TE TIRATU

Hauora
Thames

2026

Acknowledgements

Mai i Ngā Kurī-ā-Whārei ki Mahurangi i te muri.

Mai i Moehau ka piki ki Te Aroha peka atu ki Te Uru, ko Te Hapū-a-Kohe.

Ka heke ki Te Kohukohunui tae atu ki Mahurangi.

Ko Tīkapa, ko Taitamawāhine ngā moana karekare, ngā moana marino e hora nei.

Hauraki te rohe, Marutūahu te tangata!

This report has been prepared by Te Tiratū Iwi Māori Partnership Board. The Board has a statutory role to represent the hauora priorities, needs, and aspirations of Māori communities in te rohe o Waikato.

We would like to acknowledge the many whānau, health, social service and community stakeholders that provided insights. Ngā mihi nui ki a koutou katoa.

He Whakataki | Introduction

Thames, ancestrally known as **Kauaeranga** sits between **Tikapa Moana (Firth of Thames)** and Te Tara o te Whai (Coromandel ranges). The town's hauora story is inseparable from place, whakapapa, and the long arc of settlement and extraction that shaped land, waterways, and access to resources. Thames Hospital itself is rooted in manaakitanga: the whenua for the hospital was gifted as a **koha** by **Ngāti Maru Rangatira**, intended to support the wellbeing of the people of this rohe.

At the same time, Thames carries the health legacy of industrialisation and colonial disruption, pressures that continue to show up as inequities in prevention, chronic conditions, and access.

The pathway forward therefore needs to be **restorative**: honouring the original intent of the koha while designing services that work for whānau living with today's barriers (cost, travel, workforce constraints, and fragmented pathways).

Ngā Ihirangi | Contents

Whakarāpopototanga
| Executive Summary

Across Thames and its surrounding communities, a clear picture has emerged: our strength lies in the relationships, trust, and practical solutions already present within the locality. The priorities outlined here reflect what whānau, providers, and data consistently tell us: that equitable care is built not through new structures, but by reinforcing what works and removing the barriers that prevent people from completing their care journey.

Each action is deliberately grounded in place. Whether it's making care easier to navigate, lifting winter protection for Māori, stabilising long-term conditions, or scaling proven community-led models, the focus remains on supporting whānau to stay well in their own homes and communities. These priorities also recognise that Thames is unique: a township that anchors a geographically diverse region, with rural settlements and coastal communities that each bring their own strengths and challenges. With nearly a quarter of the population identifying as Māori, equity is not an abstract goal; **it is central to how the system must function**.

What ties these priorities together is stewardship. The hospital, primary care, kaupapa Māori providers, pharmacies, and community services are not separate entities; they are interdependent parts of a single care pathway. Strengthening that pathway means investing in the people who hold it together, from kaiāwhina supporting care completion, to clinicians delivering longer planned appointments, to rangatahi stepping into future hauora roles.

As we look ahead, the opportunity is to build on the momentum already present in Thames. By protecting what works, addressing the friction points that hold whānau back, and growing a workforce rooted in the community, we can create a system that is not only more equitable, but more connected, resilient, and locally led.

This summary is also an invitation to continue shaping a care system that reflects the aspirations, realities, and mana of the people it serves.

He Karanga ki te Wā
Call to Action

These actions are practical, place-based, and designed for immediate implementation. They're demand-reduction investments. Investing early in navigation, prevention, and chronic care reduces high-cost hospital demand, shortens length of stay, and prevents avoidable escalation into acute services.

Align hospital services, primary care, kaupapa Māori providers, pharmacies, and community services into one connected care pathway. Each initiative shifts care earlier, prevents escalation, and reduces avoidable use of high-cost hospital services such as emergency department presentations, acute admissions, and delayed chronic disease treatment.

Whakaarotau 1 — Whakangāwaritia te tiaki

What this means: Whānau experience system friction, transport barriers, and fragmented follow-up. High emergency department demand reflects avoidable escalation and incomplete care pathways.

Measure of success:

- Reduction in Did Not Wait / Left Before Seen (where tracked)
- Reduced repeat emergency department presentations within 7–30 days
- Increased screening and long-term

Kaiāwhina Model built to support:

- After-hours access and discharge follow-up
- Transport to and from care
- Proactive follow-up for high-risk whānau (especially post-emergency department presentation)

Whakaarotau 2 — Whakanuia te ārai rewharewha me te tiaki manawa

Increase flu vaccination (65+) and strengthen respiratory protection

What this means: Māori vaccination coverage remains below equity thresholds, and child respiratory admissions (0–4) indicate preventable winter system pressure.

Measure of success:

- Monthly Māori flu vaccination uplift (65+)
- Reduction in child respiratory admissions / Ambulatory sensitive hospital admissions (0–4) during winter period

Winter protection campaign delivered through:

- Pharmacies and community pop-ups
- Marae and community-based vaccination sites
- Transport-supported access for kaumātua
- Integration with home warmth checks and early respiratory intervention pathways

Whakaarotau 3 — Whakakaha i te tiaki mate tauroa

Strengthen chronic condition care through planned, longer consultations

What this means: Whānau experience system friction, transport barriers, and fragmented follow-up. High emergency department demand reflects avoidable escalation and incomplete care pathways.

Measure of success:

- Increase in HbA1c ≤53 achievement
- Increased CVDRA completion rates
- Reduction in avoidable acute

Structured long-term condition clinics that are funded & embedded in the system:

- 30–40 minute planned reviews
- Recall systems for regular monitoring
- Lab completion and medication adherence support
- Whānau-centred care coordination

Whakaarotau 4 — Tiakina, whakanuia ngā mahi e whai hua ana

Protect and scale effective local prevention and integrated models

What this means: Local initiatives already demonstrate strong engagement and screening performance. These should be stabilised rather than redesigned.

Measure of success:

- Sustained or improved screening participation rates
- Reduction in smoking/vaping prevalence over time
- Increased early detection and enrolment uptake

Equity Uplift Days, integrating:

- Screening services
- Smoking/vaping cessation
- Rongoā Māori and wellbeing supports
- System navigation and enrolment support

Whakaarotau 5 — Whakawhanake i te rārangi kaimahi ā-āpōpō

Grow a local workforce pipeline (rangatahi pathway)

What this means: Workforce instability directly affects continuity of care. Rangatahi want visible, structured pathways into health careers within their own communities.

Measure of success:

- Number of rangatahi engaged annually
- Enrolment into health training pathways
- Local placement and retention rates

Local rangatahi hauora workforce pipeline built for:

- School-based engagement and health career exposure
- Mentoring and clinical shadowing opportunities
- Scholarships and training pathways with local return-of-service options
- Alignment with iwi and provider workforce needs

Whakapapa me te Whenua | Our cultural foundation

The hauora of Thames is inseparable from the whakapapa of Ngāti Maru and the whenua of Kauaeranga and Kōpū. For Ngāti Maru, wellbeing is genealogical, territorial, and spiritual, grounded in enduring relationships between people, waterways, marae, and ancestral knowledge.

Ko Ngāti Maru te Mana Whenua o Kauaeranga Ngāti Maru | Mana Whenua of Thames (Kauaeranga)

Ngāti Maru, one of the five iwi of the Marutūāhu Confederation (alongside Ngāti Tamaterā, Ngāti Paoa, Ngāti Whanaunga, and Ngāti Rongoū), are tangata whenua of the Thames area. Their stronghold has historically been Kauaeranga, the area now known as Thames, with ancestral pā, urupā, gardens, and tauranga waka spread across the foreshore, river mouths, and inland valleys.

Ngāti Maru trace descent from Marutūāhu, son of Hotunui of the Tainui waka. This whakapapa situates Thames firmly within the Waikato–Tainui sphere while also centring it in the Hauraki iwi collective. The tribal seat of Ngāti Maru has long been associated with Kirikiri and Kauaeranga, just south of central Thames.

Historically, Ngāti Maru maintained sophisticated systems of food production, trade, and environmental management along the Waihou River, Thames foreshore, and adjacent valleys. These systems supported both local whānau and wider regional exchange networks well before European settlement. The rapid growth of Thames during the gold rush fundamentally disrupted these systems through land alienation, environmental degradation, and population displacement — impacts that continue to influence present-day hauora inequities.

