile Consumer for 24/7 GP Teleconsult services	Consumer payment services
Health consumer Summary Care Record available to Teleconsult providers	Non-GP Teleconsult Services
Teleconsult data repository to support monitoring and evaluation of services	Booking and Scheduling services beyond the contracted Teleconsult providers
Teleconsult provider payments and reconciliation services – including payment automation capabilities	Integrated flow into secondary care
s 9(2)(g)(i)	HNZ Telehealth platform
National shared summary record & associated data repository	
Teleconsult service recommendations based on consumer preferences	
Health consumer subsidy eligibility information available prior to appointment booking	
Health consumers can share their health records with other providers or health consumers	

Inclusions	Exclusions
s 9(2)(g)(i)	
s 9(2)(g)(i)	

Table: Scope inclusions and exclusions – digital

3.3 Workstream 2: Workforce Development

The cabinet paper sets out the following workforce initiatives.

Initiatives	Outputs
2.1 Domestic medical cap	25 more medical students in training per year from 2026.
2.2 NZREX Primary Care Pathway	100 more international doctors accredited to practice in NZ by the end of 2027.
2.3 Domestic Primary Care Pathway	50 additional full-year placements per year for PGY1 and PGY2 House Officers in primary care settings – as part of a primary care pathway – from 2026.
3.1 Nurse graduates into primary care	400 new nursing graduates per year subsidised employment into primary care settings from 2025. Baseline investment for 2024/25 is 200 (funded out of baselines), bringing the combined total to 600 supported new graduates; actual baseline employment levels vary by year based on number of primary care providers who contribute to ACE.
3.2 Nurse practitioners training	120 primary care nurse practitioners per year undertake NP training from 2026. s 9(2)(f)(iv)
3.3 Pre-NP training	120 primary care registered nurses per year undertake training which leads to becoming a NP – e.g. nurse prescribing, other Masters papers – from 2026.

Table: Workforce outputs

To deliver on these we set out three projects with critical key deliverables:

- **NZREX Primary Care Pathway** – need to stand up a web page with a way for candidates to submit EOIs for the Primary Care Pathway (and Medical Council exams); and open a process for PHOs (or similar clusters of primary care providers) to signal interest in placing NZREX doctors in primary care.
- **Nurse graduates into primary care** – need to stand up a simple application process for primary care to seek funding
- **Nurse Practitioners training** – need to rapidly confirm the 2025 cohort with our existing provider consortium.

From there to the end of the year, our focus shifts to:

- standing up our first tranche NZREX cohort for April 2025 – using the foundations of the Waikato pilot

- engaging with primary care to drive interest in employing new nursing graduates, and then rapidly reviewing and approving new graduate nursing employment applications from primary care
- starting design of our approach to funding nurse practitioner and nurse prescriber training for 2026, so we can get ready to launch expressions of interest by March 2025.

3.3.1 Timeline

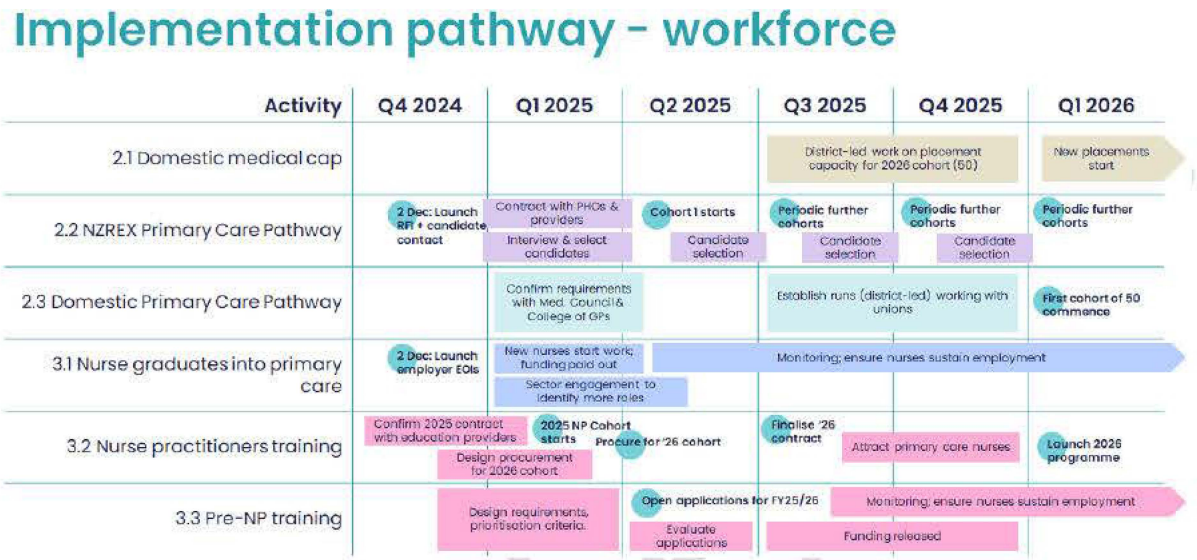


Diagram: Implementation pathway – workforce

3.3.2 Risk Management

Risk	Mitigations
s 9(2)(g)(i)	