Insurance

The role and contribution of insurance in New Zealand's healthcare

The Financial Services Council commissioned MartinJenkins to provide an independent analysis of the role and contribution of the insurance industry in New Zealand's healthcare system.

The Financial Services Council NZ (FSC) is a non-profit member organisation with a vision to grow the financial confidence and wellbeing of New Zealanders. In supporting financial confidence and financial wellbeing, FSC and its members have identified that:

New Zealanders are under-insured, and

- would benefit from understanding more about insurance – particularly life and health insurance,
- insurance benefits communities and government beyond the direct benefits to individuals and families, and
- that insurance could play a greater role in New Zealand's healthcare system.

For over 30 years MartinJenkins has been a trusted adviser to clients in the government, private, and non-profit sectors in Aotearoa New Zealand and internationally. Our services include organisational performance, employment relations, financial and economic analysis, economic development, research and evaluation, data analytics, engagement, and public policy and regulatory systems.

MARTIN JENKINS

Summary

Demographic change and rising costs are placing New Zealand's public health system under growing pressure. Government health expenditure is projected to double by 2065, while demand for services continues to outpace funding. Against this backdrop, the Financial Services Council commissioned MartinJenkins to independently assess the role private insurance could play in New Zealand's healthcare system.

Around one-third of New Zealanders currently hold health insurance. A substantial proportion have health insurance through employer-based schemes. A smaller proportion hold life and trauma-related policies. Examining how private insurance products might complement and supplement existing public provision is increasingly important. It mirrors debates playing out across OECD countries where private contributions help moderate fiscal pressure.

Any expansion of private insurance requires careful objective assessment. This report uses four criteria: efficiency, equity, fiscal sustainability, and feasibility.

The central question is whether such a shift would genuinely grow system capacity and improve health outcomes or simply redistribute access while generating new inequities and costs.

The answer depends significantly on the counterfactual. If the alternative is that funding is not spent on health at all, expanding private cover would likely improve overall outcomes based on international evidence.

If the alternative is equivalent direct public investment, then the calculus shifts. Public spending directed into the healthcare system typically delivers more health gain per dollar than subsidising private insurance.

Given the forecast fiscal constraints and growing health burden, this report examines the pros and cons – and concludes that the case for exploring a greater role for private insurance is worth serious consideration.

MARTIN JENKINS

In New Zealand, and globally, demographic changes are driving demand for health services. Public health systems are under increasing financial pressure while the need for more and better healthcare grows and gets more expensive. This poses the opportunity to consider the role of private insurances in the healthcare system.

Over the past 50 years, the share of the population aged 65+ has doubled on average across OECD countries and in only the next 27 years, the population aged 80+ is expected to double (Figure 1).[1]

Figure 1. The share of the population aged 80+ is expected to double on average across OECD countries between 2023 and 2050

Source: OECD. (2025). *Health at a glance 2025: OECD indicators*

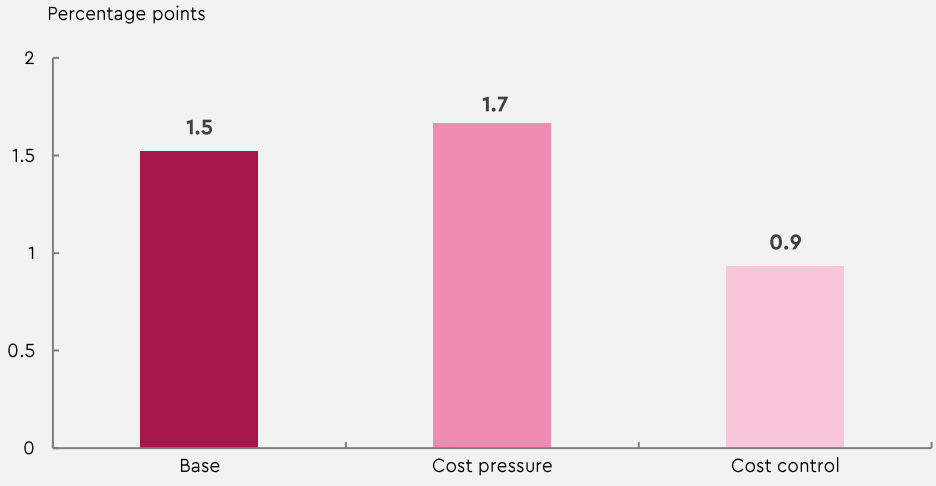
With older people making up an increasing proportion of the population, health systems will need to adapt and strengthen to meet the growing and evolving demands of that ageing population.

While New Zealand is not immune to forces that have impacted other economies, there are some factors unique to New Zealand's healthcare system:

- Our (projected) population is growing in diversity, which means that prevalence of some health conditions and therefore demand for some health services will rise
- Our physical distance from technology, capital, and other markets mean that health products and services can be more expensive than in economies that are closer to key health markets
- Low population base and therefore low tax base

As a result, the recent OECD report highlights that the average OECD country spends 15% of government expenditure on health, and projections suggest that spending will increase by 1.5 percentage points by 2045 across the OECD economies.[1]

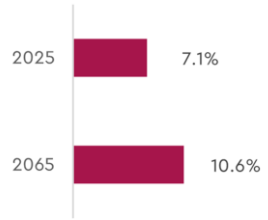
Figure 2. Under a base scenario, health spending from public sources in 2045 is expected to increase by 1.5 percentage points as a share of GDP