He aha te hāngai ki te hauora? What this tells us for hauora:

Health inequities in Thames are not accidental, **they are historically produced.** Restorative, place-based models of care are therefore essential for Ngāti Maru and for the wellbeing of the whole community.

Ko te marae o Mātai Whetū - He Punga Hauora Mātai Whetū Marae | A Living Health Anchor

Located in Kōpū, approximately 7 km south of Thames, Matai Whetū Marae is a principal marae of Ngāti Maru and a vital cultural and social anchor for the rohe. The marae complex includes the wharenui Te Rama o Hauraki.

Matai Whetū marae occupies land of deep ancestral significance. After the removal

of the ancestral wharenui Hotunui to the Auckland Museum in 1925, an event experienced by Ngāti Maru as a profound cultural loss, local whānau worked over many decades to re-establish a marae as a focal point for identity, tikanga, and collective wellbeing. Through gifts of land, community fundraising, and sustained leadership, Matai Whetū was formally re-established in the 1970s on the site of the former Kirikiri Native School, itself built on gifted Māori land at an ancient pā site.

Today, Matai Whetū Marae functions as a living hauora infrastructure:

- A place for tangihanga, hui, wānanga, and whānau decision-making.
- A base for cultural transmission, including whakapapa, waiata, and kōrero tuku iho.
- Home to Te Kōhanga Reo o Matai Whetū, supporting te reo Māori revitalisation and early-life wellbeing through whānau-centred education.

He aha te hāngai ki te hauora? What this tells us for hauora:

Marae like Matai Whetū are not peripheral to health, they are preventative, protective, and restorative health settings. They strengthen identity, reduce isolation, support early childhood development, and provide culturally safe entry points for health and social services.

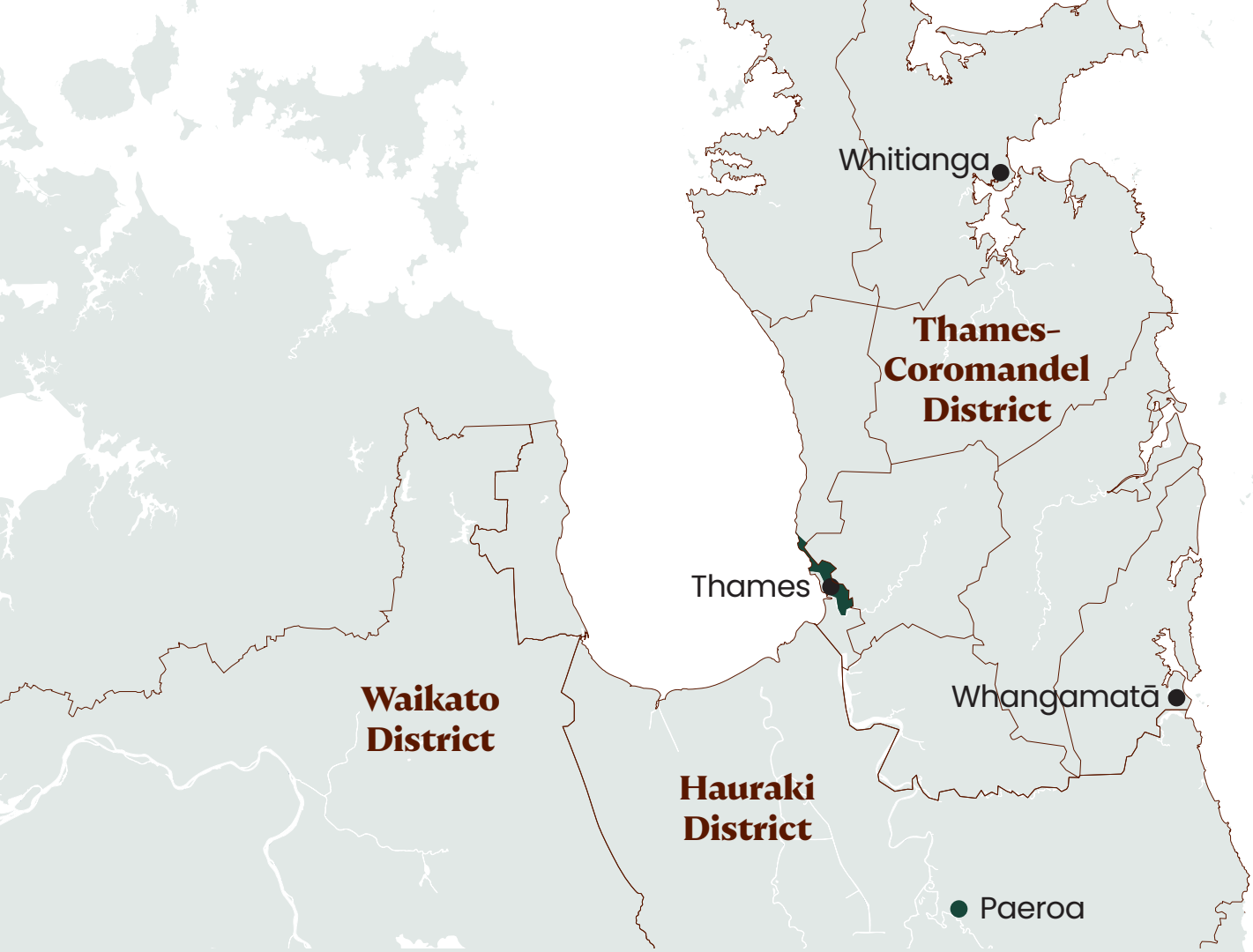
Ko te Whakapapa hei Āhuatanga Tāwharau | Whakapapa as a Protective Factor

For Ngāti Maru, hauora is sustained through whanaungatanga, manaakitanga, and kaitiakitanga. Whakapapa ties individuals to whenua, waterways, and tūpuna, creating a strong sense of belonging and purpose. Evidence across Aotearoa consistently shows that cultural connection functions as a protective determinant of health, particularly for mental wellbeing, resilience, and intergenerational outcomes.

In Thames, where long-term conditions, smoking, respiratory illness, and social deprivation intersect, strengthening marae-based and iwi-led pathways is not cultural 'nice-to-have' work, it is core health system business.

Ko te tātaritanga - What this tells us for hauora:

Marae like Matai Whetū are not peripheral to health, they are preventative, protective, and restorative health settings. They strengthen identity, reduce isolation, support early childhood development, and provide culturally safe entry points for health and social services.



He Tirohanga Whānui | Thames at a Glance

Thames serves as the primary township for a geographically diverse region. This footprint encompasses the urban township and rural settlements including **Matatoki, Puriri, and Hikutaia**, alongside nine distinct coastal communities stretching from **Ngarimu Bay to Waikawau**. In total this gives a total population of 12,180 of which approximately 25% (2,989) are Māori. Note that as of the 2023 Census Thames township itself has an estimated population of 7,230.

Figure 2: Whaitua Mapping Tool – Map of Thames area

Table 1: Whaitua Mapping Tool – settlements that are included as part of this town report

	Total population	Māori population
Thames North	1974	426
Thames Central	1068	234
Thames South	3270	951
Totara-Kopu	903	223
Kauaeranga	615	99
Thames Coast	1734	435
Hauraki Plains East	1440	348
Matatoki-Pūriri	1176	273
Total	**12180**	**2989**

