IN CONFIDENCE

Health New Zealand
Te Whatu Ora

Primary Care Annual Uplift 2026: Heads of Agreement

Version: 4 June 2026.

Note all numbers subject to final due diligence and technical review processes.

1. Purpose

This paper sets out the in-principle agreement reached by the PSAAP negotiation team for the Annual Uplift negotiations for 2026. The in-principle agreement is conditional on:

- Consultation with Contracted Providers, PHOs and Te Kāhui Hauora Māori PHOs.
- Technical due diligence on the new capitation formula and weights.
- Finalising the detailed clauses to be included in the PHO agreement.

2. Summary Package

Health NZ has agreed in principle to invest an additional $120.6M in primary care through the PHO Services Agreement in 2026/27. These are enduring funding investments made in recognition of the importance of primary care services to improving health outcomes and the optimum functioning of the health system.

The components of the in-principle agreement are described in the following sections and include:

- 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.
- $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.

The investments this year continue the approach of improving funding, modernising capitation formulae and gathering data to help demonstrate the importance of general practice in NZ.

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3. Annual Uplift – Cost Pressure

The parties agree that sustainable primary care services are critical to support a well-functioning health system, and to improve patient outcomes.

Uplift aligned to ASRFI

Health NZ agrees to increase capitation by 3.16% from 1 July 2026. This will apply to all first-level services, including VLCA and CSC rates and contingent capitation. This uplift matches the Annual Statement of Reasonable Fee Increases (ASRFI) input cost calculation for 2026/27 and builds on the significant increase in capitation rates last year and reflects a commitment to ensuring general practice is accessible and sustainable. This is a forecast investment of $45.8 million not counting increases related to a growing and aging population.

Flexible Funding

Health NZ agrees to a 2.66% uplift to flexible funding (CarePlus, Services to Improve Access, Health Promotion) excluding Management Fees. This is a forecast investment of $4.8 million and matches the general uplift being applied to NGO services this year.

Immunisation Funding

Health NZ agrees to increase all immunisation administration rates by 3.16% as required by the PHO agreement. This is a forecast investment of $1.9 million.

The parties acknowledge the critical role of General Practice in the delivery of immunisations by providing the majority of childhood vaccination services and supporting national coverage targets.

These proposals have been agreed to in principle by the PSAAP Negotiation Team.

4. Stable fees policy to support affordable General Practice

The parties agree the importance of maintaining affordable and accessible general practice services and recognise the impact of growing cost-of-living pressures on New Zealanders.

Stabilising fees

Health NZ agrees to an additional increase of 2.84% to First Contact and Contingent Capitation rates from 1 July 26 to fund a stable fees policy for standard consultations as a one-off measure for the 2026/27 year.

Key aspects of this include:

- Standard consultation fees will remain as set at 4 June 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.

To stabilise fees increases the overall uplift to capitation funding is as follows:

- General first level capitation increases by 6% (including the 3.16% cost uplift)
- Top ups for under 14s, CSC holders and VLCA practices increase by 3.16%

Which is a total forecast additional investment of $76.2 million excluding volume growth. This will be an enduring increase to capitation rates and is intended to increase GP capitation revenue, hold patients costs stable, and increase the pool of funding o support capitation reweighting.

Fees Review Process for 2026/27

The parties agree that it is important to balance affordable access to GP services against practice sustainability and an alternative process for fees review has been agreed for 2026/27.

Practices may apply via their PHO to Health NZ for an exception to the affordable fees policy related to sustainability concerns.

Applications are expected to meet one of the following criteria:

1. The practice's business sustainability is jeopardised; or
2. Unacceptable reductions in patient-facing services are required to maintain sustainability; or
3. Practice requires a fees increase to fund investments in progress (e.g. new buildings) to allow enrolment growth.

Health NZ will decide on the proposal within 20 working days:

- If approved, the practice will be able to increase their fees within the agreed parameters.
- If declined, Health NZ will refer the application to the Fees Review committee to independently determine whether the application meets the exception criteria.

The Health NZ fees review guideline maximum of $67 for an adult consultation will not apply this year.

The stable fees policy expires on 30 June 2027 and from 1 July the fees arrangements revert to the usual contractual approach.

These proposals have been agreed to in principle by the PSAAP Negotiation Team.

5. Capitation Reweighting - Funding that better meets patient needs

The parties note that the current capitation formula was developed more than 20 years ago and agree that a revised capitation formula is required to better align the available funding to aggregate patient needs.

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Introducing New Variables

Health NZ agrees to implement a revised capitation formula from 1 July that includes the following variables:

Factors	Groupings	Rationale
Age bands	0, 1, 2–4, 5–14, 15–24, 25–34, 35–49, 50–64, 65–69, 70–74, 75–79, 80+	Adding in additional older age categories recognises that health resource use increases with advancing age, and that health needs at 88 are, on average, considerably higher than health needs at 66 years.
Gender	Male, Female (standardised)	Recognises gender specific resource use.
Deprivation	NZ Dep quintile (1,2,3,4,5)	Recongises that health need generally increases with deprivation quintile.
Rurality	Geographic Classification of Health (GCH) groups ({U1/U2/R1}, R2, R3)	Adding a premium to very rural practices.
Multimorbidity	P3 score tercile groupings (=0.0, 0.01–0.42, >0.42); 1, 2, 3	P3 is a pharmaceutical index which is a proxy for morbidity.

