HEALTHCARE IN NEW ZEALAND

The changing role of the private sector.

10 March 2026

Contents

Executive summary

New Zealand's healthcare system is mostly publicly funded through general taxation, with a smaller but fast-growing private sector alongside it. That private system is funded through insurance, out-of-pocket payments, Accident Compensation Corporation (ACC) contributions, and increasing levels of outsourcing from the public sector.

Overall, New Zealand spends about 10% of its GDP on health – roughly 7% publicly and 3% privately. That's broadly in line with other OECD countries and, in general, delivers relatively strong health outcomes.

Even so, the system is under growing pressure. Investment has lagged rising demand and health costs, contributing to workforce shortages, ageing infrastructure and fragmented IT systems. An ageing population and wider social challenges are further pushing demand beyond capacity, resulting in longer waiting times and widening inequities in access to care.

In response, government is taking a closer look at how public and private healthcare can work together more effectively. The focus is on clear national priorities, delivering them locally, and strengthening accountability, with a bigger role for public-private partnerships.

Private providers already play a significant role, delivering GP services, diagnostics, elective procedures, and rehabilitation. Their flexible staffing and spare capacity mean they can often respond more quickly, freeing the public system to concentrate on acute care.

Outsourcing to the private sector is now common, particularly for elective procedures. These tend to be low-margin, high-volume services, that offer predictable demand and opportunities for specialisation, as well as investment in new facilities, IT consolidation, and digital equipment.

At the same time, government is partnering with Whānau Ora commissioning agencies to invest in and design community-based health services. These partnerships aim to improve health outcomes for Māori and Pasifika, especially in regional communities.

Looking ahead, an ageing and growing population and limited public capacity point to continued growth in private healthcare. However, the sector also faces challenges, including pricing pressures that risk making private care less affordable.

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Sector outlook and recommendations

Outlook.

- New Zealand's healthcare system is public-centred with meaningful private insurance cover. This is unlikely to change. US-style private healthcare is politically unpalatable, while an Australian Medicare model carries significant political, fiscal, and delivery risks.
- The public health system performs well overall, with New Zealand scoring above the OECD average on many health indicators,
- However, system capacity is increasingly constrained by a growing and ageing population as well as rising care complexity.
- While investment in public health is substantial, it is largely focused on maintaining existing services rather than addressing past underinvestment or expanding capacity. That has resulted in lengthening wait times for patients.
- Public health is shifting less complex elective procedures to private providers. Partnering allows for the unlocking of delivery capacity across the healthcare system, allowing the public system to deliver more acute and life-saving care. Expect more to come.
- That is likely to be accompanied by a sharper focus on efficiency, with economies of scale driving greater specialisation in public and private healthcare facilities.
- There are also other opportunities for private involvement, such as addressing infrastructure backlogs; i.e. upgrading and building of new facilities (often in underserved communities), the re-engineering of IT systems and the procurement of new digital equipment and supporting technologies.
- These opportunities matter as the private sector itself faces challenges, particularly rising medical inflation, which is reducing affordability, increasing insurance premiums and flattening insurance uptake.
- Despite these pressures, the outlook for private health is positive, with a growing partnership model in which more publicly funded services are delivered by private providers and demand for privately funded care continues as public capacity constraints persist.

Recommendations.

- Preserve a resilient mixed public-private health system that can respond flexibly to changing demand, smooth capacity pressures, and deliver strong, sustainable health outcomes.
- Redirect public health funding toward high-value investments that expand service capacity, lift productivity, and translate directly into shorter waiting times and improved access.
- Provide clear national goals and performance measures, supported by transparent reporting, while retaining flexibility in how services are delivered locally to meet community needs.
- Use public-private partnerships to improve efficiency, lower unit costs, and expand timely access to diagnostics, rehabilitation, and elective care through more predictable service arrangements.
- Encourage private investment to accelerate the development of health infrastructure, particularly in underserved areas, modern clinical facilities, and integrated digital and data systems.
- Concentrate public provision on primary, community, and life-saving tertiary services, where equity, population health impact, and clinical risk are greatest.
- Strengthen the long-term role of Māori and Pasifika providers to improve access, cultural responsiveness, and equity, particularly in communities with persistent unmet health needs.
- Increase specialisation and scale across services to raise throughput, contain medical inflation, and support more consistent quality and clinical outcomes.

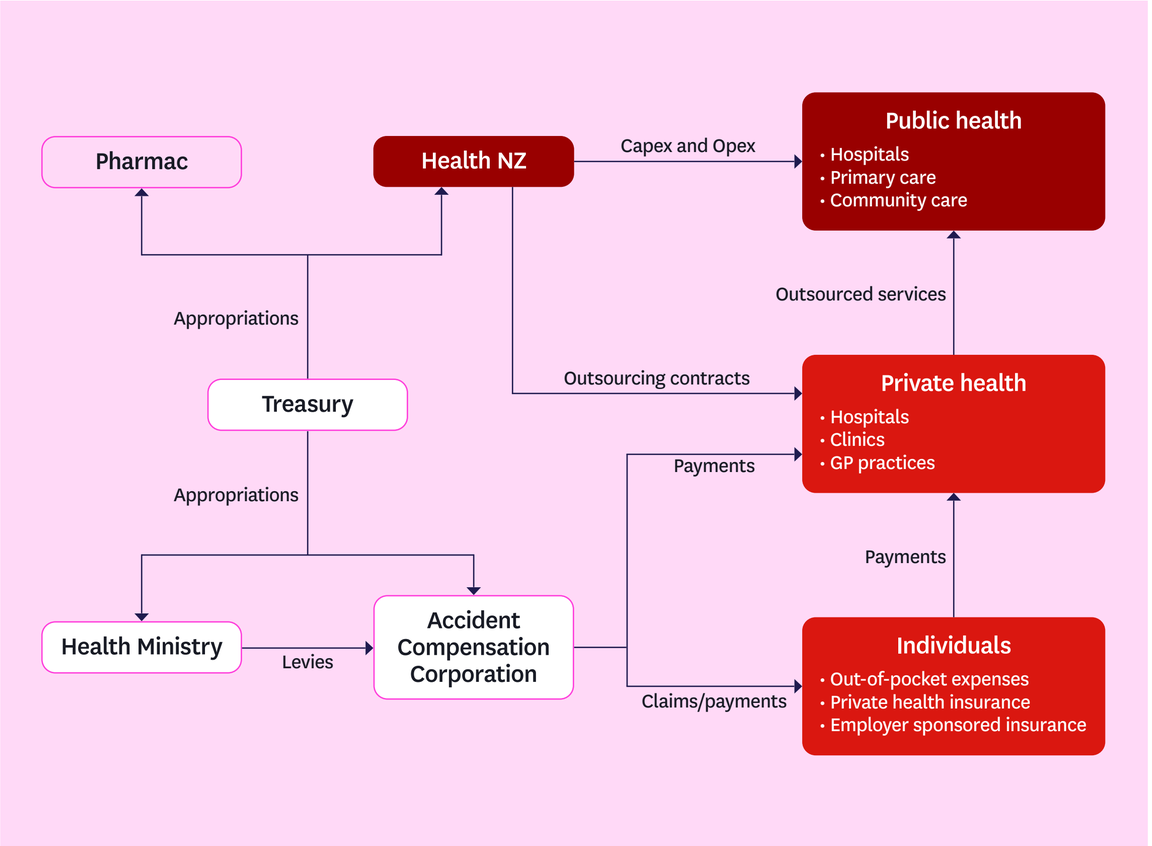
Overview of New Zealand's health system

Key entities and how they relate.

- The publicly funded healthcare system was established under the 1938 Social Security Act.
- Historically, New Zealand's public system has provided essential life saving and elective quality of life care to its residents.
- Health NZ runs the public health system, using taxation to plan, fund, and deliver hospital, primary, and community services, directly employing hospital staff while also funding independent general practices.
- It also spends on surgical and non-surgical procedures outsourced to a growing private healthcare system. That extends to capitation payments to GPs in private practice.
- Alongside the public system is a growing private health sector, largely funded by out-of-pocket payments and health insurance.
- Employers also subsidise healthcare insurance, and other initiatives aimed at improving employee wellbeing.
- In addition, the ACC funds private treatment and rehabilitation services through levies, as well as general taxation to cover those not in work.

See *Appendix A* to compare New Zealand's health system with its peers.

High level model for healthcare provision in New Zealand



Sources: Treasury, IRD, Health NZ, ACC, Westpac

Spending on healthcare

By category.

- We estimate healthcare spending in New Zealand was almost $46bn last year, equivalent to around 10% of GDP.
- About 7% of GDP is spent on public health through general taxation, covering GP co-funding, hospitals, specialist and mental health services, and community health programmes (including those that service Māori and Pasifika).
- Tax funding also supports capital investment – such as upgrades to hospitals, mental health facilities, community and specialist centres, though this is modest relative to spending on services.
- About 3% of GDP is spent on private healthcare, covering out-of-pocket spending by individuals –from co-payments for consultations to over-the-counter medicine purchases, health insurance claims, and spending by employers on wellness and/or subsidised medical insurance.
- Also included are ACC payments claimed by individuals or by private healthcare providers.
- It excludes spending by public health on outsourced services to the private sector.

