MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing for decision

Capitation reweighting – further advice

Date due to MO:	17 June 2025	**Action required by:**	23 June 2025
Security level:	IN CONFIDENCE	**Reference:**	H2025068320
To:	Hon Simeon Brown, Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
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Minister's office to complete:

☐ Approved	☐ Decline	☐ Overtaken by events
☐ Needs change	☐ Seen	
☐ See Minister's Notes	☐ Withdrawn	

Comment:

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Briefing for decision

Capitation reweighting – further advice

Security level:	IN CONFIDENCE	**Date:**	17 June 2025
To:	Hon Simeon Brown, Minister of Health		

Purpose of report

1. This report responds to your request for further details on the proposed capitation reweighting and the impact of the ethnicity variable on the distribution of funding in the proposed approach to reweight capitation.

Summary

2. The Ministry has provided you with advice on the capitation reweighting proposal [H2020066443 and H2025067084 refer].

3. Capitation funding is designed to fund primary care for all New Zealanders eligible for publicly funded health services. Reweighting the formula aims to better match funding to the distribution of primary care use to better reflect the costs of providing services to address New Zealanders' needs. Service use is currently the best proxy we have for health need.

4. The proposed capitation formula includes age, gender, deprivation, multimorbidity, rurality and ethnicity as these factors were identified as the most significant predictors of primary care costs (based on available data).

5. The slide pack attached in Appendix 1 provides you with further information on:

   a. How the current capitation formula works

   b. The overall reweighting proposal

   c. The anticipated funding impacts for practices

   d. The anticipated funding impacts with the inclusion and/or exclusion of the ethnicity variable.

6. You sought further information on the impact of including the ethnicity variable in the formula. This is proposed to better reflect how use patterns differ across the population, and therefore how costs of serving different populations differ between general practices.

7. The following table summarises the impact on funding distribution across practices, in three options: ethnicity variable included, ethnicity variable excluded, and the deprivation index increased by a factor of 3.

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s 9(2)(j)

8. As capitation funding is intended to represent average costs of serving a practice's population, we expect that practices will continue to apply their capitation funding flexibly to their enrolled populations based on their patients' health needs.

9. s 9(2)(j)

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Next steps

10. We are working to the following timeframe for your Cabinet paper:

   a. updated draft to Minister: Monday 23 June (noting that 20 June is a public holiday)

   b. feedback and amendments (including incorporating your decisions on capitation reweighting): Tuesday 24 June

   c. Ministerial consultation: Wednesday 25 June – Tuesday 8 July

   d. lodge Cabinet paper: Thursday 10 July

   e. Cabinet Social Outcomes committee: Wednesday 16 July

   f. Cabinet: Monday 21 July

   g. Ministerial announcements including capitation reweighting: Friday 25 July

Recommendations

We recommend you:

a) **Note** the information on how the proposed capitation formula would operate in practice attached in Appendix 1.

b) **Note** the evidence on ethnicity as a driver of health need, and the initial modelling on the impact of the ethnicity variable in the capitation formula and on adjusting the deprivation variable to compensate for removing ethnicity from the formula.

c) **Agree** that the following variables be included in the updated capitation formula: **Yes/No**

   i. Age (new age bands of 0,1, 2-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-69, 70-74, 75-79, 80+)
   ii. Multimorbidity (Pharmaceutical prescribing profile score of P1, P2, P3)
   iii. Rurality (Geographical Classification of Health U1/U2/R1, R2, R3)
   iv. Deprivation (Quintile 1, 2, 3, 4, 5)
   v. Sex (M/F)

d) **Indicate** your preferred approach to inclusion of the ethnicity variable in the updated capitation formula:

   i. Include Ethnicity (European/Asian, Māori/Pacific/Other) **Yes/No**

   OR

   ii. Exclude Ethnicity **Yes/No**

   OR

   ii. Exclude Ethnicity and increase the weighting of the deprivation variable by a factor of 3 **Yes/No**

Caleb Johnstone
Group Manager
Strategy, Policy and Legislation
Date:

Hon Simeon Brown
Minister of Health
Date:

ENDS.

