Hauora Taiwhenua Rural Health Network



Hauora Taiwhenua

RURAL GENERAL PRACTICE SURVEY 2026

October 2026

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ABBREVIATIONS

ESU	Enrolled Service User	**FTE**	Full-time equivalent
GCH	Geographic Classification for Health	**NP**	Nurse Practitioner
PHOSA	PHO Services Agreement	**PRIME**	Primary Response in Medical Emergencies
RNZCGP	Royal New Zealand College of General Practitioners	**VLCA**	Very Low Cost Access

EXECUTIVE SUMMARY

A Sector Under Pressure, Yet Adapting

> This third survey of rural general practice shows a sector demonstrating resilience, innovation and commitment to its communities while under significant workforce, funding and infrastructure pressure. Responses from 141 of the 241 rural practices, covering 60% of rural enrolled patients, confirm that rural primary care remains under considerable strain while adapting to a rapidly changing environment.

An Expanded Rural Sector Facing Workforce Shortages

Health NZ-led changes to the definition of rural practices increased the number of recognised rural practices from 190 in 2024 to 241 in 2026. Workforce pressures remain substantial: almost half (48%) of practices report a GP vacancy, and locums now provide around 11% of GP capacity. At the RNZCGP benchmark of one GP per 1,300 patients, the number of GPs required has risen from 574 to 752, and an overall vacancy rate of around 20% means the sector is short by approximately 151 GPs.

Rural Practices Deliver More Than Primary Care

Rural practices provide services well beyond routine primary care, including urgent and emergency care, after-hours services, palliative care, hospital-substitution activities, workforce training and extra services during seasonal population surges. Many carry responsibilities that are essential to their communities but are not adequately recognised or supported by existing funding.

Multidisciplinary Teams Are Strengthening Capacity

Rural practices are responding to workforce shortages by strengthening multidisciplinary care. Employed Nurse Practitioners have more than tripled since 2024, and physician associates and paramedics are increasingly part of rural teams. Alongside a highly skilled rural nursing workforce, these developments are expanding clinical capacity and helping maintain access to care despite ongoing GP shortages.

Infrastructure Is Constraining Growth

Most practices remain open to new enrolments, but many face workforce shortages, rising demand and ageing or constrained facilities. Nearly half say their premises are no longer fit for purpose, limiting their ability to expand services, recruit staff and host students.

Rural Practices Are Investing in the Future Workforce

Practices are heavily involved in student placements and training, and a majority would like to host more learners. Limited supervisor capacity, accommodation and infrastructure are holding them back.

Why This Survey Matters

This biennial survey is one of the most comprehensive and up-to-date assessments of rural general practice in New Zealand. By tracking workforce capacity, service demand, infrastructure and models of care over time, it provides a robust evidence base for rural health advocacy, helping policymakers, funders and health system leaders understand the pressures on rural providers and their critical contribution to rural communities. This evidence informs workforce planning, funding decisions, infrastructure investment and policies that support equitable access to healthcare for rural New Zealanders.

VITAL SIGNS

The temperature of rural general practice remains critically low

Combining the two survey measures of morale and sustainability, the overall 'temperature' of rural general practice is **−30.2** in 2026, compared with −37.3 in 2024 and −39.0 in 2023. It has improved, but remains well below zero.

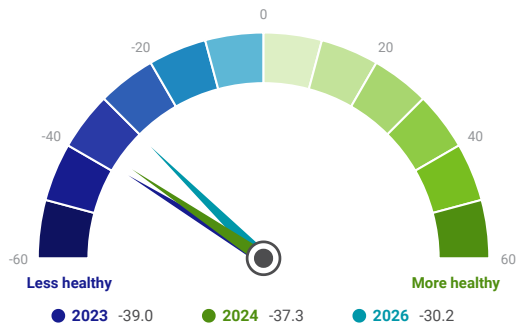


Figure 1 *Combined temperature of rural general practice: net score trend, 2023–2026*

KEY FINDINGS

Workforce

151
rural GPs missing nationwide, compared with 130 in 2024, broadly reflecting the 27% increase in rural general practices

48%
of practices have a GP vacancy, unchanged from 2024

1:1,602
patients per GP, compared with 1:1,598 in 2024

Service provision

66%
of practices are fully open to new enrolments (61% open in 2024); a further 25% are partially open

43%
of practices' patients access urgent and after-hours care via telehealth with referral to hospital ED

88%
of practices are significantly affected by summer recreation population surges

Facilities

45%
operate from commercially leased premises, impacting options for facility development

46%
regard their facilities as inadequate for the services they provide (33% in 2024)

Education and training

1,243
training placements in the past three years; 30% were for six months or longer

85%
want to host students in the next 12–18 months (87% in 2024); a lack of supervisory capacity is a major barrier to hosting students

IN THEIR WORDS

What respondents told us

Survey comments reveal a sector under significant strain. Workforce shortages, particularly the inability to recruit and retain permanent GPs, were the most frequently raised concern. Practices described growing reliance on locums, concerns about upcoming retirements, and competition from urban services and telehealth providers. Respondents also highlighted increasing workload pressures, staff burnout, and difficulty meeting rising patient demand.

A strong theme was that rural practices are expected to provide a broader range of services than urban practices, including emergency response, after-hours care, palliative support, hospital substitution activities and community transport solutions, while operating within funding models that do not adequately recognise these additional responsibilities. Many respondents emphasised the critical contribution of their interprofessional team members, and highlighted infrastructure constraints, ageing facilities and housing shortages as barriers to workforce growth and service sustainability.

Despite these challenges, many practices expressed a strong commitment to their communities and pride in the care they continue to provide under increasingly difficult circumstances.

