In Confidence

Office of the Minister of Health

Cabinet Social Outcomes Committee

Primary health care funding improvements

Proposal

1 This paper outlines my proposal to reweight the capitation funding formula to ensure primary health care services can better deliver timely access to quality care for New Zealanders. In the medium term, I also intend to work towards consolidating primary care affordability subsidies to ensure they reach and support people who need them most.

2 A companion paper, *Update on primary health care strategic priorities*, sets out my broader vision for the strategic direction of primary care.

Relation to government priorities

3 Transforming primary care aligns with the expectations and priority areas set out in the Government Policy Statement on Health 2024 -2027. Improving access to primary care will contribute to progress on health and mental health targets, particularly reducing pressure on emergency departments, access to specialists, and achieving immunisation milestones.

Executive Summary

4 Primary care is a critical part of how the health system helps to keep people well and how patients access the care that they need. My vision for primary care is that all New Zealanders have timely access to the care they need from primary care providers, to keep themselves healthy and to strengthen the overall responsiveness and sustainability of the health system.

5 A well-functioning, accessible primary care system will take the pressure off the wider health system. The key objectives I am focussed on are improving access for patients, comprehensive services that deliver more in the community, continuity of care, and coordinated care to actively support delivery of the Government's Health Targets.

6 New Zealand has a blended funding model for primary care, based on capitation funding for providers combined with co-payments from individuals and other targeted funding streams (for example, for immunisation). This blended model is an effective general funding approach for primary care. However, there are opportunities to improve the specific design of the current model through better targeting clinical need and complex care requirements, incentivising integrated models of care and prevention, and ensuring that subsidies to help people access low-cost primary care are targeted effectively.

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7 As a key step towards achieving my vision for primary care, Cabinet agreed in March 2025 to a package of near-term initiatives to improve access to primary care and boost the primary care workforce [CAB-25-MIN-0045 refers]. Work is well underway on implementing the immediate actions in the Primary Care Tactical Action Plan.

8 I am now progressing further work that builds on the Tactical Action Plan by considering fundamental primary care system settings. As part of this further work, I am asking Cabinet to:

8.1 agree reweighting of the capitation funding formula, which is the main government funding source for primary care. The majority of practices will be better off, through the addition of other existing primary care funding streams into capitation alongside recent additional Government investment into primary care (i.e. there is an increase in total capitation funding)

8.2 note that I will announce capitation reweighting in late July, with implementation from 1 July 2026, subject to Primary Health Organisation Service Agreement negotiations

8.3 s 9(2)(f)(iv)

Background

9 Primary care is critical to enabling all New Zealanders to have timely access to the healthcare they need. My key objectives to achieve this vision are:

9.1 improved access for patients

9.2 comprehensive services that deliver more in the community

9.3 continuity of care

9.4 coordinated care to actively support delivery of the Government's Health Targets.

10 In March 2025 we agreed to a suite of interventions to improve access to primary care and boost the primary care workforce, through the Primary Care Tactical Action Plan [CAB-25-MIN-0045]. These interventions form part of a wider suite of measures in my Health Delivery Plan [CAB-25-MIN-0046 refers], which focus on delivering more and better health services for New Zealanders in the context of significant challenges for the health system.

11 Alongside the Tactical Action Plan, I am also progressing improvements to the underpinning system settings for primary care, with a focus on strengthening accountability, and aligning funding and incentives.

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Improving primary care funding

12 Similar to a number of other OECD countries, New Zealand has a blended funding model for primary care, based on capitation funding for providers combined with co-payments from individuals and other targeted funding streams (for example, for immunisation). This blended model is an effective general funding approach for primary care.

13 However, there are opportunities to improve the specific design of the current model. The current structure of primary care funding is complicated, with a number of different funding streams, and does not incentivise a focus on the right outcomes. There is poor visibility of what funding is buying and the difference it makes for patients.

Reweighting the capitation formula to more closely match the distribution of health need across general practices

14 Most primary care services in New Zealand are funded via capitation. Capitation is a per-person annual payment designed to give providers flexibility to meet the needs of their enrolled patients in the best way. Funding is weighted based on people's characteristics (currently age and sex) that affect use of primary care services, as a proxy for health need.