Included settlements for Thames area

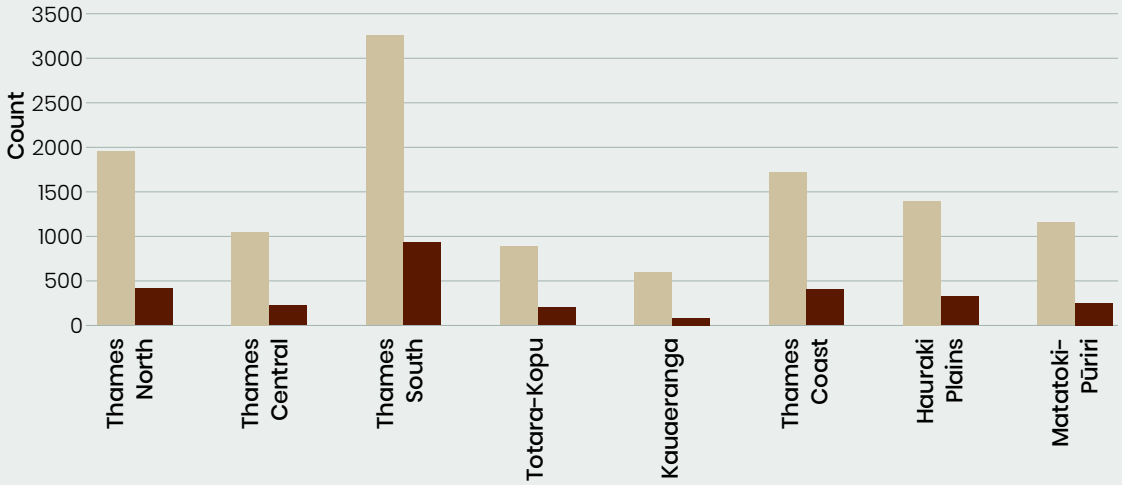


Fig 3. Included settlements for the Thames town report area (Whaitua mapping tool)

The Historical & Economic Landscape

Positioned between the Tikapa Moana (Firth of Thames) and Te Tara o te Whai (Coromandel Ranges), Thames is a heritage town with an economy transitioning from its industrial roots in gold mining and foundries to a modern mix of aquaculture, tourism, and regional services. Today, the region's economy is shaped by a mix of regional services, tourism, and industry. Major employers include the **Thames-Coromandel District Council (TCDC), Thames Hospital, Toyota NZ, Te Korowai Hauora o Hauraki and the A & G Price foundry,** with aquaculture and tourism increasingly central to the local workforce.

This economic landscape includes a significant high-deprivation profile, with **34% of whānau living in Decile 9 or 10 areas**. This contributes to place-based challenges where the cost of living and rural dispersion significantly influence infrastructure resilience and service capacity.

A Bimodal Population Profile

The health system in Thames must navigate a unique 'Bimodal Demand' that requires highly flexible resourcing:

- **An Ageing Resident Base: 35.4% of the population is over 65**, creating a high, consistent demand for chronic condition management and aged care support.
- **Seasonal Summer Surges:** As a heritage gateway to the Coromandel, seasonal influxes significantly increase pressure on urgent and unplanned care services.

Demographic Indicators & Current Reality

- **Income & Tenure:** Median income and tenure data reflect a town where financial barriers frequently lead to deferred care.
- **Māori Health Equity:** Current signals indicate significant and persistent barriers to preventative care for Māori whānau compared to non-Māori, particularly where cost, transport, and continuity intersect.
- **Housing Impact:** The high-deprivation housing profile is a direct driver of winter paediatric ED surges, where children under 14 present with increased respiratory acuity.

Ko ā mātou mahi angitū
| What we're doing well

1 Screening platform is strong
Māori screening coverage is at least comparable to non-Māori across bowel, cervical, and breast in the enrolled dataset.

2 Prevention and community hubs reduce stigma and increase reach
Pito Hauora is positioned as a key prevention model that bundles clinical services with manaakitanga.

3 Local integration capability exists
High-trust collaboration between providers and the operational existence of fast-track pathways show Thames has the relationship infrastructure to deliver integrated care.

4 Clear clinical priorities are emerging
The combined data points consistently identify COPD, diabetes, gout, smoking, flu coverage, and childhood respiratory ASH as priority focus areas.

Screening coverage: Māori n Non-Māori

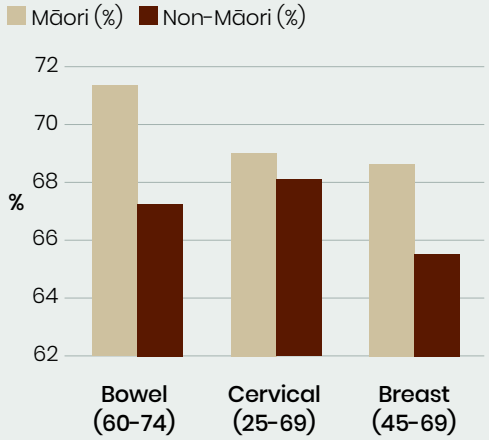


Fig 1. Preventive screening coverage (%), Māori and non-Māori, Thames enrolled cohort

Screening coverage: Māori n Non-Māori (counts)

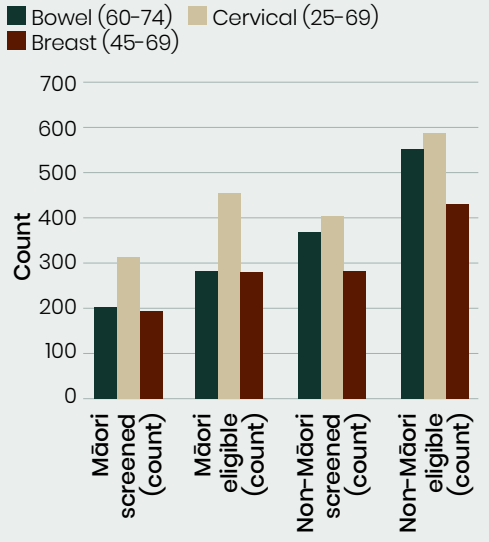


Fig 2. Preventive screening participation (counts), Māori and non-Māori, Thames enrolled cohort

E ai ki ngā raraunga, me aha? What the data signals:

- **Prevention is working in places, yet not evenly.** Screening coverage is relatively strong overall, including Māori rates that are **at or above** non-Māori for bowel, breast, and cervical screening in the Te Tiratū enrolled population.

- **Smoking/vaping prevalence remains a major driver of inequity**, with Māori smoking/vaping higher than non-Māori in the enrolled population.
- **Long-term conditions are concentrated in midlife and older Māori cohorts**, especially COPD, diabetes, and gout conditions that are highly sensitive to warm housing, food security, continuity of care, and medication access.
- **Acute demand is substantial:** ED presentations are high for both groups, and avoidable childhood admissions (respiratory/skin/dental) are visible in tamariki, indicating the ongoing role of housing and access as clinical issues.

Ko te tātaritanga - What this tells us:

Thames is not short of good services or good people, it is short of **frictionless pathways** that make prevention and chronic care easy to complete, especially for whānau who face cost, transport, and workforce barriers. This report frames practical, measurable actions to reduce that friction and lift hauora outcomes.

This information is reflected across the Thames enrolled population used for this report, Māori enrolments are younger-skewed, while non-Māori have a larger 65+ cohort.[1]

Thames enrolled population of Te Korowai Hauora o Hauraki by age cohort (counts):

- **Māori:** 0–4 (144), 5–14 (265), 15–24 (325), 25–44 (393), 45–64 (414), 65+ (241)\
  - » **Total** - 1782
- **Non-Māori:** 0–4 (83), 5–14 (188), 15–24 (204), 25–44 (455), 45–64 (583), 65+ (709)
  - » **Total** - 2222

Ko te tātaritanga - What this tells us:

Service design must meet **two realities at once:** strong whānau and tamariki needs in younger Māori cohorts, and high chronic-care demand in older non-Māori and Māori. This is where integrated local models matter most.

[1] There are two general practices in Thames. Although Pinnacle PHO data has been supplied for this report, enrolment data was provided from Hauraki PHO only, assumptions made that this accounts for a significant representation of the Thames area.