Section 1

SURVEY RESPONDENTS AND THEIR ENROLLED PATIENTS

Of the 241 rural general practices surveyed, 141 responded (59%), providing a statistically robust picture of the sector. How the survey was distributed and analysed is set out in the methodology box on page 6.

- The number of ESU attracting rural funding increased from 746,424 in 2024 to 977,711 in 2026, an increase of 31%, in line with the 27% increase in the number of practices considered rural.
- Proportionately more R3 practices are Very Low Cost Access (VLCA) practices (77%), most likely reflecting the larger proportion of rural Māori and high social deprivation populations living in the areas cared for by these respondents.

OUR SURVEY OVER TIME

2023 — **First survey**
Hauora Taiwhenua's first stocktake of rural general practice

2024 — **103 responses (54%)**
of 190 PHOSA-funded practices, caring for 385,528 ESU

2026 — **141 responses (59%)**
of 241 GCH rural practices, caring for 586,267 ESU

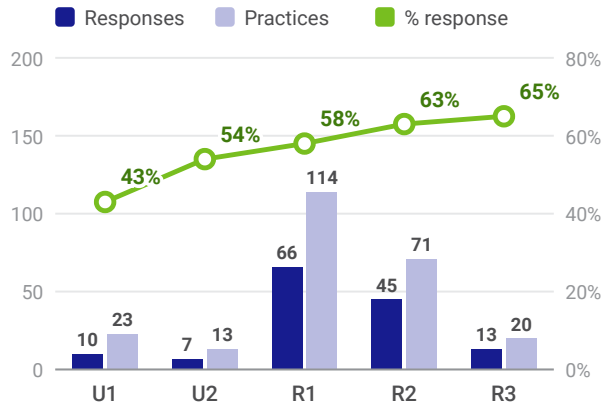


Figure 2 *Who responded to the survey: 141 responses from 241 eligible practices (59% overall response rate), by GCH category*

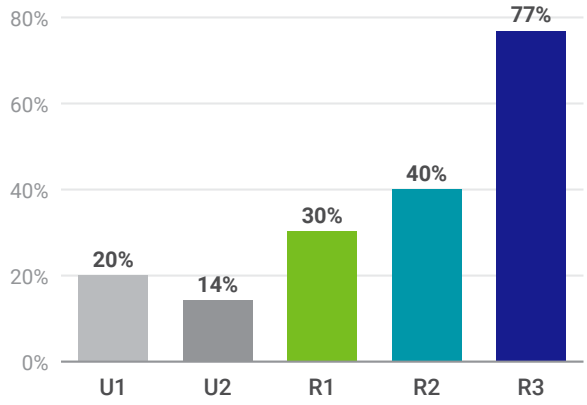


Figure 3 *Percentage of responding practices that are VLCA, by GCH category*

VITAL SIGNS

Practice sustainability

Asked whether their practice is sustainable in terms of its overall health, respondents returned a net score of **−37.4** in 2026. This is an improvement on −57.3 in 2024 and −53.1 in 2023, but the score remains firmly negative.

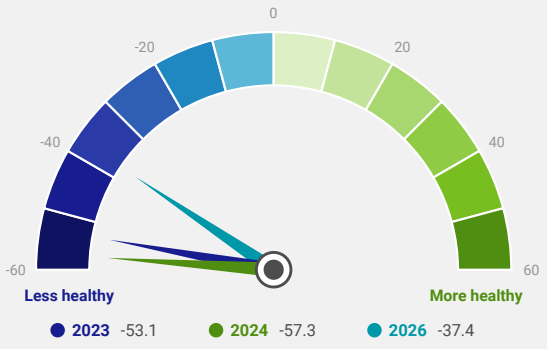


Figure 4 *Our practice is sustainable in terms of its overall 'health': net score trend, 2023–2026*

SURVEY RESPONSES

The changing shape of rural general practice

The substantial increase in the number of rural general practices, enrolled service users and workforce numbers between 2024 and 2026 is largely driven by Health NZ including the GCH with the PHOSA methodology to determine eligibility for rural primary care funding (see Survey methodology and limitations below). The survey responses include 17 out of a total of 36 U1 and U2 practices that receive rural funding under the PHOSA methodology. Rates and ratios show that while rural GP shortages remain largely unchanged, the rapid growth of the Nurse Practitioner workforce is making an increasingly important contribution to rural workforce sustainability and enabling rural communities access to primary care.

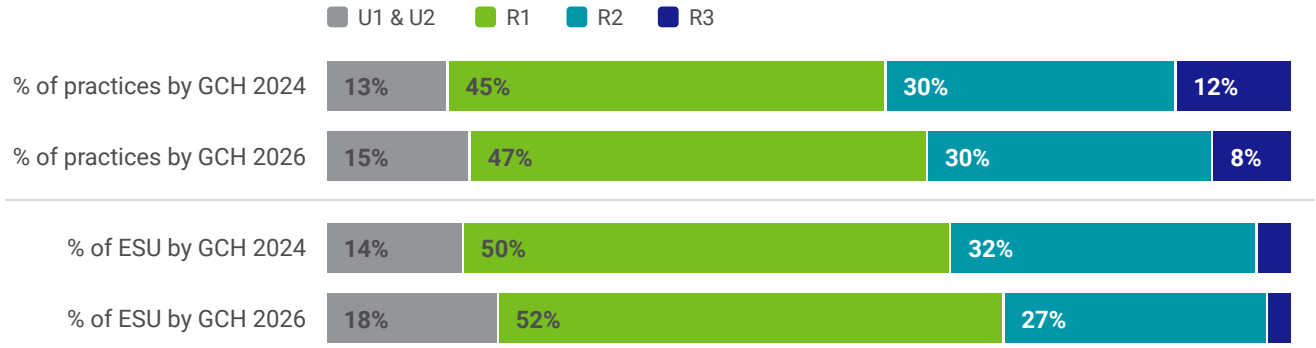


Figure 5 *Changing shape of rural general practice: share of rural practices and ESU, by GCH category, 2024 and 2026*