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Appendix 1: Impact of revising the capitation formula

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Capitation reweighting – further advice

Appendix One – Impact of revising the capitation formula

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Current formula

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Capitation funding and the current formula

- The capitation First Contact formula aims to target resources at the health needs of the population and distributes funding across general practice to recognise the costs of providing healthcare.

- Data is not currently available to measure the individual needs of all New Zealanders for general practice services for the purposes of funding. The formula therefore adjusts funding based on factors that influence people's use of general practice services, as a proxy for differences in health need and the different cost of providing care to people within the New Zealand population.

- The current formula uses the following variables:
  - Age
  - Sex
  - High Use Health Card (HUHC) (a very small proportion of patients* are eligible for the HUHC. It adjusts the capitation funding rate that providers receive for these patients)

* There were approximately 6000 HUHC holders enrolled across the whole country as of January 2024. Patients are eligible if they make 12+ general practice visits a year due to a chronic condition. Providers are not obliged to reduce co-payments for HUHC patients, though some may choose to do so.

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Key issues with the current formula

- There are two key issues with the current formula:
  - **The variables in the formula are limited:** it does not adequately reflect the different care needs of our population or use of primary care. It does not therefore distribute funding to pay general practice appropriately for delivering care to their enrolled populations. The current wide age bands for example do not reflect the higher care needs for very young children and do not distinguish between the needs of a 65-year-old compared to a 90-year-old. Therefore, it does not match with the cost of provision.
  - The formula does not take account of factors other than age and sex (and the High Use Health Card for a small number of patients) that drive use of health services and the costs of providing care.
  - **The data on which the formula is based is outdated:** the formula was developed using patterns of service use from the late 1990s and there have not been major revisions in the interim. This means it does not reflect the current or expected patterns of general practice use nor the costs of delivering care to our population.
- The proposal to reweight capitation, outlined in the next section, is still based on primary care use as a proxy for health need, and does not include a measure for unmet need. The proposal has limitations but is an improvement on the status quo in terms of distributing funding.

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Reweighting proposal

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Summary of work on capitation reweighting to date

- The proposed capitation formula attributes a set of weightings to characteristics that have been identified as the most significant predictors of primary care costs (based on available data). The modelling is based on updated information on full-time equivalent workforce in general practice and updated utilisation data (based on data from over 2 million patients from across 18 PHOs in 2023). The modelling used available data and assumptions to estimate costs which are then used in multivariate regression analysis to estimate the relevance and impact of the various characteristics as predictors of healthcare costs, and new patient weights reflecting expanded age bands.

- The Ministry has advised you [May 2025 – H2025066443] that the proposed formula is an improvement on the current approach and will be more effective in distributing funding across general practice according to service use as a proxy for health need.

- s 9(2)(f)(iv)

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Funding for First Contact services

s 9(2)(f)(iv)

