Primary Care Annual Uplift 2026

Agreements in-principle with PSAAP

Updated - 5 June 2026

Health New Zealand
Te Whatu Ora

This years offer includes:

- The introduction of a new capitation formula, which adds patient morbidity, deprivation, and rurality as new factors, helping to better match capitation funding to patient need.
- The introduction of a new rural funding model which looks to contribute to the additional costs for practices who serve rural communities
- A base increase of 3.16% cost increase to match ASRFI
- Further increases in funding for to support capitation reweighting implementation and a transitional funding package to ensure that all practices receive enough funding to stabilise fees next year. The transition funding will continue in future years, but the fees stabilisation is for one year.
- Further investment in performance based funding to strengthen the focus on performance in immunisation, access, screening for cancer, and better management of long term conditions.
- Uplifts to priority PHO flexible funding

Offer Summary

Health NZ has agreed in principle to invest $120.6M in primary care via the PHO services agreement in 2026/27:

- Funding of $45.8 million to increase capitation rates by 3.16% to recognise cost pressures
- $4.8 million to increase Careplus, SIA, and Health Promotion flexible funding by 2.66%
- $1.9 million to increase immunisation fees by 3.16%
- Reweighting of capitation to better reflect patient need using Sapere calculations
- $30.4 million to increase capitation rates by a further 2.84% to fund fees stability in 26/27 and to support capitation reweighting by increasing the overall capitation funding pool.
- A 3.16% increase in rural funding, along with a revised rural formula that better matches rural diseconomies, costing $0.9 million
- Additional funding for a transitional support package that means every practice will receive a minimum increase in their capitation funding of 4.0% for VLCA practices and 4.46% for non-VLCA practices (reflecting the difference in the contribution of patient fees to practice revenue) at a cost of $26.8 million
- An additional $10 million for performance-based funding for general practice.

Stable fees policy to support sustainable and affordable General Practice

Annual Uplift

- Funding of $45.8m to increase capitation rates by 3.16% matching the Sapere input cost calculation

Additional investment

Additional investment of $30.4 million in (2.84%) in capitation rates from 1 July 26 for fees stability in 26/27:

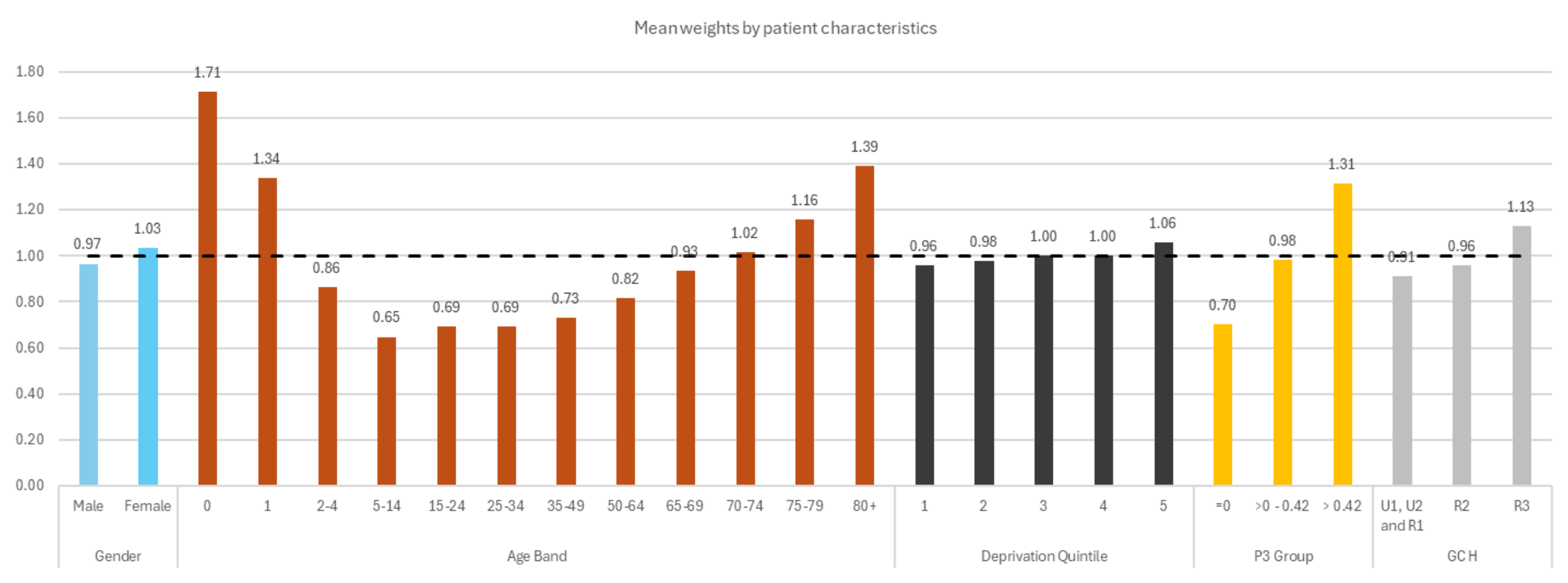
- Standard consultation fees will remain as set at 30 May 2026, with a global zero allowable increase for standard GP consultations across all age groups.
- Practices with ‘banked’ fee increase percentages from previous years retain these banked increases to use in future years, but not this year;
- The cap for adult non-CSC VLCA rate remains at $30.50
- The cap for adult CSC holders rate remains at $20.00
- The cap for 15 – 17 year old CSC holder rate remains at $13.50
- VLCA practices, and those charging CSC rates lower than the maximum in the agreement under these caps will be able to charge fees up to the contract rates above.

Fees review for 26/27

- The fees increase review criteria for 26/27 will be:
  - The practice’s business sustainability is jeopardised; or
  - Unacceptable reductions in patient-facing services are required to maintain sustainability; or
  - Practice requires a fees increase to fund investments in progress (e.g. new buildings) to allow enrolment growth.

