COMMUNITY HEALTH NEW ZEALAND — A SUSTAINABLE OPTION FOR PRIMARY CARE

A new option for staffing, funding and accessing primary care in rural and hard to staff areas

Cover image courtesy of New Zealand Doctor Rata Aotearoa

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EXECUTIVE SUMMARY

Corporate ownership of primary care is growing

Historically most GP practices were owner operated. However increasingly primary care practices are being bought up by multinational corporations, including private equity firms.

Urgent care provision is also dominated by corporate providers.

These private corporations are set to receive increasing amounts of government funding as primary care practice ownership is consolidated into corporate ownership.

Government funding for primary health is at record levels

Health New Zealand | Te Whatu Ora gives Primary Health Organisations (PHO) annual funding of around $1.56 billion. That is about $283 per New Zealander. In 2026 the funding uplift for primary care was about 13%.

Access to primary care is worsening

Primary care is struggling to find General Practitioners (GPs) to staff their services. Health NZ estimated in 2024 we were short 220 GPs and that by 2033 we will have a 25.5% shortage.[1] According to the College of GPs in 2024, 35% of GPs intend to retire in the next five years.[2]

These workforce shortages hit low income and rural New Zealanders the hardest. Around 13% of the poorest New Zealanders are not enrolled in a practice. In July 2026, a low-cost medical center in Hastings disenrolled 3,000 patients – half of its 6,000 patients – because of the GP shortage. One patient told *Hawke's Bay Today*, she expected to use ED as a first point of care.[3]

We need new alternatives to providing community primary care

One size does not fit all with respect to primary care funding and operating models. With the status quo failing, we propose an additional option to increase access in underserviced populations (particularly where there is additional stress on ED services as a result of a deficit in primary care services) wherein Health NZ sets up a primary care arm – Community Health New Zealand – allowing New Zealanders to enrol in this as their practice and PHO. Capitation funding already allocated to these patients could be used to employ GPs and deploy GPEP registrars, house officers, nurses, and allied health practitioners to provide primary care services seven days a week, and at least 16 hours a day.

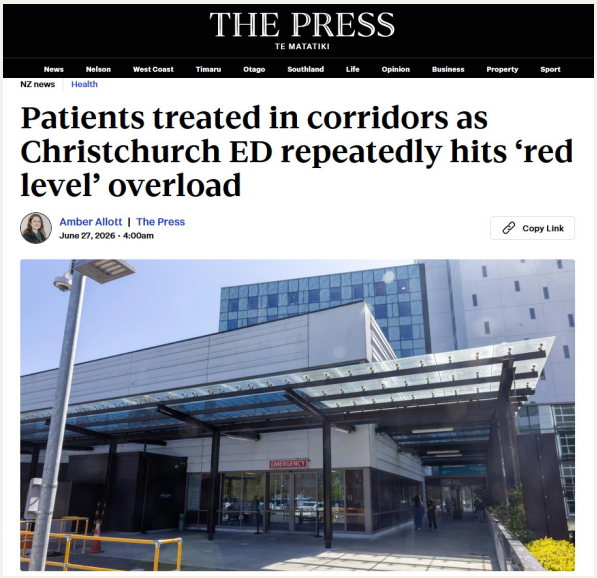
INTRODUCTION

Pressure on our emergency departments (EDs) and hospitals is mounting. Too many patients are presenting to ED because they cannot access timely, affordable primary care in the community. As a result, we are bombarded with near-daily headlines of hospitals exceeding capacity to the point where this is now the norm rather than the exception. Continuing down this path is no longer tenable.

Addressing primary care is not the only answer to easing hospital pressure. But it is part of the solution, and one of the few places where funding models and service design can be changed to relieve pressure on the system to prevent people from needing hospitalisation.

Acknowledging there are different ways of delivering primary care, this paper outlines one alternative approach to decompressing services by directing capitation funding back toward its original intended purpose – namely; providing accessible, community-based care for enroled populations.