15 Capitation funding for general practice services was introduced in 2002 and totalled $915.7 million in 2024/25. The funding formula was developed based on patterns of service use from the late 1990s. Since then we have seen demographic change with increasing comorbidity, an increase in available treatment and a move to provide more complex long term condition management in the community.

16 The formula has not been significantly revised since its introduction, although various ad hoc changes have been introduced to compensate for weaknesses and to reduce costs for some service users. These changes have complicated the funding model and means we are using a blunt instrument that does not fund based on health need. There has been consistent feedback from the general practice sector over a long period of time about the need to adjust the formula to better address health need and costs of delivering care, and several reports have highlighted its weaknesses and potential improvements.

17 The reweighted capitation formula I am proposing is based on service use data from over 2 million patients across 18 Primary Health Organisations in 2023. The proposed reweighted formula better reflects the impact of age, particularly for very young and very elderly patients, and adds the factors of socio-economic deprivation, multimorbidity, and rural/remote locations, which have an evidence-based effect on health outcomes and expected service use patterns.

18 Reweighting will more effectively distribute funding based on health needs. Across general practices, those with an enrolled population who have higher needs will receive more funding to care for those patients. Practices will continue to use capitation funding as a flexible pool to provide the most appropriate care across all their enrolled patients, from a range of healthcare practitioners.

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19 Reweighting will need to be negotiated with the sector to apply from 1 July 2026, and will be implemented within the primary care funding currently available.

20 I am seeking Cabinet agreement to reweight capitation by adding the following new variables to the first contact capitation formula:

20.1 *Multimorbidity* – individuals with multiple health conditions need additional clinical care to prevent disease onset, manage existing conditions, and avoid complications

20.2 *Rurality* – people in rural communities require additional clinical care from general practice teams due to limited access to other healthcare options

20.3 *Socio-economic deprivation* – people in deprived areas need extra clinical care due to the impact of socioeconomic factors and limited access to healthcare.

21 In addition, I am seeking agreement that:

21.1 *Sex (male/female)* remain as a variable – women need more frequent health screenings and reproductive health services

21.2 *Age* – bands are changed to reflect the additional care needed during infancy and in older age.

22 s 9(2)(j)

23 The modelling above includes a 9.69% capitation increase recently agreed for all practices for 2025/26, and also includes the first year of performance-based funding (see paragraphs 27-29 below). The Government uplift for 2025/26 is a funding increase for first contact services of 6.43 percent, and a further adjustment to capitation to offset possible fee increases of $30 million, which is equivalent to an additional 3.26 percent uplift.

24 s 9(2)(j)

25 s 9(2)(f)(iv)

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s 9(2)(f)(iv)

Consolidating and simplifying primary care funding streams

26 I believe there is scope to consolidate and simplify primary care funding streams, to ensure every dollar is used optimally to support better outcomes for patients.

27 Several additional funding streams have been introduced over time to compensate for weaknesses in the capitation formula. Following engagement with a Technical Advisory Group, I am considering repurposing two of these funding streams along with the first-contact capitation funding stream to fund reweighting of the capitation formula:

27.1 *Care Plus and the linked High Use Health Card (HUHC) provider subsidy ($96.5 million in 2024/25)* – this funding stream was added as the capitation formula did not account for high use of services or respond to complex care needs. Currently there are approximately 6000 holders of HUHC, which provides a higher capitation rate for providers. Since 2007 there has been no entitlement to a lower patient co-payment for HUHC holders, although some practices may have chosen to grandparent this entitlement. Removal of the HUHC provider subsidy is therefore not expected to impact co-payments for patients with a HUHC as these co-payments are set at the discretion of the practice. The reweighted capitation formula will automatically result in a higher capitation rate in respect of these patients with high needs. This will reduce administrative costs for providers, who currently have to apply for the HUHC on behalf of a patient. At this point I am not considering completely removing HUHC, which is under the same Health Entitlement Card Regulations as the Community Services Card. s 9(2)(f)(iv)

27.2 *Patient Access Subsidy ($1.3 million in 2024/25)* – this funding stream was introduced in 2014 to cover limited situations where a VLCA practice merged with a non-VLCA practice and was no longer eligible for VLCA status. It is paid to on a discretionary basis to 11 facilities. It provides some flexibility for the practice to apply the subsidy to patients with higher needs. This funding stream is no longer necessary now that all practices can opt into the Community Services Card scheme (introduced in 2018) to provide low-income patients with lower fees.