Estimates of public healthcare spending by category

Category	Amount (NZ$bn)
Public health (appropriations - 2025/26 budget)	**31.05**
Ministry of Health	**0.31**
Stewardship	0.23
Support to other services	0.08
Health NZ	**28.95**
Hospital & specialist services	15.73
Primary, community, public & population health services	9.70
Capital investment	2.75
Māori services	0.77
Pharmac	**1.79**
Pharmaceuticals	1.79

Sources: Treasury, Health NZ, ACC, Westpac

Estimates of private healthcare spending by category

Category	Amount (NZ$bn)
Private health - 2024	**14.8**
Individuals	**6.90**
Out-of-pocket expenses	4.90
Medical Insurance claims (as opposed to premiums)	2.00
Employers*	**0.80**
Wellness programmes	0.80
ACC	**7.00**
Claims by individuals – treatment and rehabilitation	4.00
Claims by healthcare providers (on behalf of individuals)	3.00

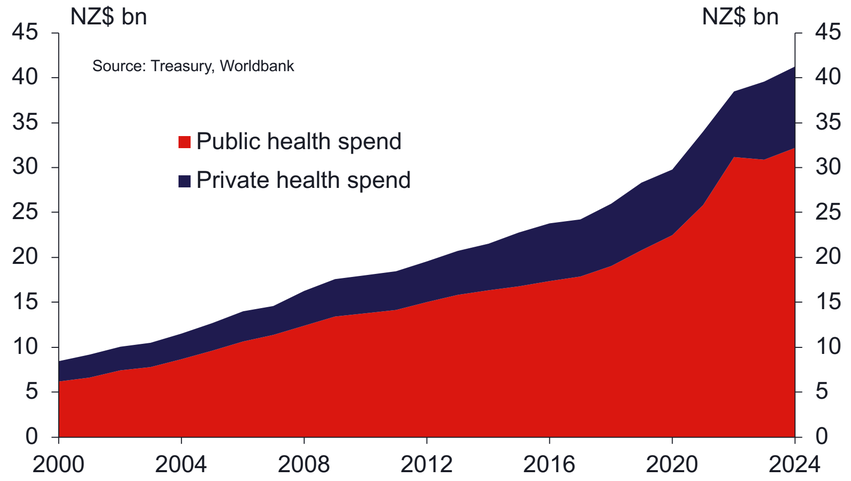
Sources: Treasury, Health NZ, ACC, Westpac

* Excludes employer subsidies with respect to medical insurance

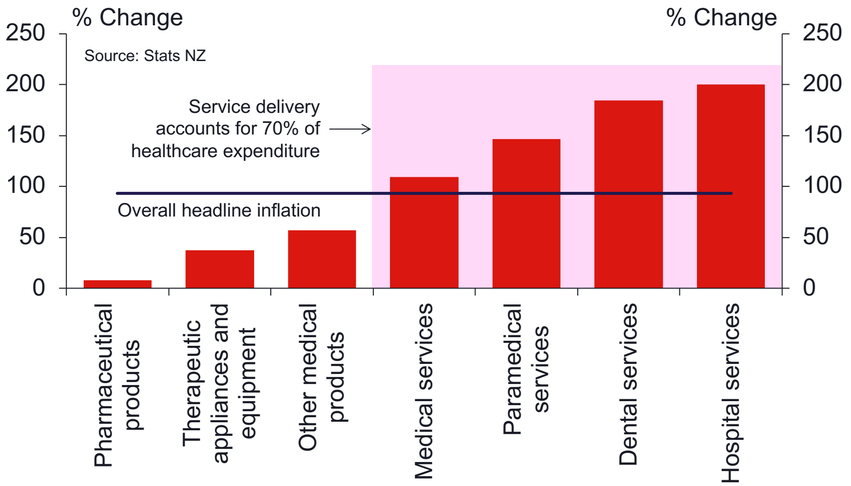
Trends.

- Public health spending increased by 500% between 2000 and 2024. Over the same period, private healthcare spending increased by almost 400%.
- Public spending has increased due to demographic-driven demand for care, health services costs outpacing inflation amid workforce shortages, and the rapid growth of more sophisticated treatments enabled by new technologies.
- These pressures have been intensified by efforts to clear structural backlogs stemming from underfunding in the 2010s, as well as Covid-related surges in demand for previously delayed procedures.
- They have also been amplified by the costs of major system reforms – including the relatively recent removal of district health boards and the creation of Health NZ – and by policy efforts to address longstanding inequities and unmet needs.
- The increase in private spend reflects growing constraints within the public system, which have encouraged more people to privately fund care through out-of-pocket expenses and the uptake of health insurance.

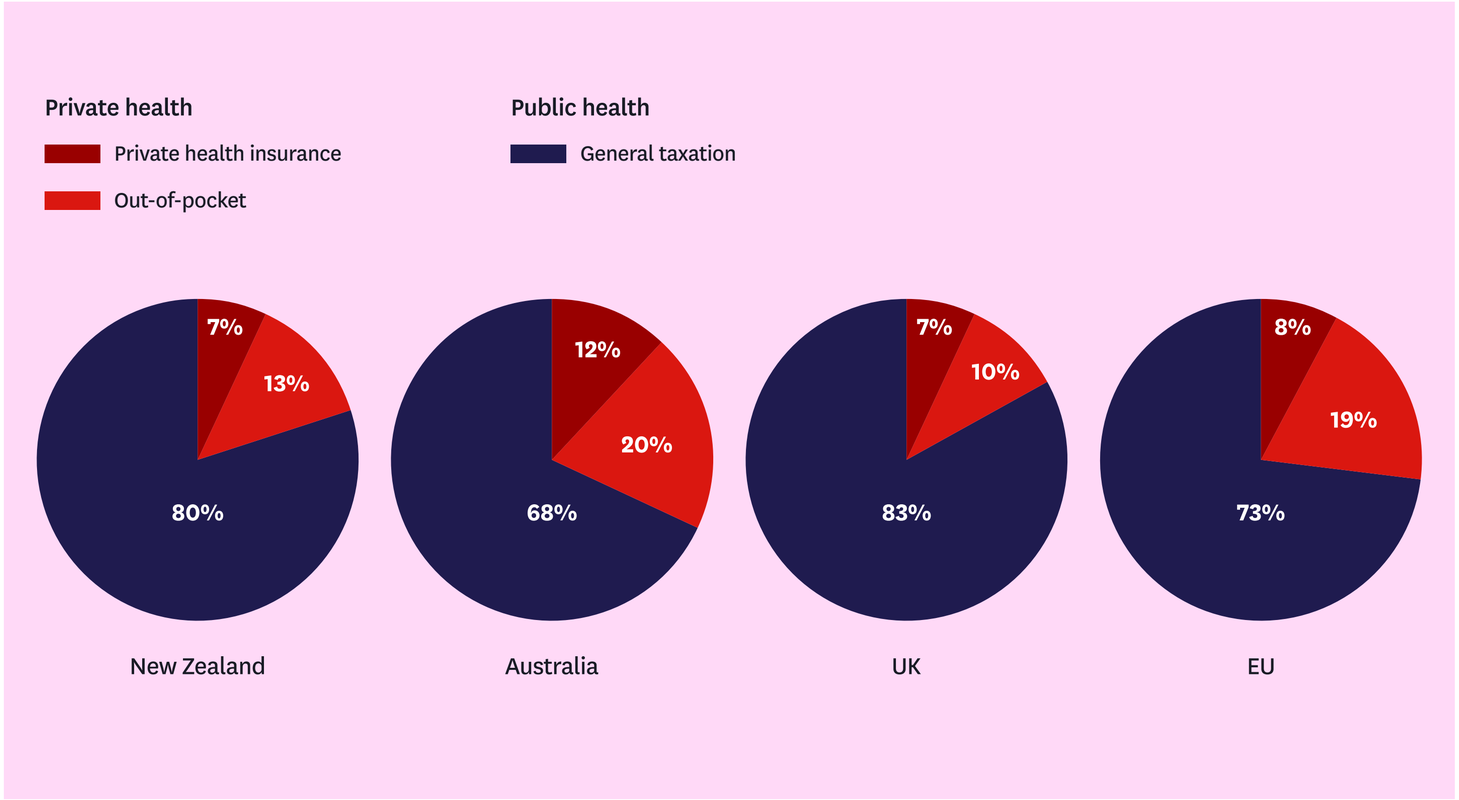
Spending on public and private healthcare in New Zealand



Price change by sub-segment (between 2000 Q4 and 2025 Q4)



Healthcare funding sources by country



Source: ACESO Health

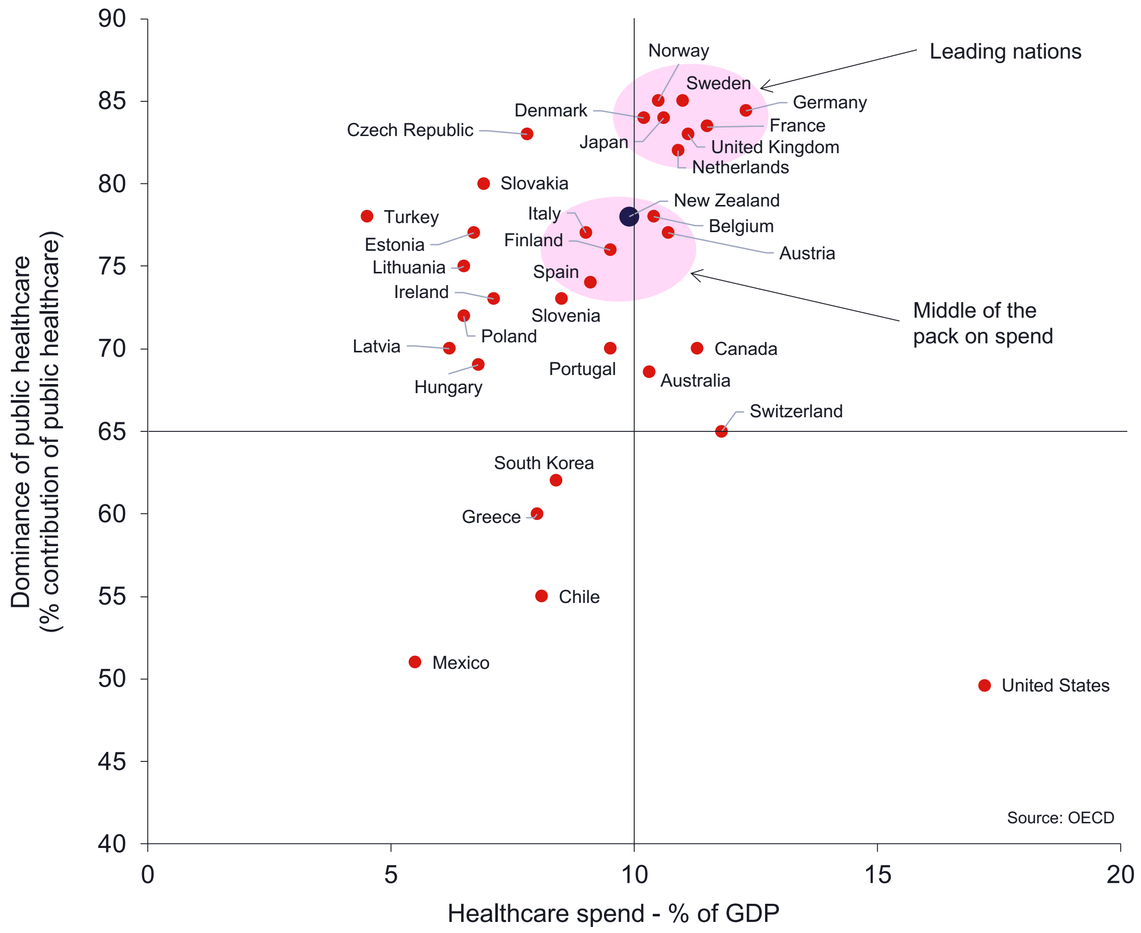
Funding of healthcare in New Zealand is similar to the UK, less so the EU and Australia.