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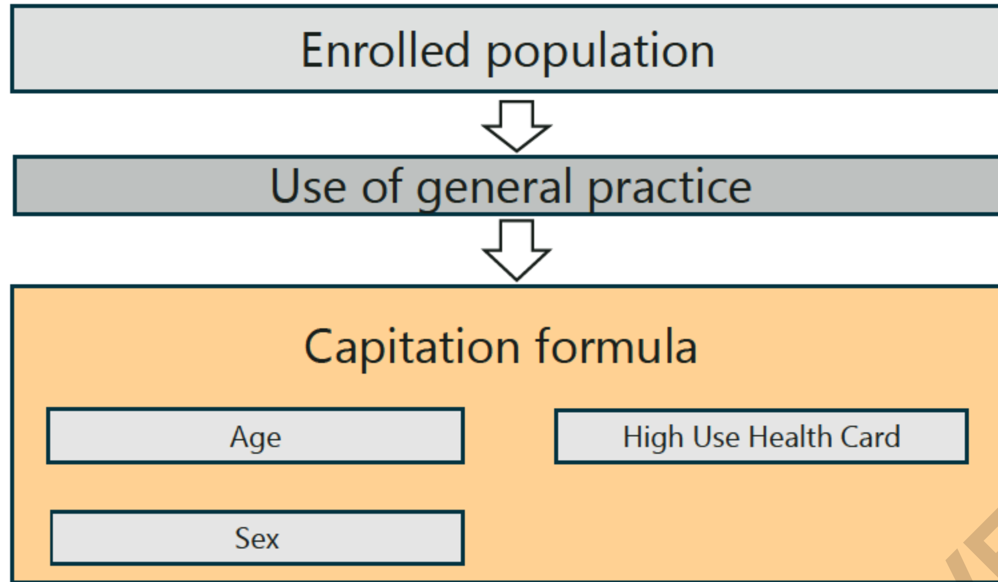
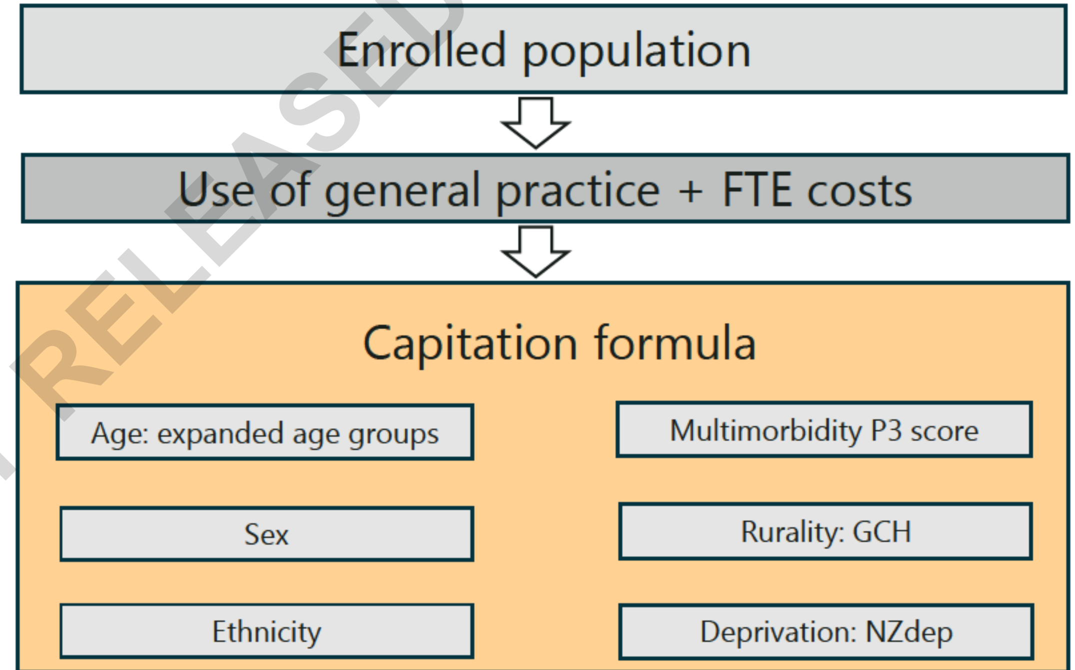
Current capitation formula

Proposed new formula





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Example funding rates per enrolled person: the new formula is more sensitive and will distribute funding to more effectively reflect care needs and costs.

Current rate			Three proposed rates (which vary depending on multimorbidity, rurality, deprivation and ethnicity)		
Age	**Gender**	**Current $**	**Minimum $**	**Mid $**	**Maximum $**
5-14	F	129.05	61.77	148.16	290.69
5-14	M	122.30	62.79	150.56	291.71
35-49	F	146.53	154.38	243.16	383.29
35-49	M	100.28	90.63	179.42	319.55
80+	F	311.16	370.98	457.21	599.90
80+	M	268.34	367.27	453.50	596.19

Implementing the reweighting: how funding is applied

1. Calculate the new weighted rate:

- Multiply enrolment count from each weighted groups (i.e. age, sex, deprivation, multimorbidity, rurality, ethnicity) by their respective updated weights.
- Sum these factors across all groups.
- Divide the total First Contact funding by this sum to get a *weighted per-unit rate*.