Source: OECD. (2025). *Health at a glance 2025: OECD indicators*

The cost of healthcare to the New Zealand government is forecast to continue to rise

The perfect storm of fiscal pressure – if policies are left unchanged, healthcare is set to rise from 7.1% of GDP to 10.6% of GDP by 2065



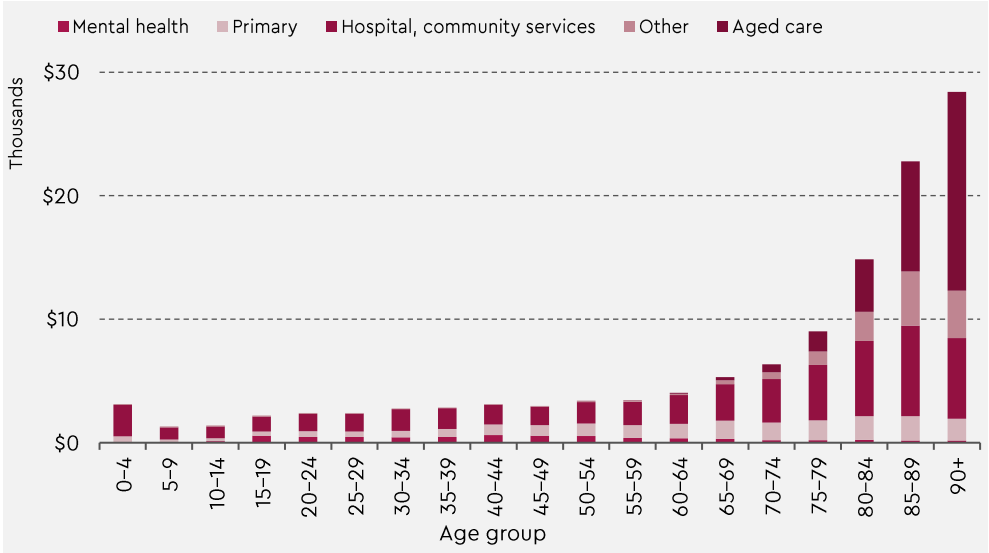
The New Zealand Treasury warns that these factors would see health expenditure rise from 7.1% of GDP now to around 10% in 2065 if policies were left unchanged.[2]

The Treasury long-term insights briefing notes that there are a range of pressures on the sustainability of fiscal policy in the coming decades, and **the most significant long-term spending pressures are from a combination of healthcare and New Zealand Superannuation.**[3] The Treasury have estimated that the ageing population has increased public expenses by 1% of GDP since 2017, due to increased demand for health services as well as superannuation.

Additionally, health infrastructure is ageing and not always well maintained. There are significant costs forecast for maintenance and asset renewal.[4] As an input into the National Infrastructure Plan, NZIER modelled that investment requirements for hospital infrastructure alone would represent between 0.4% and 1.2% of GDP annually – which is four times more than New Zealand has been spending.[5] Of the investment required, 55% is expected to be driven by the replacement and renewal of existing assets.

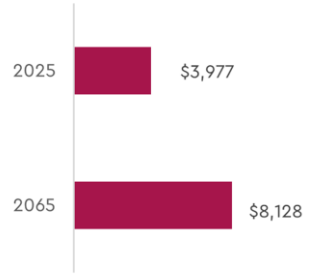
The bulk of New Zealanders' healthcare is provided publicly, paid for out of general taxation. As most tax occurs in midlife, but healthcare use tends to happen later in life, the changing age structure combined with the rising cost of providing healthcare, creates a perfect storm of fiscal pressure (Figure 3).

Figure 3. Health expenditure rises by age, with the 80+ age group consuming the most



Source: The Treasury. (2025a). *He Tirohanga Mokopuna – Long-term Fiscal Statement 2025.*

New Zealand is on a trajectory to double health costs per person from $4,000 in 2025 to $8,000 by 2065

