The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Tēnā koe Stephanie

Te Whatu Ora – Proposed National Model for Integrated Adult Palliative Care

About us
The Royal New Zealand College of General Practitioners (the College) is Aotearoa New Zealand's largest medical college, representing 6,018 specialist General Practitioners (GPs). Through its General Practice Education Programme (GPEP) and Rural Hospital Medicine Training Programme (RHMTP), the College trains the specialist GP and Rural Hospital Doctor workforce. Accredited by the Medical Council of New Zealand, the College delivers a Vocationally Registered workforce via its Continuing Professional Development Programme, which accounts for 40 percent of the country's specialist medical workforce.

The College is committed to reducing health inequities experienced by Māori, honouring Te Tiriti o Waitangi, and upholding the rights of Māori. To support this commitment, we prioritise initiatives that build cultural safety capability among our members through targeted training, professional development and quality improvement, programmes.

General practices are the first point of contact for medical care in the community. Specialist GPs and clinical teams manage 90 percent of all patient healthcare concerns in the community. Last year, 1085 general practice teams working across Aotearoa recorded 24 million patient contacts in general practice.

The Proposed National Model for Integrated Adult Palliative Care

The College welcomes the proposed National Model for Integrated Adult Palliative Care as a vital step toward a national strategy that supports high-quality end-of-life care. We believe all individuals, regardless of where they live, should have access to culturally safe and compassionate care at the end of life, and be supported to navigate services across the broader health and community system.

Despite the excellent quality of palliative care available in New Zealand, access remains uneven and complex for patients. Specialist GPs, general practice teams, community services, and whānau play a critical role in delivering palliative care in community settings, and emerging models of care in general practice have seen local models develop in response to needs. Practice experience highlights the need for greater access to resources and training to support delivery of culturally safe, community-based palliative services that respect the wishes of patients and their whānau and ensure continuity of care.

Pressures arising from rapidly growing and diverse populations are impacting on the ability to deliver consistent, accessible, and culturally safe palliative care across all regions. Without adequate investment in primary and community-based services, more patients will die in public hospital settings, using precious acute beds, due to under-resourced community services. Patients receiving palliative care in a hospital setting results in increased costs and puts additional strain on the health system. [a]

[a] P. 36 Te Whatu Ora – Proposed National Model for Integrated Adult Palliative Care in Aotearoa New Zealand.

Summary and final recommendations

The College acknowledges the thoughtful and considered approach taken in developing the proposed National Model for Integrated Adult Palliative Care. It reflects a genuine effort to respond to the evolving needs of New Zealanders and the lessons learned from recent challenges. However, to ensure the model delivers on its promise of equitable and high-quality care, further action is required, particularly in resourcing and implementation.

We strongly advocate for a centrally funded palliative care system that is fair and accessible to all, regardless of geographic location. Funding must be consistent across regions to avoid disparities in service delivery. Additionally, the system must prioritise the training of more palliative care specialists and ensure general practitioners are adequately supported with the resources, guidance, and infrastructure needed to deliver this care effectively.

To strengthen the model, the College recommends the following actions (*See appendix 1*):

- **Embed ethical care as a guiding principle**, ensuring that financial incentives do not compromise patient choice or care quality.
- **Guarantee 24/7 access to palliative care nationwide**, recognising the importance of timely, continuous support for patients and their whānau.
- **Modernise funding mechanisms** to reflect the true costs of care, including professional time, travel, and interdisciplinary collaboration.
- **Promote integrated care** by fostering collaboration across community-based services, specialist teams, and aged care providers.
- **IT systems** must support easy, efficient and timely collaboration.
- **Address regional and cultural disparities**, ensuring that all communities, urban, rural, Māori, and culturally diverse populations, receive responsive and appropriate care.
- **Engage rural communities and specialist Rural GPs** to better understand and respond to the unique challenges posed by geographic isolation and resource limitations.
- **Recognise and support the role of hospices and retirement villages**, which are increasingly central to palliative care and end-of-life care, and must be reflected in the national framework.
- **Review and rebalance funding disparities** between assisted dying and palliative care to uphold the principle of equity and avoid unintended incentives.