Capitation re-weighting

- First substantive change to capitation in over 20 years
- Adds in rurality, deprivation, morbidity and older age ranges.
- Based on Sapere calculations from data from 2 million individuals encounters with general practice.
- Builds in funding for complexity going forward as the very old population increases, and morbidity increases, funding will increase.
- To be reviewed in 2028 and every 5 years thereafter



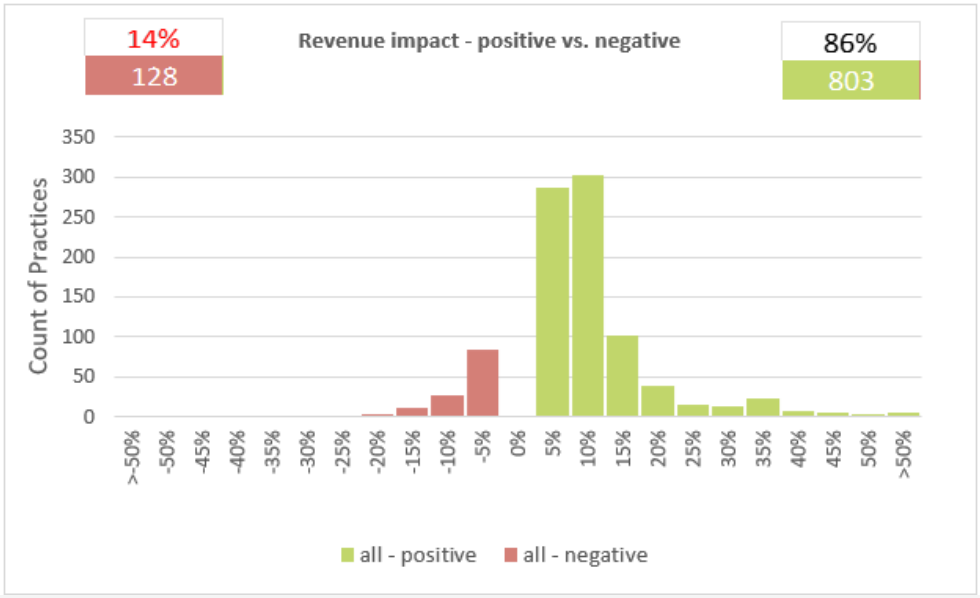
Capitation re-weighting: Transitional Funding

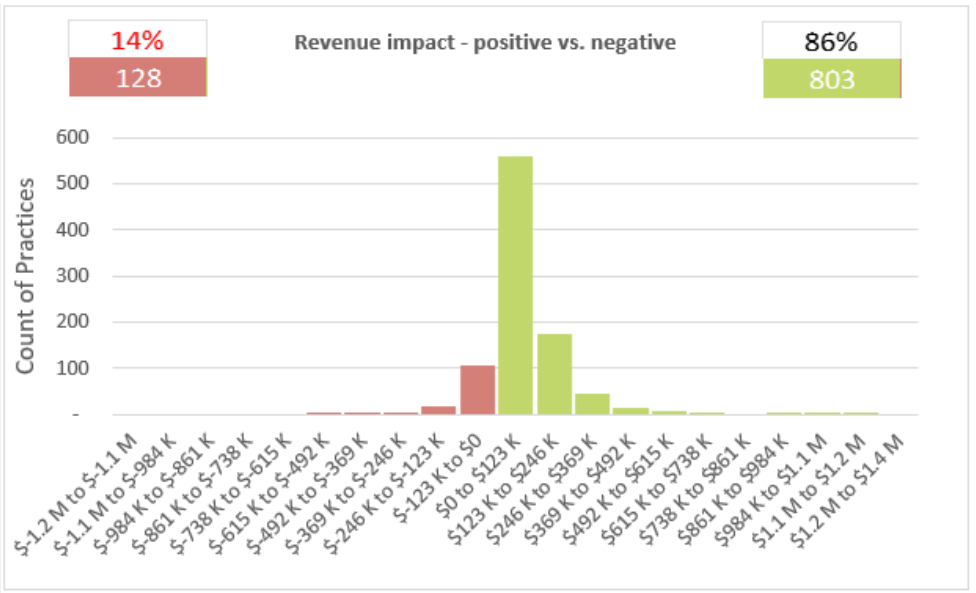
In addition to the increase in base capitation of 6%, Health NZ has agreed to provide $26M of transitional funding:

- VLCA practices transitional funding will top them up to 4% more than they would have received under the 2025/26 capitation formula plus 2025/26 rural funding formula.
- Non-VLCA practices will receive transitional funding to top them up to 4.46% more than they would have received under the previous 2025/26 capitation formula plus rural funding formula.
- The higher non-VLCA minimum top up amount is due to the higher percentage of their total revenue that comes from patient fees, and recognises the stable fees policy applying in 2026/27.
- Transitional funding will continue for four years.
- Health NZ will recalculate the transitional funding each year, with the amount payable reducing as overall capitation rates increase.
- The parties will review and agree transitional funding provisions within the PHO services agreement annually as part of the annual uplift negotiations to balance sustainability and affordable fees.
- From 1 July 2027, non VLCA practices receiving transitional funding will be able to set their fees based on their actual capitation rate increase after any reduction in transitional funding.