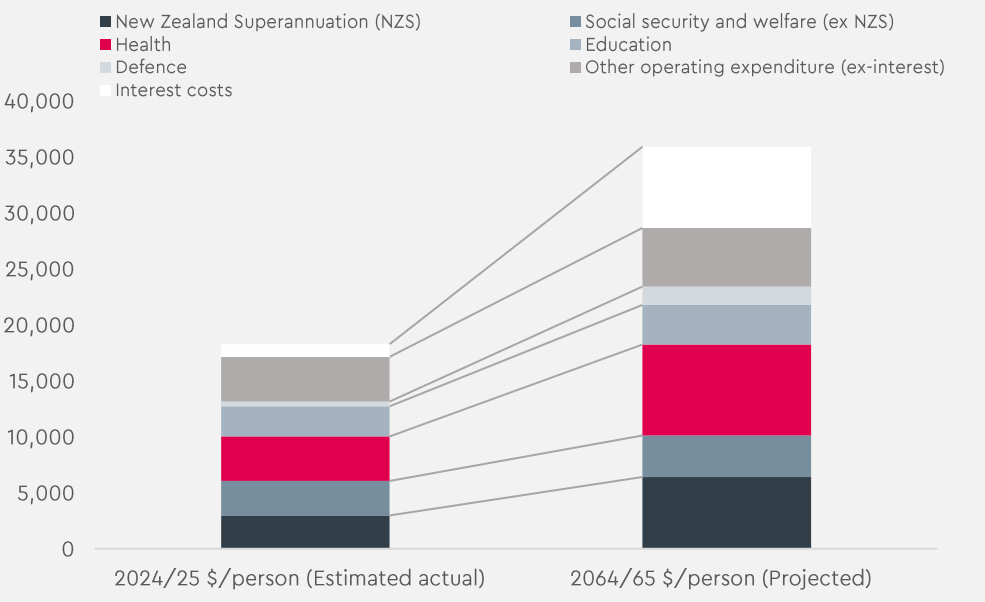


Government health costs are set to double by 2065

People are living longer, but they are also spending more years in ill health. The costs of healthcare rise significantly as age increases. There are non-demographic cost drivers too, including technological expansion, workforce costs, and increased complexity of care.

Health spending is the second-largest area of government expenditure, but also one of the most difficult to project. The Treasury's analysis suggests that on current policies and in inflation-adjusted terms, **health costs could more than double** from almost $4,000 on average per person now, to over $8,000 per person by 2065 (Figure 4).

Figure 4. Health costs could more than double from $4,000 per person now, to over $8,000 per person by 2065



Source: The Treasury. (2025c). *He Tirohanga Mokopuna – Long-term Fiscal Statement 2025*

Notes: 2009/10 dollars

Both health and superannuation are expected to more than double. Interest costs would rise more than sixfold per person, becoming one of the largest areas of government spending. This is due to the compounding impact of higher debt levels over time.

Increasing private contributions to health costs could moderate fiscal pressures

The Treasury warns that on current projections "debt reaches untenable levels".[2(p29)]

Slowing down government expenditure in health could be achieved through:

- health prevention,
- increasing efficiency, and
- increases to user pays.[2]

The Treasury *Long-term Fiscal Statement 2025* includes a combination policy scenario to show how a mix of revenue and expenditure changes could support long-term fiscal sustainability. The illustrative scenario includes a reduction in the annual rate of health cost growth premised on a mix of efficiency, health prevention, and user pays. In the scenario, health spending would increase to 9.8% of GDP by 2065, rather than 11.2% as in the baseline scenario.[2]

Voluntary and compulsory health insurance plays a significant role in many OECD economies

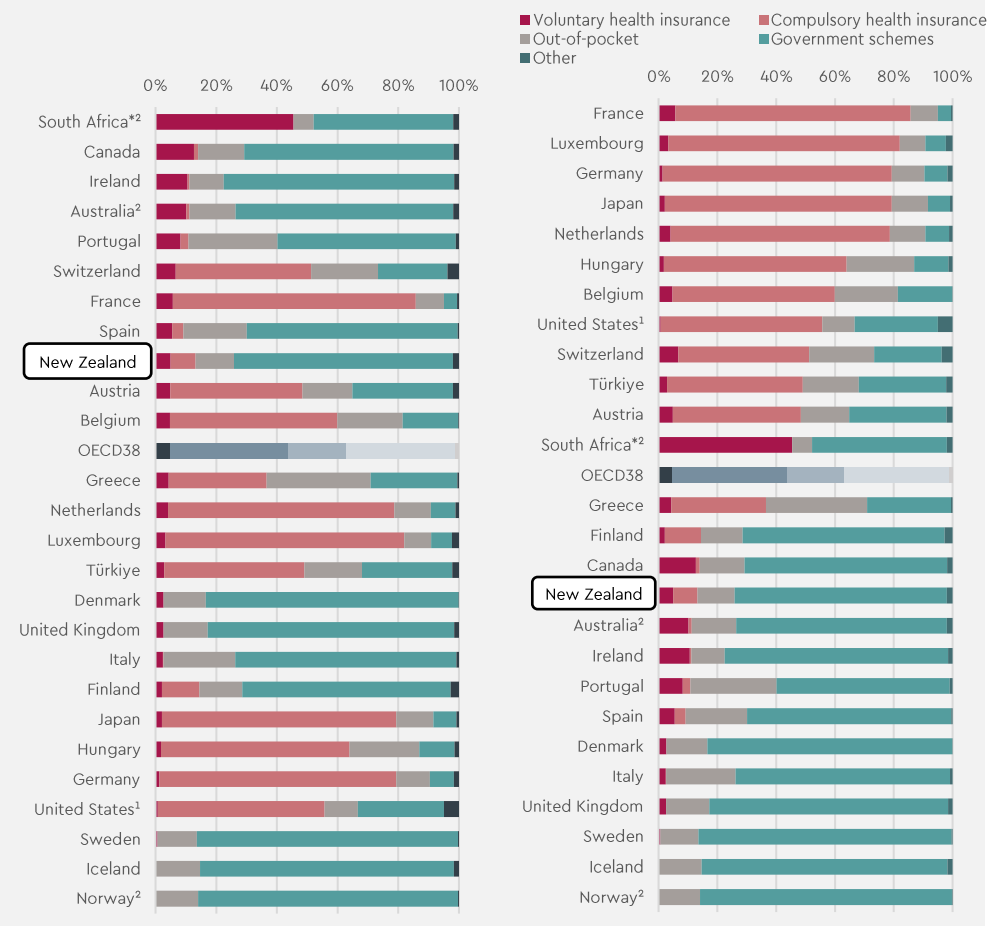
About half of OECD economies principally finance healthcare through public finance, and the other main mechanism is some form of compulsory health insurance – which can be managed through public or private entities. Voluntary health insurance also plays an important funding role in some countries.