The College remains committed to working alongside stakeholders to support a national strategy that delivers compassionate, ethical, and equitable palliative care for all New Zealanders and their whānau.

For further clarification, please contact Maureen Gillon, Manager - Policy, Advocacy and Insights. maureen.gillon@rnzcgp.org.nz.

Nāku noa, nā

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Appendix 1

In response to your questions:

1. Thinking about the core components for primary palliative care:

4. What do you think is good about these core components?

Strengths of the proposed core components
The College supports the shift from specialist hospital-based care to primary and community-based palliative care for individuals with uncomplicated needs. This transition is essential to building a sustainable system capable of meeting the projected rise in demand for palliative and end-of-life care over the next 10 to 20 years.

Equity and ethical care
We commend the inclusion of equity as a guiding principle and welcome the establishment of the Equity Working Group to ensure it remains central to decisions. Prioritising equitable access to palliative care is vital to addressing disparities and ensuring services reach all communities.

We also recommend adding a guiding principle of ethical care. This would help safeguard against financial incentives that may favour assisted dying over palliative care. It should address the current funding imbalance, where palliative care teams receive significantly lower remuneration than those facilitating assisted dying.[b]

5. What part(s) need improvement?

- **Access and availability**
  Specialist GPs play a critical role in providing continuity of care, especially in community settings. However, 24/7 palliative care is not consistently available nationwide. Existing funding models are outdated and fail to adequately support professional time, travel, and urgent, unplanned care. [1]

- **Interdisciplinary collaboration**
  New models of care must prioritise integration across disciplines to ensure continuity, quality, and culturally safe care. An integrated system is needed to support and deliver culturally safe care that respects patient preferences and provides access to appropriate resources.

- **Equity and regional disparities**
  There are significant disparities in access and outcomes across regions, between urban and rural areas, and among different population groups. Key concerns include:

  - **Aged care**: Barriers to specialist palliative care are compounded by the ageing population, raising concerns about future capacity and capability.
  - **Māori health needs**: While referral times are similar for Māori and Pākehā, Māori often require more intensive palliative care due to existing health inequities.
  - **Rural patients**: Earlier referrals and higher medical input reflect greater needs and highlight opportunities to improve urban responses.
  - **Needs of culturally diverse populations**: Traditional models often fail to meet the cultural needs of Asian, Middle Eastern, Latin American, African and other cultural communities.[2]

  More work is needed to understand workforce requirements and reduce disparities in access, cultural responsiveness, and patient experience. [3] These inequities place significant and compounding pressure on general practice teams and services.

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[b] Minimum EOL funding (including travel): $3,080.40, PHO-funded palliative care (including travel): $517.50
Source: Te Whatu Ora Assisted Dying Service Funding

6. Overall, how satisfied are you with these proposed core components?

The College is broadly satisfied with the proposed core components of community-based care and acknowledges several positive changes and adaptations that reflect evolving needs and lessons learned in general practices. We strongly support the move to invest in a primary and community-focused model of palliative care, with culturally safe services delivered in patients' homes wherever possible. This approach must be enhanced by the active involvement of family and whānau, promoting comfort, dignity, and personalised care at the end of life.

- **Remote/ in-home consultations**
  The pandemic accelerated the adoption of virtual consultations and remote care. These technologies continue to enhance communication, may reduce the need for in-person visits where appropriate, and improve accessibility and flexibility for patients and providers. The shift to remote assessments has also led to widespread upskilling of specialist GPs, nurses and other health professionals, particularly in aged care. This has strengthened clinical decision-making and assessment capabilities for palliative care and end-of-life care.

- **Cultural appropriateness and cultural safety**
  Services must be culturally appropriate and culturally safe, encompass the full spectrum of patient needs; physical, psychosocial, spiritual, and cultural, while also supporting families throughout the illness journey and into bereavement. Care must recognise and respond to the distinct needs of diverse cultural communities, especially Māori, to safeguard equitable access and outcomes. We acknowledge the guiding principles developed by the Equity Working Group. [c]

- **Culturally informed care**
  Māori communities responded to the pandemic integrating Te Ao Māori principles to develop effective wrap-around care. This enduring, community-centred model highlights the importance of culturally grounded approaches. We are pleased to see that the framework incorporates the need for specific services to meet the needs of Māori and whānau.

