

# Briefing for decision

## Reweighting capitation funding in primary care

<b>Date due to MO:</b>	9 May 2025	<b>Action required by:</b>	12 May 2025
<b>Security level:</b>	IN CONFIDENCE	<b>Reference:</b>	H2025066443
<b>To:</b>	Hon Simeon Brown, Minister of Health		
<b>Consulted:</b>	Health New Zealand: <input checked="" type="checkbox"/>	Health Assurance Unit: <input checked="" type="checkbox"/>	
<b>Proactive release:</b>	This <b>title</b> is proposed by the Ministry of Health for proactive release: <input type="checkbox"/>		

## Contact for telephone discussion

Name	Position	Telephone
<b>Caleb Johnstone</b>	Group Manager, Strategy, Policy and Legislation	s 9(2)(a)
<b>Claire Solon</b>	Manager Primary and Community Health Policy Team, Strategy, Policy and Legislation	

## Minister's office to complete:

- |   |  |
|---|--|
| <input type="checkbox"/> Noted                | <input type="checkbox"/> Seen                |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Withdrawn           |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Overtaken by events |

Comment:

# Briefing for decision

## Reweighting capitation funding in primary care

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**Security level:** IN CONFIDENCE      **Date:** 9 May 2025

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**To:** Hon Simeon Brown, Minister of Health

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### Purpose of report

1. This briefing responds to your 5 May request for advice on reweighting the capitation formula for general practice.
2. You have scheduled a workshop for 12 May to discuss capitation reweighting, including interactions with proposed enhanced capitation funding, and implementation options taking into account the timing of Primary Health Organisation Services Agreement negotiations which are currently underway.

### Summary

3. The current capitation funding model for general practice has not been significantly revised since it was introduced in the early 2000s. There has been consistent feedback over a long period of time from the general practice sector on the need to adjust the formula to better address health need and costs of delivering care.
4. The *Report of the Primary Care Working Group on General Practice Sustainability in 2015* examined the funding of general practice and found issues with the current capitation model and the need for increased investment. The Health Transition Unit at the Department of Prime Minister and Cabinet commissioned Sapere Research Group to explore the funding of general practice in 2022. The methodology in this research was updated for Health New Zealand (Health NZ) in 2024 and analysed general practice data to inform the development of a proposal to reweight the capitation formula to better reflect health needs and the costs of providing care.
5. The capitation formula, and funding for primary care overall, needs to better respond to patient and provider needs. The reweighting proposal is designed to improve the effectiveness of the core capitation formula in better targeting resources at the current and expected health needs of the population and distributing funding more effectively across general practice to recognise the costs of care.
6. The proposal is to add additional variables to the capitation formula to better reflect the impact of age and other determinants that have an evidence-based effect on health outcomes (namely socio-economic deprivation, rurality, multimorbidity and ethnicity) and on expected service use patterns.
7. The Ministry has assessed the Health NZ model and considers the proposed new variables are an improvement on the current capitation funding formula. The measures align with sector leaders' expectations, and with a long-standing recognition that the formula omits important key variables. s 9(2)(g)(i)

s 9(2)(g)(i)

8. The Ministry considers it appropriate to progress with the proposal and to have a regular review process that enables more comprehensive capture of data and subsequent adjustments to the formula. s 9(2)(g)(i)

9. s 9(2)(g)(i)

10. s 9(2)(j)

11. s 9(2)(j)

12. We recommend that you seek Cabinet agreement to updating the variables in the capitation formula as adding new variables represents a significant policy change. The Ministry considers that the technical specification of the formula itself is an operational decision for Health New Zealand based on health need.