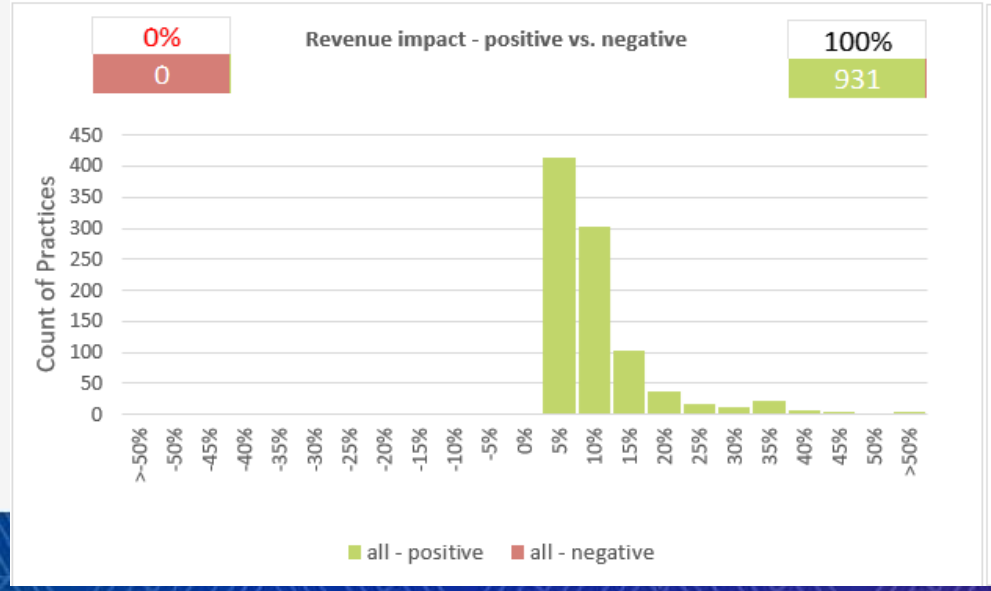
Impact of Re-weighting - all practices combined

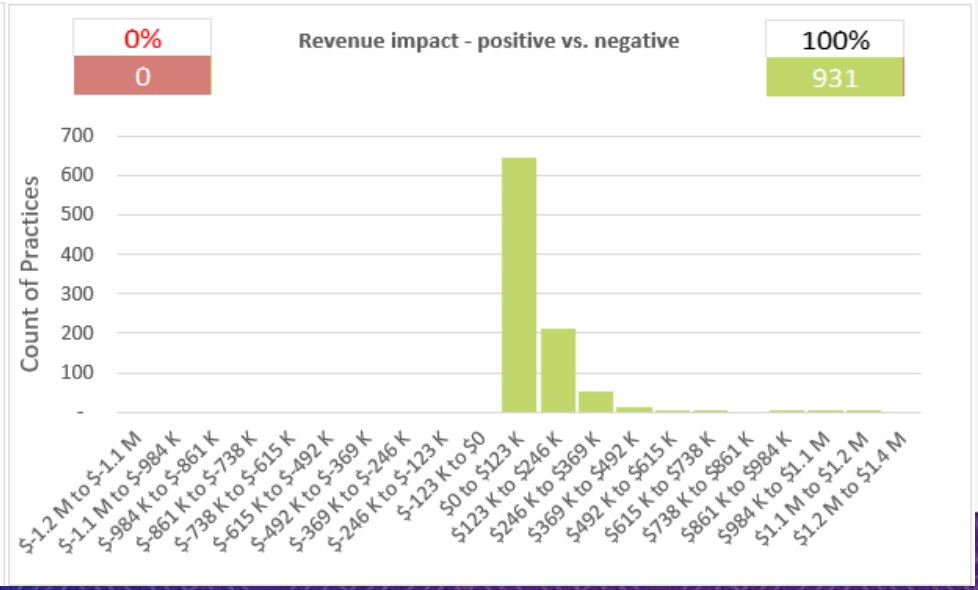
Pre mitigation





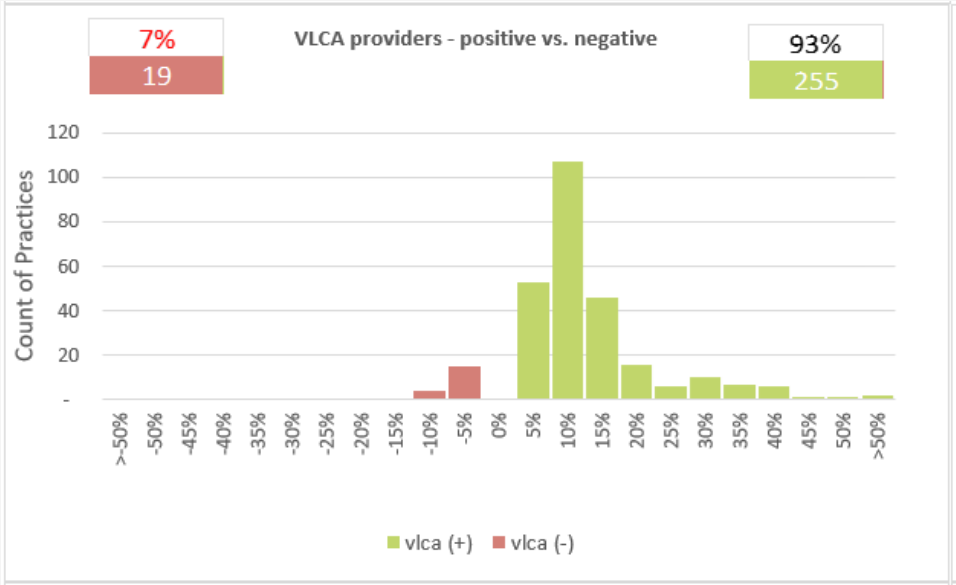
Post mitigation with the transition funding