2. Thinking about the core components for specialist palliative care

7. What do you think is good about these core components?

The College strongly supports the emphasis on integration and collaboration as key enablers of the proposed national model. The general practice experience of COVID-19 fostered stronger collaboration across the health system, including hospice, general practices, aged care facilities and Primary Health Organisations. This has led to changing models of care that highlight the need for improved integration to coordinate continuity of patient care.

- **Integration support**
  General practitioners are specialists within the scope of general practice[d], and the College strongly advocates for their inclusion in the specialist palliative care section of the framework.

  Specialist palliative care teams play a critical role in managing complex cases, offering expert guidance and ensuring patients receive high-quality, individualised care. Their work spans the health system, contributing essential expertise across settings.

- **IT systems must support easy, efficient and timely collaboration**
  To improve patient experiences, it is vital that improved IT systems are developed to support integration between specialist palliative care teams, hospital-based specialists, and specialist GPs. This would enhance continuity of care and allow patients to remain in familiar, supportive environments.

[c] The National Palliative Care Equity Working Group.
[d] Medical Council of New Zealand.

8. What part(s) of these core components need improvement?

While the core components are promising, access to specialist palliative care remains inconsistent, particularly in rural and underserved communities. Investment in integration, outreach services and access to telehealth are essential to bridge these gaps.

- **Sustainable funding models**
  Funding must reflect the complexity and time-intensive nature of specialist palliative care. Current models do not compensate adequately for travel, after-hours care, and interdisciplinary collaboration. Additionally, ongoing training opportunities are essential to maintain clinical governance capability, uphold standards of excellence, and shape emerging models of palliative care.

- **Collaboration and integration with Aged Care and Retirement Village sectors**
  Specialist services need stronger integration with aged residential care and retirement villages, which are increasingly central to palliative care and end-of-life care delivery.

- **Support for bereavement Services**
  Specialist teams should be resourced to provide ongoing support for families following a patient's death, recognising the emotional and psychological impact of bereavement.

9. Overall, how satisfied are you with these proposed core components for specialist palliative care?

The College is cautiously optimistic about the proposed components for specialist palliative care. They reflect a thoughtful and inclusive approach to service delivery, but success will depend on:

- Investment in an equitable funding model that addresses regional disparities and workforce needs.
- Integration with across the hospital, secondary, general practice, primary and community interfaces.
- Commitment to cultural safety and cultural responsiveness.
- Embedding learning and development opportunities in palliative care and end-of-life care.

Continued engagement with all key groups is essential to ensure these components are integrated and implemented effectively to support compassionate, high-quality palliative care and end-of-life care.

3. Overall model

10. Overall, what do you think is good about the proposed National Model for Integrated Adult Palliative Care?

The College supports the intent and direction of the proposed National Model. We welcome its emphasis on equity, integration, and the development of clearly defined components that aim to ensure palliative care is valued and appropriately resourced across Aotearoa New Zealand.

- We commend the model's recognition of the increasing demand for palliative care and its strategic shift from specialist hospital services to primary care for uncomplicated needs. This is a logical and necessary evolution, particularly in rural communities, where primary care teams have already taken on this role, often without specialist support.

- We are concerned about the term "rural deprived populations," which conflates two distinct challenges. While deprivation creates barriers to care, rurality introduces unique logistical, financial, and workforce constraints. It is unclear whether rural representation was included in the model's development, and strongly recommend that rural voices, including a specialist Rural GP, be actively engaged in future planning.

- At present, the model lacks clarity on how primary care will be supported to assume this central role. We urge the committee to prioritise resolving equity issues in rural palliative care and use these insights to inform broader urban planning.

11. Overall, what do you think needs improvement?

There must be a deeper understanding of the critical role specialist GPs play in ensuring continuity of care. Without this recognition, the system also risks placing unsustainable pressure on primary care providers in the system.