Enrolled population by age

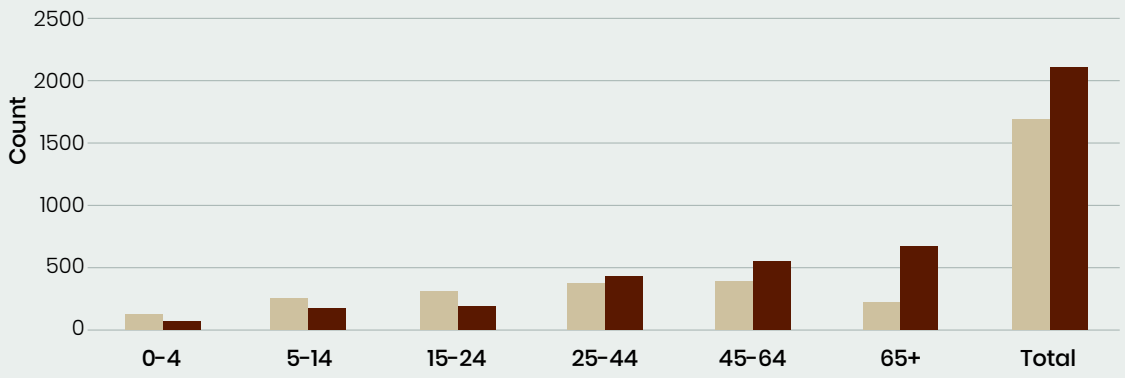


Fig 4. Enrolled population by age cohort (counts), Te Korowai Hauora o Hauraki Thames clinic cohort

Te Reo o te Whānau

| Lived experience

Whānau voice gathered for Thames consistently points to the same system pressure points: affordability, timeliness, culturally grounded care, transport/navigation, and stronger mental health response.

Access & affordability

> "Availability of all services. Cheaper or free services. Longer GP appointments. Quicker access to services/support. Dental for adults."

Theme: reduce cost barriers; extend appointment length for long-term conditions; improve adult dental access.

Support workers & clear communication

> "Someone to listen to me effectively and doctors who can explain things more easily. Mental health crisis team."

Theme: kaimanaaki / navigators are not 'extras', they are critical health infrastructure.

Māori / holistic models of care

> "Holistic approach. Seen through a Māori lens. Cultural diversity."

Theme: embed rongoā/mirimiri and whānau-centred care into mainstream pathways.

Kahu Taurima | Hapū māmā & First 2000 Days

> "Changing midwives... repeating my story... missed appointments due to lack of funds for transport... no follow-up care... not enough support for māmā and pēpi... limited birthing centre options."

Theme: continuity and transport are decisive for maternal/infant outcomes.

Rangatahi pathways into hauora

> "Promotion... needs to happen in schools... inspire those who don't feel worthy... remove the stigma... not enough practical learning."

Theme: local pipeline needs early exposure, mentoring, and practical pathways.

Ko te tātaritanga – What this tells us:

In Thames, whānau are asking for the same thing across all themes: **a system that is easier to navigate and completes care.** When whānau can finish what the clinician starts (screening, prescriptions, follow-ups), outcomes lift and ED demand falls.

Ko ngā Mahi Hauora | Ngā angitū ā-Hapori | Hauora in Action | Community wins

Thames has effective community-led models that already demonstrate 'what works' when manaakitanga is embedded into delivery:

- **Pito Hauora (Thames)** as a prevention-focused hub bringing screening and immunisation into a welcoming, community space reducing stigma and increasing engagement.
- **Te Kura o te Kauaeranga (Māra Kai)** supporting food security, health literacy, and connection to whenua.
- **Proven blueprints** such as mobile dental and healthy homes approaches are referenced as scalable solutions that can be re-activated or strengthened with continuity funding: Formerly funded initiatives like Niho Ora (Mobile Dental) and Ahuru Mowai / AWHI (Healthy Homes) remain as tested and proven solutions for the community need. These programs have existing community trust and proven protocols to address the Decile 9 & 10 health gaps.

Ko te tātaritanga - What this tells us:

Thames is not starting from scratch. The community has already built credible interventions. The system's job is to **stabilise and scale** them.

Ngā Ratonga i Kauaeranga
| Thames services

Key local services in Thames include: Hospital and ED pathways, primary care providers, kaupapa Māori and allied providers, pharmacies, aged care supports, and community connectors.

- **Hospital & ED:** Thames Hospital emergency and acute flow; cultural kaitiaki support available.
- **Primary Care:** Thames Medical Centre; Te Korowai Hauora o Hauraki, Thames.
- **Pharmacies:** Thames Centre; Unichem Thames (546 Pollen St); Pollen Street Pharmacy (330 Pollen St); Goldfields Pharmacy (100 Mary St).
- **Aged Care:** Bupa Tararu (921 Tararu Rd); The Booms (604 Parawai Rd).
- **Community & Safety:** Supported Life Style Hauraki Trust; Family Relationship Services Trust; Te Whāriki Manawāhine o Hauraki (Women's Refuge); St John Health Shuttle (Thames/Paeroa/Ngatea).
- **Kaupapa Māori & Allied:** Io Mata Hauora (Rongoā Māori); CAPS Hauraki; audiology/physio/osteopathy; optometry; dentist; Bay Audiology
- **Alternative healthcare:** ConTact C.A.R.E

Ko te tātaritanga – What this tells us:

The service footprint exists; the challenge is integration, **navigation, and friction removal**, especially for transport, follow-ups, and culturally safe continuity.

Figure 3: Traditional Māori, marae based health clinics are offered in Thames and the wider Hauraki population.

Ngā Rongo ā-Whānau, ngā Āputa me ngā Mahi

| Coverage, gaps & actions

Whānau theme	Current coverage	Gap observed	Action we can take
Cost barriers; short appointment slots; adult dental	Primary care + prevention hubs (incl. Pito Hauora); local providers	Deferred care; LTC reviews too short	**Longer LTC appointments** (structured 30–40 min blocks); fee-free prevention days; **re-activate mobile dental blueprint**
Care completion after ED / after-hours	ED + ad hoc whānau support + shuttles	Unsafe discharges; poor follow-through	**Care-Completion Kaiāwhina + transport** pathway; after-hours follow-up calls for high-risk discharges
Māori models of care	Kaupapa Māori and rongoā services	Uneven integration and funding	Embed Māori models **within** pathways (LTC, maternity, mental health), not peripheral
Warm, dry homes	Healthy homes approaches referenced in local work	Housing-driven respiratory and skin burden	Treat housing as clinical intervention: **Whare Ora prescriptions** and targeted healthy homes delivery
First 2000 days	Taurima / maternity supports referenced	Midwifery continuity and transport gaps	**Local caseload midwifery team,** integrated immunisation/WCTO pathway, transport support
Rangatahi pathways	Schools and youth programmes	Visibility, confidence, practical access	**Rangatahi hauora pathway:** placements, mentoring, scholarships with return-of-service

Ngā Tohutohu Raraunga
Data-linked insights[2]

The following data-linked insights are presented to support shared understanding, not to stand alone. In this report, data is used as a navigation tool to help identify patterns, confirm lived experience, and guide practical decision-making rather than as an end in itself.

These indicators draw on the Te Korowai Hauora o Hauraki Thames Clinic enrolled population and practice-level data (as supplied by Hauraki PHO) to illustrate where the Thames system is working well, where inequities persist, and where targeted action is most likely to reduce avoidable harm. Wherever possible, insights are interpreted alongside whānau voice, local context, and known system pressures.

Importantly, several measures, particularly immunisation milestone cohorts and some practice-level indicators, involve small denominators. These figures should therefore be read as directional signals, not precise performance targets. The emphasis throughout is on patterns and relationships, rather than isolated numbers.

The charts that follow are intentionally selective. They focus on areas most relevant to:

- Prevention and early intervention,
- Long-term condition management,
- Equity of access,
- And system flow between community, primary care, and hospital services.

Screening

Preventative screening is one of the strongest indicators of a health system's ability to support early intervention and avoid downstream harm. In Thames, screening data provides a clear signal of what works when access barriers are reduced and services are delivered in culturally safe, low-friction ways.

Screening coverage: (core prevention signal)

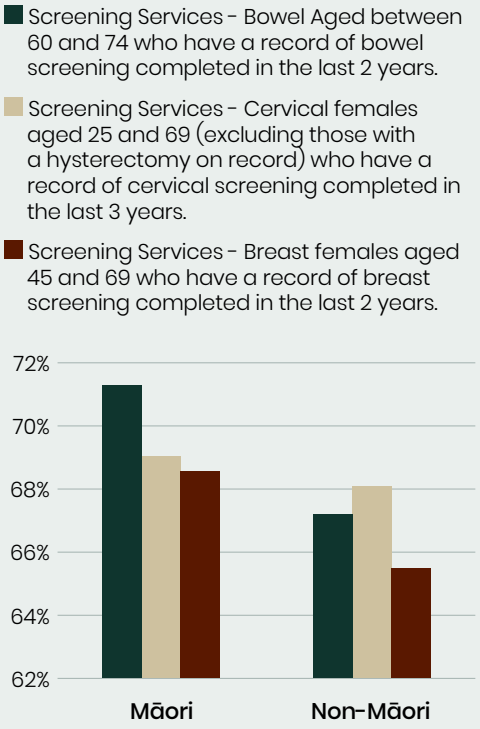


Figure 5: Preventative screening coverage in Thames – Māori and non-Māori

Screening coverage for bowel (60–74), cervical (25–69), and breast (45–69) cancer among Te Korowai Hauora o Hauraki enrolled population. Māori participation is comparable to, and in some areas exceeds, non-Māori participation.