Survey methodology and limitations

Who was surveyed? Health NZ provided a March 2026 extract of all 260 contracted rural primary care contracts. Inactive contracts were excluded, and contracts with fewer than 60 ESUs were consolidated with the main contracted provider, resulting in a survey population of 241 rural general practices. This included 23 U1 and 13 U2 practices that receive rural funding under the PHO Services Agreement (PHOSA) methodology. A total of 141 practices responded (59%), representing 586,267 ESUs, or 60% of all ESUs enrolled with rural practices.

A larger rural sector. Between 2024 and 2026, Health NZ added practices classified as rural under the GCH 2023 to those recognised under the PHOSA methodology. The 2026 survey therefore covers 241 practices and 977,711 ESU, compared with 190 practices and 746,424 ESU in 2024. Absolute numbers are not directly comparable, so change is measured using rates, ratios and proportions.

National estimates. National estimates were extrapolated from survey results, using the 59% ratio of responding practices to total practices.

GCH categories. The Geographic Classification for Health (GCH), developed by the University of Otago to support health policy, funding, service planning, research and monitoring, groups communities by their level of rurality and access to health services into five categories: U1 (Urban 1), U2 (Urban 2), R1 (Rural 1), R2 (Rural 2) and R3 (Rural 3). U1 represents large metropolitan cities and R3 the most rural and remote communities.

Rural nursing workforce data is not included. Respondents to the 2024 survey found it difficult to provide reliable nursing workforce data, because many rural nurses work part-time FTE and across more than one team. We therefore decided not to collect nursing workforce data in the 2026 survey. This means the significant role rural nurses play in the multidisciplinary team is not captured in this report.

Limitations. Responses are self-reported at a point in time, and responding practices may differ from those that did not respond. Not every practice answered every question; some questions depended on earlier answers and some allowed more than one response. National figures should only be used as indicative estimates.



Section 2

THE RURAL GENERAL PRACTICE WORKFORCE

The survey paints a picture of a rural workforce that is simultaneously growing and adapting, but still under significant pressure. Longstanding GP workforce shortages remain stubbornly entrenched, and practices are increasingly relying on locums and alternative workforce models to maintain services.

574 → 752

Based on the RNZCGP benchmark of one GP per 1,300 rural patients, the estimated GP requirement for the expanded rural general practice sector has increased from 574 to 752 GPs. Meeting this additional demand will be challenging, given that rural general practice continues to experience an overall GP vacancy rate of around 20%. The growing gap between workforce requirements and available GPs highlights the increasing pressure on rural practices and the importance of multidisciplinary teams in maintaining access to care.

WORKFORCE

GP workforce shortages remain unchanged

48%
of responding practices have a GP vacancy

When locum-filled roles are treated as vacancies, because they do not provide long-term workforce stability, responding practices were effectively operating with 92 vacant GP FTE: an **overall vacancy rate of 20.1%**, which is virtually unchanged from the 19% vacancy rate in 2024. This means that there are approximately 151 rural GPs missing from the sector.

Almost half of practices reported a GP vacancy, as was the case in 2024. Some practices remain particularly vulnerable, with 10 respondents relying on a single GP and a further six operating with less than one GP FTE, supported by locum cover.

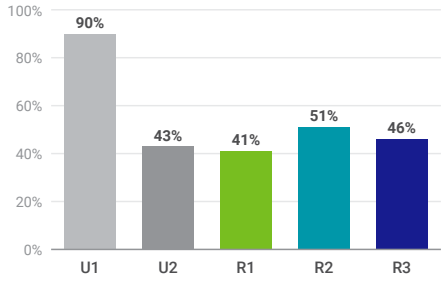


Figure 6a *The % of responding practices with a GP vacancy, by GCH category*

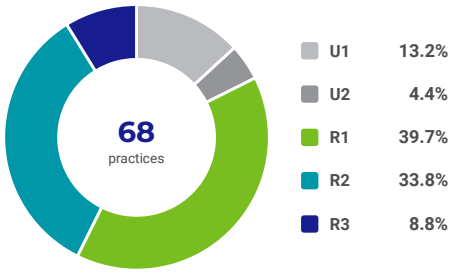


Figure 6b *Distribution of GP vacancies, among responding practices (48% of respondents) by GCH*

Vacancy rates persist

The effective rural GP vacancy rate increased slightly from 19.0% in 2024 to 20.1% in 2026, indicating that the underlying workforce shortage has not materially improved despite ongoing workforce initiatives. While the number of vacant GP positions reported by responding practices fell from 54 to 42, this reduction was largely offset by increased reliance on locums, with GP locum FTE rising from 24 in 2024 to 50 in 2026.

WORKFORCE

Increasing reliance on locums

There is a growing reliance on locum doctors. In 2024, locums accounted for approximately 7.5% of GP capacity among respondent practices. By 2026, that figure had increased to 11%. Applying that rate nationally suggests rural practices may be relying on as many as **82 GP FTE provided by locums**, up from 44 in 2024.

While locums play a critical role in maintaining service continuity, heavy dependence on temporary staffing can increase costs, reduce continuity of care, and create challenges for workforce sustainability.