Understanding health expenditure by type of financing with a focus on voluntary health insurance shows New Zealand (2023 or nearest year) is at the top half of the OECD but lower than Switzerland, Australia, Ireland, and Canada (Figure 5).

Voluntary health insurance only covered 5% of all healthcare costs across the OECD but financed more than 10% of the total health budget in Canada and Ireland. South Africa is the outlier with 45% of funding from voluntary health insurance.

If countries are ordered by combined voluntary and compulsory health insurance, New Zealand is placed at the bottom of the OECD, between Canada and Australia. New Zealand's compulsory health insurance in Figure 5 refers to the Accident Compensation Scheme.

Figure 5. Insurance plays a significant role in funding healthcare in some OECD countries



Source: OECD (2025). *Health at a glance 2025*

Notes: Countries included were OECD members when New Zealand joined the OECD. South Africa is included as it has the highest proportion of funding from voluntary health insurance. Category "Other" refers to financing by NGOs, employers, non-resident schemes and unknown schemes.

All spending by private health insurance companies reported under compulsory health insurance.

2. Latest available data from 2022.

Private health insurance plays different roles in countries depending on their financing framework

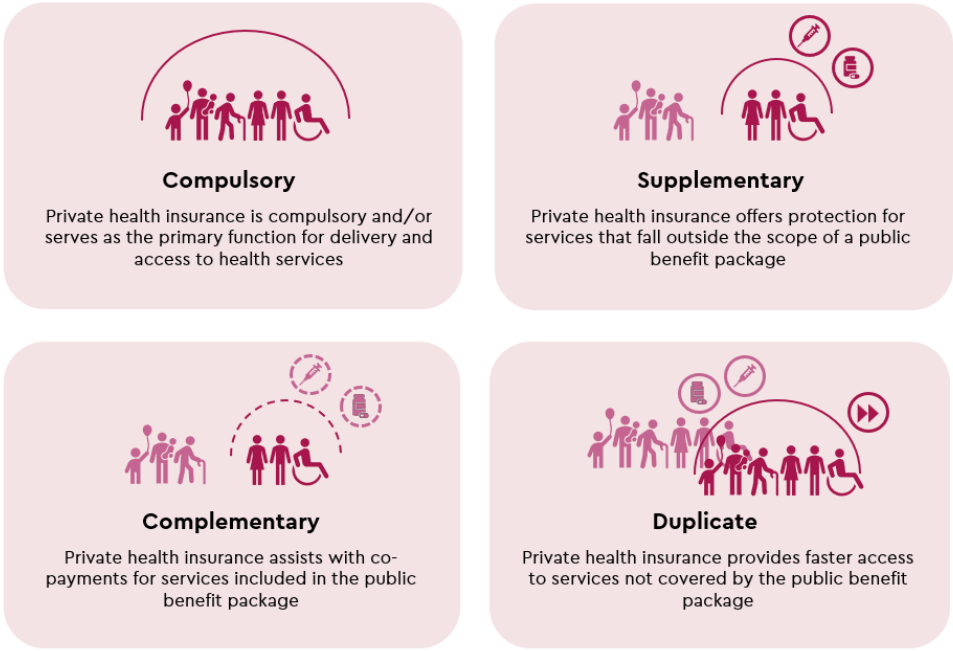
In most OECD countries, healthcare financing is organised through government or social health insurance schemes. These schemes provide access to a set of public health services, which ensures a minimum set of health services is available to all resident individuals.

Private health insurance is compulsory and/or serves a primary function in delivery and access to health services in some countries, notably Netherlands and Switzerland, Chile and Germany.

Private health insurance plays a secondary role in other jurisdictions, where private insurance supplements, complements, and overlaps with public healthcare (Figure 6):

- **Supplementary:** Offers protection for services that fall outside the scope of the public benefit package, as observed in countries like Israel and Canada.
- **Complementary:** Assists with co-payments required for services included in the public benefit package, with examples including France and Slovenia.
- **Duplicate:** Provides access to services from providers not covered by the public benefit package, allowing individuals to obtain care more quickly or to widen their choices of provider. This approach is present in countries such as Australia and Ireland.

Figure 6. Private health insurance models around the world



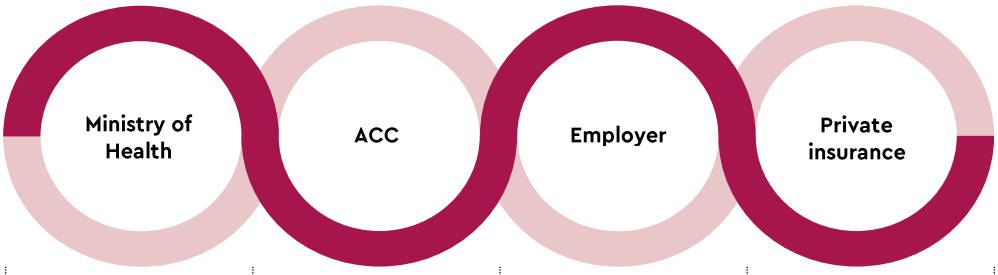
Insurance is integrated into New Zealand's healthcare system

The OECD comparative analysis shows that healthcare financing for most economies is a mixture of public and private sources. There doesn't appear to be an optimal mix or solution for financing and healthcare delivery. Health systems are also path dependent, stemming from cumulative policies and adjustments over time.[6]

In New Zealand, funding and delivery of healthcare services is split between several ministries and departments but is primarily via the Ministry of Health[a] and ACC, as well as employers (through employee assistance programmes and subsidised private insurance) and private insurance (Figure 7).