New Zealand versus peer group.

- Countries with a dominant public health system tend to spend more on healthcare than those that don't. The exception perhaps is the US, which has a large private health sector.
- Healthcare spend in New Zealand is in line with its OECD peers – both in terms of how much is spent on health as a % of GDP as well as private/public spend contributions.
- The outsized contribution of public health spend reflects its mandate, i.e. to deliver mostly free universal healthcare to all residents. By contrast private health delivers a narrower range of services, for which it charges a price.
- Healthcare spending in New Zealand seems to concord most with mid-sized countries in central and southern Europe. The exception here is Italy, one of the world's largest economies.
- That said, New Zealand spends a bit less than some larger economies, which tend to have even more dominant public healthcare systems - a legacy of post world war reconstruction.
- Countries often viewed as being similar to New Zealand show some surprising differences. Ireland, for example, only spends 6% of its GDP on healthcare, and has a larger private healthcare system.

See *Appendix B* for more detail on how New Zealand compares to other countries on healthcare spend.

Public sector dominance vs spend as a % of GDP

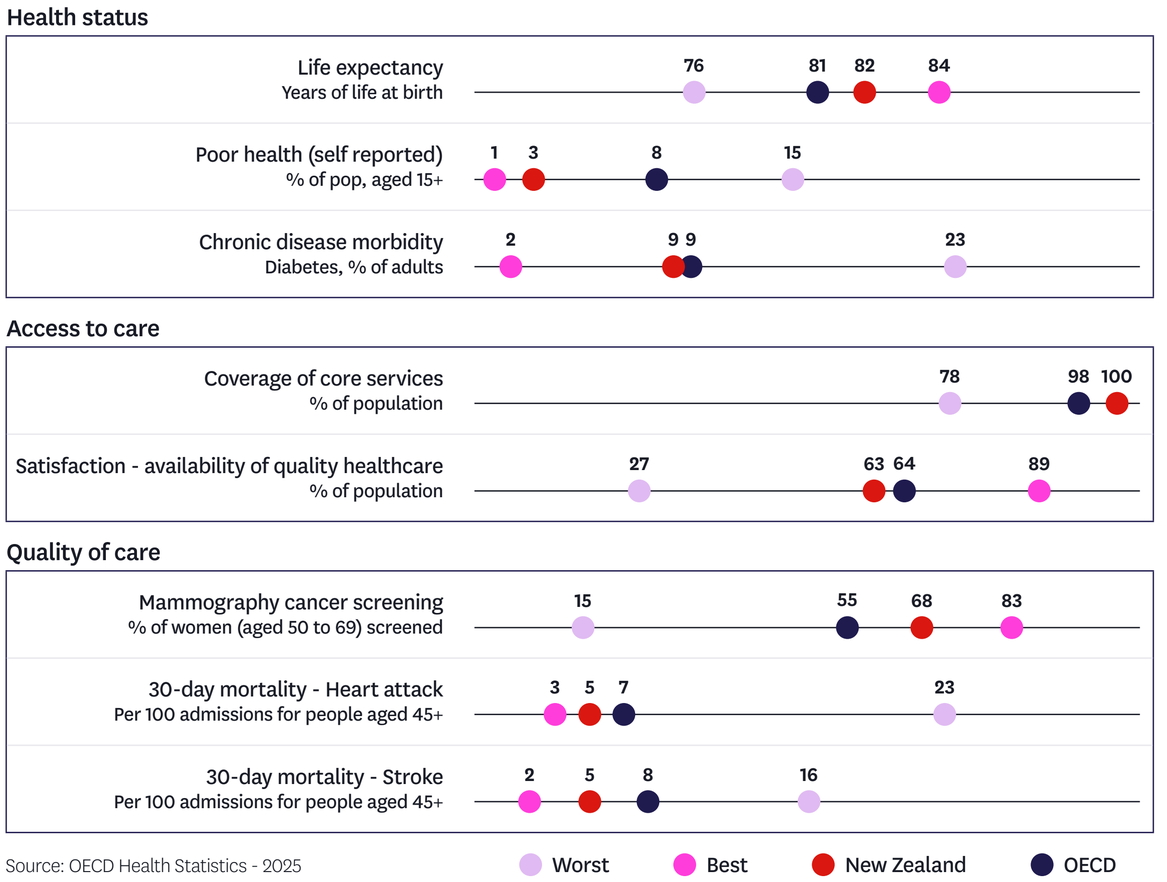


Health outcomes

New Zealand versus peer group.

- New Zealand's health system compares favourably with OECD peers on several fronts.
- New Zealanders, for example, tend to live longer than most in the OECD. While a performing health system is not a sufficient condition for longevity, it is a necessary one.
- Official health statistics suggest that people in New Zealand currently aged 65 can expect to live another 20.7 years, with many of those in good health.
- Similarly, only 3% of New Zealand adults self-reported as being in poor health in 2024. That compares favourably to the 8% OECD average.
- Coverage of health services in New Zealand also stands out. That said, satisfaction levels lag well behind best in group, and even trail the OECD average – a reflection perhaps of growing capacity constraints within the health system.
- Despite constraints, New Zealand's health system is more effective in delivering preventative care than most in the OECD. A significantly higher proportion of people in New Zealand are screening for breast and bowel cancer.
- Ditto for effective secondary care, with lower mortality rates in New Zealand compared to the OECD average.

Comparative performance of New Zealand's healthcare system



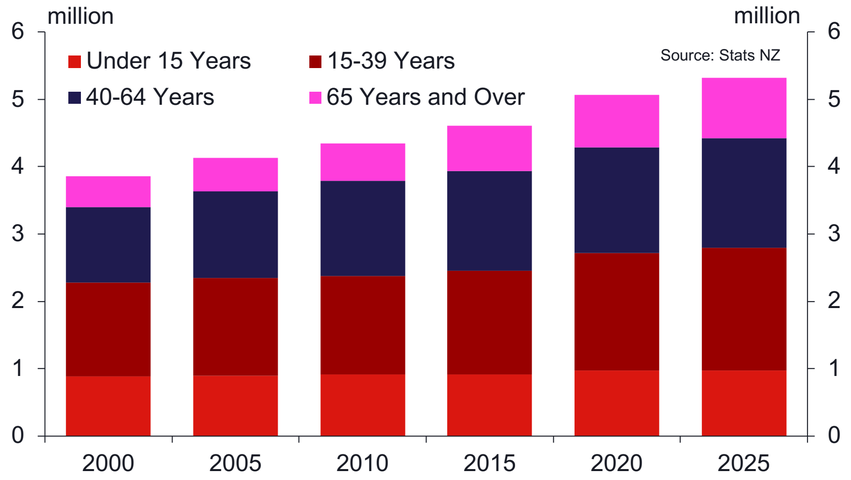
Source: OECD Health Statistics - 2025

Healthcare demand drivers

Demographics and societal factors.

- Demand for healthcare in New Zealand continues to grow.
- That reflects an increase in population size. There are 37% more people in New Zealand today than there were in 2000.
- It also reflects an ageing population, with faster growth seen in older age groups, who tend to require more primary care, hospital treatment, and chronic disease management.
- Meanwhile, worsening key social determinants are also fueling demand for healthcare.
- Life-expectancy gaps between ethnic and regional groups in New Zealand have grown. Add to that rising financial hardship, with many households now struggling with food security, and longstanding housing problems that remain a persistent and well-established driver of poor health and inequality.
- Health survey data also show that psychological distress has increased, especially among Māori, Pasifika, disabled people and young people, while climate change related heat risks for older adults have grown, with local government/ health providers now expected to develop heat health plans.

Population demographics by age cohort



Impact of social determinants of health on demand for health services

Indicator	Statistics	Māori/Pasifika impacts	Health demand impacts
Life expectancy	Urban–rural gap ~4yrs; Māori–Pākehā gap ~8yrs;	Shorter life expectancy	Higher preventable disease burden
GP access barriers	25.5% wait too long; 14.9% avoid due to cost	Māori 18.7%, Pasifika 25.1%	More ED use, late presentations
Mental distress	14.3% adults have high distress	Māori 22.5%, Pasifika 23.8%	Higher mental health service demand
Food insecurity	21.4% of children affected	Māori 32.3%, Pasifika 44.3%	More illness & admissions
Obesity	34.2% adults obese	Higher in deprived areas	More chronic disease
Emergency Department use	17.1% adults; 19.1% children	Higher in deprived groups	Unmet primary care
Heat exposure	10.9 heatwave days	Older adults mostly affected	More heat-related illness

Sources: MoH, Public Health Advisory Committee, Association of Salaried Medical Specialists, Lancet

Healthcare supply drivers

Service delivery factors.

Constraints within the public healthcare system

Supply drivers	Constraints*	Impacts on service delivery	Consequence
Workforce	· There are thousands of unfilled roles across hospitals, primary care, mental health, aged care and community services. · Shortages are structural, persistent and unevenly distributed across disciplines and regions.	· Reduced accessibility on primary care. · Increased pressures on emergency departments and hospitals. · Increased staff burnout.	Longer wait times for New Zealanders.
Infrastructure and technology	· Many public facilities are reaching or are at end of design life, with an increasing number now “not fit for purpose”. · Digital clinical systems and telehealth are widely used, but digital capacity is underpowered at a system level. · The health system relies on thousands of legacy applications with weak interoperability.	· System bottlenecks lead to overcrowding. · Limited bed/theatre capacity compromises service quality. · Digital technologies support care, but do not materially relieve workforce or infrastructure pressure.	
Process	· Strong national rules and annual planning cycles prioritise consistency but limit adaptability at a local level. · Frontline processes are slow, cumbersome and bureaucratic, with reduced local autonomy and higher admin burden.	· Reduced accessibility to primary care. · Increased pressures on emergency departments and hospitals. · System bottlenecks lead to overcrowding and unmet needs. · Inconsistency in local responsiveness.	