> *We desperately need at least one GP. We cannot wait for new training centres to be built. Lots of our town GPs are nearing retirement age.*
>
> SURVEY RESPONDENT

WORKFORCE

Nurse Practitioners emerge as a major workforce success story

The most positive finding in the survey is the rapid growth of the rural Nurse Practitioner (NP) workforce. Between 2024 and 2026:

27 → 86
Employed NP FTE in responding practices

24 → 78
Responding practices employing an NP

The NP workforce has **more than tripled**, with employed NP FTE in responding practices growing from 27 in 2024 to 86 in 2026, demonstrating that rural practices are increasingly embracing Nurse Practitioners as an integral part of the multidisciplinary care team. R1 practices experienced the largest increase, adding around 30 NP FTEs, although this may be partly influenced by their higher representation among survey respondents.

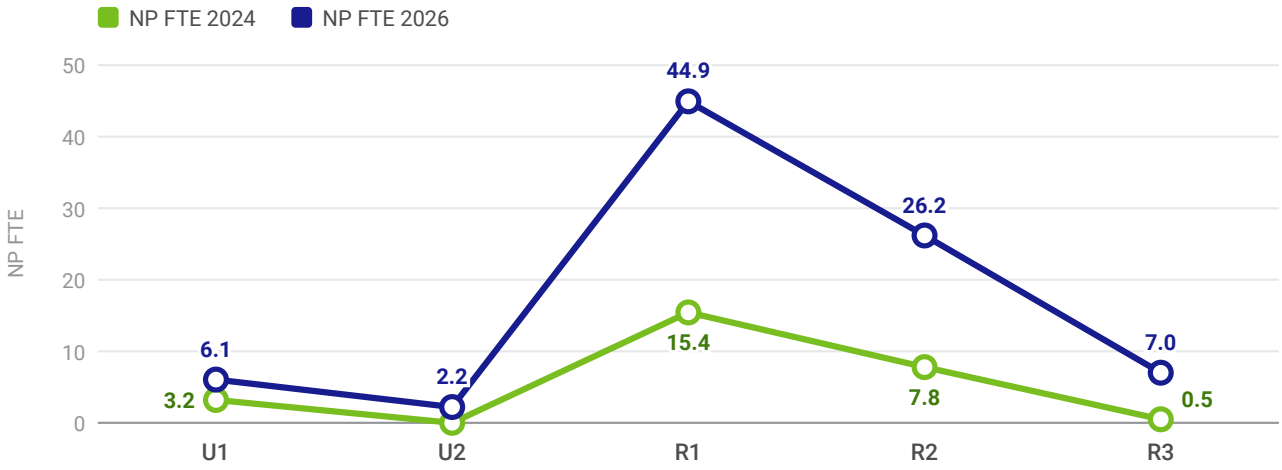


Figure 7 *Increase in Nurse Practitioner FTE in responding practices, by GCH category, 2024 and 2026*

> *We rely increasingly on training up Nurse Practitioners to work in our practice.*
>
> SURVEY RESPONDENT

> *Recruitment of clinicians is the hardest it has ever been. Cannot get a GP or NP to work on site, only offering seems to be remote telemedicine, but patients want to be seen in person, face to face.*
>
> SURVEY RESPONDENT

WORKFORCE

Clinical workload across the multidisciplinary team

Note: The RNZCGP GP-to-patient ratio is the only recognised clinical workload benchmark and, while not ideally suited to multidisciplinary rural practice models, has been applied consistently across both surveys to support comparison.

- The average ratio of GP to ESU across all responding practices was **1:1,602**.
- Combined NP and GP teams lower the ratio to **1:1,295**.
- U1, U2 and R1 were relatively consistent, at around 280–290 ESU per GP above the RNZCGP recommended ratio of 1 GP to 1,300 patients.
- R2 recorded the highest GP ESU (1,668), exceeding the RNZCGP benchmark by 368 patients per GP.
- R3 stands out, with the lowest GP ESU (1,367) and GP & NP ESU of 918, resulting in a comparatively higher cost per ESU.

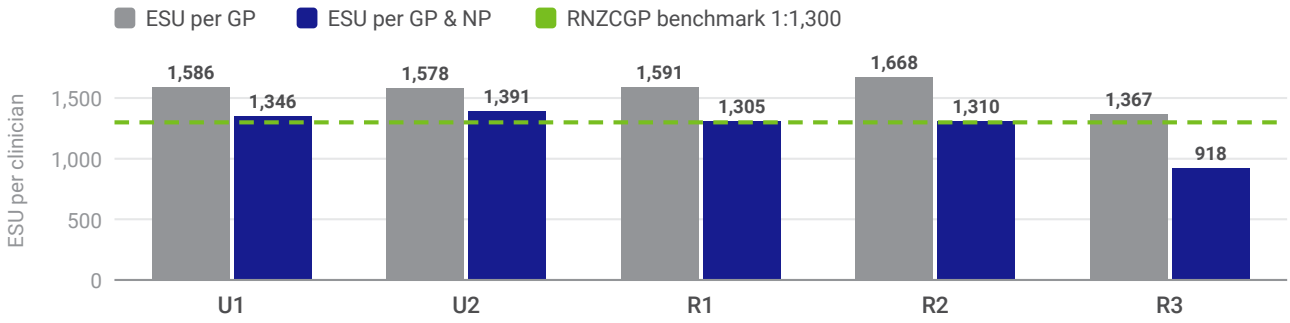


Figure 8 *Ratio of GP, and GP and NP, to ESU, by GCH category*

While the substantial increase in Nurse Practitioners since 2024 is a key driver of the reduction in clinical workload, the continued expansion of rural multidisciplinary teams including Registered Nurses, Physician Associates, and Paramedics is effectively increasing clinical capacity.