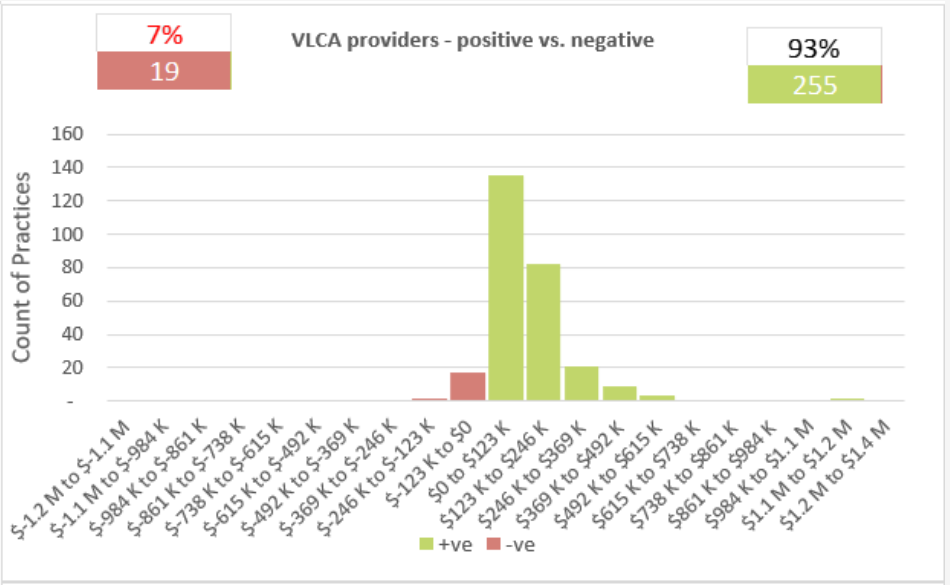




Impact of Re-weighting - VLCA

Pre mitigation





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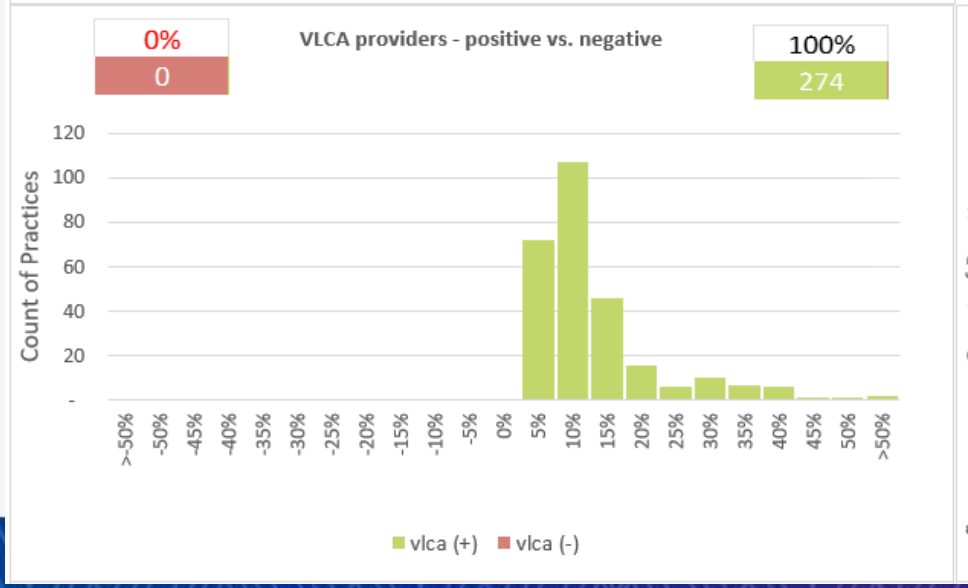
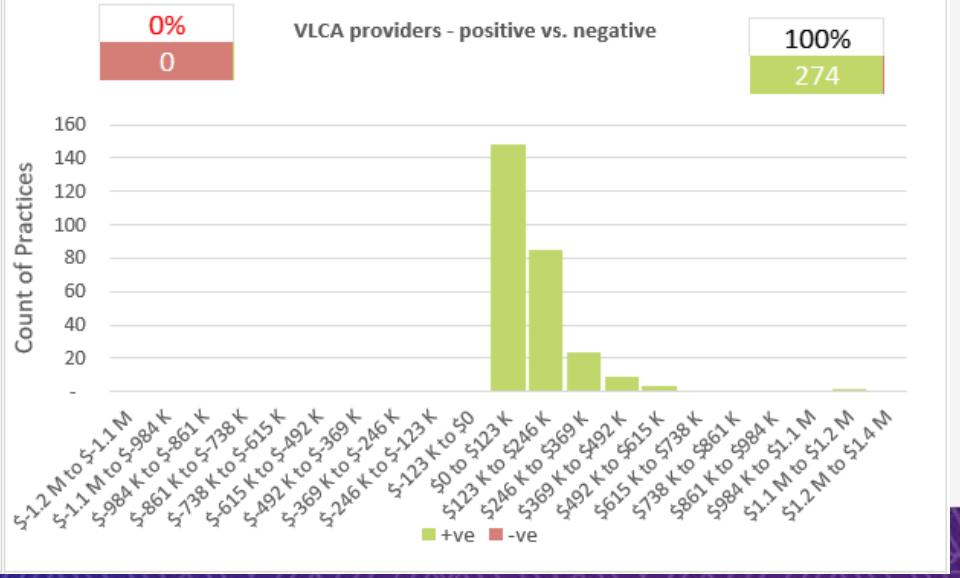
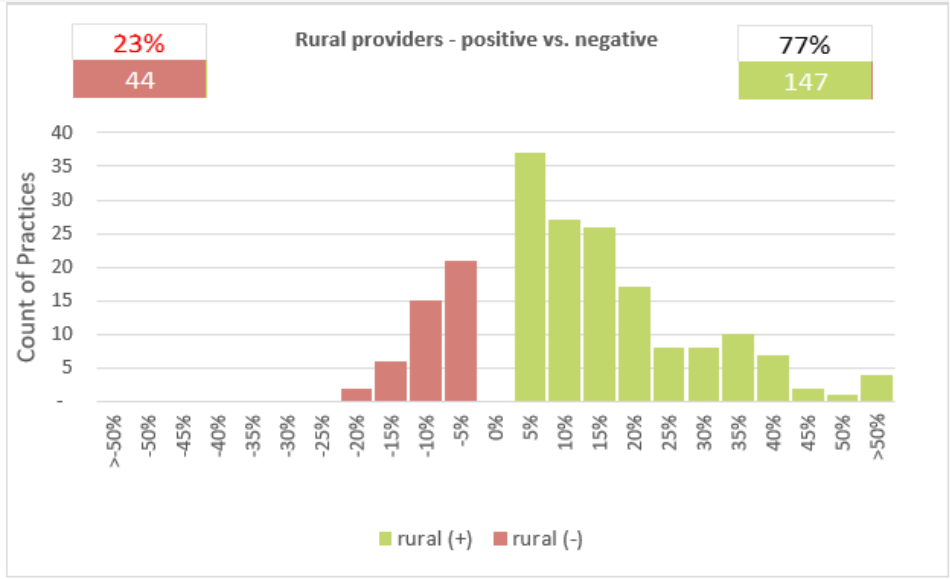
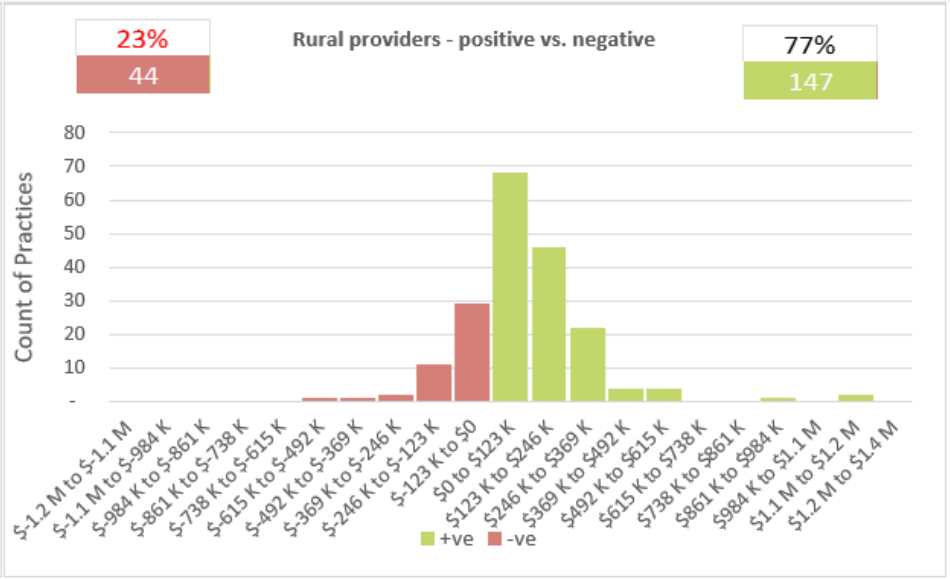