Source: Westpac

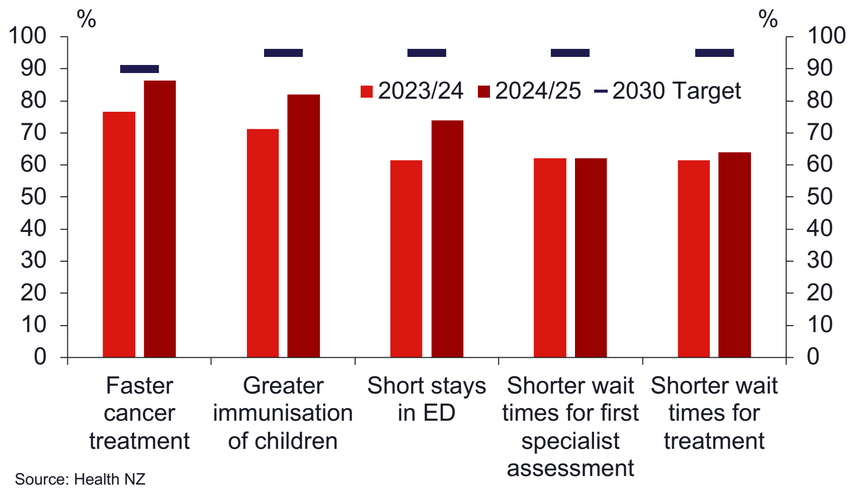
* See *Appendix C* for more detail on constraints within the public health system.

Addressing growing constraints

Reforming the system.

- The New Zealand government continues to spend large on healthcare – but that is about maintaining services.
- In principle, the Government could ease system constraints over time through higher spending, but this would affect other spending priorities, taxation, and debt levels.
- The other approach is to reform the system. That's about generating greater efficiencies/better value for taxpayer money.
- Reforms are not new. The health system has been repeatedly restructured over decades in response to changing health needs, costs and political priorities.
- For example, in 2022, the Labour government consolidated the planning, funding, and delivery of publicly funded health services within a single national organisation, Health NZ.
- By 2024, the National government had refocused Health NZ, reaffirming national planning while placing greater emphasis on local delivery of care.
- By 2025, it had released New Zealand's first Health Infrastructure Plan and an updated Health Workforce Plan, alongside clearer targets and a strengthened performance measurement framework.

Government core healthcare targets – actual (2025) vs target (2030)



Source: Health NZ

Core healthcare targets and opportunities for outsourcing

Core targets (2024 – 2030)	Outsourcing opportunity	Trend towards target
90% of patients to receive cancer treatment with 31 days of the decision to treat	Medium	Edging higher
95% of children are fully immunised at 24 months of age	Low	Rising gradually
95% of patients to be admitted, discharged or transfer from an ED within 6 hours	Low	Moving sideways
95% of people wait less than four months for a first specialist assessment	High	Edging higher
95% of people wait less than four months for elective treatment	High	Edging higher

Sources: Ministry of Health, Health NZ

Expanding the scope of private sector involvement.

The government's 2030 core targets focus on reducing elective surgery backlogs and wait times, partly through increased private sector involvement. That involvement covers a number of potential areas.

Public sector constraints and potential opportunities for private health involvement

Public health constraints	Public health impacts	Private health capabilities	Private health delivery benefits	Comment
Workforce shortages (nurses, GPs, specialists).	Limited elective capacity; growing waitlists for non-urgent procedures; staff burnout and low morale.	Flexible staffing; expanded use of nurse practitioners and allied health at top of scope; faster international recruitment.	Higher clinician throughput; faster scale-up of planned care; improved pay and flexibility to attract staff.	Private capacity offers immediate pressure relief at peak demand.
Rigid employment and rostering rules.	Hard to surge capacity when demand spikes, resulting in backlogs.	Variable pay; extended hours & weekend theatres; productivity-linked rostering.	Shorter waits for assessment and treatment; guaranteed treatment timelines.	Fewer rostering and industrial constraints.
Fragmented, legacy IT systems.	Slow referrals; duplicate data entry; poor visibility across/along pathways.	Interoperable Electronic Health Records, digital referral intake; patient online booking.	Faster patient flow; lower administration costs; improved patient experience.	Ease of access to health services for patients.
Stalled national digital transformation.	Limited virtual care and poor demand management.	Telehealth-first models; remote monitoring; digital triage; demand filtering.	Improved access to healthcare without the need for beds; scalable capacity.	Lower barriers to experimentation.
Slow public infrastructure delivery.	Shortages of theatres, imaging, and step-down beds, leading to long waits.	Modular clinics; day-stay surgery centres; rapid-deployment imaging hubs.	Faster delivery and earlier capacity expansion, particularly in underserved areas.	Avoids upfront public capital investment.
Rigid annual planning & commissioning.	Difficult to re-prioritise or add capacity mid-year.	Standardised care bundles; streamlined admission-to-discharge pathways.	Higher throughput; more predictable delivery.	Greater flexibility to meet demand surges.
Diagnostic bottlenecks (MRI, CT, endoscopy).	Delays cascade across entire care pathways.	Private diagnostics expansion; imaging networks; blended public-private referrals.	Pull-through demand across specialties for faster diagnosis (and ultimately treatment).	Reduces delays and improves patient experience.
Limited step-down and rehab capacity.	Acute beds blocked by patients awaiting discharge.	Private rehab & transitional care facilities.	Hospital relief; long-stay revenue streams.	Free acute hospital beds.
Fiscal & capital constraints on Government.	Preference to buy capacity instead of building.	Build/own/operate facilities (day surgery; diagnostics).	Creates predictable private demand; stable multi-year revenue; lowers political risk.	Avoids upfront public capital investment.

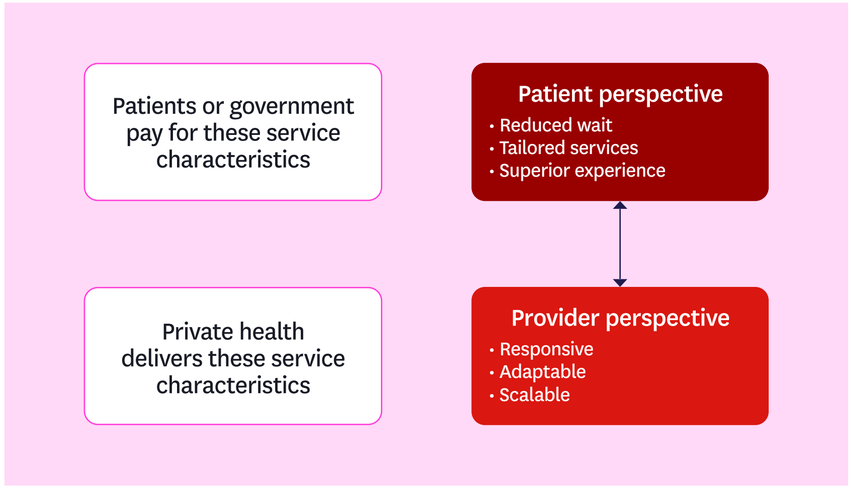
Sources: Health NZ, Ministry of Health, NZ Medical Journal, Medical Council of NZ, Nursing Council, Infrastructure Commission, Health informatics NZ

Private health – value proposition

Adding to capacity/capability.

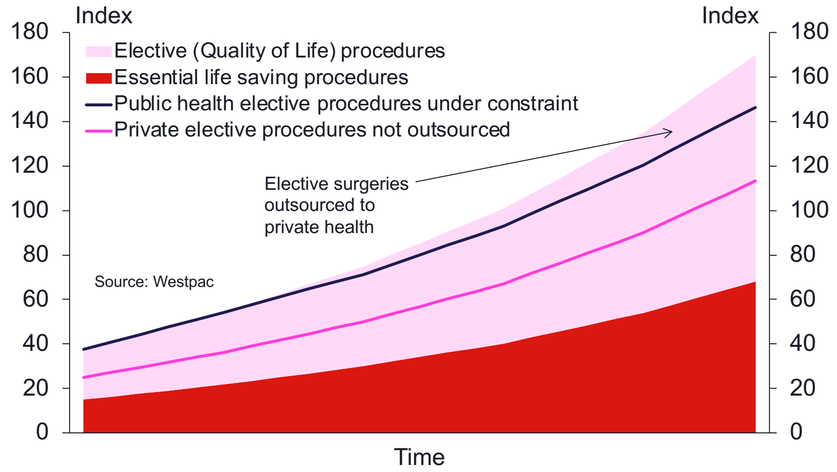
- The private health system aspires to provide world-class healthcare services with a high standard of customer service.
- However, delivering a world-class healthcare service is not a point of difference. While private health may offer a more personalised service and a better customer experience, the public system still delivers a top notch service.
- The key difference is how quickly private health providers are able to respond to changes in demand.
- This reflects flexible staffing, spare capacity (beds and theatres), and IT systems that streamline scheduling for high-volume low-complexity elective care and rapid surge response. Private providers can also actively manage demand through pricing.
- By contrast, the public system, constrained by capacity, prioritises urgent and complex care, which can often be more time consuming/ resource hungry. That leaves less room for routine elective procedures which are increasingly outsourced.
- And of course, the public sector does not charge. To that end, demand for its services are “infinite”, and can only be “rationed” by rescheduling; i.e. longer wait times.

Value proposition canvas for private healthcare in New Zealand



Source: Strategyzer, Westpac

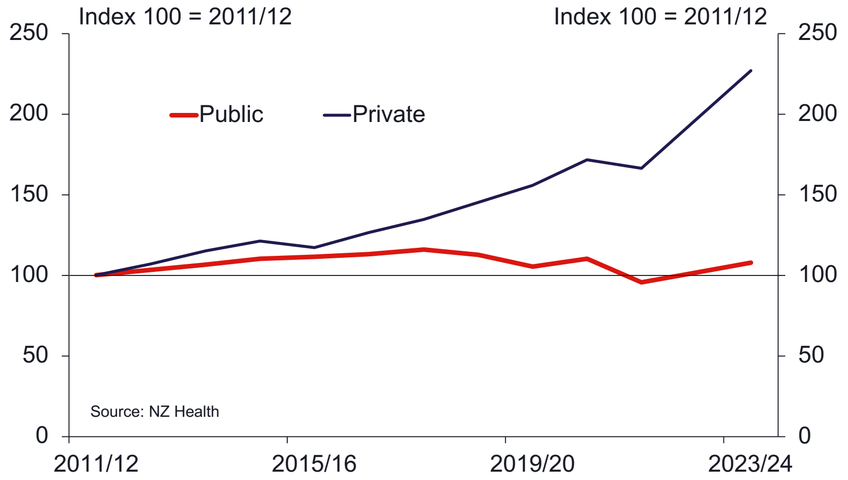
Proportion of elective surgeries outsourced to the private sector



Outsourcing trends.