This approach termed *'Community Health New Zealand'* could support a publicly owned primary care service that decompresses EDs by closing the primary care access gap and preventing hospitals from becoming the default point of care.



Chapter 1

THE CHANGING STRUCTURE OF PRIMARY CARE

What is primary care and what are PHOs?

Primary care covers medical and health services provided in the community – beyond hospital care – by General Practitioners (GPs), nurses and other health professionals. Good quality primary care improves population health while reducing the need for hospitalisation and resource-intensive specialist care.[4]

In Aotearoa, Health New Zealand | Te Whatu Ora contracts Primary Health Organisations (PHOs) to provide primary care within specific geographical areas. PHOs are groups of medical practices "which work together to care for patients who are registered with them" by delivering care directly or through contracts with general practices.[5]

What is the problem with PHOs and the current funding model?

Whilst historically primary care has been delivered through local owner-operated medical practices, increasingly private health corporations are taking over. One in four general practices are now owned by large corporates – a figure that is expected to rise in the coming years.[6] In June 2026, *The New Zealand Herald* reported that "two corporations are poised to consolidate control of more than 15% of New Zealand general practice, its family doctors and the primary healthcare that sits around them".[7]

These trends toward corporatisation are shifting the primary care landscape. New business-focused practices and PHOs are emerging in the wake of established local practices closing, leaving patients and staff caught in the crossfire. Within this environment, staffing and resources shift out of those communities who most need it and into regions that can afford higher co-payments.

This is why policy solutions such as offering interest free loans for GPs to buy into practices are unlikely to generate the sustainable change that primary care needs.

Much of this corporate jockeying for position is driven by structural incentives of the current funding model; based primarily on bulk funding patient enrolments with very little governance of where this funding is invested. According to an internal ministerial briefing, the structural factors impacting PHOs include:

a. PHOs receive funding that is dependent on the enrolled population of their constituent practices.

b. Practices are financially rewarded for contracting with PHOs that pass on a greater share of their funding.

c. The geographical overlap between PHOs means in some areas they 'compete' for practices to some extent, and can be incentivised to meet practice needs over those of their enrolled populations.

Yet, despite the known issues with PHOs and the funding model, no one appears prepared to challenge the power of the GP business lobby or the paradigm of capitation funding. We need more than band-aid solutions to tackle this systemic crisis.

The changing landscape of general practice

Available to all and free at the point of use, GPs were at the heart of the original plan for a national health service. When Kurow GP Dr Gervan McMillan set out the principles of a national health service for New Zealand in his 1934 pamphlet *A National Health Service – New Zealand of Tomorrow*, it included the principles that a future health service must:

> *"...[B]e based upon the principle of the provision of a family doctor for every person. The human body is a delicate and eccentric unit, and its medical attendant must have the benefit of a long and thorough knowledge of his patient. This can only be obtained by long and personal contact.*

Eighty-six years later Heather Simpson's 2020 Health and Disability System Review – which led to the restructuring of twenty District Health Boards into Te Whatu Ora – Health New Zealand – recommended that the role of PHOs be phased out:[8]

> *The Review considered the potential role of PHOs in a locality framework and concluded that split accountabilities between DHBs and PHOs for population health outcomes do not serve the objectives of the future system. While some developments by PHOs, such as the Health Care Home model, are improving service delivery in some places when compared with a traditional general practice model of care,119 at a system level, they still do little to change the paradigm.*
>
> ***It is recommended that DHBs no longer be required to contract PHOs for primary health care services,*** *and that within five years there is a deliberate move away from the National PHO Services Agreement. Alliance arrangements required by the PHO Services Agreement and DHB Operating Policy Framework should also no longer be mandatory.*
>
> *While a DHB could choose to continue to fund services via a PHO in the interim using the current PHO Services Agreement,* ***DHBs would be expected to take on the responsibility for population data analysis and the management functions currently contracted out to PHOs.*** *Funding for Tier 1 services would also increasingly be managed by DHBs and paid directly to providers through new commissioning arrangements. Health NZ would monitor this transition.*

Effectively, it was recommended that PHOs be dispensed with entirely, with Health NZ taking over these functions instead.