Using the health financing framework discussed above, New Zealand's private health insurance market serves a secondary function and offers duplicate coverage – providing provider choice, and the ability to access health services in a more time sensitive way (both faster and with greater flexibility) than offered in the public system.

Figure 7. Insurance is integrated into New Zealand's healthcare system



Primary and community health **Secondary and specialist health**	**Physical injury** **Mental injury**	**Employee assistance programmes** **Private insurance**	**Health insurance** **Life insurance** **Trauma insurance** **Income protection**
• Promotion, awareness, and prevention • Hospital, primary, and community health services • Promoting and protection consumer rights • Health research • Medicines and related products • Service safety and quality	• Prevention • Costs of recovery – treatment, support, help with income	• Awareness and education • In-house wellbeing programmes • Paid special leave • Paid insurance as part of remuneration package	• Awareness and education • Prevention • Private specialist providers • Specialist NGO services • Private hospitals • Help with income • Financial impact on family

[a] Health New Zealand, Pharmac, MedSafe, the Cancer Control Agency, Health Quality & Safety Commission, Health Research Council of New Zealand, and New Zealand Blood Service are considered as part of the Ministry of Health through Vote Health.

HEALTH INSURANCE LANDSCAPE

The Retirement Commission defines financial resilience as "people can weather life's storms, or unexpected financial hits, without falling into damaging debt".[7] The Commission recommends three ways to improve financial resilience – insurance, emergency funds, and wills and enduring powers of attorney.

Over a third of Kiwi have private health insurance

35%

of adults have private health insurance

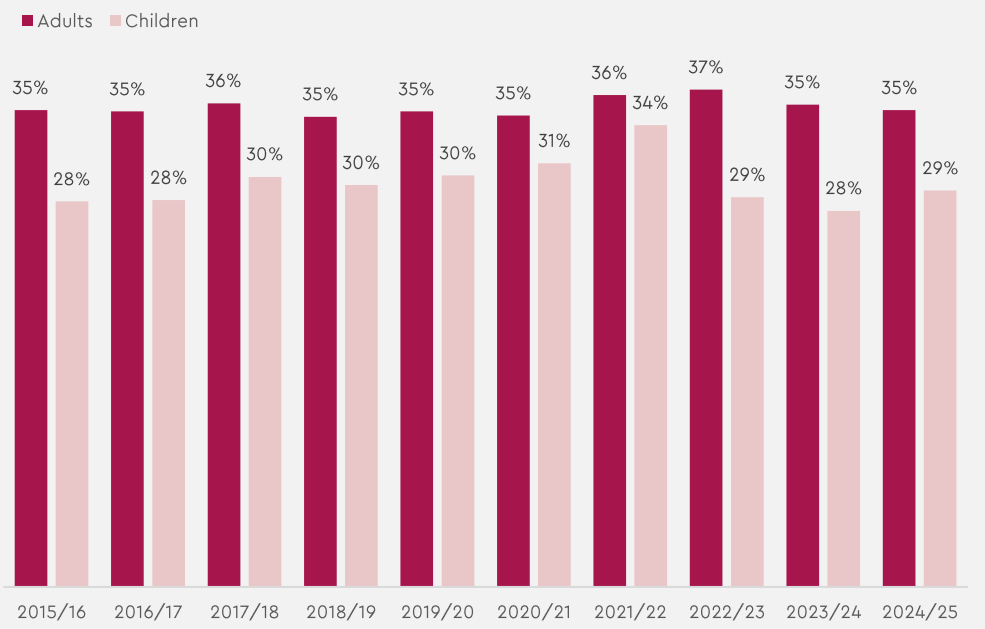
In 2024/25, the New Zealand Health Survey[8] showed that over 1.5 million adults (1,519,000 or 35% of adults) indicated they had private health insurance. Additionally, 29% of children were insured.

Health insurance coverage has been relatively static over the last 10 years (Figure 8).[8] Internationally, New Zealand's private health insurance coverage sits below the OECD average (Figure 9). The OECD do not include New Zealand in its insurance indicators dataset, so it is not clear to what extent insurance is costly in New Zealand relative to OECD averages and therefore one of the reasons why coverage could be lower. However, other OECD analysis shows that New Zealand experienced one of the highest insurance policy price growth rates across the OECD in 2024 (Figure 17).