2. Apply the new weights to redistribute funding:

- Multiply the new rate by each group's enrollee count and updated multivariate weights.
- This yields the updated funding amount per group

3. Apply results to the First Contact funding pool for each practice's enrolled population

- s 9(2)(f)(iv)

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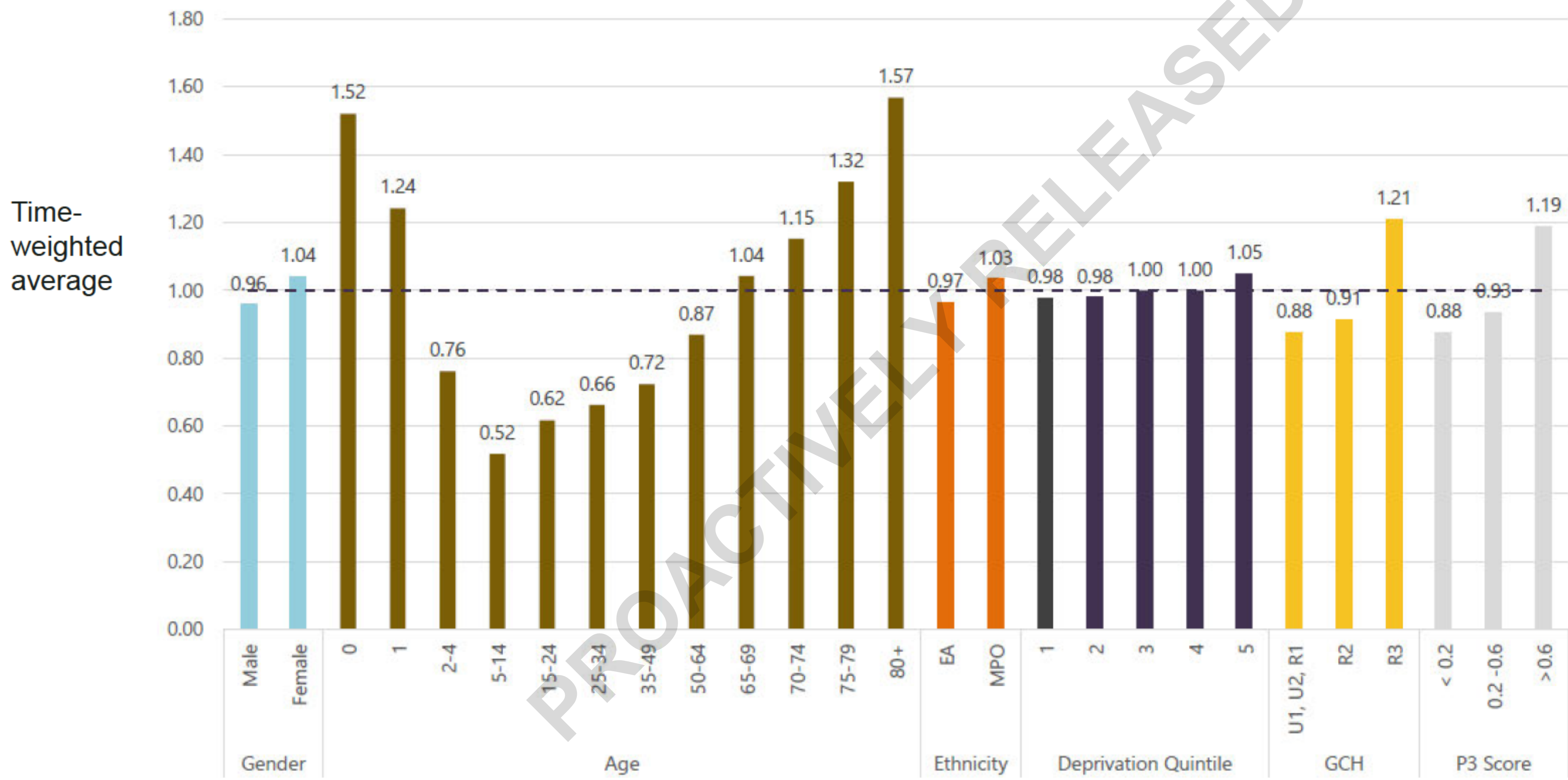
Proposed new variables – impact on primary care time use