Of note, the shifting demographics of our medical workforce has seen a growing preference for being employed rather than being a practice owner. Gone are the days of primary care being delivered by a small group of GPs during business hours in a renovated villa, with limited administrative and nursing support. Instead, it is becoming increasingly evident that primary care is best delivered by a network of practices with medical and allied health support including psychologists, social workers and physiotherapists, and on-site pharmacy, radiology, laboratory and urgent care.

Chapter 2

PRIMARY CARE FUNDING AT RECORD LEVELS

PHOs continue to absorb a substantial portion of health budgets

According to General Practice New Zealand, over $1.56 billion dollars of government money is now provided to PHOs each year; a figure that rises every year.[9] Funding is received through a 'capitation' model, where primary care practices – through PHOs –collect annual funding for each enrolled person. Capitation amounts range from more than $800 for babies in the most deprived areas to $75 for adolescents in the least deprived areas, and are separate from patient charges (co-payments). Together, these payments fund primary care services and company profits within the sector.

PHOs are also funded to provide after-hours care. Traditionally this has involved urgent GP clinics during evenings, overnights (on call), and/or weekends. Nowadays after-hours care is usually provided by high volume urgent care centers like White Cross that lack the resourcing to deal with high acuity presentations and which many impecunious patients avoid anyway. In many communities, this PHO funding draws money away from metropolitan and rural hospital emergency departments which provide the bulk of these services.

Of note, PHO funding is received regardless of whether the patient accesses primary care services that year. PHOs also collect additional funding for "services to improve access", "health promotion", as well as PHO management fees of up to $609,870 per year.

In addition to capitation, PHOs also received management services fees of $36.3 million in addition to other funding streams including Care Plus, Services to Improve Access, Health Promotion and Immunisation. According to an *RNZ* report:[10]

> *Top-heavy, overly-bureaucratic primary health organisations (PHOs) are siphoning off too much government funding before it gets to frontline GPs, according to an independent report by a retired accountant.*
>
> *Murray Lilley told Nine to Noon his analysis of publicly available records for eight PHOs showed their overheads had increased by 70 to 100 percent in the last five years.*
>
> *"If you go back 15 years, the average cost that these people took off from all sources of government funding was less than 10c in the dollar. Now, the same organisations are taking anywhere between 20 and 50 percent."*

Chapter 3

MISSING OUT ON CARE

Barriers to primary care access

Cost

This remains one of the most obvious barriers to accessing primary care.[11] Although PHO funding subsidises GP consultations, many patients still face co-payments for appointments, prescriptions, transport, and time away from work. For low-income whānau, these costs may represent the difference between getting timely care and waiting until their condition has deteriorated significantly to the point where they need emergency care.

Availability

Setting aside affordability, many people struggle to get a timely appointment. Workforce shortages, closed enrolments, and limited after-hours services can mean that access becomes a postcode lottery. This is particularly true in rural and high deprivation communities, where the patients with the greatest health needs are often those least able to access timely primary care services.

Enrolment

Access to subsidised primary care is contingent on being enrolled with a general practice, yet hundreds of thousands of New Zealanders remain unenrolled. This means under the current capitation model the system can count people for funding without guaranteeing them meaningful access to care.

The following section explores who is currently enrolled, who is missing out, and where the gaps are most pronounced.

Who is and is not enrolled with PHOs?

According to Health NZ, in January 2026 5,115,872 people were enrolled with a PHO, representing 94% of our population. This leaves 320,338 people (6%) unenrolled and missing out on subsidised doctor visits or foregoing primary care entirely.

The table overleaf shows some district variation, with Tairāwhiti having the lowest percentage of enrolled patients (91.3%) followed by Midcentral and Hawke's Bay (both at 91.8%), then Waikato and Lakes (92.7%).