- Outsourcing has become a major part of elective surgery, shifting from a marginal practice in the mid-2000s.
- According to Health Informatics New Zealand, private hospitals undertook 232k elective procedures for FY June 2025, including about 30k outsourced from the public system (up from 27K in the year prior and 14k a decade earlier).
- Public hospitals completed 133k elective procedures, down from 139k the previous year, alongside around 65k acute, life-saving emergency surgeries.
- Government's *Elective Boost* initiative aims to deliver 21k additional elective surgeries in 2025/26, largely through public-private partnerships.
- Of the 30k surgeries outsourced to the private sector, about 65% were high-volume, lower cost procedures, with shorter surgical times, minimal risk and shorter inpatient stays.
- Outsourcing reduces public wait times but saddles public hospitals with more complex, higher-cost cases.
- For private providers, it offers consistent demand and assured cashflows.

Low complexity elective surgeries by sector over time



Low complexity elective surgeries by sector – 2023/24

Surgery type	Public	Private
Cataract Surgery	12,340	8,950
Knee Arthroscopy	4,210	3,780
Hernia Repair	3,560	2,940
Tonsillectomy	2,870	2,110
Grommet Insertion (ENT)	2,430	1,920
Skin Lesion Removal	3,120	2,760
Varicose Vein Surgery	1,980	2,340
Carpal Tunnel Release	2,150	1,870

Source: Health NZ

Outsourcing considerations

Pros and cons.

The growing partnership between public and private health is delivering clear benefits.

- Public-private initiatives such as the Government's *Elective Boost* initiative are reducing wait times, with a higher share of patients receiving treatment within four months, and increasing overall throughput by adding thousands of elective surgeries.
- By providing a stable flow of low-complexity procedures, these initiatives help to underpin investment in infrastructure, digital health technologies, and service expansion in the private sector.
- They also create employment and training opportunities, encouraging the transfer of best practice and driving innovation in care models and digital solutions, which ultimately lead to improved patient outcomes.
- It also enables greater specialisation across public and private healthcare, in pursuit of economies of scale and efficiency gains.

But also some challenges.

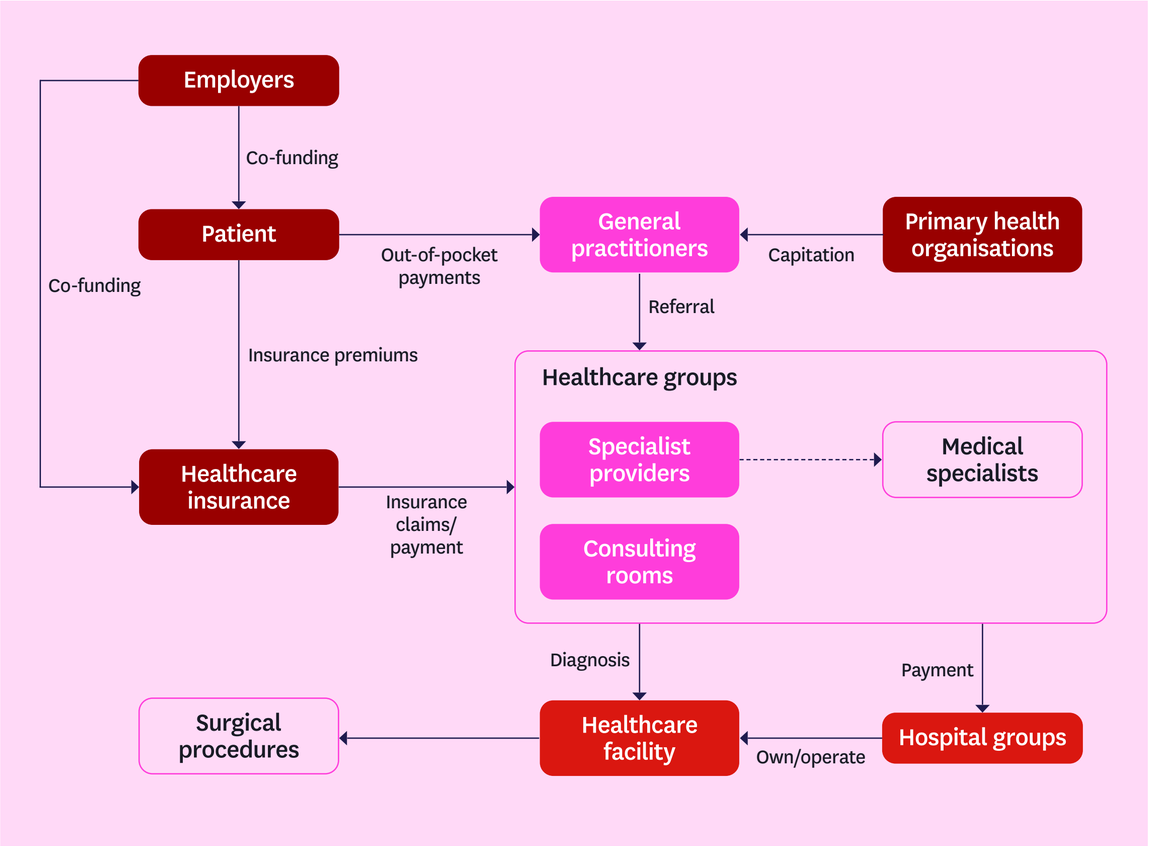
- Outsourcing can constrain public capacity as clinicians shift hours to better-paid, more flexible private work, while public hospitals are saddled with more complex, resource-intensive cases.
- The result is longer waits for those reliant on public care – often lower-income, Māori, Pasifika, disabled, or older people with complex needs – while those who can pay continue to access timely private care, widening health inequalities.
- Reliance on outsourcing can weaken public workforce development by reducing training opportunities in a system that has traditionally trained health professionals.

Overview of the private health system

How it works.

- GPs are the main gateway to private health services in New Zealand, with most of the 5,900 practitioners funded through public capitation and patient co-payments.
- While GPs diagnose and treat most patients themselves, they also make referrals to about 3400 private practices, which collectively employ about 4,800 specialists. We estimate these practices generated revenue of around $2.9bn in 2024/25.
- There are about 20 large healthcare groups in New Zealand, consisting of multiple practices spread across the country. The largest of these is Southern Cross Healthcare. Most practices though are standalone, typically employing 1-5 specialists each.
- Larger practices often run their own specialist clinics, while most operate from consulting rooms near hospitals and rent hospital facilities and equipment.
- The Ministry of Health reports 76 private hospitals and 16 hospital groups in New Zealand that rent facilities and equipment. Southern Cross Hospitals is the largest provider, alongside others such as MercyAscot, with an estimated annual revenue of about $1.7bn.

Simplified model of the key inter-relationships in private health

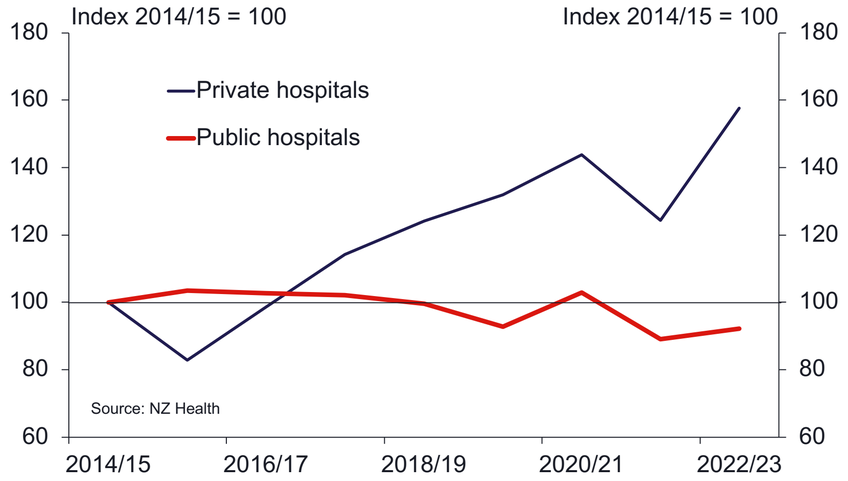


Source: NZ Health

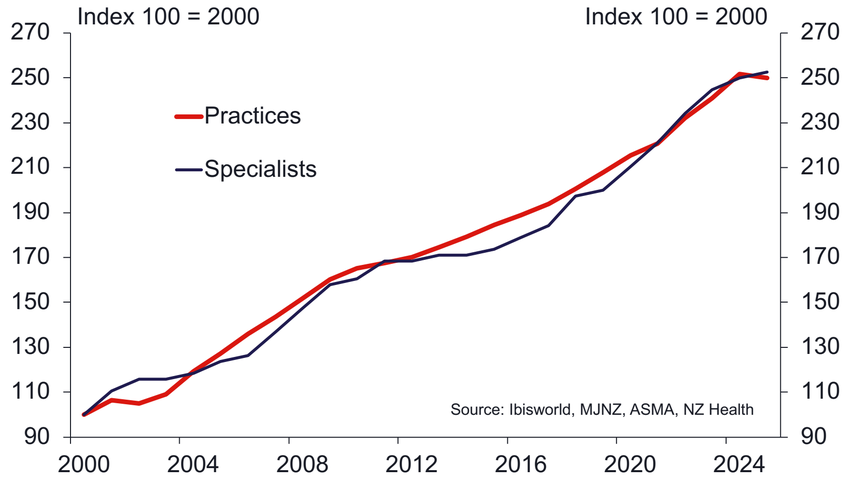
Building capacity.

- Not surprisingly, as opportunities to partner with the public sector have expanded, so too has the capacity of the private health system.
- That is partly evidenced by an increase in the number private practices operating in New Zealand. According to Ibisworld, the number of private practices rose by 63% between 2000 and 2024, while specialists operating out of them increased by 71%.
- Over the same period, practice revenues rose by circa 220%.
- Private hospitals have increased from 45 in 2000 to 76 in 2025, with further expansion likely as demand grows, particularly in underserved regions.
- The number of hospital groups has fallen from 22 in 2000 to 16 today, reflecting a shift toward larger, more resilient operators with economies of scale and stronger bargaining power with insurers.
- Fewer hospital groups also reflect the fact that public outsourcing contracts typically favour well capitalised providers.