28 In developing the capitation reweighting proposal, Health New Zealand established a Technical Advisory Group comprised of sector representatives, to ensure the proposals reflected operational considerations from general practice, urgent care, nursing, rural health, Māori health, Pacific health, PHO leadership and management, practice management, and academia. The Technical Advisory Group generally supported the inclusion of both Care Plus and the Patient Access Subsidy in the funding pool for capitation reweighting.

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29 s 9(2)(j)

29.1 *PHO Management Services (approximately $36 million)* – this funding stream is a scaled payment based on the size of the PHO's enrolled population (with larger PHOs receiving a lower per-person amount). The Management Services funding stream is to fund the required clinical governance, relationship management, data and digital, administration, communication, governance and financial systems that enable delivery of the PHO functions.

29.2 *PHO Services to Improve Access (approximately $67 million)* – this funding stream is for PHOs to target population groups experiencing worse health status than the general population, through providing new services or improved access.

29.3 *PHO Health Promotion (approximately $14 million)* – this funding stream is for PHOs to deliver population-based initiatives such as encouraging healthy eating and physical activity that target populations who have not been reached through existing health promotional activities.

29.4 *PHO System Level Measures (approximately $27 million)* – this funding was introduced in 2016 to be used to build capacity and capability in primary care towards the achievement of six outcome measures (set out in the PHO Services Agreement).

29.5 *Rural Funding (approximately $29 million)* – this funding recognises the higher workforce and infrastructure costs faced by rural practices. It is not included in capitation reweighting because it is paid by practice.

29.6 *Immunisation (approximately $47 million)* – this funding is paid on a fee for service basis to practices for the delivery of each immunisation.

30 s 9(2)(f)(iv)

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Funding to focus on outcomes and improve the performance of general practice

31 In March 2025 I announced a range of measures designed to create a stronger focus on outcomes and improve the performance of general practice. I have outlined further details in the companion paper *Update on primary health care strategic priorities*.

32 As a first implementation step, Health New Zealand will use baseline funding to direct $95 million per annum over three years starting in 2025/26 ($285 million total) of performance-based funding into general practice, on top of the annual cost pressure adjustment to capitation.[1] The first year of this performance-based funding will focus on better data-sharing, to support the proposed primary care health target and future performance monitoring, and on childhood immunisations.

33 s 9(2)(f)(iv)

34 s 9(2)(f)(iv)

s 9(2)(f)(iv)

35 The Government is focused on making sure that patients who need to be able to access lower cost primary care are able to. I am not proposing any changes to the current affordability subsidies for patients, which reduce co-payments (Very Low-Cost Access Scheme (VLCA) and Community Services Card (CSC). I am also not proposing any changes to zero fees for under 14-year-olds.

36 s 9(2)(f)(iv)

37 The Very Low-Cost Access (VLCA) scheme and the Community Services Card (CSC) provide low-cost access to primary care for people on low incomes by subsidising and capping the co-payments practices can charge patients:

37.1 Low-cost access for Community Services Card (CSC) holders caps the maximum co-payment at $19.50 for adult card holders, regardless of where they are enrolled.

37.2 VLCA caps the maximum co-payment at $19.50 for CSC holders and $29.50 for non-CSC holders (less for under 18s). This applies to all people enrolled in a VLCA practice, irrespective of their individual circumstances and income.

38 VLCA was introduced in October 2006, to support general practices to provide lower patient fees. While any practice was eligible initially, the criteria were tightened in

[1] The $95 million is made up of $60 million to encourage improvements in data sharing, $30 million in performance-based funding for improving childhood immunisation outcomes, and $5 million to expand access to minor planned care procedures in the community.

