

# Annual statement of reasonable GP fee increases - 2025/26 update

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Report prepared for Te Whatu Ora- Health New Zealand

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June 2025

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## Executive summary

This report contains the 2025/26 update of the annual statement of reasonable GP fee increase. The reasonable patient co-payment increase in 2025/26 is **3.18 per cent** for practices with a 50/50 revenue split between Government funding and patient co-payments.

This figure is based on a weighted average increase in input costs of **6.43 per cent** and a government funding uplift of **9.69 per cent** (last year the uplift was four per cent). The Government uplift represents a funding rise for first contact services of 6.43 per cent, and a further adjustment to capitation to offset possible fee increases of \$30 million (equivalent to an additional 3.26 per cent uplift).

This is the seventh year in which revised weights resulting from a stakeholder review were used, so comparison with the last six years' figures is possible. The revised weightings placed more emphasis on the labour component of costs (see Table 1).

Table 1 Revised index weightings

Index	Previous weight	Revised weight
<b>PPI-Inputs Health and Community Services</b>	20%	15%
<b>LCI-Health care and Social assistance</b>	70%	80%
<b>CGPI-Non-residential buildings</b>	5%	2.5%
<b>CGPI-Plant, machinery and equipment</b>	5%	2.5%

As the government funding increase is above the increase in input costs, the reasonable patient co-payment increase differs across practices, depending on the share of practice revenue the government uplift represents. For instance, where the government uplift represents 80 per cent of practice revenue, patient fees would need to **reduce** by around 6.6 per cent to be considered reasonable. Conversely, where the government uplift accounts for 20 per cent of practice revenue, the reasonable patient co-payment would be 5.61 per cent for the 2025/26 year.

*Using MECA salary rates would result in a reasonable fee increase of 3.14 per cent*

The earlier stakeholder review also recommended that DHB MECA salary rates be used in place of the Labour Cost Index (LCI) for comparative purposes. Using cost shares of 64 per cent (Medical), 23 per cent (Nursing) and 13 per cent (Admin) and the median value across all steps in the relevant salary scales results in an estimated labour cost change figure of 2.94 per cent for the MECA-based approach. The labour cost change figure using the LCI was 7.04 per cent.

Using the 2.94 per cent change from the MECAs would result in an annual fee increase of 2.29 per cent, for practices with a 50/50 government/patient fee split and a four per cent government funding uplift. The equivalent figure with a three per cent government funding uplift is 3.29 per cent.

The divergence in the respective labour cost change numbers is a function of how collective agreements work (i.e. they cover multiple years, cover more than just salary rates and take time to

negotiate). For this year's calculations, the relevant MECAs were either being negotiated (i.e. the SMO and NZNO Nursing MECAs) or waiting to be ratified (Admin).

Thus, the figures used for comparison relate to within-period changes that were part of the previous MECA but did not come into force in time for inclusion in last year's calculations.

For this year's calculations, the SMO MECA resulted in an increase of around 2.9 per cent for the most recent year, whereas last year the figure was 4.7 per cent, and 2.6 per cent for the year before that. The relevant MECA expired on 31 August 2024 and is being renegotiated at present.

The Clerical (Admin) MECA which expired on 28 March 2021 we have previously used has been renegotiated and effectively bundles together administrative and clerical staff that were previously separated. We have matched the previous category used as closely as possible to the new categories and see that there has been an increase of three per cent for the last calendar year.

The Nurses MECA expired on 31 October 2024, but also included an automatic uplift on 1 April 2024 of three per cent. In contrast, the uplift figure for the previous year's calculations was around 24 per cent.

These changes highlight two important timing-related factors in considering the use of MECAs in this process. The first is that agreements often cover multiple years and adjustments may be more frequent than annually (i.e. the MECA includes two or more salary changes in a calendar year). The second is that once renegotiated the agreements become effective from a certain date, meaning that costs change from that particular date.

# 1. Introduction

## 1.1 Purpose of the annual statement

This report presents the update of the annual statement of reasonable GP fee increase for the 2025/26 period.

## 1.2 Background

In 2006, a project team from LECG Asia Pacific (now renamed Sapere Research Group) was commissioned by DHBNZ to develop a methodology for setting the annual statement of reasonable GP fee increases. The team worked under the guidance of an Advisory Group, involving representatives from DHBs and the primary health care sector. Once the methodology had been developed, Sapere produced the first annual statements relating to the 2005/06 and 2006/07 June years. Subsequently, Sapere has produced further update reports on an annual basis for DHBs' National Primary Care Team, which now sits in Te Whatu Ora – Health New Zealand.