Data also indicates that 132,652 Māori or 14% of the population are not enrolled with a PHO, with the lowest enrolment rates in Auckland and Midcentral (81%), Waitematā (82%) and Counties Manukau (83%). This same data indicates 30% of Pacific people are not enrolled with a PHO in Nelson Marlborough, 26% in Tairāwhiti, and 19% in Hawke's Bay. At least some of this gap may be accounted for by Pacific regional migrant workers. Asian population enrolments are also well-below national levels in Nelson Marlborough and Capital and Coast (80%), Midcentral (81%) and Hutt Valley (82%).

Access to Primary Care by Prioritised Ethnicity (January 2026)

This report shows the number and estimated percentage of the New Zealand population (based on Stats NZ population projections) who are enrolled in a PHO by prioritised ethnicity.

	Total			Māori			Pacific		
District of Domicile	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%
Auckland	487771	520390	94%	37099	45660	81%	56233	57380	98%
Bay of Plenty	265757	287620	92%	64819	74770	87%	5417	6340	85%
Canterbury	613352	639290	96%	59154	66690	89%	19004	20010	95%
Capital and Coast	305096	328550	93%	35312	40620	87%	22672	24750	92%
Counties Manukau	629882	655470	96%	83191	100660	83%	155220	150660	103%
Hawke's Bay	172018	187360	92%	45693	52060	88%	6794	8430	81%
Hutt Valley	154936	165910	93%	26264	29410	89%	12411	13180	94%
Lakes	113581	122470	93%	41353	47030	88%	3169	3400	93%
MidCentral	181100	197200	92%	36613	44930	81%	6434	7520	86%
Nelson Marlborough	158804	169320	94%	17116	20400	84%	3241	4620	70%
Northland	196743	208800	94%	70052	76690	91%	4732	5120	92%
South Canterbury	61631	65350	94%	5418	6350	85%	1711	1870	91%
Southern	345118	372040	93%	36528	42750	85%	9981	11100	90%
Tairāwhiti	49498	54200	91%	25052	29600	85%	1363	1840	74%
Taranaki	123706	132270	94%	24290	29000	84%	1931	2000	97%
Waikato	447154	482190	93%	100017	116780	86%	16104	15620	103%
Wairarapa	50170	52445	96%	9341	10120	92%	1276	1305	98%
Waitematā	659162	689850	96%	59464	72700	82%	49160	51710	95%
West Coast	33102	34665	95%	4093	4630	88%	431	400	108%
Whanganui	67291	70820	95%	18589	21260	87%	2138	2130	100%
National	**5,115,872**	**5,436,210**	**94%**	**799,458**	**932,110**	**86%**	**379,422**	**389,385**	**97%**

	Asian			Other		
District of Domicile	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%
Auckland	170348	207410	82%	224091	209940	107%
Bay of Plenty	25845	28100	92%	169676	178410	95%
Canterbury	94958	108280	88%	440236	444310	99%
Capital and Coast	51752	64830	80%	195360	198350	98%
Counties Manukau	211051	247250	85%	180420	156900	115%
Hawke's Bay	12716	14860	86%	106815	112010	95%
Hutt Valley	28749	35140	82%	87512	88180	99%
Lakes	10665	12340	86%	58394	59700	98%
MidCentral	17088	21130	81%	120965	123620	98%
Nelson Marlborough	10391	12990	80%	128056	131310	98%
Northland	10603	11050	96%	111356	115940	96%
South Canterbury	4696	5420	87%	49806	51710	96%
Southern	31843	36520	87%	266766	281670	95%
Tairāwhiti	2446	2570	95%	20637	20190	102%
Taranaki	7600	9010	84%	89885	92260	97%
Waikato	62916	74360	85%	268117	275430	97%
Wairarapa	2530	2710	93%	37023	38310	97%
Waitematā	197131	234940	84%	353407	330500	107%
West Coast	1752	1765	99%	26826	27870	96%
Whanganui	3410	3750	91%	43154	43680	99%
National	**958,490**	**1,134,425**	**84%**	**2,978,502**	**2,980,290**	**100%**

Note: The estimated percentage of those who are enrolled in a PHO may exceed 100% as data is sourced from two different places (Enrolment submissions to HNZ & Stats NZ).