[2] Te Korowai Hauora o Hauraki data has been cited here to support insights as volumes are more indicative for insights.

Bowel Screening Participation — Māori Thames (2022-2025)

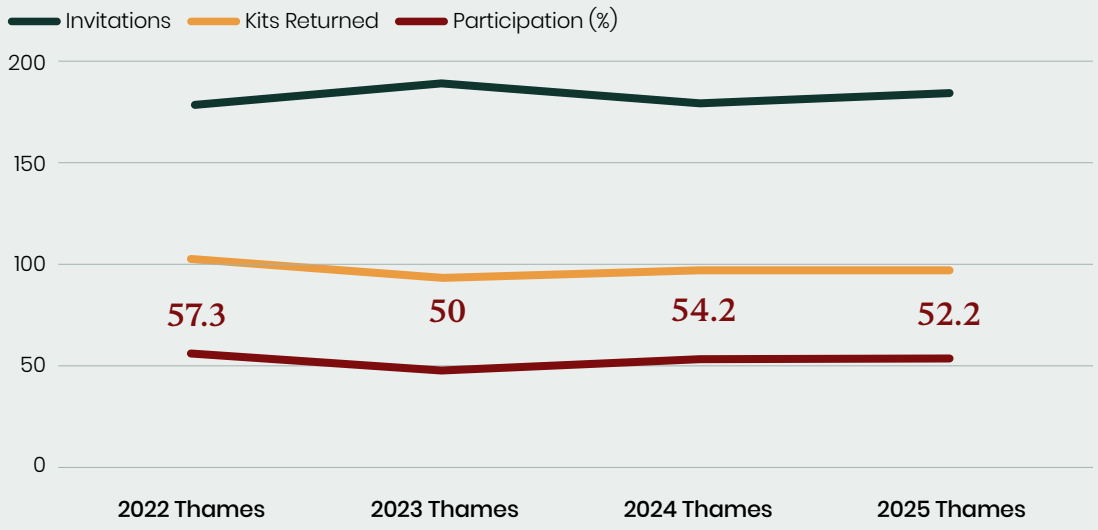


Fig 6 Source Health NZ

Breast Screening Coverage — Māori Thames (2022-2025)

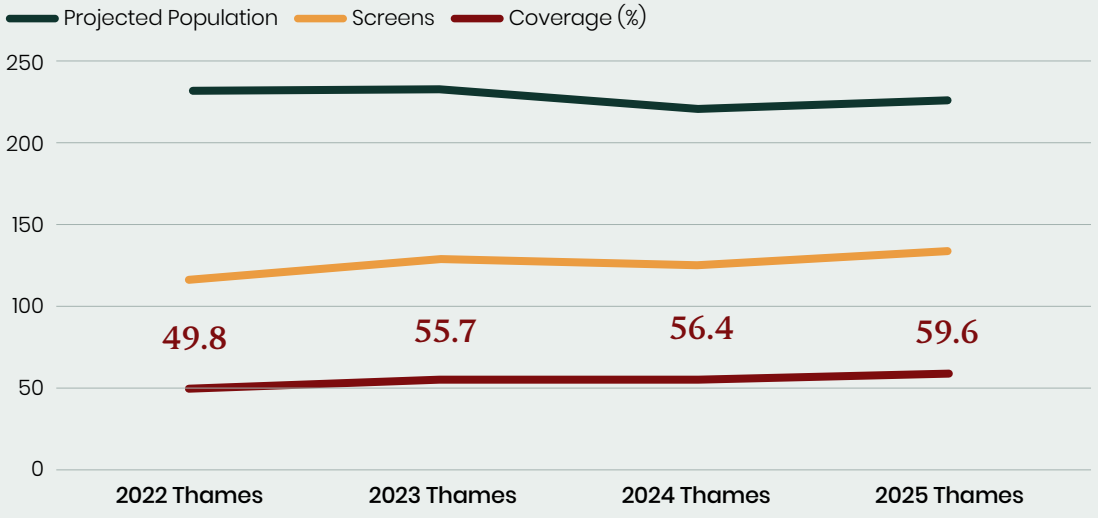


Fig 7 Source Health NZ

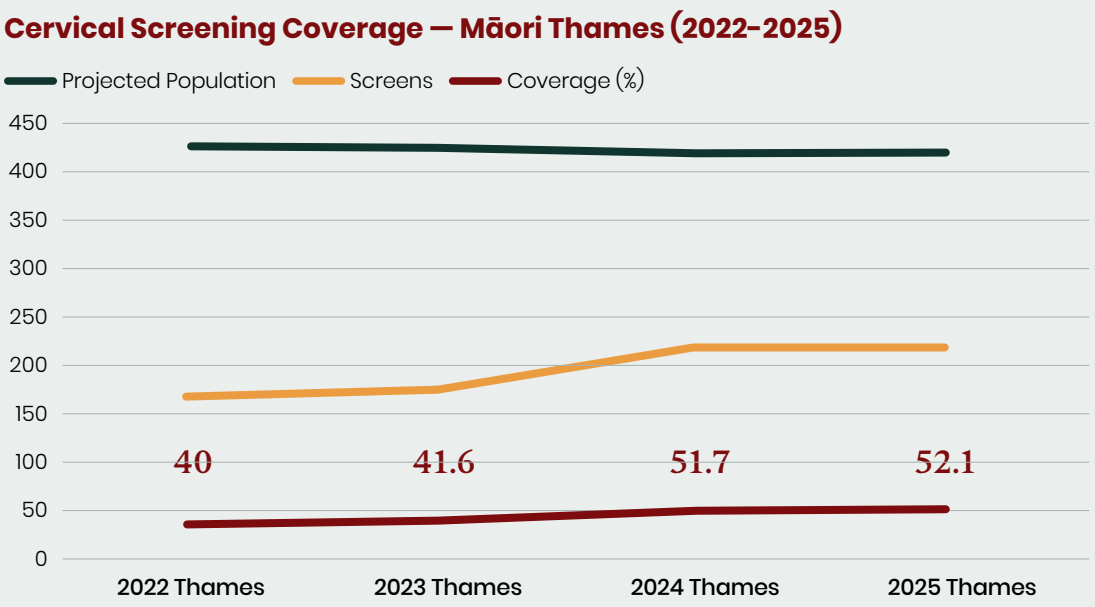


Fig 8 Source: National Cervical Screening Programme Data Warehouse, Health NZ; Stats NZ population projections. Extracted 10 February 2026. Ethnicity prioritised Māori. Coverage calculated as screens divided by projected eligible population based on HPV test date. 2025 data preliminary due to 6-month kit return window.

Ko te tātaritanga - What this tells us:

Thames has a **strong prevention platform**, particularly for Māori whānau. Where screening is accessible and supported through trusted pathways, engagement is high. These results represent system assets that should be protected and strengthened.

From an equity perspective, maintaining low-barrier access to screening and diagnostics is essential to sustaining these gains and preventing avoidable escalation into acute care.

Smoking and vaping

Smoking and vaping remain among the most significant modifiable drivers of long-term condition burden and acute hospital demand. Understanding this pattern is critical to targeting effective prevention and early intervention.