PHOs, Te Kāhui Hauora Māori, and some contracted providers expressly sought the inclusion of ethnicity as a variable in the capitation reweighting, in accordance with the weights produced by Sapere. That request was not accepted as it is outside of the parameters for the new formula and policy settings agreed by Cabinet. The parties record that ethnicity remains a known and material driver of healthcare need and commit to revisit its inclusion at the 2028 review.

Review of the re-weighted capitation formula

The parties agree that while the revised weightings better reflect need, further improvements can be made over time, and that they will participate in a further review of the capitation model in 2028 in line with Cabinet decisions. This will include but is not limited to:

- Further development of the P3 measures, and/or identification of alternative measures for multi-morbidity; and
- Consideration of the inclusion of any other factors driving health need.

Removing variables no longer fit for purpose

As the re-weighted capitation formula will better allocate funding based on the needs of the practice's enrolled population, the parties have agreed to the following changes to further simplify capitation funding:

- Removal of the historical Access/Non-Access Practice distinction
- Removal of High User Health Card specific rates from first level capitation

These proposals have been agreed to in principle by the PSAAP Negotiation Team.

6. Rural Funding

The parties agree that the current rural funding model is not fit for purpose. To ensure nationally consistent, transparent, and equitable rural funding, an updated model has been developed. There is also recognition for the ongoing investment in rural funding to support rural based practices and communities.

Updated rural funding model supported with cost pressure uplift

Health NZ agrees to a 3.16% uplift to rural funding in recognition of the ongoing sustainability challenges for rural practices. This is a forecast investment of $0.9M.

The PSAAP rural funding working group has recommended a revised funding framework includes:

- A revised and simplified definition of the purpose of rural funding focused on recognising cost premiums associated with workforce sustainability, workforce development, and rural-related overheads;
- A nationally consistent definition of rural funding eligibility based on the provider being located in a rural area according to the Geographic Classification for Health;
- A nationally consistent funding allocation formula.

The parties recognise implementing the new rural framework will have significant impacts for some practices who may lose their rural status under the framework. The parties agree that an Exceptions Process will be established by PSAAP to provide an opportunity for practices that consider that they have a rural character and related rural costs, to make a case for inclusion in the rural funding allocation.

Health NZ agrees to implement the revised rural funding framework from 1 July 2026 in line with the recommendations of the rural funding working group, with the proviso that until such time as a rural funding Exceptions Process and criteria are agreed by PSAAP, all practices currently receiving rural funding will continue to be considered rural for funding purposes.

Phased implementation of rural funding changes

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. Any practices assessed as moving from a rural categorisation to an urban classification, will be allocated R1 status from 1 July 2026.

An exceptions process will be created to assess any practices who potentially may be losing eligibility under the new framework. The exceptions process and criteria will be agreed by the PSAAP negotiation team parties.

The intent is to have the exceptions process finalised by the end of July 2026 and be opened for applications from impacted practices in August 2026. If this is achieved, then applications will be assessed and decisions on their rural funding issued in December 2026 to take effect from 1 July 2027.

Practices with changed rural funding from 1 July 2027 will have their transitional funding amount updated to account for this change in funding, in accordance with the agreed transition process below.

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In the absence of an agreed exceptions process, all current practices receiving rural funding will continue to be classified as rural.

7. Transitional Funding

The parties recognise that changes arising from capitation and rural funding re-weighting will result in additional revenue for some practices and reduced revenue for others and agree that mitigating negative impacts for practices as we move to new funding formulas is important.

In addition to a global increase in general capitation, Health NZ agrees to provide additional transitional funding as follows to smooth this transition:

1. VLCA practices will receive transitional funding to top them up to 4% more than they would have received under the 2025/26 capitation formula plus 2025/26 rural funding formula.
2. 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.
3. Transitional funding will continue for four years.
4. The level of transitional funding provided to a practice will be calculated annually based on their population and level of capitation funding as of 1 March and will be paid on a monthly basis.
5. Health NZ will recalculate the transitional funding each year, with the amount payable reducing as overall capitation rates increase.
6. The parties will review and agree changes to transitional funding provisions within the PHO services agreement annually as part of the annual uplift negotiations to balance:
    a. A gradual movement to the new capitation weights;
    b. Ensuring practice sustainability
    c. Ensuring affordability through reasonable copayments.

   The parties will ensure that practice capitation plus transitional funding revenue increases for practices receiving transitional funding, are, at a minimum, sufficient to cover usual increases in capped fees services (VLCA, CSC, under 14s).
   Noting that the arrangement is to provide a funding floor – practice level funding can't go down (unless their enrolled population changes).
7. From 1 July 2027, non VLCA practices receiving transitional funding will be able to set their fees based on their total practice revenue including capitation funding and recognising any reduction in transitional funding.