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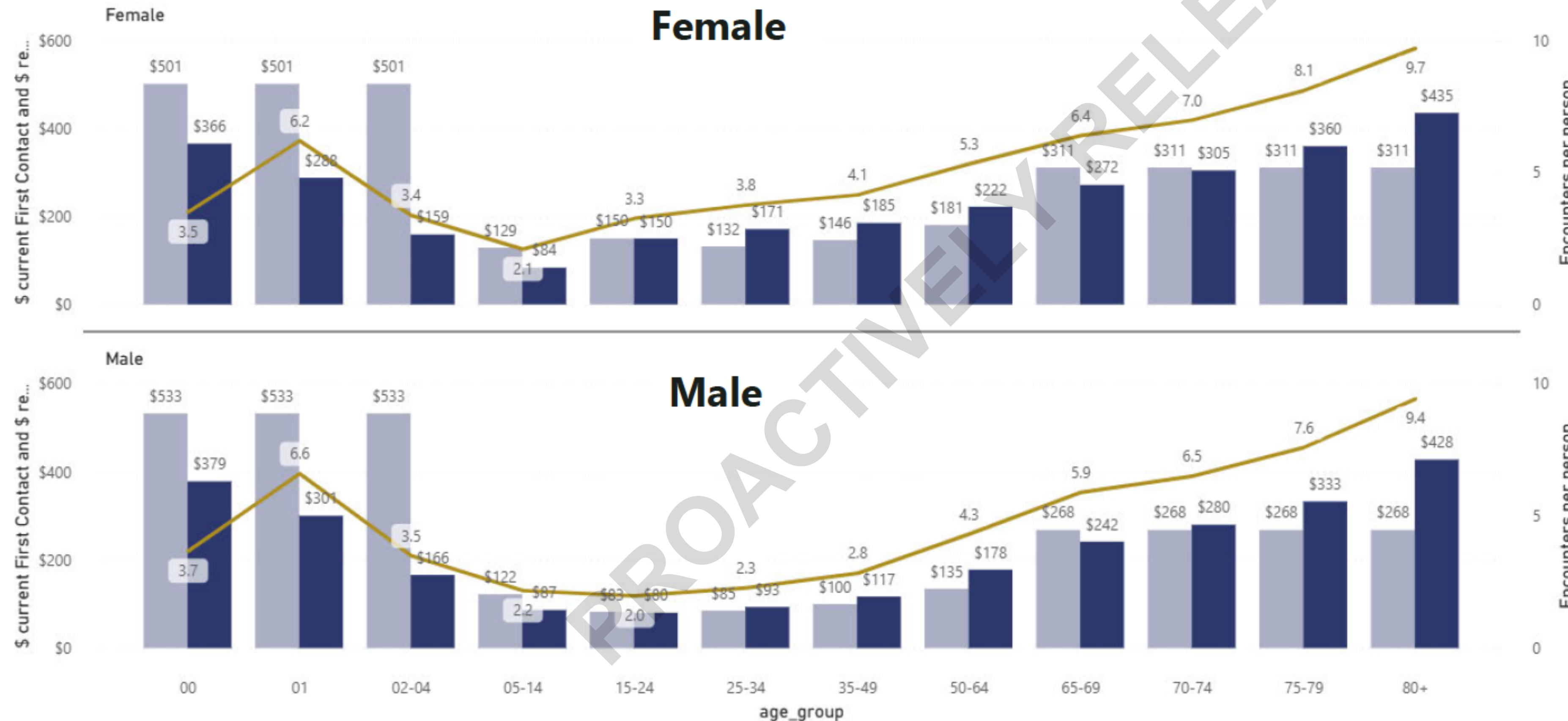
Note: EA = European and Asian, MPO – Māori, Pacific and Other ethnicities