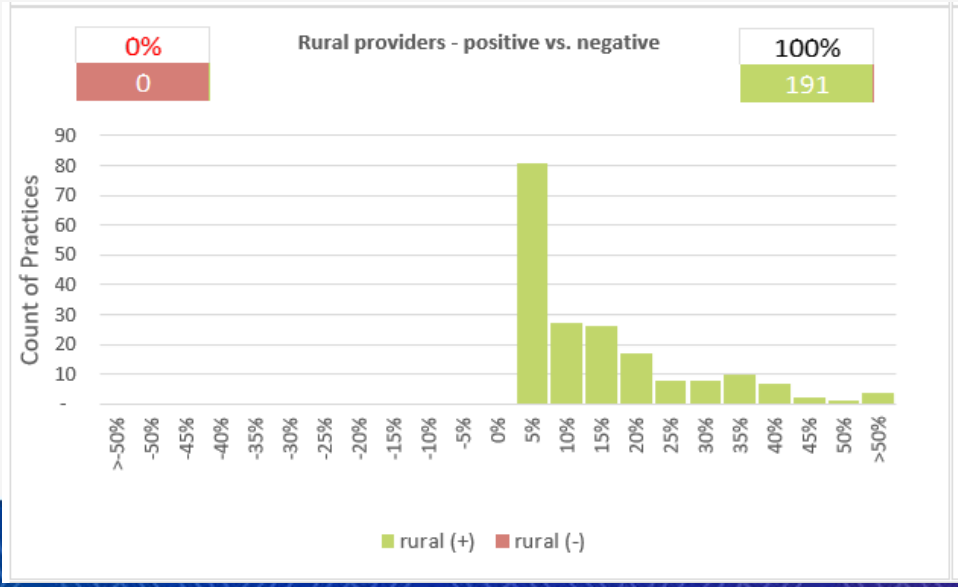
Impact of Re-weighting - Rural

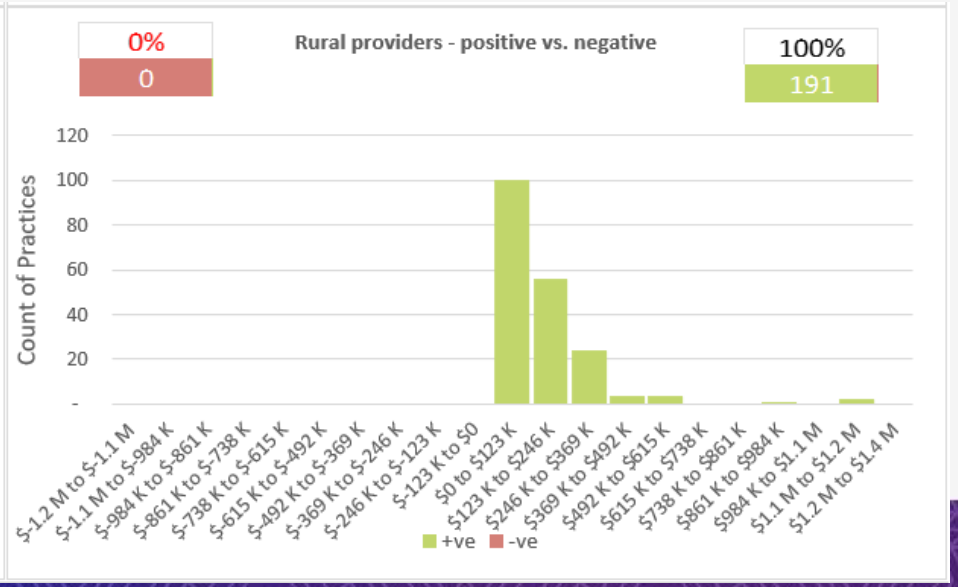
Pre mitigation





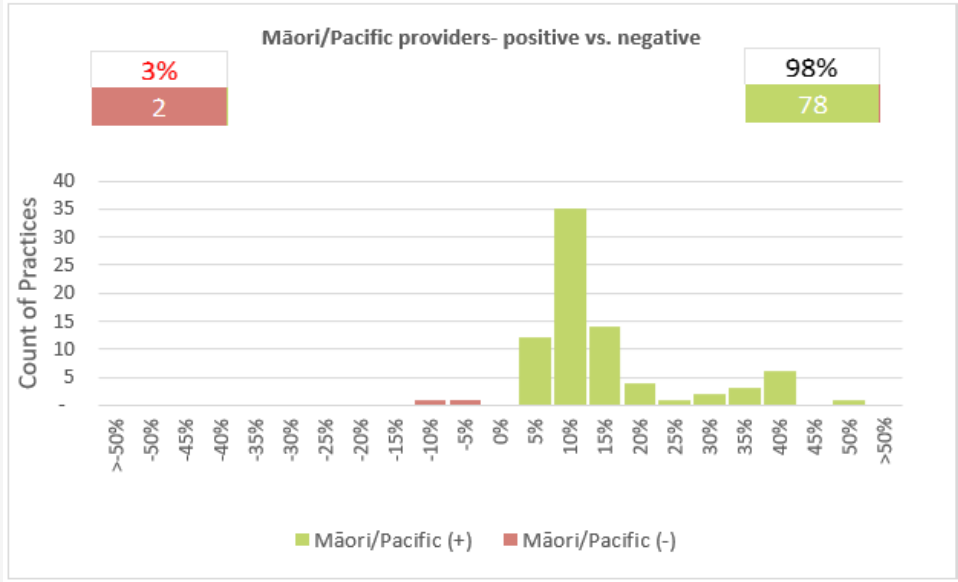