Hospital discharges by sector



Practices and specialists in private health

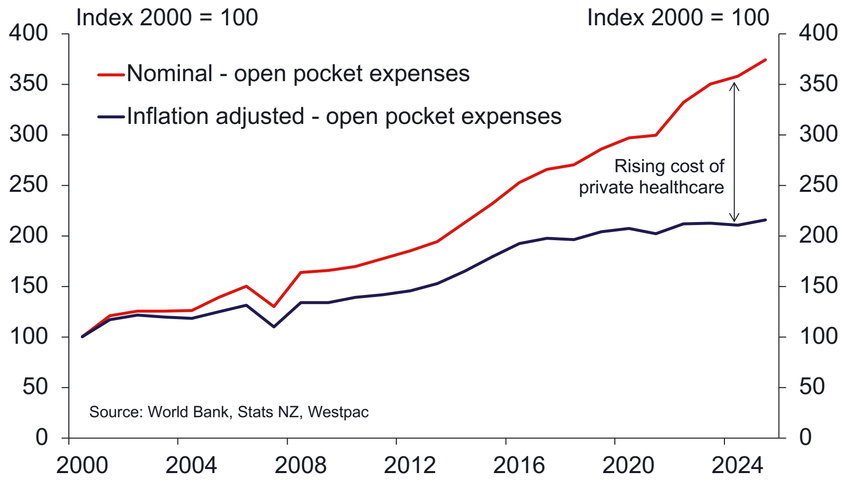


Private health challenges

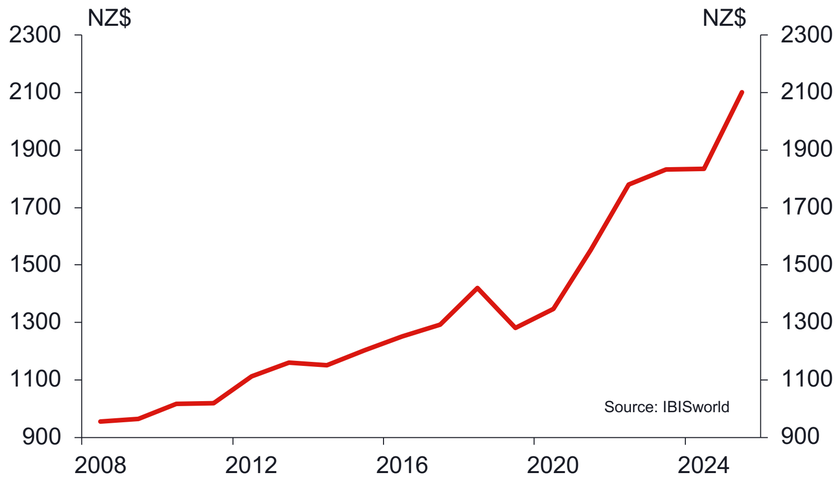
Rising costs.

- Rising public-system pressures and wait times have pushed more New Zealanders toward private healthcare.
- This has been funded through out-of-pocket spending and health insurance premiums, both of which have risen.
- Out-of-pocket spend on healthcare in New Zealand increased from $2.9bn in 2015 to an estimated $5.1bn in 2025. About 39% of this increase relates to the rising cost of medical care. Over the same period, overall inflation grew by 31%.
- Rising costs are reflected in medical insurance premiums, which doubled from $1.6bn to $3.3bn between 2015 and 2025 despite flat membership of about 1.4m, with premiums on many policies rising by 20-30% in 2025.
- Much of that has to do with the rising cost of healthcare. Increased demand for private healthcare implies more labour and higher wages. Add to that the cost of new medicines/treatments and the latest advances in digital equipment.

Out of pocket healthcare expenses – nominal vs inflation adjusted



Out of pocket healthcare expenses – nominal vs inflation adjusted

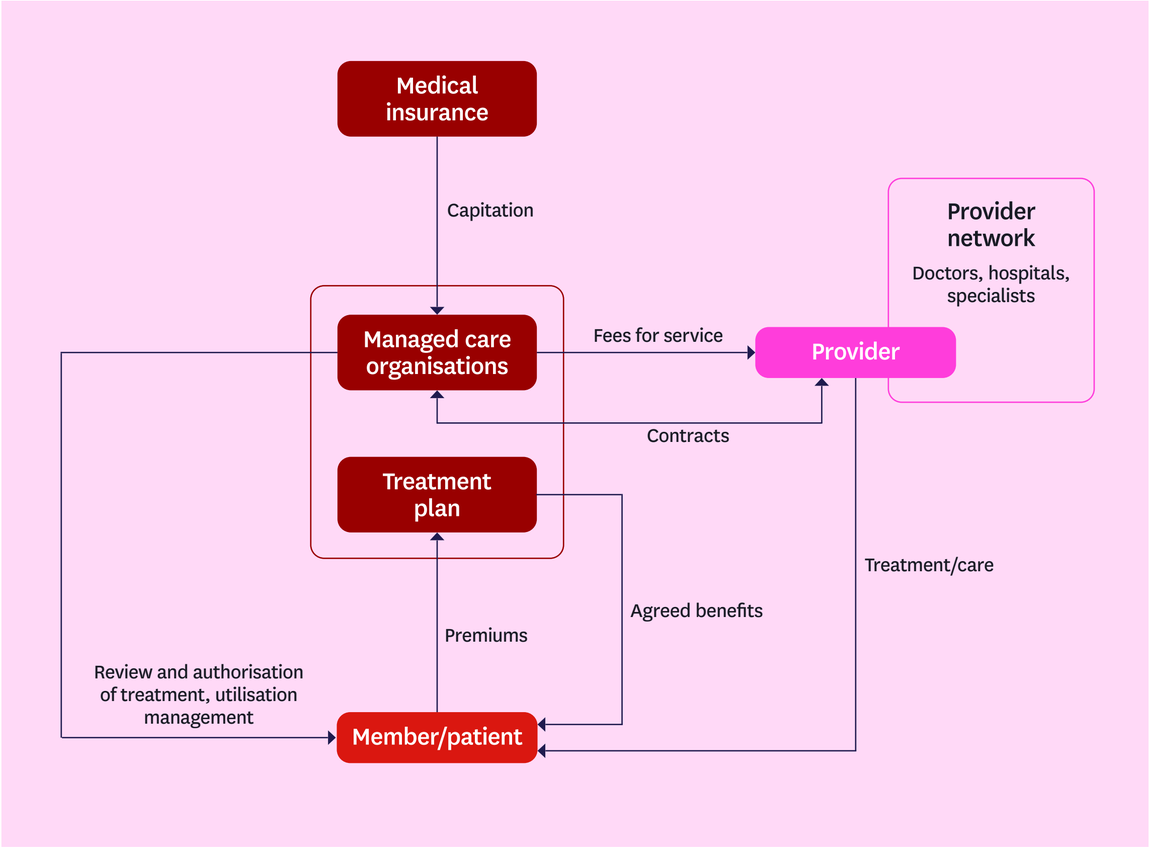


Rising cost pressures could prove unsustainable.

Cost control options.

- If unchecked, rising costs could make private healthcare less affordable and threaten its long-term viability.
- As mentioned throughout this report, these factors are in part being counterbalanced by capacity pressures in the public system, which are driving increased demand for private services.
- That said, cost control remains critical; without it, consolidation is likely as insurers, private hospitals and specialist practices look to reduce unit costs through scale efficiencies.
- There are ways to mitigate this risk, including insurers using managed care to control costs through preferred provider networks and care management.
- Another option is risk-rated premiums beyond age and existing conditions, with lower premiums for preventive health behaviours.
- Changes to the referral system might also help to reduce cost. There is no reason why the first contact with the health system should be a GP or that interventions should typically involve a specialist.

Simplified managed healthcare model



Source: National Institutes of Health (US); Progress in Medical Sciences

Managed care organisations include:

Health maintenance organisations – Lowest cost, but requires GPs for referrals to specialists with care limited to the network.

Preferred provider organisations – Higher cost, but does not require a referral and patients can consult out of network providers.

Summary

- New Zealand's healthcare system is large and complex, with spending estimated at around 10% of GDP, mostly on publicly funded universal services. Alongside this sits a smaller but fast-growing private sector.
- Public health performs well, with New Zealand consistently scoring above the OECD average on health indicators, broadly in line with comparable European peers.
- However, the system faces major challenges and is struggling to meet rising demand, reflecting prolonged underinvestment relative to health inflation and population pressures, despite significant government spending.
- The current Government is focused on improving value for money and system efficiency, introducing reforms and encouraging public-private partnerships to better use capacity across both sectors.
- Outsourcing is now common, with longer contracts and private providers delivering more less complex elective procedures that improve quality of life, allowing the public system to focus on acute, life-saving care. This in turn creates opportunity for greater specialisation in both public and private health facilities.
- Further opportunities for private involvement include addressing infrastructure backlogs in underserved areas, implementing integrated IT systems, and investing in new digital equipment.
- At the same time, the government is partnering with Whānau Ora commission agents to invest in, design and manage community based health services that deliver better health outcomes for Māori and Pasifika, especially in the regions.
- These opportunities emerge as the private sector faces challenges of its own, with medical inflation well above CPI, driving higher insurance premiums and reducing affordability.
- Looking ahead, a partnership model is likely, with a broader range of publicly funded services delivered by private providers, alongside continued demand for privately funded care if public capacity constraints persist.

Appendices

Appendix A

How healthcare works – selected countries.