WORKFORCE

Expanding multidisciplinary teams

While GPs make up the largest proportion of the workforce in every category, Nurse Practitioners, Paramedics and Physician Associates **play a much greater role in the clinical teams in R2 and R3 practices**. While this survey does not measure the contribution of registered nurses, we recognise their critical role and will endeavour to capture this in the 2028 survey.

55%
of practices employ a Nurse Practitioner

16%
employ a Paramedic

7%
employ a Physician Associate

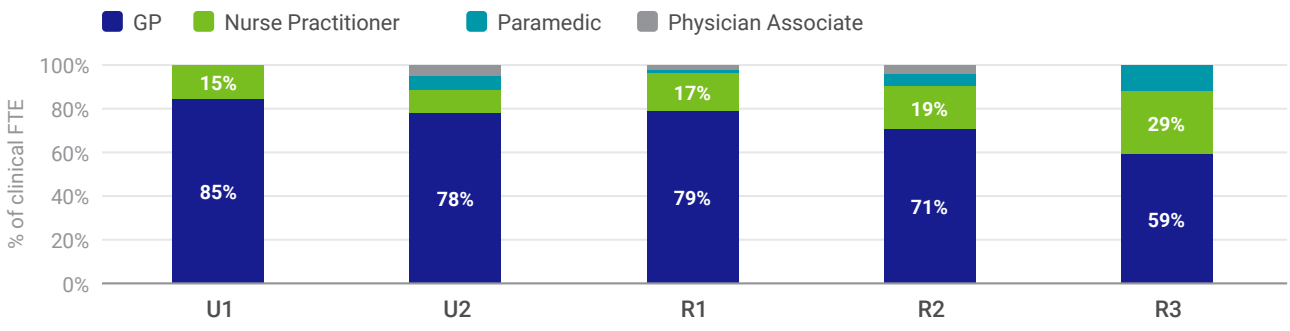


Figure 9 *Composition of multidisciplinary teams in rural general practices (% of clinical FTE), by GCH category*

Section 3

SERVICE PROVISION

SERVICE PROVISION

Accepting new enrolments

- **Two-thirds (66%) of practices are fully open** to new enrolments, and a further 25% are partially open. Nine percent are closed to new patients.
- Workforce shortages and limited GP availability are the main barriers to practices being able to accept new enrolments.
- Many practices restrict new enrolments to ensure their existing patients are able to access services when they need to.
- Many practices prioritise enrolling patients who are new to the area, those without a GP, and people living within the local catchment.

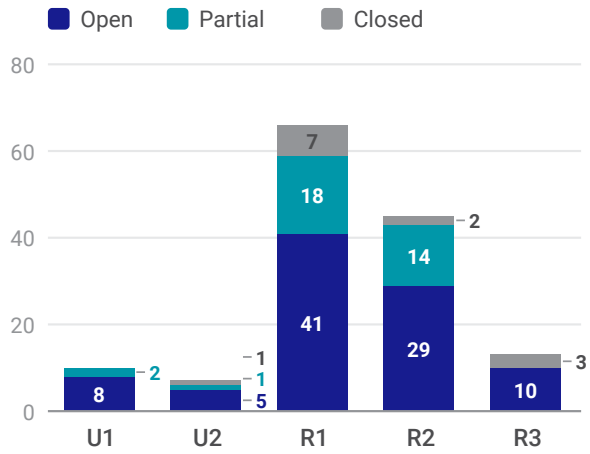


Figure 10 *Practices accepting new patients, by GCH category (number of practices)*

> *We are both the urgent care provider and the immediate emergency response.*
>
> SURVEY RESPONDENT

> *Patient load and low clinical staffing resources at times like these are exhausting for all the team. We try our best but it sometimes feels like there is no light at the end of the tunnel.*
>
> SURVEY RESPONDENT

WORKFORCE WELLBEING

Staff energy and motivation is under strain

Asked whether staff in their practice are energised and motivated, respondents returned a net score of **−22.9** in 2026, down from −17.3 in 2024 and close to the −24.8 recorded in 2023.

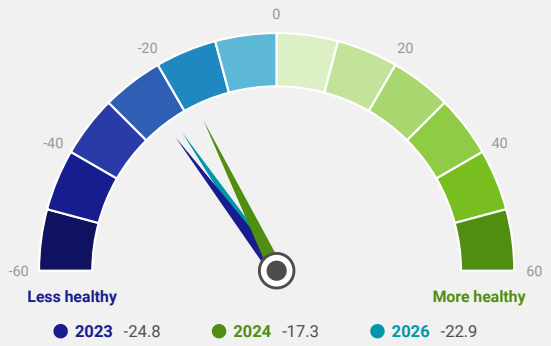


Figure 11 *Staff in our practice are energised and motivated: net score trend, 2023–2026*

SERVICE PROVISION

Urgent and after-hours care

- Experiences varied across communities. Some reported reduced local access to after-hours services, while others benefited from new urgent care clinics, expanded services or increased staffing.
- Telehealth with referral to hospital ED is the most common way patients of rural practices access urgent and after-hours care. This could mean many rural patients face significant travel time and expense to access care.
- Most practices reported no significant change to their after-hours arrangements over the past year. Where changes had occurred, they most commonly involved greater use of Ka Ora, the national rural telehealth service, and other telehealth providers to support after-hours care, often reducing reliance on locally provided GP-led after-hours services.
- Several practices reported growing demand for after-hours care, contributing to longer wait times and increased use of emergency departments.