There is a clear inverse link between socioeconomic deprivation and PHO enrolment. Areas with the least deprivation (NZ Dep 1-2) have full coverage for PHO enrolment, whereas 13% of people in the most deprived regions (NZ Dep 9-10) are not enrolled with a PHO.

NZ DEP 1-2	NZ DEP 3-4	NZ DEP 5-6	NZ DEP 7-8	NZ DEP 9-10
102%	95%	93%	91%	87%

PHO enrolment is also graded by age. Within 15-24 year olds, districts with universities including Southern, Midcentral, Auckland and Capital and Coast have large numbers consistently unenrolled (6% of the population), which may reflect international student numbers.

0-4 year olds	5-14 year olds	15-24 year olds	25-44 year olds	45-64 year olds	65+ year olds
95%	99%	87%	92%	95%	98%

Nationally, only 73% of general practices were enrolling new patients or enrolling with restrictions nationally during the December 2025 quarter. That leaves over a quarter (27%) of GP practices around the country not open to enrolling new patients.[12]

Our failure to provide an effective, responsive and affordable primary care service has knock-on impacts right through the health system, but particularly on EDs, which see large numbers of non-acute patients who either cannot access or cannot afford a GP or mental health appointment. In response, some EDs, including Starship Hospital, have begun employing GPs to provide primary care in hospitals.

Chapter 4

AN OPTION FOR SUSTAINABLE PRIMARY CARE

There are five interlinked problems with the current model of primary care.

1. **Too few GPs and other primary care professionals;**
2. **Too many patients needing (often complex) care;**
3. **A capitation funding model that drives 15 minute appointments regardless of complexity and incentivises less attendance;**
4. **Cost barriers to accessing care; and**
5. **Increasing private ownership of health.**

If New Zealand continues to double down on a model of primary care that is failing some of our most vulnerable populations and adding overwhelming pressure to our ED services, these problems will only worsen. We need a new option that ensures everyone has access to primary care when they need it.

Taxpayers are now paying twice for primary care services: once through PHOs and again through Health NZ, who are increasingly left to plug gaps in primary care within EDs.

An alternative, sustainable way forward is for Health NZ to create its own primary care arm, organised either nationally or within the four regions (Northern, Midland, Central, and South Island). This primary care service, which we have termed *Community Health New Zealand*, would have the immediate ability to employ GPs and deploy GPEP registrars and house officers on GP pathways, as well as nurses and allied health staff. It would be self-funded, publicly owned, and would have flexibility to provide both high-volume and time-sensitive appointments (e.g., via tele-health) as well as timely care for complex, high health needs patients.

Under this model, seven-day services could be delivered over extended hours, rather than the traditional Monday to Friday business hours of general practice. Further, utilising the resources of the national health service, *Community Health New Zealand* could tackle significant population health interventions at scale; drawing on the expertise of staff already employed in Health NZ including in areas like public health, paediatrics, and psychiatry.

Having the same primary and secondary care providers eradicates any interfacing difficulties between systems. Primary care would also benefit from having access to a single national suite of services including IT, payroll & HR, property and procurement. We would also see pay parity issues between primary and secondary services disappear, to the benefit of workforce recruitment and retention. And in hard to staff areas, such as Tairāwhiti, Northland and South Auckland, primary care services could be delivered directly from the hospital or other Health NZ sites in the community.

Most importantly, this model is scalable. Other practices could affiliate with *Community Health New Zealand* and directly receive a fixed proportion of capitation funding as well as any other services funding. Patients who then accessed hospital or other specialist services, who were not already enrolled in a PHO or practice could also be auto enrolled into this primary care arm. Longer term, *Community Health New Zealand* could be funded to purchase GP practices across the country, establishing a network of Health NZ primary care centers.

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