GCH – Geographical Classification of Health (rurality score)

P3 – Multimorbidity Index

The proposed weights have a closer alignment with the encounter data



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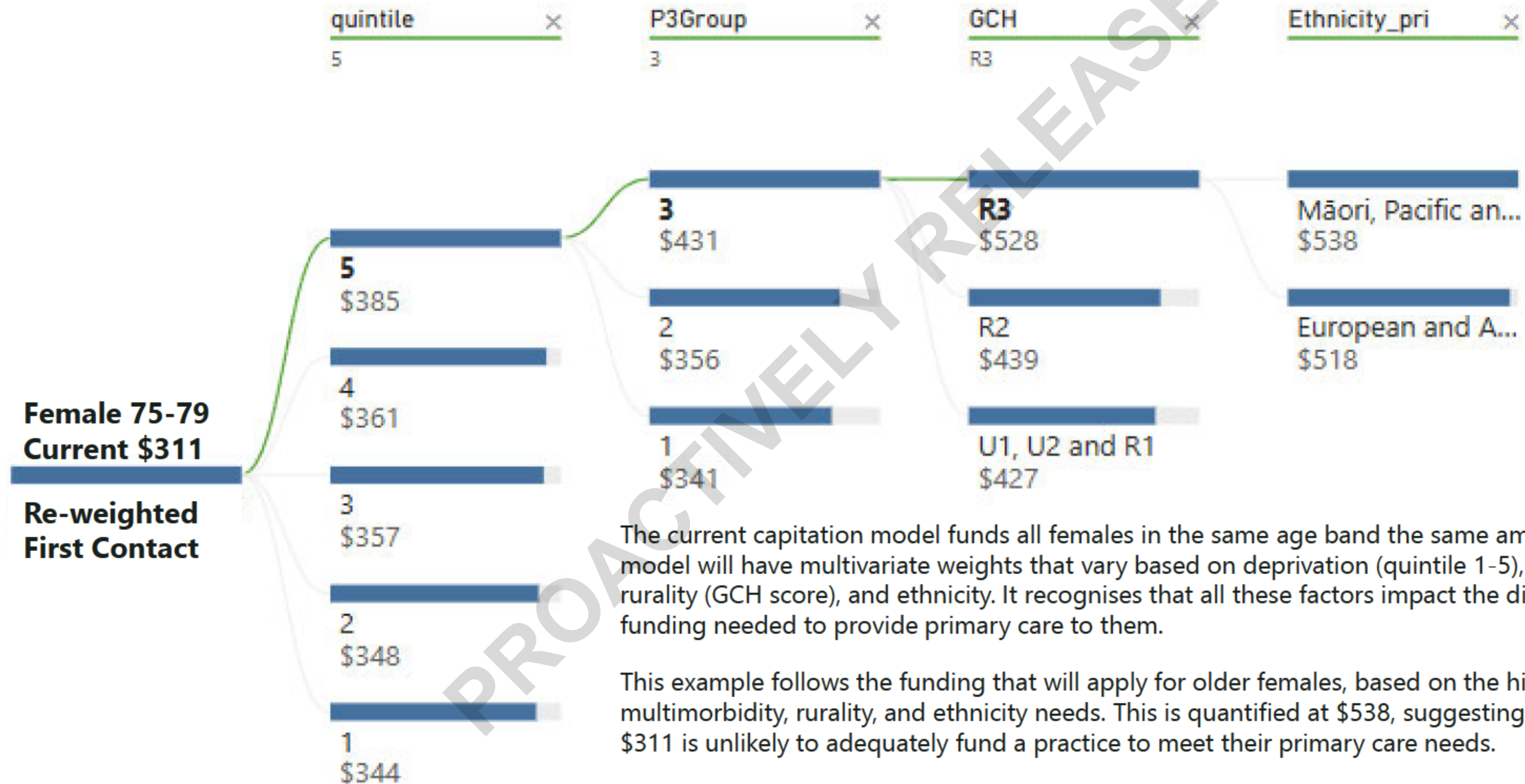
As expected, the new weights (in dark blue) are a better reflection of how people are using and need access to primary care (illustrated by the gold line).