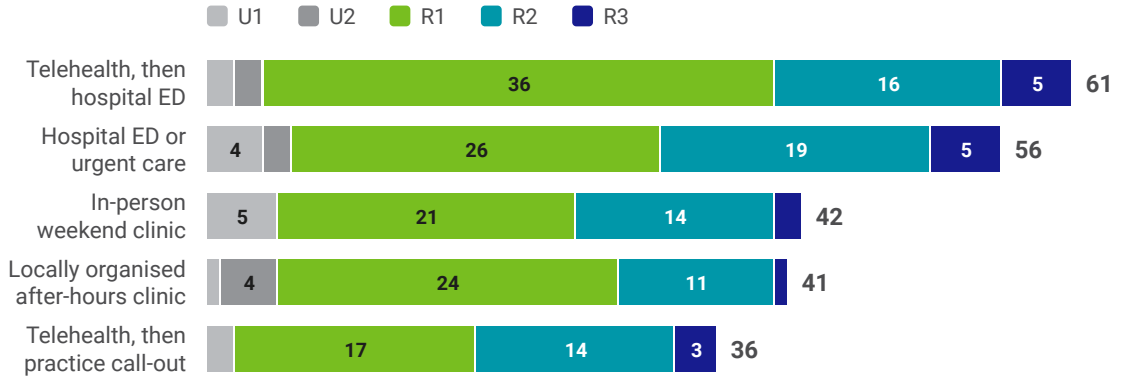


Figure 12 *How patients access urgent and after-hours care, by GCH category (number of practices; more than one option could be selected)*

> *There is no additional funding for the clinical time, staffing, equipment or disruption this creates; we manage it because there is no safe alternative.*
>
> SURVEY RESPONDENT

SERVICE PROVISION

Rural community access to emergency care services

Access to transport and ambulance availability were the most frequently named barriers to emergency care, while helicopter and air transport, followed by ambulance services, were the most frequently named enablers.

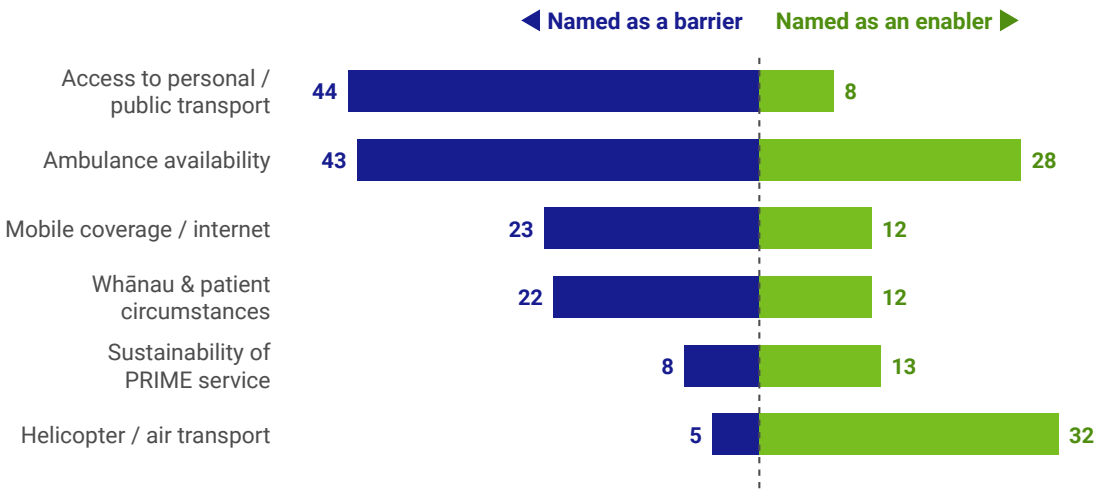


Figure 13 *Barriers and enablers of emergency care in rural communities (number of practices)*

SERVICE PROVISION

Responding to seasonal surges in population

88% of practices are significantly affected by summer recreation population surges, and most are also affected by winter recreation seasons and major events. The most common approach to increasing clinical capacity to meet the extra demand is through additional locum or casual staff, but many practices make no special arrangements.

2.68
average level of impact of summer recreation surges, on a scale of 1 (low) to 4 (high)

88%
affected by summer recreation (3–4 months)

86%
affected by winter recreation (3–4 months)

77%
affected by major entertainment or sporting events

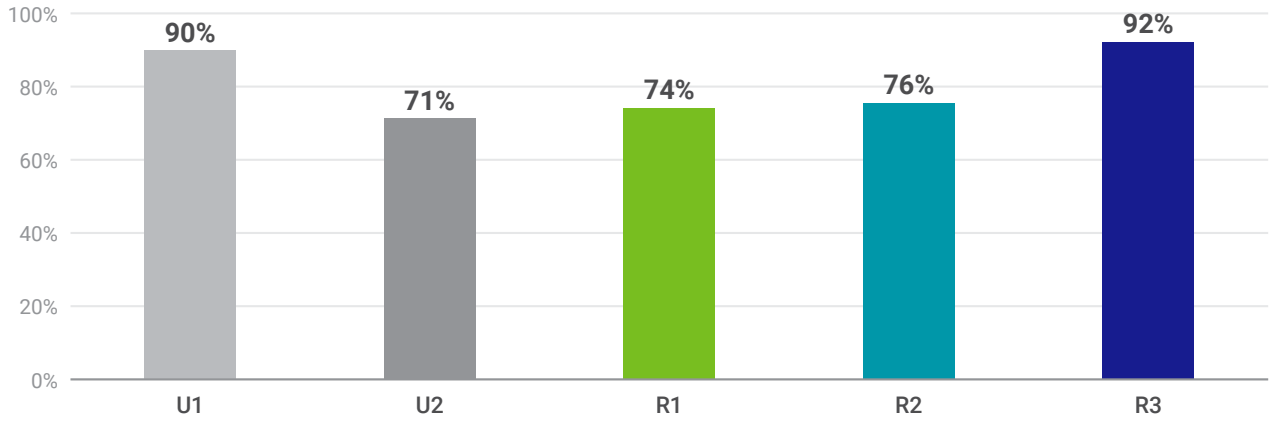


Figure 14 *Percentage of responding practices impacted by seasonal population surges, by GCH category*