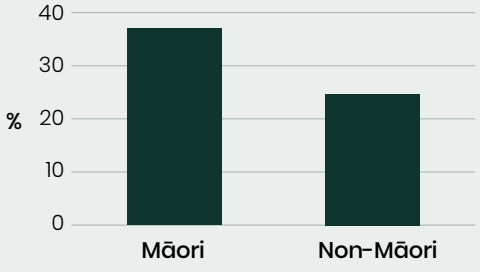


Figure 9: Smoking and vaping prevalence (15+) – Te Korowai Hauora o Hauraki Thames enrolled population

Smoking/Vaping Prevalence (15+)

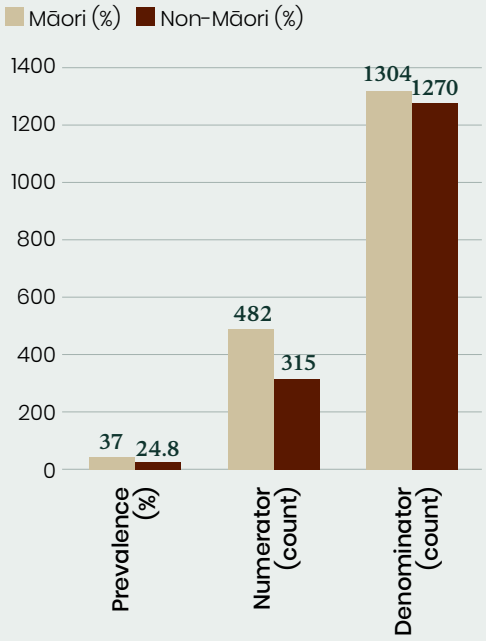


Fig 10. Smoking and vaping prevalence (15+), Māori and non-Māori, Thames enrolled cohort

Ko te tātaritanga - What this tells us:

Higher smoking and vaping prevalence among Māori continues to compound inequities across respiratory disease, cardiovascular risk, and cancer outcomes. This reinforces the importance of **integrated cessation support**, delivered alongside primary care, community outreach, and whānau navigation rather than as a standalone intervention.

Long-term conditions

Long-term conditions account for a significant proportion of preventable morbidity and health system demand in Thames. The conditions shown below were selected because they are **high-impact, highly preventable, and sensitive to continuity of care, housing quality, and access to medicines.**

Selected Long-Term Condition Prevalence (Māori vs Non-Māori)

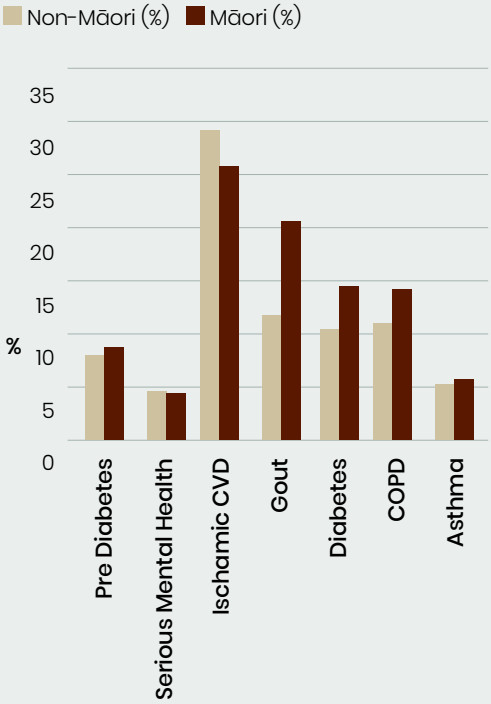


Figure 11: Prevalence of selected long-term conditions (COPD 40+, Diabetes 30+, Gout 30+ males) within the enrolled Thames population.1) Prevention & primary care

9. Long-term condition prevalence (%), Māori and non-Māori, Thames enrolled cohort

Ko te tātaritanga - What this tells us:

Higher prevalence of COPD, diabetes, and gout among Māori highlights the importance of **planned, long-term condition care** rather than reactive treatment. Longer appointments, proactive recall, medication support, and attention to housing conditions are likely to have the greatest impact on reducing avoidable hospital use.

1) Te Tiaki Mātāmua hei aukati | Primary care prevention

Whai Awhikiri – Immunisation (milestone cohorts)

Note immunisation is sources for enrolled Patients (as at 1 October 2025) turning 24 months during July 1 - Sep 30 2025, These are very small cohorts for both Māori and non-Māori.

- **Fully immunised @ 24 months:** Māori **9/10 (90%)**; non-Māori **1/1 (100%)**. *(Very small denominators—interpret cautiously)*
- Fully immunised @ 8 months: Māori **5/7 (71.4%)**; non-Māori **2/3 (66.7%)**. *(Small denominators.)*

Ko te tātaritanga - What this tells us:

In the measured cohorts, immunisation completion is strong, but the small cohort size means local operational focus should be on **recall systems, transport support, and continuity**, rather than over-interpreting percentages.

Rongoā Rewharewha - Flu vaccination (65+)

Flu vaccination (65+) Māori vs Non-Māori

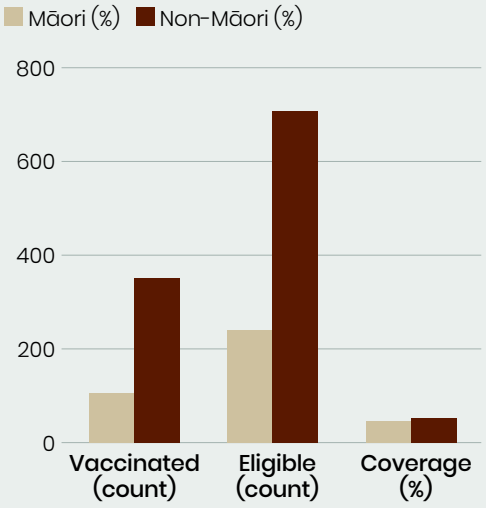


Fig 12. Flu vaccination coverage (65+), Māori and non-Māori, since 1 April 2025 (Thames cohort)

- Māori **103/237 (43.5%)** vs non-Māori **345/702 (49.1%)** vaccinated since 1 April 2025.
- Māori **89** (51.4%) – Thames Medical Centre

Ko te tātaritanga - What this tells us:

Flu coverage is a practical, winnable uplift area for Māori kaumātua especially through pharmacy + community pop-ups and transport-enabled access.

Whakamātautau kohura - Screening (coverage)

- **Bowel (60–74):** Māori **199/279 (71.3%)** vs non-Māori **369/549 (67.2%)**
- **Cervical (25–69):** Māori **312/452 (69.0%)** vs non-Māori **401/589 (68.1%)**
- **Breast 45–69):** Māori **192/280 (68.6%)** vs non-Māori **281/429 (65.5%)**

Ko te tātaritanga - What this tells us:

Thames has a strong platform for screening. Māori participation is **at least comparable** to non-Māori in this enrolled dataset. The system priority should be to **protect and stabilise** this performance through navigation, transport supports, and culturally safe delivery.

2) E auau ana te Momi me te Momirehu | Smoking/Vaping prevalence

- **Smoking/vaping prevalence (15+):** Māori **482/1304 (37.0%)** vs non-Māori **315/1270 (24.8%).**

Ko te tātaritanga - What this tells us:

Smoking/vaping remains a key driver of inequity and future hospital demand, especially when paired with COPD, CVD risk, and housing-related respiratory triggers.

3) Mate tauroa | Long-term conditions

Higher Māori prevalence (priority conditions)

- **COPD (40+):** Māori **107/756 (14.2%)** vs non-Māori **153/1402 (10.9%)**
- **Diabetes (30+):** Māori **135/940 (14.4%)** vs non-Māori **171/1648 (10.4%)**
- **Gout (30+ males):** Māori **89/435 (20.5%)** vs non-Māori **91/779 (11.7%)**

Comparable / mixed

- **Asthma (all ages):** Māori 101/1803 (5.6%) vs non-Māori 114/2193 (5.2%)
- **Ischaemic CVD (40+):** Māori **194/756 (25.7%)** vs non-Māori **407/1402 (29.0%)**
- **Serious mental health (all ages):** Māori **78/1803 (4.3%)** vs non-Māori **100/2193 (4.6%)**
- **Pre-diabetes:** Māori **156/1803 (8.7%)** vs non-Māori **173/2193 (7.9%)**

Ko te tātaritanga - What this tells us:

Thames prevention must actively wrap around COPD, diabetes, and gout because these are the conditions most sensitive to: warm housing, medication access, kai ora support, and continuity of care.