- **24/7 care**
  A key barrier to delivering 24/7 palliative care is the lack of consultation with specialist GPs and insufficient funding. As services shift toward primary care, there is an expectation that specialist GPs will assume greater responsibility. However, this overlooks the realities of general practice and the significant amount of 'invisible work' involved in providing continuity of care[4], to facilitate and support palliative care. [5]

- **Funding inequity between palliative care and end-of-life care**
  There is a significant disparity in funding between assisted dying and palliative care. Under current arrangements, a doctor may receive up to six times more funding to facilitate assisted dying than to provide palliative support.

  It is ethically problematic to financially incentivise ending a person's life over supporting them through high-quality palliative care. Both services require compassion, skill, and time. Funding arrangements should reflect this parity, ensuring that no form of care is privileged over another due to financial considerations.

  The College proposes that the inclusion of ethical care is included as an additional guiding principle as this funding approach creates disparities, risks creating unintended incentives, undermines the principles of equitable care and fairness, and creates regional variation and inequity.

- **Integration with aged care, retirement villages and bereavement services**
  The proposed national model must be better integrated with aged residential care and retirement villages, which are increasingly central to end-of-life care delivery.

- **Support for bereavement care**
  Specialist teams should be trained and resourced to recognise the emotional and psychological impact of loss to support families after a patient's death.

- **Hospice care**
  Hospice services are notably absent from the proposed model. Many specialist GPs provide care in hospice settings, which are under increasing strain due to rising demand and inadequate funding. Our members report that recent service cuts have led to patients being admitted to hospital. These admissions occupy acute beds and drive up health system costs.

- **Retirement villages**
  Retirement villages are an emerging consideration for the model due to the expanding role of retirement villages in end-of-life care. As of 2025, over 53,000 people aged 60+ reside in retirement villages, with numbers growing by 130 on a weekly basis.[6] Around 65% of registered villages offer aged residential care, yet approximately 20 percent of residents do not have health insurance. [7]

- **Supporting rural and on-call services**
  As Te Whatu Ora develops Enhanced Primary and Community Care funding arrangements, it is essential that these frameworks recognise additional acknowledge the time, cost, and emotional toll of after-hours palliative care incurred by rural providers, e.g., time, cost and emotional toll of 24/7 unscheduled care, and travel.

12. How satisfied are you with this as a future model?

The College is cautiously optimistic about the proposed model. While its intent is commendable, its success will depend on meaningful investment, inclusive planning, and a commitment to ethical and equitable care. We urge Te Whatu Ora to address the gaps identified and ensure that implementation is guided by the lived realities of those delivering and receiving palliative care.

References

1 D'Souza C. Palliative care in Zealand is critically ill. The Royal New Zealand College of General Practitioners. Available at: https://www.rnzcgp.org.nz/news/clinical/palliative-care-in-new-zealand-is-critically-ill/

2 Shah S, Ameratunga S, Peiris-John R, Ramalho R, Moeke-Maxwell T, Wolffram P. Dying well in Aotearoa New Zealand for ethnic minority communities: a time for reclamation? NZMJ.2024 Jul 5; 137(1598). ISSN 1175-8716 https://www.nzmj.org.nz/

3 Stevenson R, Ferguson L. Examining ethnic and geographic disparities in end-of-life care pathways and community specialist palliative care engagement: insights from the Waikato Region. N Z Med J. 2025 Aug 15;138(1620):54-64. doi: 10.26635/6965.6711. PMID: 40811844.

4 Wood P. The Heart of Healthcare: Renewing New Zealand's Primary Care System. 2025. https://www.rnzcgp.org.nz/news/college/gps-want-patients-to-be-seen-heard-and-known/

5 The Royal New Zealand College of General Practitioners. Your Work Counts Project. https://www.rnzcgp.org.nz/resources/advocacy/your-work-counts/

6 The Retirement Villages Association of New Zealand. Source – accessed 10.10.25.

7 Office of the Auditor General NZ. Indicator 27: Medical insurance. https://oag.parliament.nz/2013/ageing/our-ageing-population-indicators/indicator-27