Peer	Financing model	Policy features	Public sector coverage	Private sector coverage
New Zealand	Tax-funded public system. No tax incentives for private insurance, which covers about 30% of the population.	Historically decentralised, but now centralised under Health NZ.	Universal public coverage. Co-payments for GP visits and prescriptions.	Private hospitals offer faster access to the health system, handling surgeries outsourced from the public system and elective surgeries opted by individuals.
Australia	Tax-funded universal health insurance scheme (Medicare); Private insurance incentivised by tax rebates, covers 45% of the population.	The federal government funds Medicare. State and territory government manages public hospitals and community health services.	Universal public coverage – public hospitals are funded by Medicare.	Private hospitals play a larger role than in NZ, providing more choice for patients. They handle a significant share of elective and acute care; private insurance often covers hospital and extras (dental, physio, etc).
UK	Tax funded healthcare system (National Health System) with no significant role for private insurance.	Strong focus on centralised planning and workforce integration.	Universal public coverage – provides comprehensive free-at-point-of-use care by public health providers.	Limited. Private sector is small and supplementary, offering faster elective care or luxury options. Private hospitals also treat a small number of NHS patients under outsourcing agreements.
Canada	Tax-funded public system with limited role for private insurance.	Federal government sets the standards and provides funding, while provinces administer provision of healthcare services.	Universal public coverage specified by the Canada Health Act. Regulation limits competition from the private sector and there is a ban on mixed public-private practice.	Limited scope for private hospitals. Private care is funded through private insurance, and is restricted to non-core services, i.e. dental, vision, pharmaceuticals. Caps on private fee setting also applies.
France	Social health insurance funds the public healthcare system. All residents contribute to the fund through payroll taxes, other income taxes and industry levies. Complementary health insurance covers costs not reimbursed by the public system.	The Ministry of Health sets national strategy, while regional health agencies oversee the planning, financing and delivery of public healthcare at a local level.	Universal public coverage provides residents with hospital care, outpatient services, maternity care, mental health and long-term care.	Standalone private insurance is used to fund outpatient and specialist healthcare services provided by the private sector. Private clinics/hospitals typically offer shorter wait times, more personalised care, and better coverage for dental, vision, and alternative therapies.
US	Mixed public-private system with voluntary insurance and out-of-pocket expenses.	Market driven. Budget control is fragmented across federal, state, and private system.	No universal coverage. Key public programmes include Medicare for older people, Medicaid for low income families, CHIP for children that cannot afford private insurance, and VA & TRICARE for military personnel.	Dominant private sector – fragmented service delivery that relies heavily on the ability to pay, dominated by employer-sponsored and individual insurance.

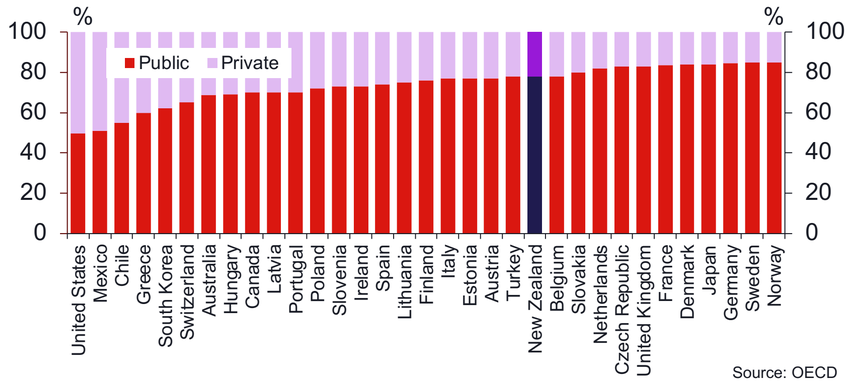
Size/shape of the healthcare system – comparisons.

Peer	Public			Private		
	Patients seen (Million)	Capacity (Number)	Procedures (Million)	Patients seen (Million)	Capacity (Number)	Procedures (Million)
New Zealand	More than 3.5m patient contacts a year. That includes 1.1m hospital admission and discharges; and 1.44m ED presentations.	84 hospitals; 6.4k senior medical officers (SMO); 4.9k resident medical officers (RMO); 5.0k GPs; 29k nurses; 30k allied health professionals (AHS).	Up to 1m elective and emergency procedures.	Between 399k to 400k patient contacts a year. Approx. 220k patient hospital admissions discharges – mostly elective surgeries.	>70 certified hospitals; 1.2k SMO; 0.8k RMO; 2.0k GPs; 8k nurses; 10k AHS.	Approx 220k; two-thirds are elective surgeries; Approx 26k are contracted from the public sector (Health NZ).
Australia	12.6m hospitalisations a year and 8.8m ED presentations.	701 hospitals; 25k SMO; 18k RMO; 32k GPs; 300k nurses & 195k AHS.	7.2m hospital procedures, about 5.0m are non-surgical and 1.2m surgical. Includes 778k elective surgeries.	Between 6m to 7m patient contacts, of which 5.1m patients were in admitted care.	633 hospitals & day surgeries; 8k SMO; 6k RMO; 10k GPs; 100k nurses; 60k AHS.	5.0m procedures funded by private health insurance.
UK	>20m hospitalisations (17.1m in England); >30m ED presentations (26.3m in England).	930 NHS hospitals; 47k SMO; 55k RMO; 37k GPs; 700k nurses; & 500k AHS.	>100m outpatient services; approx. 7.9 m surgical procedures.	939k in-patient admissions; the private system sees 1m NHS patients a year as part of outsourcing agreements.	807 hospitals & 2.4k clinics, diagnostic centres and treatment units; 10k SMO; 12k RMO; 15k GPs; 200k nurses; & 150 AHS.	Approx. 1.5m of which 439k were privately funded procedures; and just over 1m NHS funded.
Canada	3m inpatient hospitalisations, and 11m ED presentations.	1088 hospitals; 32k SMO; 25k RMO; 45k GPs; 300k nurses; & 200k AHS.	Estimates range from 1.1m to 2.3m inpatient surgeries.	Approx. 2m inpatient hospitalisations – about 65% of Canadians have private insurance.	32 hospitals; 7k SMO; 5k RMO; 12k GPs; 100k nurses; & 80k AHS.	N/A - private hospitals and clinics perform a small fraction of Canada's total surgical volume.
France	Approx 12m patients a year, including both inpatient and outpatient services.	1347 hospitals; 45k SMO; 30k RMO; 102k GPs; 700k nurses; & 400k AHS.	Based on how many patients are seen, public hospitals are estimated to undertake circa 6m procedures a year.	Private hospitals treat over 8m people a year, providing inpatient and outpatient services.	980 for profit hospitals & 658 non-profit hospitals; 12k SMO; 8k RMO; 40k GPs; 300k nurses; & 200k AHS.	Private hospitals undertake 4m procedures a year.
US	10m hospitalisations at public hospital and community health centres.	1127 hospitals; 210k SMO; 120k RMO; 118k GPs; 3.3m nurses; & 1.2m AHS.	Estimated 10m inpatient procedures a year.	Approx. 25m hospital admissions inpatient hospitalisations.	1,214 private for-profit & 2,978 private non-profit hospitals; 90k SMO; 40k RMO; 50k GPs; 1m nurses; & 500k AHS.	Approx. 41m procedures a year, covering inpatient and outpatients.

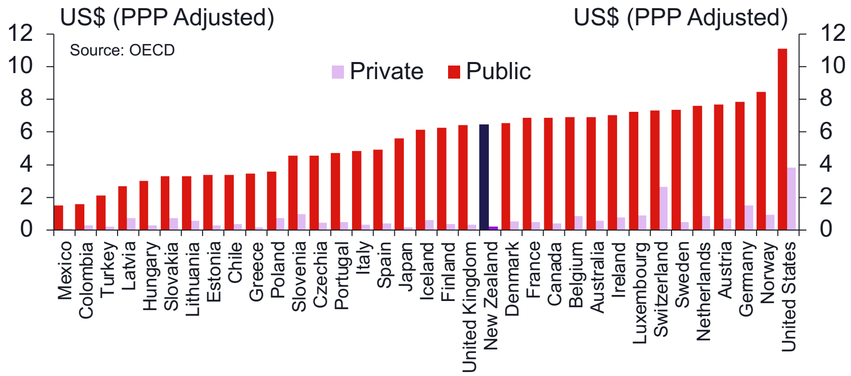
Appendix B

How New Zealand compares on healthcare spend.

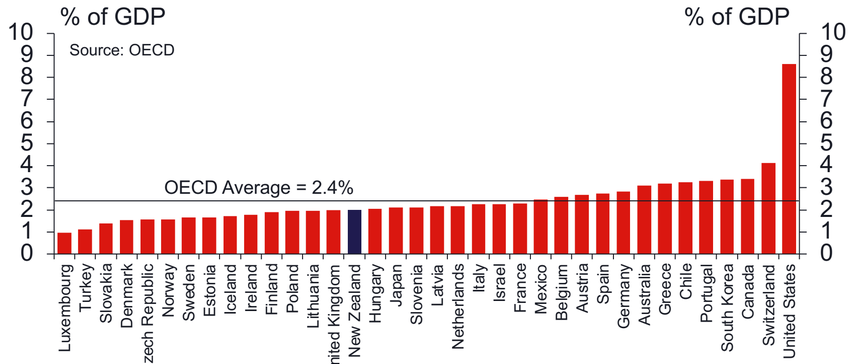
Public/Private healthcare spending mix



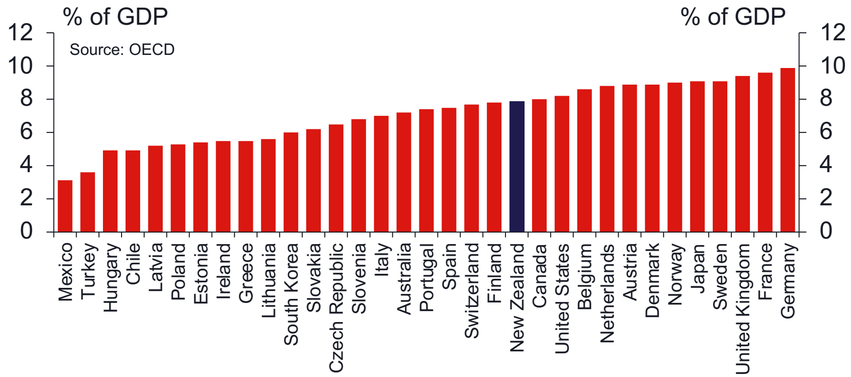
Public/Private healthcare spend per capita