29%

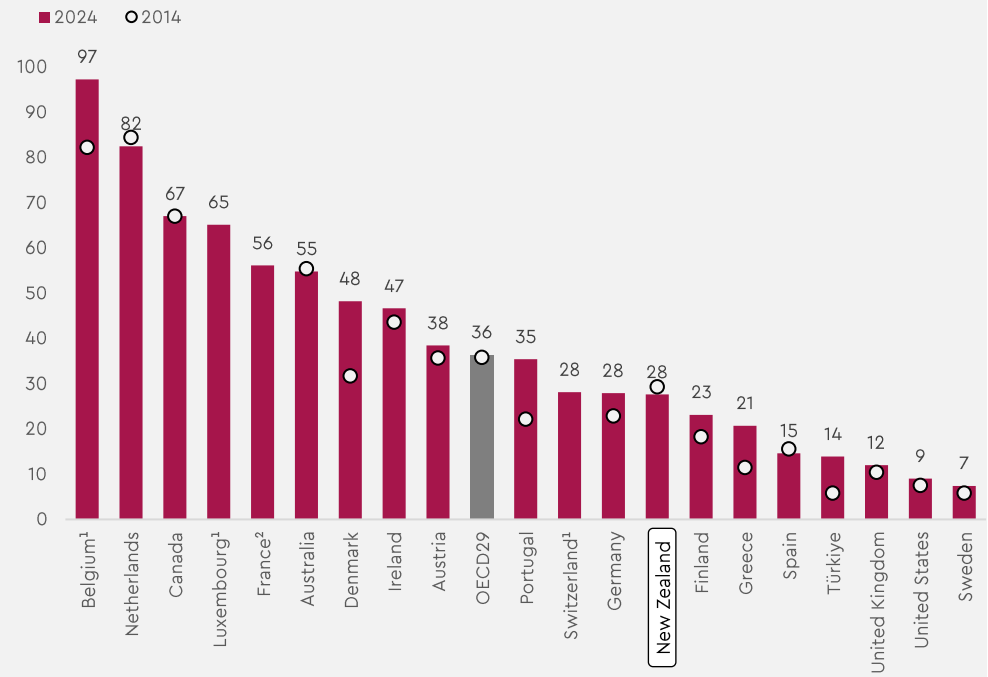
of children have private health insurance

Figure 8. Around a third of Kiwi have private health insurance and the rate of insurance has stayed relatively the same over the last 10 years



Source: Ministry of Health. (2025). *New Zealand Health Survey*[8]

Figure 9. New Zealand is below the OECD average for private health insurance coverage in 2023-24



Source: OECD. (2025). *Health at a glance 2025.*[1]

Notes: They exclude primary private insurance coverage, which exists in Germany, Switzerland and the United States. 1. Latest data from 2022. 2. Latest data from 2019.

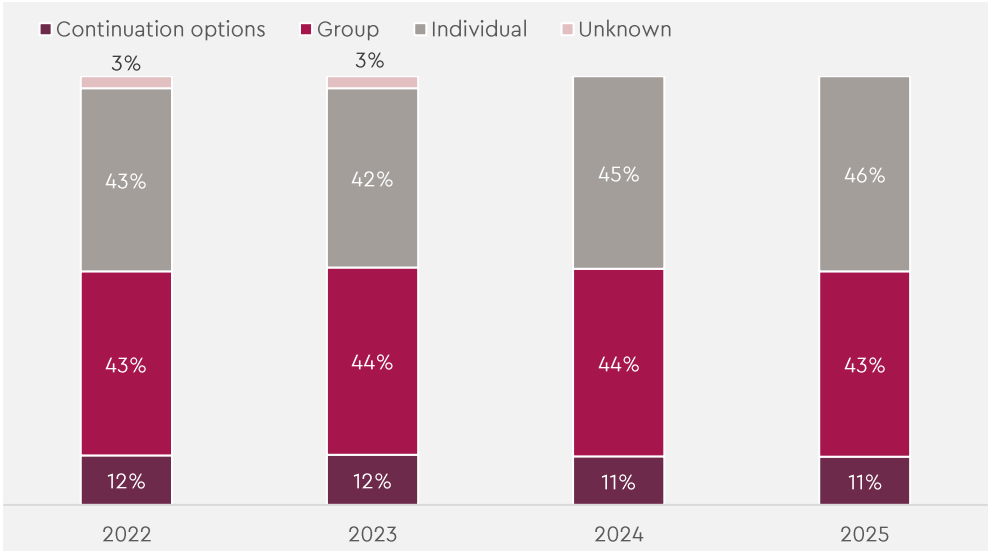
Employers play a large role in private health insurance provision

43%

of health insurance policies are provided by employers

The type of policy holder has remained broadly the same over time. In 2025, 57% were individual policy holders and 43% were covered under a group scheme subsidised by an employer or other scheme sponsor (Figure 10). The remainder (11%) had exited a policy that was previously subsidised by an employer and took out an individual policy.

Figure 10. 43% of those insured are covered through an employer scheme



Source: Financial Services Council Health insurance member dataset

Notes: Data for year ending 31 December.

Voluntary top-ups and family additions are included in "group"

Continuation options: Customers who have left a group scheme and have exercised an option to retain cover as an individual

Employer-based private health insurance explains high levels of private coverage in some jurisdictions

A 2022 OECD report identified that there were financial incentives in place for employers to actively promote health and wellbeing at work, through insurance, tax credits, and subsidies and grants.[9] In part, this has led to high levels of coverage in some jurisdictions.

Compulsory employer and employee contributions to health insurance exist in France, Germany, Japan[9], Netherlands[10] and in Belgium[11]. While employers in the US are required to provide health insurance coverage for employees, only about 55% of the US population receive employment-sponsored health insurance.[9]

Ireland

In 2024, 46% of people in Ireland had health insurance.[12] In the 2023 two-yearly review of private health insurance in Ireland, a survey of those with health insurance found that the most common main reason for having health insurance was because it was offered with employment – 19% of those surveyed.[13] The next most common reason was "inadequate standard of public services" with 13% indicating this as their main reason why they had health insurance.