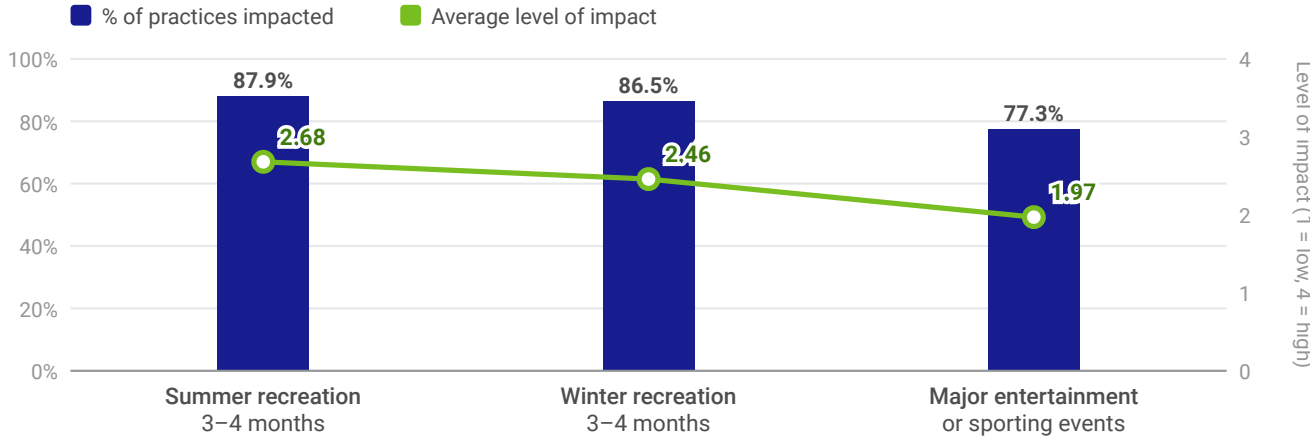


Figure 15 *Reasons and extent of seasonal population surges*

Section 4

RURAL GENERAL PRACTICE FACILITIES

The ownership model of rural general practice facilities appears less important than the common challenge experienced across all ownership types: insufficient space to meet growing demand. Regardless of whether premises were owned, leased commercially, or operated through community trusts, practices repeatedly reported:

- Limited capacity to expand services
- Insufficient consultation rooms
- Inability to accommodate additional clinicians
- Difficulty hosting students and visiting providers
- Growing populations outpacing facility capacity

FACILITIES

Facilities fit for purpose

54.4% of practices rated their facilities generally fit for purpose, down from 67% in 2024. The remaining 45.6% do not regard their facilities as being fit for purpose.

FACILITIES

Facility ownership models

- Almost **half of rural general practices operate from commercially leased premises**, by far the most common model. Many practices therefore have limited control over building expansion, redevelopment and long-term infrastructure planning.
- Approximately one quarter (**24.2%**) own their own facilities. Ownership provides greater autonomy and security, but does not on its own solve infrastructure challenges: many owners need additional rooms and larger treatment areas. A lack of funding for expansion projects was cited as the most common barrier to doing so.
- A further **18.9%** operate from **Community or Iwi Trust-owned facilities**, highlighting the role that local communities and iwi continue to play in supporting rural health infrastructure. Several were described as ageing and in need of refurbishment, with funding a major barrier to upgrades.

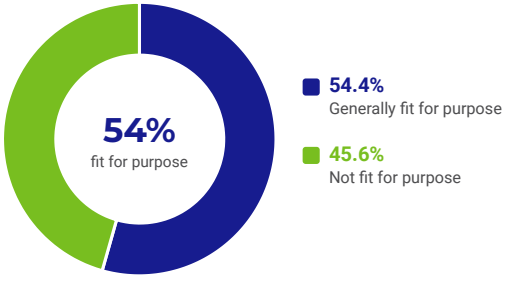


Figure 16 *Are our facilities fit for purpose?*

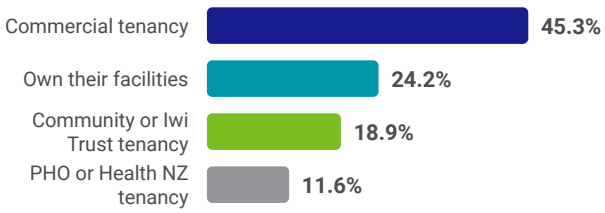


Figure 17 *Facility ownership models (% of practices)*

Section 5

TRAINING THE FUTURE RURAL HEALTH WORKFORCE

EDUCATION AND TRAINING

The range of students on placement

97% of survey respondents completed this section; response numbers vary across answered questions (see Survey methodology and limitations, page 6).

A total of **1,243 training placements** and workforce development opportunities were delivered by responding practices over the past three years. Extrapolating this nationally results in an estimated **2,130 training placements** provided by all rural practices over a three-year period. Medical students accounted for the largest share, followed by registered nurses and then registrars. While most placements were short-term, **368 participants (30%) engaged in programmes lasting six months or longer** or participated in ongoing workplace-based training.