Further background on the application of the annual statement and the processes within which it is used can be found at [PHO Services Agreement – Te Whatu Ora - Health New Zealand](#)

## 1.3 Review of methodology in 2019/20 resulted in greater weighting for labour costs and inclusion of comparator

In 2019/20, a review of the Annual Statement of Reasonable Fee Increase (ASRFI) process was conducted by a working group comprising representatives from primary care, DHBs and the Ministry of Health.

A range of different alternative options was canvassed around the calculation of the annual fee increase, including:

- construction of a bespoke index to improve representativeness of data
- introducing a forecasting element to reduce time lags
- using Ministry-collected DHB financial data to improve both timing and representativeness of data
- using cost data from negotiated Multi Employer Collective Agreements (MECAs) to improve representativeness of data

The working group made two recommendations to alter the calculation process. The first recommendation was to increase the weighting of labour costs relative to other costs. Table 2 compares the previous weightings used to those recommended by the working group.

Table 2: Revised index weightings

Index	Previous weight	Revised weight
PPI-Inputs Health and Community Services	20%	15%

<b>LCI- Health care and Social assistance</b>	70%	80%
<b>CGPI-Non-residential buildings</b>	5%	2.5%
<b>CGPI-Plant, machinery and equipment</b>	5%	2.5%

The second recommended change was to use cost data from relevant MECAs instead of the LCI, as a comparator. Using cost shares provided by primary care representatives of 64 per cent (Medical), 23 per cent (Nursing) and 13 per cent (Admin) and the median value across all steps in the salary scale results in an estimated labour cost change figure of 2.94 per cent for the MECA-based approach, compared to an annual change of 7.04 per cent for the LCI-based (existing) approach.

Using the MECA-based 2.94 per cent figure in the existing weighted average calculation process would result in an input-cost related adjustment figure of 3.14 per cent for the 2025/26 year (compared to the existing method that derives a figure of 6.43 per cent).

## 2. Recap of methodology

### 2.1 Indices used

Calculating annual fee changes is driven by weighted average changes to prices of three key inputs used to produce the services provided by GPs. Together the three indices provide measures of the extent to which changes in business input costs put pressure on the output prices charged for goods and services.

#### 2.1.1 Labour Cost Index

The price of labour is a major driver of potential changes in operating costs and hence the fees charged by practices. The measure used is the *Labour Cost Index – All Salaries and Wage Rates* (LCI), which gives a measure of movements in the cost of labour. The index covers jobs filled by paid employees in all occupations and in all industries except for private households employing staff. As outlined further below in section 2.2, the component of the LCI used in the calculation process is that which is deemed most relevant to the provision of primary care services (i.e. Health Care and Social Assistance).<sup>1</sup>

#### 2.1.2 Producer's Price Index

The *Producer's Price Index - Inputs* (PPI-I) is a measure of the change in prices of items such as: materials; fuels and electricity; transport and communication; rent and lease of land; building, vehicles and plant; commission and contract services; business services; and insurance premiums less claims. It excludes labour depreciation costs and GST. The relevant component of the PPI-I used for this exercise relates specifically to the Health sector (previously known as Health and Community Services).

#### 2.1.3 Capital Goods Price Index

The *Capital Goods Price Index* (CGPI) is a measure of the change in the general level of prices for physical capital assets (for example, buildings). It excludes large value items (such as aircraft) and second-hand equipment. The relevant components of the CGPI used for this exercise relate to Non-residential Buildings and Plant, Machinery and Equipment.

While the CGPI has been rebased (from the September quarter of 1999 to the September quarter of 2022) there is no practical effect on the calculations used in this report, as the movement across quarters is what matters, rather than the actual index numbers themselves. Nevertheless, for the sake

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<sup>1</sup> Note that this category was previously referred to as Health and Community Services, both in the LCI itself and past annual statement updates. It is a name change only. We note that Statistics New Zealand is currently reviewing the weights used to construct the LCI. The intention of such a reweighting exercise is to ensure that the index remains "fit-for-purpose" over time (i.e. to reflect changes in the way resources are used). Our assessment is that the effect of such a reweighting will be similar to the re-basing that took place previously. It will make comparison with previous years difficult, but will still reflect the important and relevant cost factors used in our calculations. We will comment further in any subsequent reports, once the reweighting exercise is complete.

of completeness, we have updated all previous index numbers for both components used in this report.