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.

Health NZ estimates that approximately 14% of practices would require transitional funding to bring them up to current capitation funding.

Health NZ estimates that approximately 39% of practices will require transitional funding to smooth the combined impact of the capitation formula changes, rural funding changes and the co-payment freeze, supported through minimum uplifts of 4.0% for VLCA practices and 4.46% for non-VLCA practices. In 2027/28 the number requiring transitional support is estimated to reduces to 20% and after 4 years reduces to 3%.

This is a total forecast investment of $26.8M in transitional funding for 2026/27.

8. Performance Framework

The parties agree to support:

- the development of a primary care dataset to make more visible the work done in general practice settings.
- the new primary care health target
- the development and implementation of a new primary care performance framework.

Health NZ has proposed to make a further $10 million available for Performance Funding 2026/27 and to bring together the performance programs. This investment will be in addition to the current $30 million available for performance capitation funding and $27.3m available for the system level measure programme. The total forecast investment for performance-based funding is $67.3 million.

Each practice will have the option of opting out of participation in the Performance Framework.

The parties agree that the pre-requisites for receiving performance funding will be:

1. That the practice participates in the HQSC consumer experience survey; and
2. Participates in data-sharing with Health NZ

In addition, PHOs and contracted providers agree to work with Health NZ to maintain enrolment options in every area, and to prioritise access where restrictions on enrolment are necessary. The parties agree that the PHO services agreement will be updated to include this requirement for PHOs.

Performance framework measures

Health NZ will finalise the performance framework measures with sector input and advice in the first quarter of this year, for implementation from 1 October. The measures are being developed with the clinical sub-group, and that the final list of measures and associated performance funding model will be confirmed with the negotiation team prior to implementation. It is expected that the framework will evolve and expand in future years as more data becomes available.

The framework will include the new primary care health target and measures to balance the access target measure, 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

These measures are indicative and not yet agreed.

Performance Payments

Health NZ has signalled intention in principle to make performance payments for the following measures, subject to final discussions with PSAAP parties and input from the clinical subgroup:

- 24-month immunisation rate
- Cervical Screening
- Cardiovascular risk assessment

Public reporting

The parties agree that a quality improvement approach should be the focus of the performance framework, and that initial reporting should be made available to PHOs, and practices of their own data, and a comparison to their peers.

Public reporting of performance would be under the following reporting categories:

- Access
- Immunisation
- Cancer screening
- Long term condition prevention and management

Health NZ has proposed a gradual transition towards public reporting at a practice level and will work with the Primary Care Data Governance Group and PSAAP prior to the public reporting of measures at a practice level.

The parties agree that public reporting of performance will only be considered when the data is shown to be reliable and valid at the practice level. A minimum of 12 months of baseline data, including a 6-month shadow reporting process to work through any data issues would be required prior to public reporting.

Opting out of the Performance Framework and data provision

Practices currently have the option of opting out of reporting primary care data, in which case they lose access to a share of $60m in contingent capitation (and have the right to increase fees by up to 3%).

Once the performance framework is implemented, Health NZ agrees in principle to transfer the data sharing requirements and opt off option to performance funding (including SLM funding) and to integrate contingent capitation with the rest of the capitation funding. If a practice opts out of the performance framework, they will lose access to a share of $67m in performance funding.

The System Level Measures funding arrangements will be amended to reflect this change.

9. Cyber Security

The parties agree that all New Zealanders must have trust and confidence their private health information is appropriately managed and safeguarded. While reviews of recent breaches are ongoing, it is apparent there is variation in protective standards among digital health suppliers.

Health NZ, PHOs and Contracted Providers are responsible for the security and protection of health data, and it is Health NZs expectation that proactive steps are taken to meet the following requirements:

- Health sector organisations must be aligned to HISO 10029:2002 and the Health Information Security Framework (HISF) which defines policies and procedures for establishing and maintaining security of health data and systems: Security frameworks – Health New Zealand | Te Whatu Ora.
- As a minimum, all organisations that access, collect, manage or share personal health information must comply with the National Cyber Security Centre's Minimum Cyber Security Standards - Cyber Security Capability Maturity Model Level 2 (CS CMM 2): https://www.ncsc.govt.nz/protect-your-organisation/capability-maturity model/ We require a specific focus on the use of access controls and Multi-Factor Authentication (MFA) aligned to the CS-CMM 2 standards.

To improve clarity of roles and responsibilities for Cyber Assurance and Privacy, and subject to the agreement on the detailed clauses, the parties agree to incorporate additional clauses into the PHO services agreement.

Health NZ agrees to make $1M of funding as grants to practices to support their compliance with cyber security requirements.

10. Counterfactual

This in principle agreement is being circulated for feedback from contracted providers and PHOs. If that process results in feedback that can be accommodated by the parties, then they will reconvene PSAAP and seek to agree required changes to implement the agreement.

If feedback indicates that no substantive agreement is possible then Health NZ expects to offer a simple 3.16% uplift from 1 July.