In Ireland there are financial incentives for medical insurance (health insurance and/or dental insurance) paid by an employer. When insurance premiums are paid by an employer, it creates a taxable benefit in kind (BIK) in the same manner as fringe benefit tax (FBT) in New Zealand. However, in the Irish tax system, employees can claim Medical Insurance Relief – 20% of the cost of the policy, up to a maximum credit of EUR 200 for an adult and EUR 100 for a child.[14]

Canada

Employers in Canada commonly provide private health insurance as an employee benefit.[9] Employer incentives for premium payments or contributions to private health insurance plans are generous. Employer contributions to plans that meet all the conditions of defined Private Health Services Plans are considered a non-taxable benefit[15] meaning that it is effectively a significant tax subsidy.

In 1993, the Quebec government removed the exclusion of employer contributions to supplementary health insurance from taxable income. However, in all other provinces and at the federal level the tax subsidy remained in place. A study examining the effects of this policy change found that the removal of tax subsidies for employer-provided private health insurance led to a 18-19% decrease in workplace coverage.[16] The change also led to a more pronounced reaction from smaller firms (those with less than 20 employees). Smaller firms had a 19-26 percentage point reduction in coverage, compared to a 6-7 percentage point reduction in firms with more than 500 employees. The author suggests that the administrative gains in providing group insurance plans for smaller firms would likely be small, in the absence of a tax subsidy.[16]

New Zealand

New Zealand currently applies FBT to benefits supplied to employees or shareholder-employees. This includes:

- Sickness, accident, or death benefit funds
- Life, pension, personal accident, or sickness insurance policies
- Friendly society insurance fund schemes

- Funeral trusts.[17,18]

The Financial Services Council (FSC) has been advocating for the removal of FBT on employer-provided health and life insurance to ensure that employees can benefit from better health insurance and life insurance coverage.

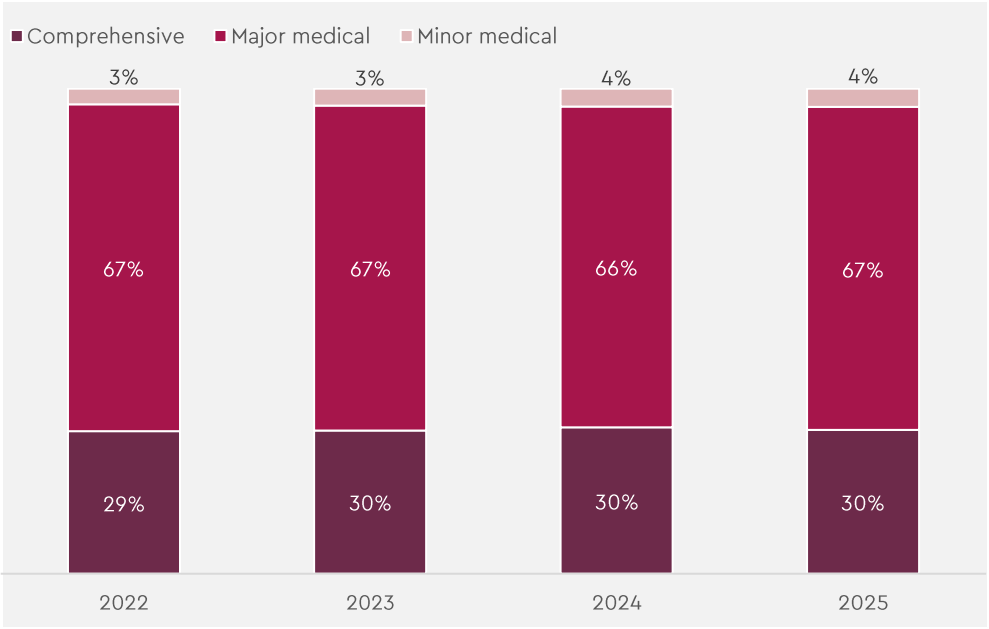
Two-thirds of policy holders have major medical health insurance

66%

of insurance policies cover major medical expenses only

The types of policies held have largely remained unchanged in the last few years. Most policies are for major medical coverage, such as surgery and medical hospitalisations (and associated specialists and diagnostic testing) (Figure 11).

Figure 11. Major medical coverage is the most common policy



Source: Financial Services Council Health insurance member dataset

Notes: Data for year ending 31 December.

Comprehensive: major medical policies combined with minor medical coverage.

Major medical: Cover for major treatments (surgery, medical hospitalisation) and optional specialists and diagnostic testing. Excludes GP, dental, optical, ancillary.