2,130

estimated placements across all rural practices over the past three years

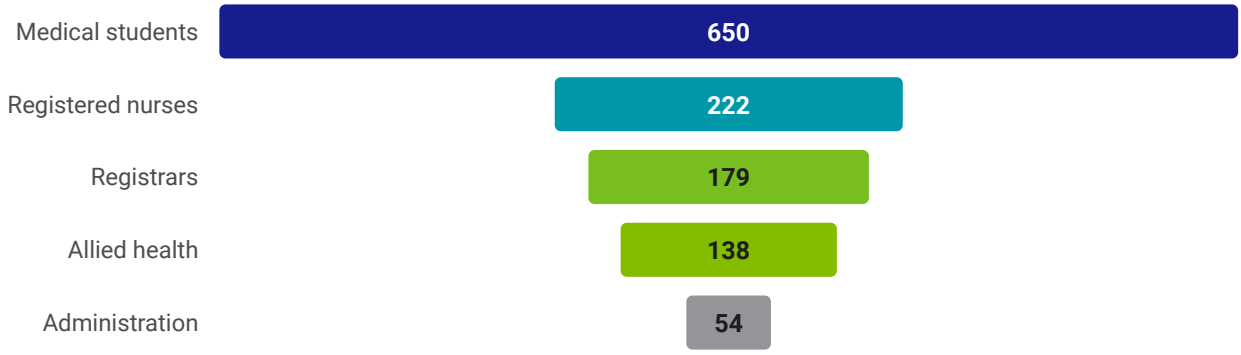


Figure 18 *Student placements in rural general practices over the past three years, by profession*

> *It is a knife edge. There is not adequate funding for the infrastructure to support the practice.*
>
> SURVEY RESPONDENT

EDUCATION AND TRAINING

Intentions to host students

85% of practices would like to host health students in the next 12–18 months, but many face significant barriers to doing so. The most commonly reported challenges are limited supervisor capacity, the cost of providing supervision, and a lack of suitable space within practice facilities to accommodate students.

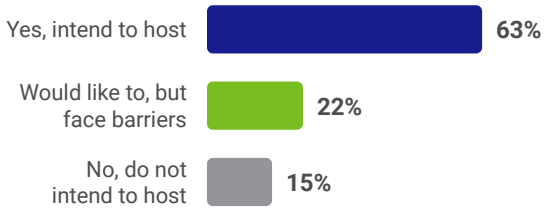


Figure 19 *Intentions to host students in the future (% of practices)*

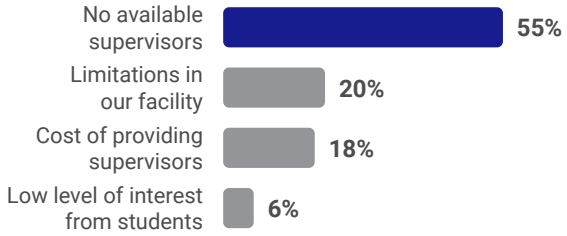


Figure 20 *Main barrier to hosting students (% of practices that named a barrier)*

EDUCATION AND TRAINING

Supporting students on placement

Only a third of practices run a coordinated support programme for students on placement with them, and practices facing barriers to hosting are the least likely to have one.

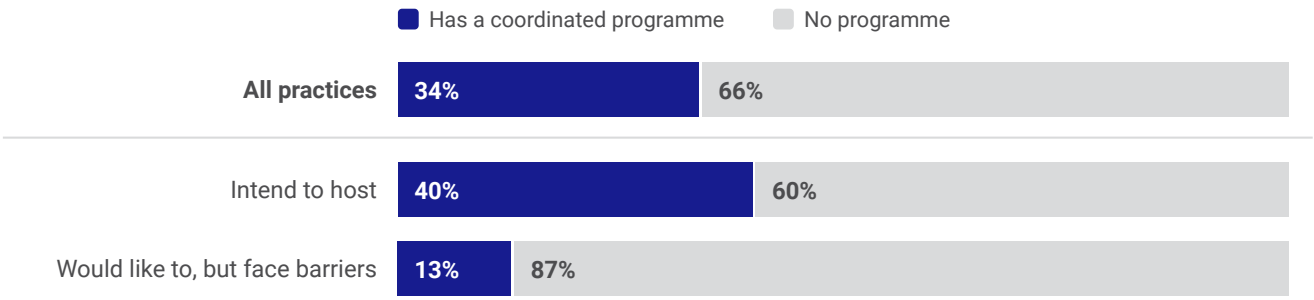


Figure 21 *Practices running a coordinated support programme for students on placement*

The programmes they offer include orientation to the practice team, systems, clinical environment and supervision arrangements. Students also spend time with community and allied health services, including district nursing, pharmacy, aged residential care, marae clinics and local social services.

Practices told us hosting students could be better supported through:

Meaningful reimbursement for supervision

Enough to cover staff time lost to teaching, or a locum to free up GP time, rather than a token amount.

Help with travel

Many rural clinics have no public transport, and daily commuting from cities is not sustainable.

Coordination and orientation

A coordinator or structured orientation that links students with local people, community groups, tikanga and Hauora Māori models of care before and during the placement.

Longer placements and a pathway to local employment

Such as bonding or a regional medical school, so that students are more likely to stay in the area.

NGĀ MIHI

Thank you

We appreciate the time that so many rural general practices took to complete this survey. Thank you for sharing your insights and information with us so that, together, we strengthen the united voice of our Hauora Taiwhenua Rural Health Network.

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