Post mitigation with the transition funding

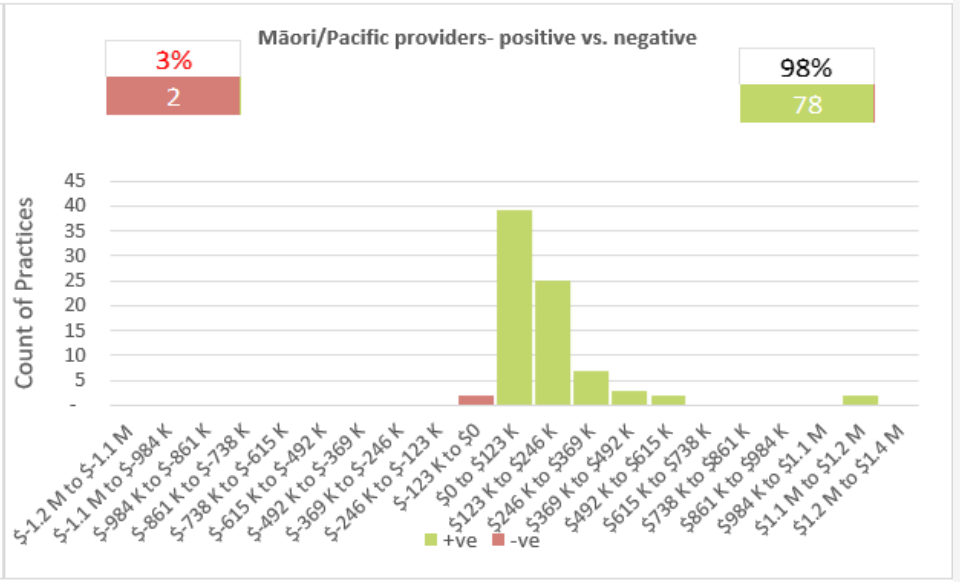




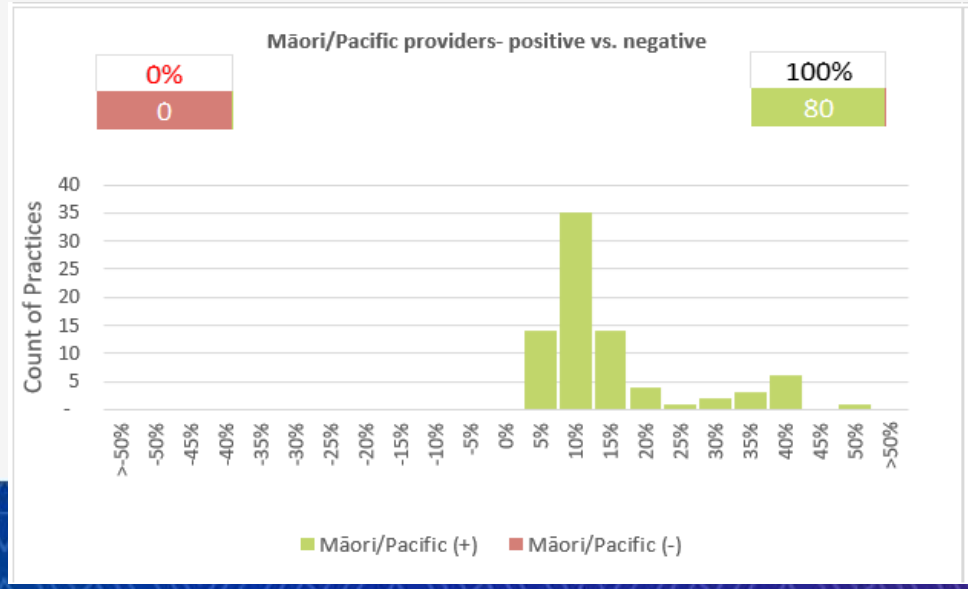
Impact of Re-weighting – Māori / Pacific providers