The new age bands reflect differences in use in very young and very old age groups:

- One 0-4 band becomes 0, 1, and 2-4.
- One 65+ band becomes 65-69, 70-74, 75-79, and 80+

Example of implementation: reweighting for people with higher health needs



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The current capitation model funds all females in the same age band the same amount. The reweighted model will have multivariate weights that vary based on deprivation (quintile 1-5), multimorbidity (P3 score), rurality (GCH score), and ethnicity. It recognises that all these factors impact the different time and therefore funding needed to provide primary care to them.

This example follows the funding that will apply for older females, based on the highest levels of deprivation, multimorbidity, rurality, and ethnicity needs. This is quantified at $538, suggesting that the current funding of $311 is unlikely to adequately fund a practice to meet their primary care needs.

Note these amounts are prior to any increases in First Contact funding from 1 July 2025

Anticipated funding impacts for practices

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Impact of capitation reweighting on practice revenue ($)

Summary of the impact of implementing capitation reweighting across all practices in NZ (excluding enhanced capitation and uplift to apply from July 2025)

s 9(2)(j)

- s 9(2)(j)
- s 9(2)(f)(iv)
-

As capitation funding is intended to represent average costs of serving a practice's population, we expect that practices will continue to apply their capitation funding flexibly to their enrolled populations based on their patients' health needs.

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s 9(2)(b)(ii)

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Anticipated funding impacts with inclusion/exclusion of ethnicity variable

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Impact of inclusion of ethnicity variable

- The proposed factors for inclusion in the reweighted capitation formula are age (with more granular age bands), sex, multimorbidity, rurality, deprivation, and ethnicity. Analysis shows that these factors all have a significant influence on people's use of primary care services.

- Ethnicity contributes to differences between people's use of primary care services, even when you isolate and control for the effects of other variables such as deprivation and rurality.

- The purpose of the capitation funding model is to reflect the distribution of primary care use among the population as a proxy for health need. Including ethnicity as a variable in the formula helps the model explain how use patterns differ across the population, and therefore how costs of serving different populations differ between general practices.

- Applying a higher weighting to the deprivation variable (3x) in place of using ethnicity as a variable in the formula would not distribute as much funding to those providers we know serve the highest needs populations (See graphs on slides 25 and 26).

- Not including ethnicity would mean that general practices that care for some ethnicities as a high proportion of their population would receive lower funding than the demand they face.

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Consistency with requirements in CO (24) 5

- Capitation funding is designed to fund primary care for all New Zealanders who are eligible for publicly funded health services. The aim of reweighting is to ensure that funding is better matched with the distribution of primary care use to better reflect the costs of providing services to address all New Zealanders' needs.

- The proposed new model includes age, gender, deprivation, multimorbidity, rurality and ethnicity. The Ministry considers that the reweighting proposal is consistent with the expectations set out in Cabinet Office Circular CO (24) 5: Needs-based Service Provision because it aims to:
  (a) better position the capitation formula to be responsive to all New Zealanders' needs, through the inclusion of new variables that reflect the distribution of service use
  (b) ensure the formula reflects updated data, including information on modern general practice workforce models and utilisation data from over 2 million patients in 2023.

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How the ethnicity variable works in the reweighted capitation formula

- The current proposal to reweight capitation would adjust for ethnicity based on whether a patient's prioritised ethnicity is recorded as European/Asian or Māori/Pacific/Other.
- This categorisation distinguishes between population groups based on where we currently have:
  - robust New Zealand evidence on health needs that have a specific link to ethnicity, and
  - sufficient data on service use to support applying a different weighting.
- s 9(2)(f)(iv)

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Evidence on ethnicity as a factor that influences health need in New Zealand

- Current New Zealand evidence (refer to sources in slide 27) highlights all-cause mortality and life expectancy as two particular areas where there are health differences between ethnicities after controlling for socio-economic deprivation and other factors.