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October 2009 to limit eligibility to general practices which had 50 percent of their population defined as being high needs,[2] and which were currently charging low fees or were prepared to reduce their fees. VLCA is a voluntary scheme, and practices can opt out at any time. As of 1 June 2024, 270 practices out of 948 (28 percent) are part of VLCA.

39 The VLCA scheme is effective for practices serving populations with high concentrations of need. However, using geographic area as the basis for targeting rather than individual patient characteristics means that some higher income patients benefit from low fees if their local practice happens to be a VLCA practice. Conversely, many lower income patients are unable to access a VLCA practice.

40 s 9(2)(f)(iv)

41

Implementation

42 s 9(2)(j)

Year one of the performance-based funding package has recently been agreed through the 2025/26 PHOSA negotiations. s 9(2)(j)

43 s 9(2)(f)(iv)

Cost-of-living Implications

44 Improvements in access to primary care and general practice performance will improve health outcomes and reduce the likelihood of costs associated with ill-health, such as reduced income.

[2] Defined as Māori, Pacific or New Zealand Deprivation Index quintile 5.

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Financial Implications

45 There are no direct financial implications of the proposal. Capitation reweighting will be funded from within the existing primary care appropriation, including through consolidation of existing funding streams. s 9(2)(f)(iv)

Legislative implications

46 The proposals in this paper do not have legislative implications.

Impact Analysis

Regulatory Impact Statement

47 Regulatory impact analysis requirements do not apply to the proposals in this paper.

Climate Implications of Policy Assessment

48 The Climate Implications of Policy Assessment (CIPA) team has been consulted and confirms that the CIPA requirements do not apply to this proposal as the threshold for significance is not met.

Population Implications

49 It is well known that some population groups experience greater issues accessing primary healthcare. Those experiencing socio-economic deprivation, rural populations, Māori, Pacific peoples, and disabled people are all groups with longstanding access challenges linked to poor health outcomes. Capitation reweighting will add additional variables to the capitation formula to better distribute primary care funding in line with patient health needs. This will increase funding for providers that serve higher needs populations, which should result in improved access and health outcomes for these groups.

50 s 9(2)(f)(iv)

Human Rights

51 The proposals in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Use of external resources

52 No Ministry of Health external resources were used in the production of this paper or associated work. Health New Zealand contracted an external provider to undertake analysis and modelling of capitation reweighting.

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Consultation

53 The following agencies were consulted: Treasury, Ministry of Social Development s 9(2)(f)(iv) Department of Internal Affairs s 9(2)(f)(iv) . The Department of Prime Minister and Cabinet was informed.

Communications

54 I intend to announce capitation reweighting at GP25: Conference for General Practice on 25 July 2025, with implementation from 1 July 2026 subject to negotiation through the Primary Health Organisation Services Agreement.

Proactive Release

55 This Cabinet paper will be released subject to decisions being confirmed by the Cabinet and following announcements, with redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health (the Minister) recommends that the Committee:

1 **note** that the Minister of Health is proposing changes to funding settings to achieve Government's primary care objectives of: improving access for patients, comprehensive services that deliver more in the community, continuity of care, and coordinated care to actively support delivery of the Government's Health Targets;

Improving capitation funding for primary care

2 **agree** to the following new variables being included in the calculation of capitation funding for general practice, based on a practice's enrolled population:

2.1 multi-morbidity

2.2 rurality

2.3 socio-economic deprivation

3 **agree** to retain sex (male/female) as a variable in the calculation of capitation funding;

4 **agree** to introduce new, narrower age bands as a variable in the calculation of capitation funding, to better reflect health needs of infants and older people;

5 s 9(2)(f)(iv)

6 s 9(2)(f)(iv)

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7 **note** capitation reweighting changes could take effect from 1 July 2026, subject to negotiation through the Primary Health Organisation Service Agreement;

Funding to focus on outcomes and improve the performance of general practice

8 **note** that the Minister of Health intends to introduce an outcomes framework to support $95 million per annum of performance-based funding for general practices over three years from 2025/26, which was announced in March 2025;

9 **note** that targeted sector engagement on performance measures associated with performance-based funding will occur alongside engagement on the proposed primary care target;

s 9(2)(f)(iv)

Hon Simeon Brown

Minister of Health

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