## **2.2 Annual statement calculation**

As described in previous reports, the process of calculation takes place sequentially, involving two components - the change in input costs component and the change in capitation-based Government funding received (i.e. First Contact funding). The latter was previously known as the Future Funding Track (FFT) and has also previously been referred to as a "cost pressures adjustment."

The first step involves determining the annual percentage change for the relevant components of each index and averaging over the previous 12 months. We use the March, June, September and December quarters of the preceding calendar year for these calculations. That is, we calculate the annual percentage change for all the quarters in the relevant year from the same quarter in the prior year, and then average across the four quarters to get an annual percentage change figure for input costs.

Following this, we apply weightings agreed to by PSAAP following a review of: 80 per cent labour (LCI); 15 per cent other inputs (PPI-I); and five per cent for capital (2.5 per cent for each component of CGPI).

Using this weighted average, we assess the effect of input cost changes on total fees (i.e. GP fees in the absence of capitation payments). From this, we use the known Government funding contribution to derive the reasonable level of co-payment increase.



## 3. Changes in indices

### 3.1 Data sources

All data used in the production of this statement has been sourced from Statistics New Zealand. The relevant files can be accessed directly from the Statistics New Zealand website<sup>2</sup>.

### 3.2 Overview of trends across indices

A summary of movements in relevant indices is provided below in Table 3. The changes in the LCI compared to the same quarter in the previous year and the previous (September) quarter in the 2023 calendar year stand out, indicating that there are clear health sector wage cost pressures being picked up in the data. However, both figures are lower than those from last year (2.2 per cent and 6.6 per cent respectively).

Table 3: Index movements up to December 2024 quarter

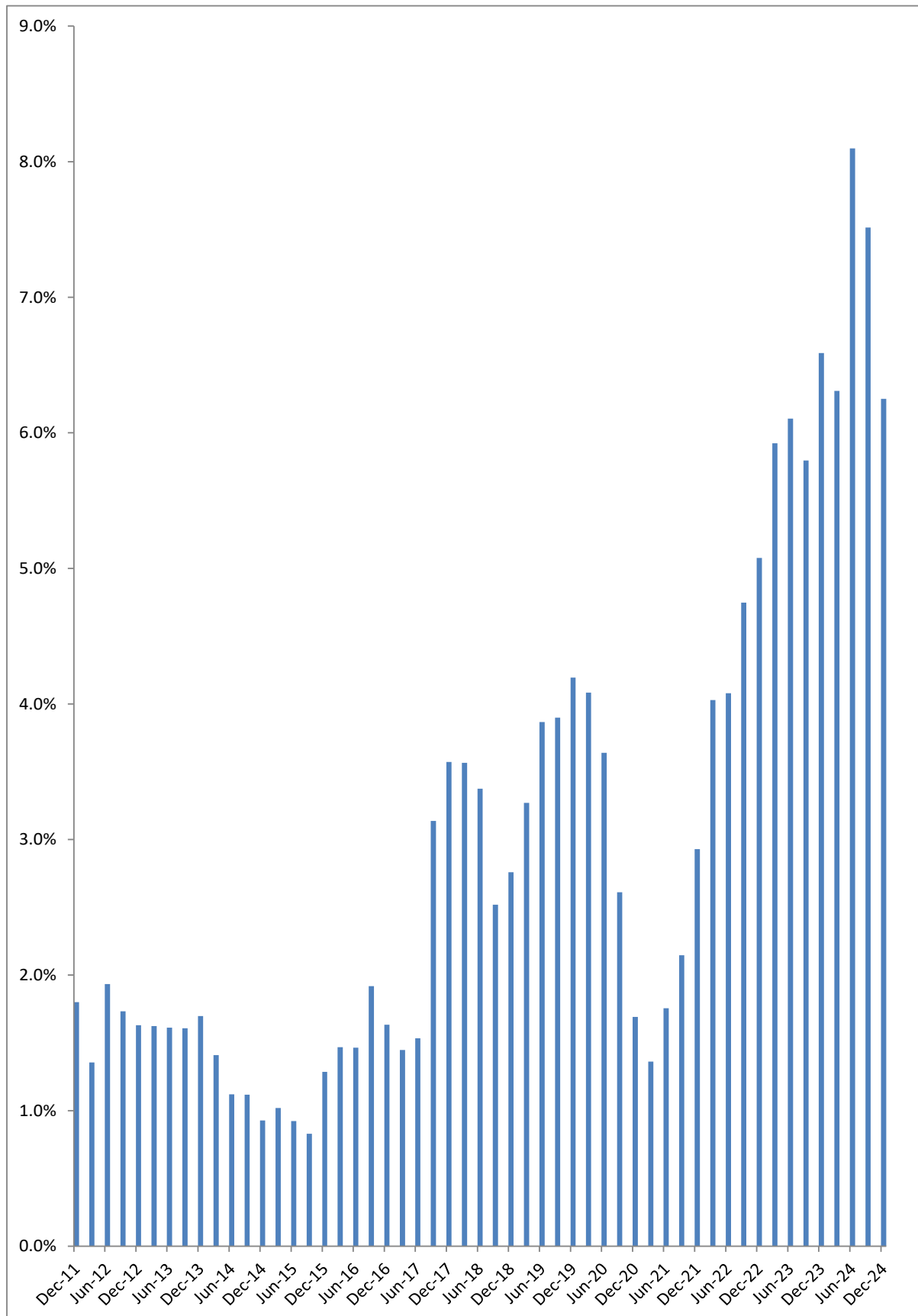
Index	Change from previous quarter (from September 2024 qtr.)	Change from same quarter previous year (from December 2023 qtr.)
PPI Inputs Health	0.3%	3.3%
LCI Health Care and Social Assistance	1.0%	6.2%
CGPI Non-residential Buildings	0.4%	2.5%
CGPI Plant, Machinery and Equipment	0.6%	0.3%