- New Zealand all-cause mortality data shows that Māori tend to have higher mortality rates than non-Māori after controlling for all other factors. In 2022, the rate of Māori deaths was 1.7 times that of non-Māori.

- Further, analysis of life expectancy trends in New Zealand shows that:

  - Māori and Pacific peoples had the lowest life expectancy (76.8 years and 77.3 years). Compared to non-Māori and non-Pacific groups, Māori and Pacific peoples' life expectancy is 6.6 years and 6.1 years lower.

  - Māori living in areas of higher deprivation experience a 7.4-year life expectancy gap compared to non-Māori and non-Pacific people living in the same areas. For Pacific peoples this gap is 4.6 years. Māori living in least deprived areas have a smaller, yet still substantial 2.2-year life expectancy gap, compared with non-Māori and non-Pacific peoples living those areas.

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Impact of inclusion of ethnicity variable: graphs

The following slides provide an indicative view of the impact of:

1) The impacts on practices of including vs excluding ethnicity as a variable in the formula
2) The impacts of including ethnicity vs adjusting how deprivation is weighted in place of the ethnicity variable

This indicative modelling does not allow for the interdependency between variables, so should be considered illustrative only of the likely direction and magnitude of impact.

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Implementing re-weighting: comparing with and without ethnicity

s 9(2)(f)(iv)

This slide shows the revenue impact as a % of each practice's total capitation funding. Slide 24 shows the revenue impact in dollars.

With Ethnicity

s 9(2)(j)

Without Ethnicity – no changes to weightings for deprivation

s 9(2)(j)

s 9(2)(j)

s 9(2)(j)

Without ethnicity, there is a shift of funding away from providers who are known to provide care for higher needs populations (particularly VLCA providers)

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s 9(2)(j)

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Implementing re-weighting without ethnicity variable: revenue impact ($)

Summary of the impact of implementing capitation reweighting across all practices in NZ (without ethnicity) (excluding enhanced capitation and the uplift to apply from July 2025)

s 9(2)(j)

s 9(2)

s 9(2)

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Adjustment to the deprivation weighting can mitigate to some extent the absence of an ethnicity variable, with some funding distribution impacts

s 9(2)(f)(iv)

This slide shows the revenue impact as a % of each practice's total capitation funding.

With Ethnicity

s 9(2)(j)

Without Ethnicity – 3x weightings for deprivation

s 9(2)(j)

s 9(2)(j)

By increasing the deprivation weighting 3x, there is some adjustment for the removal of the ethnicity factor, but the impacts are different on different types of practices depending on their patient profile.

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s 9(2)(j)

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Key sources on ethnicity as a factor explaining differences in health need

- Blakely, T. (2002). The New Zealand Census-Mortality Study: Socioeconomic inequalities and adult mortality 1991-94. Wellington, Ministry of Health. Available at: https://www.otago.ac.nz/__data/assets/pdf_file/0014/331610/the-new-zealand-census-mortality-study-socioeconomic-inequalities-and-adult-mortality-1991-94-024508.pdf

- Blakely, T. et al. (2007). Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981-2004. Wellington, Ministry of Health. Available at: https://www.otago.ac.nz/__data/assets/pdf_file/0018/331434/tracking-disparity-trends-in-ethnic-and-socioeconomic-inequalities-in-mortality-1981-2004-024504.pdf

- https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/mortality-web-tool

- Health New Zealand - Te Whatu Ora. 2024. Life Expectancy in Aotearoa New Zealand: An Analysis of Socioeconomic, Geographic, Sex and Ethnic Variation from 2001 to 2022. Wellington. Available at: https://www.tewhatuora.govt.nz/assets/Publications/Mortality/Life-Expectancy-in-Aotearoa-NZ-An-analysis-of-socioeconomic-geographic-sex-and-ethnic-variation-from-2001-2022-Technical-report.pdf

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