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Primary Care Annual Uplift 2026: Heads of Agreement

Version: 11 June 2026.

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

1. Purpose

This paper sets out the revised in-principle agreement reached by the PSAAP negotiation team for the Annual Uplift negotiations for 2026 as of 10 June 2026. This revision responds to early feedback from General Practice forums.

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.
- Establishment of a working group to further develop the future rural funding model.

2. Key revisions:

The revisions to the original offer agreed to in-principle by the PSAAP negotiation team are:

- An overall increase in the uplift to capitation funding from 6% to 6.32%;
- Introduction of an annual minimum uplift for practices receiving transitional funding; and
- Removal of the proposed changes to the rural funding formula for 2026/27 but allocating an additional \$3.1m to R1, R2 and R3 practices who do not currently receive rural funding to be added to existing rural funding agreements.

With the removal of the rural funding formula from the offer, the required transitional funding drops to \$26.8 million to \$18.0 million. The \$8.0million of savings in transitional funding has been reinvested into the offer to enable the increase in the uplift and for the additional rural funding.

3. 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.

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- A further \$33.8 million to increase capitation rates by a further 3.16% to fund fees stability in 26/27 and to support capitation reweighting by increasing the overall capitation funding pool.
- An additional \$2.3 million has been allocated to increase CSC capitation rates and under 14s. an
- \$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.
- A 3.16% increase in rural funding costing \$0.9 million. In addition, \$3.1 million will be provided to enable R1, R2 and R3 practices who do not currently receive rural funding to be included in existing funding agreements.
- 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 \$18.0 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.

4. 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.

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5. Stable fees 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 policy

Health NZ agrees to an additional increase of 3.16% 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 8 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 6.32% (including the 3.16% cost uplift)
- Top ups for CSC holders increase by 3.80%, under 14s by 4.00% and VLCA practice top ups increase by 3.16%. This is to recognise that these cohorts may require additional funding support to enable the lower fees requirements.

Which is a total forecast additional investment of \$82.0 million excluding volume growth. This will be an enduring increase to capitation rates and is intended to increase GP capitation revenue, hold patient costs stable, and increase the pool of funding to 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.

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- The practice is receiving transitional funding and can show that they have a copayment to capitation revenue ratio such that they are not fully compensated through the 4.46% uplift for the standard 3.16% cost adjustment without a fees increase.

Health NZ will decide on the proposal within 10 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.
- Health NZ will accept the findings of the Fees Review Committee.

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.

6. 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.

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)	Recognises 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.

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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.

7. Rural Funding

The parties agree that the current rural funding model is not fit for purpose and that we need ongoing investment in rural funding to support rural based practices and communities.

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.

Rural funding will continue to be distributed via the existing local rural funding administration processes (ie SLATs, RRS) in 2026/27.

Updated rural funding

A further \$3.1M in rural funding will be provided to fund the R1, R2, and R3¹ practices who do not currently receive rural funding. This \$3.1M is available to support currently unfunded practices only – a contracted provider who currently receives Rural Funding is not eligible for additional funding.

The additional \$3.1M will be allocated for distribution via the existing local rural funding administration processes. The district-level allocations will be based on the number of newly eligible practices in each district and the proportional level of funding that those practices would have received under the new funding model.

¹ Based on the Geographical Classification for Health classification of practices' address.

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The \$0.9M uplift and \$3.1M additional funding will be included in the existing rural funding pool in future years.

The parties agree to establish a rural working group and remain committed to working together to confirm:

- 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 agree to continue to refine the rural funding framework including an exceptions process ahead of the 2027/28 negotiation.

Health NZ accepts that a transitional approach will be required to ensure no abrupt changes to patient access to services when the revised funding framework is implemented.

Letters of notice on existing contracts

On 31 March 2026, Health NZ sent letters to PHOs and practices currently receiving rural funding to give notice of our intention to exit existing Rural Funding contracts subject to PSAAP agreement of changes to Rural Funding arrangements.

As this agreement has not been reached, these notice of exit letters do not hold.

8. Transitional Funding

The parties recognise that changes arising from capitation 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

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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.
8. For the duration of the transitional funding period, Health NZ commits to ensuring that any practices receiving transitional funding receive at least 50% of the general capitation uplift provided to primary care each year.

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 11% of practices would require transitional funding to bring them up to current capitation funding.

Health NZ estimates that approximately 35% of practices will require transitional funding to smooth the combined impact of the capitation formula changes and the co-payment limitation, 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 reduce to 24% and after 4 years reduces to 10%.

The parties recognize that this proposal will advantage practices for whom standard consult fees make up <41% of revenue – estimated at 58% of practices requiring transition funding. Practices who have copay consult revenue >41% may be disadvantaged (estimated at 42% of practices receiving transitional funding/119 practices or 12% of practices nationally). Those who may be disadvantaged can seek fees uplift under the stable fees policy fees review process.

This is a total forecast investment of \$18.0M in transitional funding for 2026/27, noting the opportunity cost of the stable co-payment fees policy.

9. 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.

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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 seek agreement via Primary Care Data Governance Group and PSAAP prior to the public reporting of measures at a practice level.

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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. Public reporting at practice level would not occur in the 2026/27 year.

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.

10. 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.

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11. 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.