4) Te whakahaere o ngā mate tauroa | Long-term condition management

- **Diabetes control (HbA1c ≤53, Type 2 diabetes cohort):** Māori **62/124 (50.0%)** vs non-Māori **81/133 (60.9%)**
- **Cardiovascular risk assessments (eligible cohort):** Māori **381/760 (50.1%)** vs non-Māori **479/878 (54.6%)**

Care quality signals

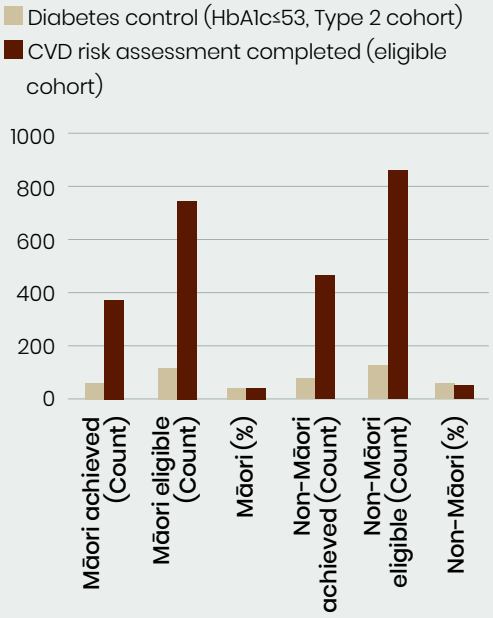


Fig 13. Completion of key preventive/chronic care measures, Māori and non-Māori, Thames cohort

Ko te tātaritanga - What this tells us:

The opportunity is not only diagnosis, it's **structured follow-up**. Lifting CVDRA and diabetes control requires longer appointments, planned recall, and navigator support to complete labs and reviews.

5) Te tiaki mamae tārū, ā-hōhipera hoki | Acute & hospital care

Childhood ASH (0–4) — signals of avoidable admissions

Avoidable childhood admissions

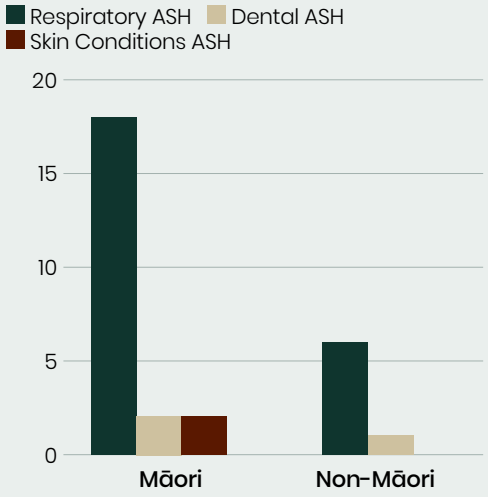


Fig 14. Avoidable childhood admissions (ASH) in 0–4 cohort (counts), Thames enrolled cohort

- **Diabetes control (HbA1c ≤53, Type 2 diabetes cohort):** Māori **62/124 (50.0%)** vs non-Māori **81/133 (60.9%)**
- **Cardiovascular risk assessments (eligible cohort):** Māori **381/760 (50.1%)** vs non-Māori **479/878 (54.6%)**

Ko te tātaritanga - What this tells us:

Tamariki ASH especially respiratory strongly supports investing in warm, dry homes and proactive paediatric respiratory pathways, alongside access and cost relief.

Ngā tataunga o te Taiwhanga Ohotata - Emergency Department presentations (all ages)

ED presentations (all ages)

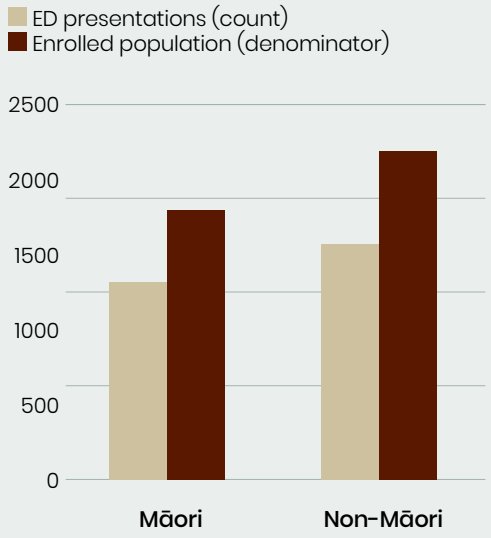


Fig 15. Emergency Department presentations (counts) and enrolled denominators, Thames cohort

- Māori **1330** presentations (denominator 1803) vs non-Māori **1568** (denominator 2193).

Ko te tātaritanga - What this tells us:

ED demand is high for both groups; reducing avoidable demand requires strengthened fast-track pathways, after-hours navigation, and community respiratory/LTC management.

Ngā Kāhua Hōhipera - Hospital activity profiles (all ages)

Hospital volumes and bed-days show substantial demand across injury/poisoning, respiratory, digestive, pregnancy/childbirth, circulatory and neoplasm categories, and these patterns vary by ethnicity.

Ko te tātaritanga - What this tells us:

Injury and respiratory volumes remain key pressure points; prevention must include housing, smoking cessation, and accessible primary care review cycles.

6) Ngā Tāpui Mātanga | First Specialist Appointment (FSA) activity

Across **all facilities** (1 July 2024–30 June 2025), Māori and non-Māori FSA activity is concentrated in dental surgery, allied health, orthopaedics, nursing, maternity, ophthalmology, cardiology, gynaecology, oncology, and general surgery.

A second view: **Thames-only FSAs** shows Thames hospital's local specialist activity notably in allied health, orthopaedics, maternity, cardiology, ophthalmology, and general surgery.

Ko te tātaritanga - What this tells us:

Thames services are functioning as a local anchor, but to reduce escalation to specialist and acute pathways, primary care needs the resourcing to do planned LTC reviews, smoking cessation, and transport-enabled preventive completion.

He kāhua Mahinga Hauora - Practice Lens | PHO Māori cohort snapshot (Thames Medical Centre)

The PHO snapshot adds a 'frontline coding lens' on Māori health need within a practice context:

- **Māori diabetes (count):** 74, with most cases in **45–64 (38)** and **65+ (27).**
- **Pre-diabetes range HbA1c 41–49 (count): 69,** concentrated from 25–44 upward.
- **Asthma (count): 197**, with notable representation in 14–24 and 25–44.
- **Gout (count): 61**, concentrated in 45–64 and 65+.
- **Primary mental health referrals (ever): 130**, with most referrals in 14–24, 25–44 and 45–64.
- **Flu vaccination (65+): 89 (51.4%)** in the Māori cohort reported
- **Smoking status:** The PHO notes Māori smoking prevalence/status overall **27%** (with age-group variation shown), and very low recorded smoking cessation referral counts due to suppression (<7).

Important note on interpretation: The PHO table includes suppression rules ('<7') and may reflect only the practice's Māori cohort rather than the entire Thames enrolled population.

Ko te tātaritanga - What this tells us:

Ko te tātaritanga - What this tells us: The practice-level view reinforces the midlife-to-older concentration of diabetes/gout and the significant primary mental health need supporting integrated, planned long-term condition and mental health models with navigators and longer appointment slots.

Ngā Māramatanga ā-Hauora me te Hoahoa pūnaha | Clinical insights & system design

Thames hauora services manage **dual demand** - ongoing resident need (LTC/kaumātua) alongside episodic surges (including paediatric acuity). Thames strength is its functioning **fast-track low acuity stream** linking hospital and primary care providers.

This report strengthens that narrative with data:

- Childhood respiratory ASH is visible (0–4 cohort), supporting targeted prevention and warm housing responses.
- Smoking/vaping is significantly higher for Māori, aligning with COPD/diabetes inequities and reinforcing the need for integrated cessation pathways.
- Diabetes control and CVD risk assessment completion are not yet where they need to be for either group—meaning planned recall and care completion are the practical levers.

Ko te tātaritanga - What this tells us:

Thames needs **stability and scale** for what is already proven: prevention hubs, navigator-led pathways, and integrated fast-track models.