Figure 1 shows the annual per cent change for each quarter in the LCI since the December 2011 quarter. As shown, the growth in the recent past (due to pay settlements) is prominent, with changes in the June 2024 and September 2024 quarters being the highest since this process began.

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<sup>2</sup> <http://www.stats.govt.nz>

Figure 1: Annual percentage change in LCI



A suggestion has been put forward that instead of using the average of the percentage change across all four quarters to calculate the relevant annual change figure (described in 2.2 above), that we utilise only the change in the December quarter relative to the same quarter the previous year. While not shown in the graph above, the effect of this change would be to lower the input-cost-related adjustment.

Across all indexes the result would be a 5.56 per cent input-cost-related adjustment as opposed to the calculated 6.43 per cent figure shown below. We do not support such a move as it:

- ignores valuable information from the other three quarters;
- elevates the December quarter, with no obvious reason to do so;
- alters past practice since inception, making comparison across years difficult; and
- does not fix any obvious problem.

On the latter point, we understand that there is a suspicion that the current process has a systematic bias (in this case downwards in the value for the input-cost-related adjustment). To assess that claim, we compared the results of the current process to using only the December quarter percentage change relative to the prior December quarter, for the data we have using the same calendar year process. We use the most important index for this comparison (i.e. the LCI)

Table 4 indicates there is no clear systematic bias. While positive (upward) changes are estimated more frequently than negative changes for the December quarter only method, the biggest difference was in 2021, where the current approach led to a figure 1.32 per cent above what it might have been using the alternative approach. Summing the positives and negatives across the 14-year period results in a total difference of 0.83 per cent (equivalently around 0.06 per cent a year).

Table 4 Comparative approaches using LCI data

Year	December quarter only	Four quarters used (existing)	Difference
2011	1.37%	1.79%	-0.42%
2012	1.80%	1.75%	0.05%
2013	1.63%	1.66%	-0.03%
2014	1.70%	1.64%	0.06%
2015	0.93%	1.14%	-0.22%
2016	1.29%	1.01%	0.27%
2017	1.63%	1.62%	0.01%
2018	3.57%	2.42%	1.15%
2019	2.76%	3.05%	-0.30%
2020	4.19%	3.81%	0.39%
2021	1.69%	3.01%	-1.32%
2022	2.93%	2.05%	0.88%
2023	5.08%	4.48%	0.59%
2024	6.60%	6.10%	0.50%
2025	6.20%	7.04%	-0.84%

## 4. Calculation of the annual statement

### 4.1 Step 1: Input-cost related adjustment rate

Using the process outlined in section 2.2, we generate a total fee adjustment rate of **6.43 per cent** for 2025/26. This weighted average figure represents the **input-cost related change** to the total fee for a given year, a crucial intermediate input into the annual statement determination. Given relative weightings, it is closely related to the LCI.