Private healthcare spend as a % of GDP

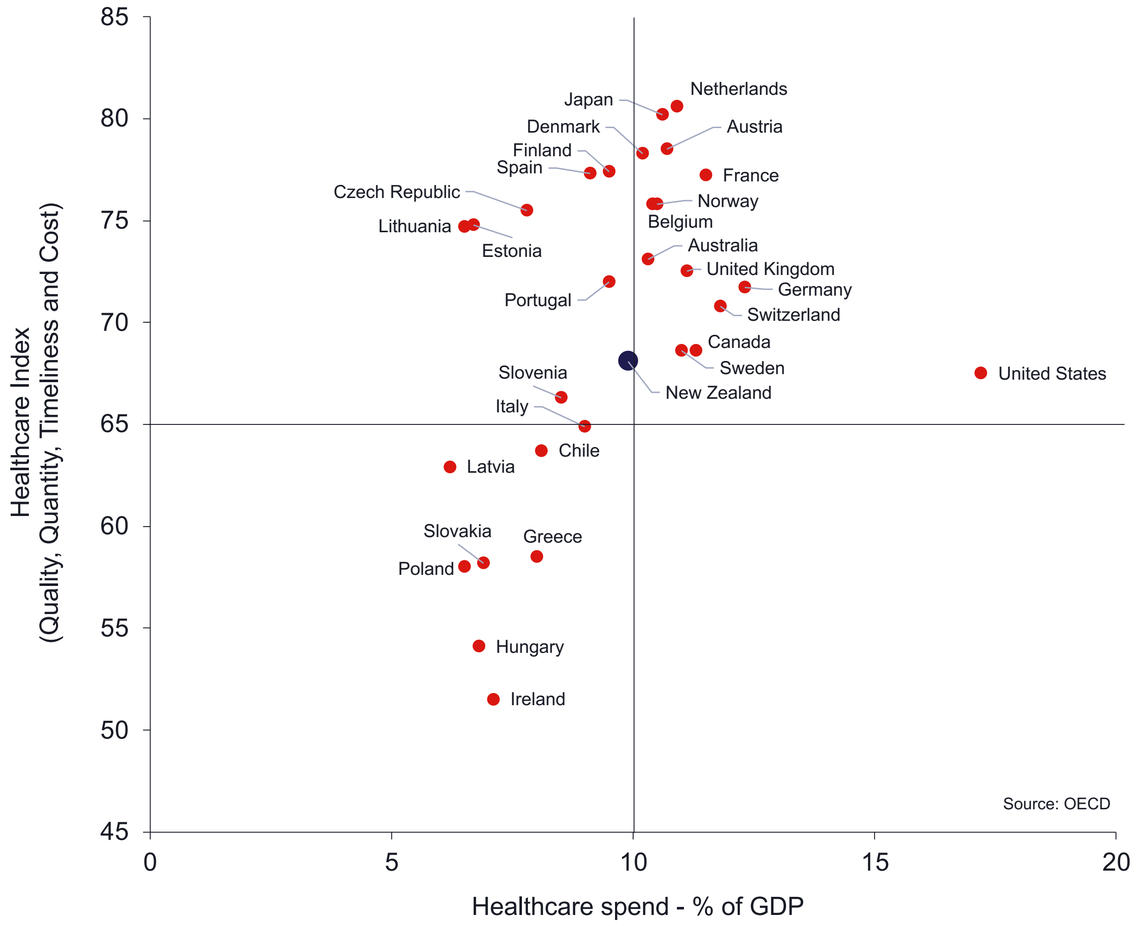


Public healthcare spend as a % of GDP

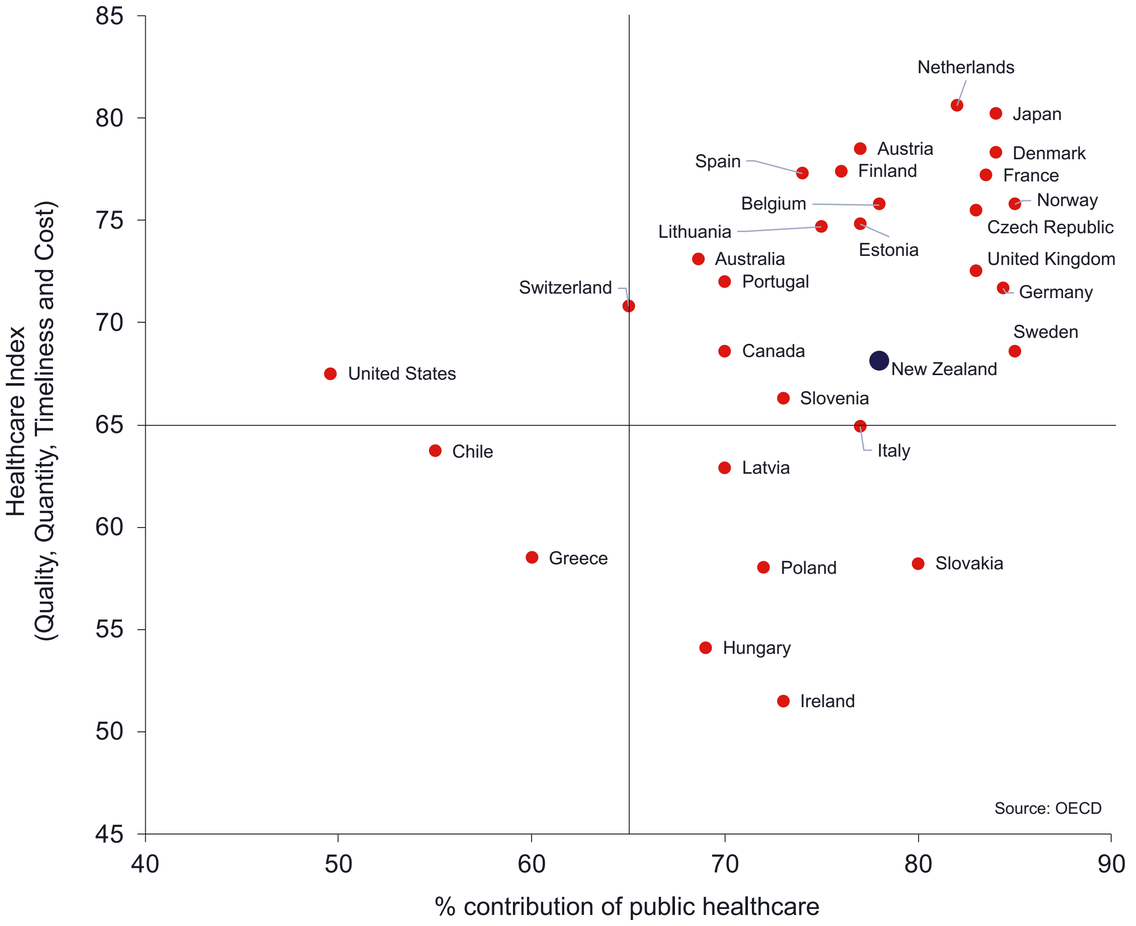


How New Zealand compares on delivering health outcomes.

Proxy outcome measure (healthcare index) vs spend as a % of GDP



Proxy outcome measure (healthcare index) vs public health as a % of total health spend



Appendix C

Public health system constraints.

Constraint	Dimension	Impact on delivery capacity
Transition challenges and weakened governance	· Historically, NZ had 20 DHBs, 32 PHOs, and thousands of NGOs, creating duplication and inefficiency. · Reforms in 2022 replaced the these bodies with a national entity, Health NZ (Te Whatu Ora).	· Centralisation has strengthened national co-ordination, particularly during crisis periods. · But reforms have also weakened local decision making, slowed operational responsiveness and contributed to widening performance gaps.
Financial deficits and under funding	· Health NZ's deficits have been driven by rapidly rising workforce costs (including thousands more nurses than budgeted), structural cost pressures inherited from DHBs, legacy liabilities such as Holidays Act remediation, and unplanned expenditures like surplus COVID-19 stock write-offs and higher outsourcing costs as demand surges.	· Serious financial instability, which necessitated the appointment of a commissioner in 2024, has constrained the ability of the health system to expand capacity, invest in infrastructure and address persistent workforce shortages.
Chronic workforce shortages	· According to Health NZ, public health is short of 4,800 nurses, 1,140 senior medical officers (consultants/specialists), 450 resident medical officers (junior doctors) and 500 GPs. · Hospitals short an average of 635 FTE nurses every shift (2022–2024). · Many wards understaffed on 45–50% of shifts.	· Workforce shortages have made It harder to access primary care, leading to greater pressure on emergency departments and already stretched hospitals. · Widespread understaffing in hospitals has slowed patient flows, lengthened emergency department and specialist wait times, and driven burnout, further eroding the system's ability to deliver timely safe care.
Infrastructure and technology gaps	· Over 30% of hospital building are rated poor or very poor with major safety capacity and digital shortcomings. · Digital and asset management systems are outdated.	· Outdated infrastructure creates bottlenecks, limits bed and theatre capacity and makes it harder to deliver modern models of care. · Inconsistent outdated technology slows patient flow, reduces productivity, and restrict the ability of the health system to scale up services.
Process inflexibility	· Processes often span multiple departments and providers, making coordination difficult. · Initiatives to improve efficiency focus narrowly on segments (e.g. discharge planning) rather than the full patient journey, causing bottlenecks elsewhere. · Appropriateness of treatment pathways to customer needs, which build cost into the system.	· Top down processes have slowed operational decision making and weakened front-line clinical governance, reducing the systems ability to adapt quickly to global needs or pressures. · Inefficient administrative, digital and asset management process effectively reduces system efficiencies, which in turn perpetuate long waits and bottlenecks.

Operational and capital backlogs.

Decade	Estimated shortfall	Timeframe	Key drivers	Notes
Operational				
Cumulative	$60-$100bn	2010/24	Lower per capita spend than peers; growing pay gaps; rising demand.	NZCTU estimate – Benchmarked against OECD spend.
Annual (to maintain current service levels)	$1.4–$1.6bn	2024/25	Population growth; ageing; inflation; wage pressures.	Health NZ tasked with $1.4bn savings; overspend of about $130m per month.
Budget gap estimate	$0.25 ->$1.0bn	2025/26	Demographic growth; unfunded pay-equity liabilities; savings/cuts.	ASMS estimate.
Capital				
Cumulative	>$20bn	As at 2025	Aging hospitals; deferred maintenance; capacity expansion.	Health NZ estimate – Health Infrastructure Plan.
Planned Infrastructure Needs	$24 -$47bn	Next decade	Existing plans for 300 infrastructure projects; there are 82 “very high priority” risks, 319 “high” and 18 “medium priority” risks at 32 hospital sites.	Health NZ estimate – Health Infrastructure Plan; Nationwide service and Campus Planning report.
Long-term projection	$115bn	Next 30 years	Maintenance and renewals; additional space; cost escalation.	NZIER estimate; Infrastructure Commission.

Source: New Zealand Council of Trade Unions; Infrastructure Commission, Association of salaried medical Specialises (ASMS), Health NZ, Treasury, NZIER, New Zealand medical journal

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