Te Hautū Hōhipera me te Tiaki Pūnaha | Hospital Leadership and System Stewardship

Te Tiaki Pūnaha me te mahi a te Hōhipera o Kauaeranga | System Stewardship and the Role of Thames Hospital

The data and lived experience in this report point to an important opportunity: Thames Hospital's leadership role is most powerful when it acts not only as an acute provider, but as a system steward for the locality.

The hospital already functions as the clinical anchor for a geographically dispersed and demographically complex population. Its influence extends beyond inpatient care into:

- specialist access,
- diagnostics,
- outpatient coordination,
- and system flow across primary, community, and kaupapa Māori providers.

Ko te tātaritanga - What this tells us:

Hospital leadership in Thames is not primarily about absorbing demand, it is about shaping how demand is prevented, redirected, and supported earlier.

Kia Taurite ngā wāhanga Tārū, Aukati, me te Whai Wāhi | System Stewardship and the Role of Thames Hospital

This report shows that preventative care and community-based screening are working, particularly when they are:

- culturally safe,
- low-barrier,
- and embedded in trusted local pathways.

Strong screening uptake among Māori whānau demonstrates that when access is easy and equity-led, engagement follows. These gains represent system assets that should be protected.

As the hospital and locality partners consider future configuration of outpatient and diagnostic services, the data suggests a key principle:

Any reconfiguration should strengthen not dilute the accessibility and trust that underpin current prevention success.

Ko Ngā Mātāpono Hei Ārahi i Ngā Ratonga ā mua | Guiding Principles for Future Service Configuration

Rather than prescribing specific relocations or models, this report proposes shared principles to guide local decision-making:

- Protect low-barrier access to screening and diagnostics, particularly for Māori, kaumātua, and rurally dispersed whānau.
- Strengthen outpatient and ambulatory care capacity at the hospital level to reduce escalation into acute pathways.
- Ensure primary and kaupapa Māori services remain closely connected to diagnostics and specialist advice, even when delivered from different physical sites.
- Test all service changes against equity impact, ask: **"Will this make it easier, or harder for whānau to complete care?"**

Ko te tātaritanga - What this tells us:

Thames integrated care requires:

- Strong community-based prevention,
- A well-resourced outpatient and diagnostic backbone,
- And hospital leadership that holds the whole system together.

Seen this way, hospital leadership is not diminished by prevention success, **it is strengthened by it.**

Ngā Whakaaro Whakamutunga - Final Reflections

The picture that emerges from Thames is one of a locality with real capability not just in data, but in people, relationships, and models of care that already work. The foundations are strong: screening coverage for Māori is holding steady, prevention hubs like Pito Hauora are reducing stigma and extending reach, and providers across the rohe are demonstrating what high-trust, integrated care can look like in practice. These are not abstract strengths; they are lived, proven examples of what happens when services are designed with whānau, not just for them.

At the same time, the clinical priorities are becoming unmistakably clear. COPD, diabetes, gout, smoking, flu protection, and childhood respiratory ASH consistently surface as the areas where focused, collective effort will make the greatest difference. These priorities reflect both the data and the lived realities of whānau, and they point toward a system that must be proactive, connected, and grounded in prevention.

The guiding principles for future service configuration reinforce this direction. Protecting low-barrier access, strengthening outpatient and ambulatory care, keeping primary and kaupapa Māori services closely linked to diagnostics, and testing every change against its equity impact are not constraints, but commitments. They ensure that as the system evolves, it does so in a way that makes care easier to complete, not harder.

Taken together, these insights tell a clear story about what integrated care in Thames requires: strong community-based prevention, a reliable and well-resourced outpatient and diagnostic backbone, and hospital leadership that sees itself as the steward of the whole system, not just the acute end of it. In this view, prevention does not diminish the role of the hospital; it strengthens it by ensuring that care is timely, coordinated, and anchored in the needs of the community.

This reflection closes with a simple truth: Thames already has many of the ingredients for a high-performing, equitable local system. The task ahead is to protect what works, focus where the need is greatest, and continue building a system where every part, from marae-based clinics to specialist services, moves with the same purpose.

Supporting whānau to live well, stay well, and complete their care with dignity and ease.

Whakakōpani - Mai i te maunga ki te moana e hora nei, e kiia nei ko Hauraki te rohe, Marutūahu te tangata, ko te tini ngerongero ka hao ake e te kupenga o Hauora Kauaeranga, tēnā tātou katoa.

Āpitihanga | Ngā Puna me nga Pitopito Kōrero |

Data sources & notes

Quantitative

- Thames datasets (enrolment, immunisation, screening, flu, smoking/vaping, LTC prevalence, LTC management, acute/hospital activity, ED, and FSA), as provided.
  - Pinnacle PHO
  - Hauraki PHO
  - oHealth New Zealand, Te Whatu Ora

Qualitative

Strategic connections have been made to support streamlined data gathering.

- In person interviews completed with key stakeholders including CEOs of Te Korowai Hauora o Hauraki and Hauraki PHO, Te Whatu Ora leadership and mana whenua
- Regular hui and exploration hui with Te Whatu Ora and Hauraki PHO data scientists/analysts to support both overall and Paeroa and Thames reports.
- Contextual inquiry/informal kōrero: Proactive participant observation at key forums (e.g., community events, service presentations, Ministerial visits) to capture the current political realities, community sentiment, and nuanced lived experience to support literature and interviews.

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Te Whakamāoritanga me ngā Whakatūpato - Interpretation cautions

- Several prevention indicators (e.g., immunisation milestone cohorts) have very small denominators in the dataset, so percentages should be treated as directional only.
- PHO practice snapshot uses suppression for small counts ('<7') and reflects a subset practice view; it complements but does not replace the whole-of-enrolled picture.

He Tūtohi Raraunga me ngā Puna Kōrero - Data Tables and Sources

Selected datasets were sourced from Stats NZ, Whaitua, PHO enrolment and condition prevalence, and other relevant sources. The tables within this report provide the quantitative foundation for the trends and signals discussed in the main sections.

The main report focuses on interpretation and implications rather than reproducing full datasets.

Ngā Tepenga Raraunga me Te Whakamāoritanga | Data Limitations and Interpretation

The data referenced in this report comes from multiple sources, including PHO datasets, national surveys, and regional indicators. These sources are not always aligned in definitions, classifications, or reporting practices. Apparent differences

between datasets may therefore reflect methodological variation rather than actual differences in service delivery or population need.

In some cases, small numbers and aggregation methods limit the reliability of conclusions, particularly at the local or sub-population level. Certain datasets also lack sufficient transparency to allow full interrogation of assumptions or data handling processes. Where town-level data is unavailable or suppressed for privacy reasons, regional data has been used for context only.

Accordingly, while the data provides useful directional insights, it should not be relied upon in isolation for definitive decision-making. Interpretation requires caution, contextual knowledge, and triangulation with qualitative evidence, including Whānau Voice.

Te Pūtake me Te Whakamahinga o Ngā Raraunga – Purpose and Use of Data

This report brings together Whānau Voice and a selection of health system data to understand access and system pressures in Thames. The information presented is intended to support shared understanding and informed discussion, not to judge individuals, assess provider performance, or claim precise local prevalence.

- **Contextual data:** Some data in this report is regional rather than town-specific. It is included to provide context where local data is limited or suppressed, and to support understanding of system patterns.
- **Integrated perspective:** By combining local service data, regional indicators, and Whānau Voice, the report aims to illuminate pressures and access patterns without attributing causality or assessing individual behaviour.
- **Kaupapa-aligned approach:** Whānau Voice is central to understanding system pressures. Data is used to support learning and shared understanding, not to define communities, measure individual behaviour, or evaluate service effort.

Tepenga - Limitations

This report has the following limitations:

- Reliance on secondary data sources
- Limited Māori-specific town-level data for some health indicators
- Absence of service-level performance analysis
- Absence of cost, funding, or workforce modelling

These limitations are consistent with the purpose of the report, which is to support system sense-making rather than programme evaluation.

The information within this report is subject to what was sourced at the time of drafting it noting that services change.

Ngā uiui e pā ana ki ngā raraunga, tukua ki - Enquiries about data can be made here:

Whakapā mai | Contact us - Te Tiratū Iwi Māori Partnership Board

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