Capitation Reweighting Q&A
November 2025

Background

Why are we changing capitation?
The current capitation formula is outdated and only uses age and sex. It doesn't reflect the complexity of people's health needs or the challenges faced by practices serving high needs communities. The sector has been calling for this review for years, recognising that the old formula was based on 1990s utilisation data. This change responds to long-standing concerns and brings the funding model more in line with today's health needs. As announced by the Minister of Health earlier this year, the new formula introduces broader weightings of, deprivation, rurality, and multimorbidity, so funding will better match the actual health needs of enrolled populations.

How will the new formula be implemented, and what's the impact on current funding streams (including flexible funding)?
The new formula is proposed to roll out from 1 July 2026. It is proposed several funding lines are being considered for inclusion into the new formula, including Care Plus and the Patient Access Subsidy (PAS) schemes. There is ongoing work to understand the current use of these funding lines and the impact of their incorporation into the formula. This work will inform options for targeted mitigation for affected practices and services.

Funding changes and impact

How will the new capitation model change funding for practices and patients?
The new model uses updated factors to better match funding to actual patient needs. Some practices may see funding increase, others may see a decrease. The intention is to avoid increased patient charges, and proposed mitigation options are being developed for practices that may lose funding.

How will practices and PHOs know the impact of the new formula, and when will they be notified?
Detailed modelling will be shared with practices and PHOs as soon as possible, allowing time for planning before the new model starts. The calculation method will be made available so practices can check and forecast their funding.

How will practices be supported to understand and reconcile their funding under the new model?
Practices will receive detailed information and tools to help them understand and

reconcile their funding. The calculation algorithm will be shared, and support will be available for queries.

What support is available for practices during the transition, and how will changes be reviewed?
Proposed mitigation options are being developed for practices negatively affected. The model will be reviewed after two years, then every five years, with independent evaluation and sector input.

Model design and variables

How are key variables like deprivation, rurality, and multimorbidity defined and used?
Deprivation and rurality are based on patient address. Multimorbidity is measured using prescribed and dispensed medicines (the P3 score). These factors are combined to calculate funding for each enrolled patient and are reviewed regularly.

How will the model handle changes in patient need, such as changes in multimorbidity or deprivation?
Patient factors like multimorbidity (P3 score) and deprivation are reviewed regularly (monthly), and funding is adjusted accordingly. The model is designed to reflect current need, but no system is perfect. Ongoing review and adjustment are planned.

How are medicines and data from different systems (like Medimap or 1chart) included in the model?
Currently, only medicines recorded in the national pharmaceutical collection are included in the P3 score. Work is ongoing to improve data capture from all relevant sources.

Equity and populations

Why isn't ethnicity included in the new formula, and will this be reviewed?
Ethnicity was analysed but not included due to limited differences in utilisation and a government decision. There is ongoing commitment to equity, and the model will be reviewed after implementation, with further adjustments possible if needed.

How will the model support innovation, youth health, and specific high-need groups?
The model aims to better reflect need for high-need groups through its weighting system. Additional targeted funding or programs for innovation, youth health, or specific populations may be considered through other mechanisms.

Patient charges and funding streams

Will there be changes to co-payments, community service card subsidies, or high user health cards?
There are no immediate changes to co-payment rules or the community service card subsidy. High user health cards will continue, but there will be no explicit link to capitation funding if this funding line is included in the formula.

Quality, gaming, and access

How will the new model address concerns about gaming, quality of care, and access for high-need or unenrolled populations?
Ongoing monitoring, contract management, and professional standards will help prevent gaming and ensure quality. The model is focused on enrolled populations, but Health NZ is working to improve access for high-need and unenrolled groups through other programs.

Will the new model include minimum standards of care or quality indicators?
Yes, there is a move towards performance-based funding and the development of a primary care outcomes framework to support consistent, high-quality care.

Broader sector and workforce issues

How does the new model relate to broader workforce and service delivery challenges in primary care?
The capitation review is part of a wider strategy to improve sustainability, including workforce initiatives and funding uplifts. Broader issues like GP pay parity and service access are being addressed through other sector work.

What is the process for reviewing and updating the model, and how can the sector provide input?
The model will be reviewed after two years, then every five years, with opportunities for sector input and independent evaluation. Feedback and data from practices will inform future adjustments.

Will POAC (Primary Options for Acute Care) or EPCC (Enhanced Primary and Community Care) be affected by the new capitation model?

POAC and similar planned care initiatives are being brought together under a national programme called Enhanced Primary and Community Care (EPCC). This includes both acute and planned care services, such as abnormal uterine bleeding, oncology infusions, non-cancer medicine infusions, and skin lesion excisions.

The aim is to create more consistent access and pricing across the country. A steering group and clinical advisory group are overseeing this work, with working groups focused on specific service areas. While EPCC is separate from the capitation reweighting model, both are part of a broader effort to strengthen primary care delivery and improve access to services closer to home.

Further details on EPCC will be shared as the programme develops, and expressions of interest for involvement (e.g. in working groups) are welcome.

Next steps

What are the next steps for development?

- Engagement with the sector is ongoing.
- Practice level impact data will be shared once key decisions are finalised.
- The Capitation Technical Advisory Group (TAG) made up of sector and primary care leaders and experts is guiding implementation and supporting practices that may be financially negatively impacted.
- More PHO data is being collected to understand the impact of transitioning Care Plus and base capitation.
- The model will be reviewed after implementation to ensure it's delivering on its goals.
- The goal is to land decisions before Christmas to allow for planning of transitional arrangements to allow for implementation 1 July 2026.