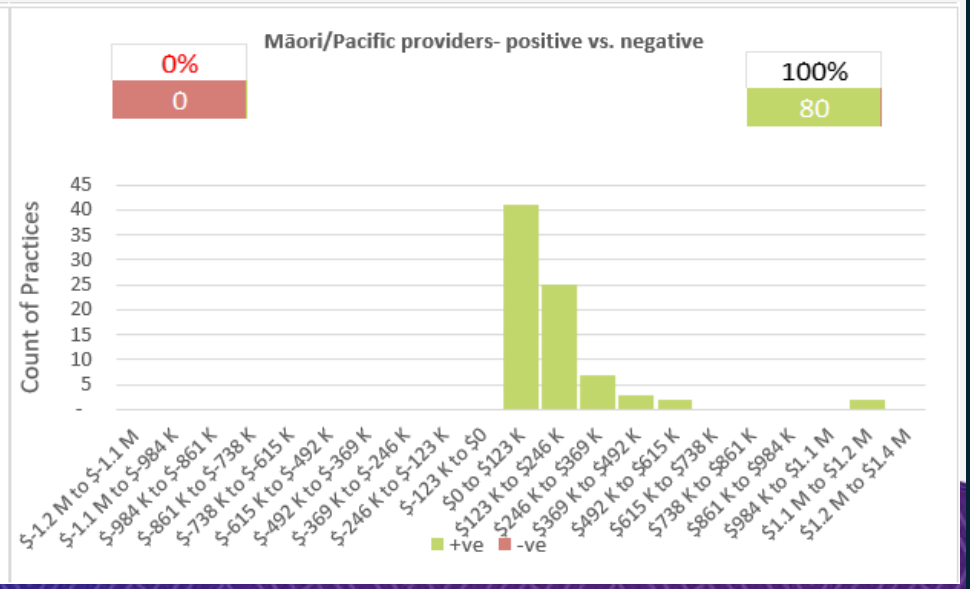
Pre mitigation





Post mitigation with the transition funding





Primary Care Performance Framework

- Health NZ will invest $67 million in performance funding in 2026/27 (including $26m current SLM funding).
- Pre-requisites for performance funding are participation in the HQSC consumer experience survey and data-sharing with Health NZ.
- Practices have the option of opting out of performance funding.
- Performance measures to be finalised with sector input and advice for implementation from 1 October.

- Measures will be focused on access and include the Primary Health Target, plus other measures such as:
  - Clinical FTE per adjusted 1000 population
  - Encounter rates per adjusted 1000 population
  - Continuity of care measures
  - Patient satisfaction with access
  - ED attendances per adjusted 1000 population
- Remunerated measures likely to include:
  - 24-month immunisation rate
  - Cervical Screening
  - Cardiovascular risk assessment

Rural funding

- Health NZ has agreed to implement a new nationally consistent rural funding formula based on recommendations from the rural working group.
- The new processes using the geographic classification for health to determine rurality, and specific criteria to determine quantum of funding.
- All practices currently receiving rural funding will continue to receive rural funding from 1 July 2026 plus any new practices identified as being eligible under the new framework.
- An exceptions process will be created and agreed by PSAAP to assess any practices who potentially may be losing eligibility under the new framework.
- Applications will be assessed and before December 2026, with any changes in rural funding implemented for 1 July 2027.
- Rural practices impacted by rural funding changes will receive transitional funding to mitigate the impact so that every practice receives an increase in total PHO funding.

Supplementary Information (updated 5/6/2026)

- Rural funding model and exceptions process
- Sustainable fees calculations

Background to Rural Funding (PHOSA)

Purpose

The purpose of Rural Funding is to contribute towards the unique cost premiums incurred by **practices** due to operating in the rural context.

The case for refreshing Rural Funding

Rural Funding has existed as part of PHOSA for more than 25 years. Over time the framework has evolved differently across districts, resulting in:

- Multiple and diffuse funding purposes
- Inconsistent definitions of eligibility (rurality)
- Varied funding formulas and payment methods
- Limited transparency and national oversight and understanding

Noting that any classification system will have limitations, we now have better definitions and data to inform the way we fund for rurality. Applying the Geographical Classification for Health (GCH) shows there are currently several practices who are R1, 2 or 3 who receive no rural funding.

Funding Approach

Rural Funding is a facility-level payment not a patient-level payment (like capitation). The funding is allocated based on the attributes of the practice.

How the proposed funding model works

Basic approach:
The funding model works by allocating each practice's eligible facilities a portion of the total Rural Funding budget ($28.4mil).

Each facility is assigned "points" based on the facility's attributes. The funding allocated to the facility equals their proportion of the total points.

For example:
A facility may recieve 16.5 points made up of being located in an R2 area (10 points), having an average enrollee deprivation score of Q4 (4 points) and 25% of their ESUs being Māori (2.5 points).