Table 5 below provides the equivalent input-cost related adjustment factors for this and previous years.<sup>3</sup>

Table 5: Input-cost related adjustment rate

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Input-cost adjustment	1.50%	1.18%	1.10%	1.12%	1.57%	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	5.88%	6.43%

### 4.2 Step 2: Adjustment for Government funding and calculation of annual statement

We have been advised that a total Government funding adjustment of **9.69 per cent** will apply this (fiscal) year to first contact services (6.43 per cent), with a further adjustment to capitation to offset possible fee increases of \$30 million (equivalent to an additional 3.26 per cent uplift). Table 6 shows how this adjustment compares to previous Government funding adjustments. This year's figure is well above last year's figure and continues a rising trend in the uplift in recent years, reflecting cost pressures in the sector.

This adjustment is combined with the findings from the previous step to determine the reasonable increase to co-payment levels.

Table 6: Annual percentage change in funding for First Level (First Contact) Services

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Government adjustment	1.0%	1.0%	0.8%	1.0%	1.82%	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	4.0%	9.69%

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<sup>3</sup> The LCI was re-based from a June 2001 base to a June 2009 base. Similarly, the PPI-I was rebased from a December 1997 to a December 2010 base, and as mentioned the CGPI was recently re-based to a September 2022 base. Therefore, index values that contributed to past annual statements (prior to that period) are not able to be directly compared with the current values. In addition, the revised weightings used in the last four years mean direct comparison with previous years is not possible.

As shown in Table 7 below, **based on a 50/50 capitation/co-payment revenue split**, the reasonable fee (patient co-payment) increase for 2025/26 is **3.18 per cent** for a government funding uplift of **9.69 per cent**. This fee increase is well below last year's figure, when the Government uplift was below the rise in input costs.

Table 7: Annual levels for reasonable increases to GP patient co-payments (for practices with 50/50 government/fee revenue shares)

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Reasonable fee increase	2.01%	1.37%	1.40%	1.25%	1.32%	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	7.76%	3.18%

This value is a function of the relativity between (capitation/first contact) funding from the Government and the input-related adjustment factor for the total fee, given an assumed split.<sup>4</sup> When the Government-generated adjustment is greater than the input-related adjustment factor, the co-payment increase will be less than the input-related adjustment factor and *vice versa*.<sup>5</sup>

Table 8 below provides the annual statement change for various capitation/co-payment splits, compared with the equivalent figures for previous annual statements. The table is most relevant for comparing the two most recent years, as this year's Government funding uplift altered the previous pattern of the uplift matching the input cost rise.

Notably, the prospect of fee reductions for some practices features. There is no precedent for such an occurrence, but presumably the Fees Review Committee process would operate in the same way as it would for any practice that sought to change fees in a manner that diverges from the estimated reasonable change. That is, if practices did not feel they were able to reduce fees to the reasonable level, they would need to plead their case to the committee as they would in the case of fee increases above previously estimated rises.

Last year, co-payments needed to do more 'heavy lifting' given the difference between the Government funding uplift and the cost pressure adjustment. This year, however, there is far less pressure on the fee component, given the Government uplift exceeds the cost pressures identified in the relevant indexes.

Note that figures prior to the 2010/11 year were calculated using a different time period, so are not directly comparable with this year's figure. Similarly, the revised weightings applied from 2019/20 onwards mean direct comparison between years prior to, and after that time, is not possible.

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<sup>4</sup> The fee template associated with the annual statement gives the opportunity to use practice, or practice group specific data where this split is not appropriate.

<sup>5</sup> This is because the effective weighting attached to the capitation subsidy is greater than that of the co-payment, meaning that when the capitation adjustment is greater than the input-related adjustment factor, there is effectively less work to do by the co-payment in order for the total fee adjustment to match the change in costs faced by practices.

Table 8: Annual statement and general adjustments for different capitation/co-payment contribution to revenue splits

		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Level of reasonable co-payment fee increase	Assuming 80/20 split	7.05%	-2.53%	1.11%	3.52%	1.92%	2.31%	1.62%	0.57%
	70/30 split	5.37%	-1.02%	1.24%	2.68%	1.61%	1.81%	1.42%	0.99%
	60/40 split	4.53%	-0.26%	1.30%	2.26%	1.46%	1.55%	1.31%	1.20%
	50/50 split	4.02%	0.19%	1.34%	2.01%	1.37%	1.40%	1.25%	1.32%

		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Level of reasonable co-payment fee increase	Assuming 80/20 split	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	13.39%	-6.63%
	70/30 split	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	10.26%	-1.19%
	60/40 split	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	8.70%	1.53%
	50/50 split	2.38%	2.91%	3.51%	2.78%	2.38%	4.92%	7.76%	3.16%

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