## Recommendations

We recommend you:

- a) **Note** that the capitation funding formula is intended to align primary care funding with expected patient needs and has not been fundamentally updated since its introduction in the early 2000s
- b) **Note** that the proposal to reweight capitation involves adding variables to further break down the age bands, and add new measures for deprivation, geography (rural/remote), multimorbidity and ethnicity to the formula
- c) s 9(2)(f)(iv)

d) **Note** that the Ministry has undertaken detailed reviews of the Sapere Research Group reports in 2022 and 2024 and supports the capitation reweighting proposal developed by Health New Zealand as a first step towards addressing the challenges with the primary care funding model

e) **Note** that it is not feasible to implement changes to the formula from 1 July 2025

f) s 9(2)(j) [Redacted]

OR

s 9(2)(j) [Redacted]

g) s 9(2)(f)(iv) [Redacted]

h) **Agree** to seek Cabinet agreement to the addition of new variables to the capitation formula because this is a significant policy change **Yes/No**

i) s 9(2)(f)(iv) [Redacted]



Steve Barnes  
Acting Deputy Director-General  
**Strategy, Policy and Legislation**  
Date:

Hon Simeon Brown  
**Minister of Health**  
Date:

# Reweighting capitation funding in primary care

## Background

13. Capitation funding for general practice services was introduced in 2002. The funding formula was developed based on patterns of service use from the late 1990s and since then we have seen demographic change with increasing comorbidity, an increase in available treatment interventions and a move to provide more complex long term condition management in the community. There have not been major revisions to the formula in the interim although there have been additions to the formula aimed at reducing patient charges for some groups.
14. The current formula is largely based on age bands and sex and does not reflect several other factors that drive health need and costs.<sup>1</sup> Various ad hoc changes have been introduced to compensate for weaknesses in the existing formula and to mitigate costs to some service users. These changes have complicated the funding model and created some perverse outcomes without resolving the core issues.
15. The Sapere analysis, commissioned by the Health Transition Unit at the Department of Prime Minister and Cabinet in 2022 and updated for Health NZ in 2024, has explored factors likely to influence use of care and analysed the impact of adding the statistically significant factors of socio-economic deprivation, multimorbidity, rurality, and ethnicity to the formula for distributing capitation to general practice. The age variable is also further broken down to better respond to workload and costs particularly for very young people within the population and those over 65.
16. To undertake the analysis Sapere obtained primary care service use data for over 2 million patients from across 18 PHOs for the year 2023, used available data and assumptions to estimate costs, and then used multivariate regression analysis to estimate the relevance and impact of the various characteristics as predictors on healthcare costs. The work was supported by a Technical Advisory Group (TAG) of sector leaders and was also the subject of local and international peer review.

## Reweighting proposal developed by Health NZ based on Sapere analysis

17. The work undertaken aims to develop a formula that better targets resources at the health needs of the enrolled population and distributes funding more effectively across general practice to recognise the costs of care.
18. The analysis conducted by Sapere tested the hypothesis that the accuracy of capitation weights could be improved by expanding the formula beyond the variables of age and sex to include rurality, socio-economic deprivation, ethnicity, and multimorbidity, as well

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<sup>1</sup> The original formula included socio-economic deprivation, but this was later removed.

as refining the age bands. This is due to existing research that identifies these variables as influencing people’s health and therefore impacting the costs of care.

19. The Sapere model predicts that these variables help explain the variation in utilisation between different groups. For example, people from more deprived areas, those with comorbidities, and older people appear to have increased healthcare use and costs. While age continues to be the strongest predictor of primary care activity, socio-economic deprivation, multimorbidity, ethnicity, and rurality, as measured by the Geographical Classification of Health (GCH), also explain some variation in primary care costs. Adding rurality shows that more rural areas, areas R2 and particularly R3 in the Geographical Classification of Health, were predictors of higher associated general practice costs.
20. The table below lists the factors in order of their impact. The table outlines the rationale for adding each of these variables to the formula to adjust funding based on differences in health needs:

Age	Additional care is essential during infancy for conditions and proactive health needs, and in older age due to a higher likelihood of age-related health issues. For example, babies require immunisation support, while older adults often face frailty and cognitive decline.
Multimorbidity	Individuals with multiple health conditions need additional clinical care to prevent disease onset, manage existing conditions, and avoid complications. For example, people with heart problems require medication management, monitoring, and proactive care to prevent hospitalisations, and many people would benefit from cardiovascular risk assessments to identify their needs earlier.
Rurality	People in rural communities require additional clinical care from general practice teams due to limited access to other healthcare options. For example, rural residents often receive more complex care, such as minor surgical procedures, from their general practice team.
Deprivation	People in deprived areas need extra clinical care due to the impact of socioeconomic factors and limited access to healthcare. For example, those in high deprivation areas may lack the resources to maintain good health and may face financial barriers to accessing timely care.
Gender	Women need more frequent health screenings and reproductive health services. For instance, they require HPV screening and pregnancy-related care.
Ethnicity	There are demonstrated inequities in health outcomes between different ethnic groups in New Zealand. Certain ethnic groups need extra clinical care due to genetic and cultural predispositions to specific health conditions. For instance, Pacific people have a higher prevalence of diabetes and related complications.

21. A revised formula would aim to make more effective use of the current First Contact funding stream as well as repurposing some of the other primary care funding streams

that fit the purpose of delivering first contact services. These funding streams sit in the same appropriation as capitation.

22. s 9(2)(f)(iv)

s 9(2)(f)(iv)

### **Ministry of Health assessment of proposal and impact**

25. The Ministry undertook reviews and gave detailed feedback on the first Sapere models, some of which was adopted. We believe that the data collected, analysis conducted, and the proposed new variables are an improvement on current practice and a step in the right direction in relation to the funding of primary care. The measures align with sector leaders' expectations, and with a long-standing recognition that the formula omits important key variables.
26. However, there are risks that the weightings are not accurate, given the limitations of the data and analysis, as these are based on current utilisation of primary care rather than unmet need. The Ministry considers that the technical specification of the formula is an operational matter for Health NZ based on health need.
27. The Ministry supports the following variables and associated measures being included in the core capitation formula:
- 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)
- vi. ethnicity (European/Asian, Māori/Pacific/Other))

28. s 9(2)(j)



*Limitations and need for regular review*

29. s 9(2)(f)(iv)



30.

*Including ethnicity as a variable that affects health need*

31. The Ministry agrees with the inclusion of the ethnicity variable in the formula. The evidence shows that ethnicity has an independent impact on the use of primary care that

cannot be accounted for via factors such as socio-economic deprivation, multimorbidity, nor geography.<sup>2</sup>

32. Following an initial assessment the Ministry considers that the reweighting proposal is likely to be consistent with the expectations set out in CO (24) 5. Capitation funding is not targeted to any specific population groups; it is designed to fund primary care for all New Zealanders who are eligible for publicly funded health services. All variables in the capitation funding formula are necessarily proxy measures to some extent. The intention of the reweighting proposal is to ensure the variables in the formula are updated based on evidence about population characteristics that drive differences in health need and that providers servicing higher need populations are not penalised. We will further assess the alignment with the expectations set out in CO (24) 5.

s 9(2)(j)

33. s 9(2)(j)

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s 9(2)(j)

37. s 9(2)(j)

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<sup>2</sup> B. Loring et. al., Ethnicity is an evidence-based marker of need (and targeting services is good medical practice), New Zealand Medical Journal, 2024 Sep 27; 137 (1603). [1603-editorial.pdf](#)

s 9(2)(j)

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43.

PROACTIVELY RELEASED

s 9(2)(j)



s 9(2)(f)(iv)

s 9(2)(f)(iv)

44.



**Next steps**

- 45. Ministry and Health NZ officials will discuss this advice and next steps with you in the workshop arranged for 12 May 2025.

ENDS.

PROACTIVELY RELEASED

s 9(2)(f)(iv)

PROACTIVELY RELEASED