If that points score equalled 1% of the total points allocated to practices (e.g., 16.5 / 1,650), that practice would receive 1% of the total funding - e.g., $284,000 being 1% of $28.4mil.

Component	Subcomponent	Points
Rurality (GCH classification)	R1	5
	R2	10
	R3	15
Deprivation (average quintile of enrolled population of the Rural Practice) (see note 1).	Q1	1
	Q2	2
	Q3	3
	Q4	4
	Q5	5
Ethnicity (proportion of the Enrolled Population of the Rural Practice) (see note 1).	[x]% of 10 available points, where [x] is the percentage of Māori enrolled with the Contracted Provider	Up to 10 – eg, if 25% of the Contracted Provider's Enrolled Population are Māori, this equates to 2.5 points, being 25 percent of the 10 available points.

Understanding practice level impact

2025/26 Rural Funding data

HNZ's practice facility-level 2025/26 funding values are compiled from different sources as there is no single point of documentation currently. HNZ will work with PHOs to validate the accuracy of 2025/26 data.

Note: 2025/26 funding levels do not impact how the new Rural Funding formula is proposed to be applied.

Understanding the variation in impact

While the impact of the proposed changes are modest for many providers, there are some outliers. This variation reflects the historical, local decisions made by DHBs around the allocation of Rural Funding.

For example, in some areas rural funding has predominantly been used to fund afterhours delivery. While Rural Funding will continue to support practices with general overheads and practice-related costs which recognise that afterhours provision is different in rural areas, under the proposed model, there is no longer an explicit distribution of Rural Funding based on Afterhours service provision.

Over the next 18 months, HNZ will work with PHOs and practices to implement the *New Urgent Care and Afterhours Framework* and associated funding, while also supporting the transition to re-weighted capitation and the new Rural Funding formula.

Exceptions process

Any formula or classification system will have limitations in its application in some scenarios.

HNZ is working with a PSAAP working group to finalise an exceptions process, to enable practices to request re-consideration of how the Rural Funding formula applies in their context, in some circumstances.

The intention is to establish an expert group to work with HNZ to assess whether an exception is consistent with the purpose and fair application of Rural Funding.

The exceptions process will be an annual process.

More information on the exceptions process will be available in the coming weeks, following finalisation with PSAAP.

Resources appended to this PowerPoint

What	Description	File appended
Current rural funding (25-26)	These practice facility-level values are compiled from different sources as there is no single point of documentation currently.	Included in PHO Spreadsheet
Proposed rural funding (26-27)	These practice facility-level values are produced using the funding formula. They are not affected by current funding levels, as the new model is standalone and based on practice "points" (explained overleaf)	Included in PHO Spreadsheet
Combined impact / grandparenting information	These values aggregate facilities by practice and include the capitation reweighting information to provide a single practice-level combined impact	Previously supplied

Funding to Stabilise Fees – VLCA Practices

VLCA practices revenue	Base 2025/26	ASRFI	ASRFI uplift	proposed uplift %	proposed uplift $
Current first contact funding	$297,099,713	3.16%	$9,388,351	6.00%	$17,825,983
Current contingent capitation funding	$17,817,670	3.16%	$563,038	6.00%	$1,069,060
Current csc_card funding	$89,079,449	3.16%	$2,814,911	3.16%	$2,814,911
Current U14 funding	$33,250,005	3.16%	$1,050,700	3.16%	$1,050,700
Current VLCA (non-csc) funding	$43,046,223	3.16%	$1,360,261	3.16%	$1,360,261
Co-payments (approx.19% of capitation)	$91,735,974	3.16%	$2,898,857	0.00%	$-
Total	$572,029,034	3.16%	$18,076,117	4.22% (average)	$24,120,914
% capitation uplift required	$480,293,060	3.76%			$24,120,914
agreed minimum % of uplift for vlca practices				4.00%	

As per the offer all capitation and co-payment scheme rates have been increased by the ASRFI or more than ASRFI e.g. 6% for core capitation.

On average, applying the 3.16% ASRFI to all revenue lines (including copayments) would require a 3.76% uplift to the funded capitation lines for VLCA practices.

For VLCA practices a 4% uplift to funded capitiation lines is being offered.

With the minimum 4% uplift offer, on average this increases revenue by 5.02%, with no increase in co-payments required.

Funding to Stabilise Fees –non VLCA Practices

Non-VLCA practices	Base 2025/26	ASRFI	ASRFI uplift	proposed uplift %	proposed uplift $
Current first contact funding	$712,470,040	3.16%	$22,514,053	6.00%	$42,748,202
Current contingent capitation funding	$42,725,823	3.16%	$1,350,136	6.00%	$2,563,549
Current csc_card funding	$149,144,305	3.16%	$4,712,960	3.16%	$4,712,960
Current U14 funding	$65,893,903	3.16%	$2,082,247	3.16%	$2,082,247
Co-payments (approx. 41% of capitation) *NB: This has been generated using actual copayment data and modelled on population specific encounter rates.*	$397,795,969	3.16%	$12,570,353	0.00%	$-
Total	$1,368,030,040	3.16%	$43,229,749	3.81% (average)	$52,106,959
% of capitation uplift required	$970,234,071	4.46%			$52,106,959
agreed minimum % of uplift for non-vlca practices				**4.46%**	

As per the offer all capitation and co-payment scheme rates have been increased by the ASRFI or more than ASRFI e.g. 6% for core capitation.

On average, applying the 3.16% ASRFI to all revenue lines (including copayments) would require a 4.46% uplift to the funded capitation lines which is being offered. A higher uplift is required to meet the higher proportion of revenue from copayments for these practices.

With the a minimum 4.46% uplift offer, on average this increases revenue by 5.37% for non-VLCA practices, with no increase in co-payments required.