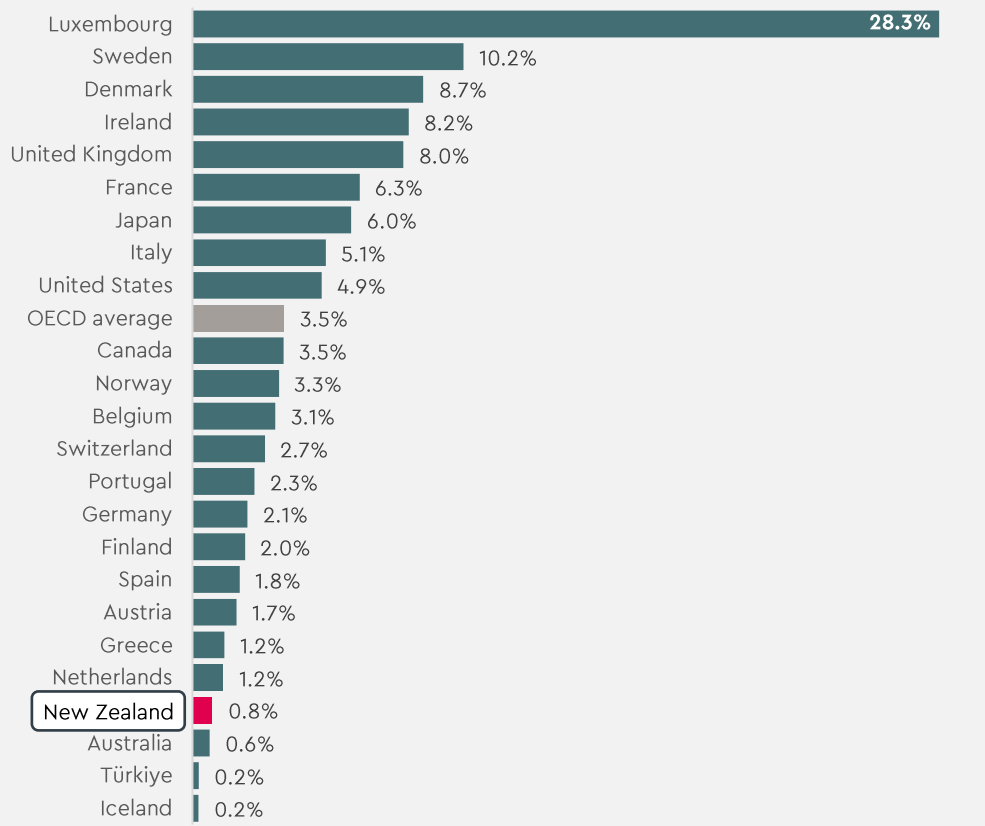
Minor medical: reimbursement for GP, dental, optical, ancillary

Other insurances are available in circumstances not covered by ACC or private health insurance

Other insurance products are available – such as life, trauma, total and permanent disability, and income protection insurance – that intersect with the broader health system.

Life insurance penetration, measured as a percentage of GDP, in New Zealand is well below the OECD average (Figure 12). This indicates that the sector is relatively small, but is also a function of New Zealanders' reliance on ACC to mitigate some risks that would otherwise be part of the life insurance sector.[19]

Figure 12. Life insurance penetration, total premiums as a percentage of GDP, is low in New Zealand at 0.8% compared to the OECD average of 3.5%

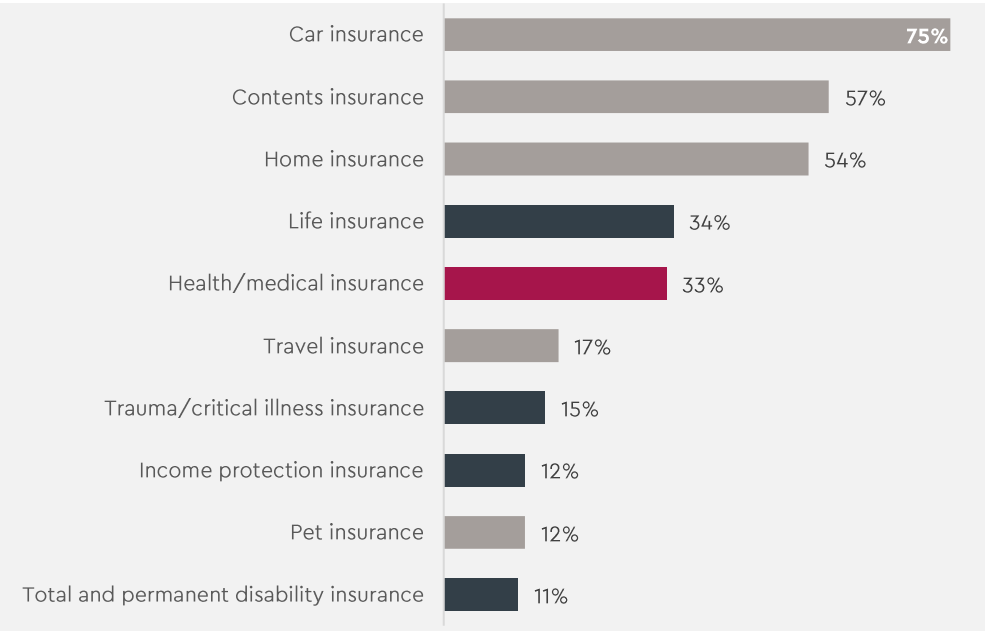


Source: OECD. (2025). *Global insurance market trends 2025.*[20]

Notes: All data is for 2024 except New Zealand which relies on data from 2021.

A recent survey of New Zealanders by the FSC found that most had car insurance, but life, health, and other insurances were less common (Figure 13).[21]

Figure 13. New Zealanders are more likely to insure their possessions than themselves



Source: Financial Services Council. (2025). *Money & you: Valuing belongings over ourselves*[21]

Notes: Based on data from a survey conducted by CoreData in February 2025 of 2,005 adults who are representative of the New Zealand adult population.

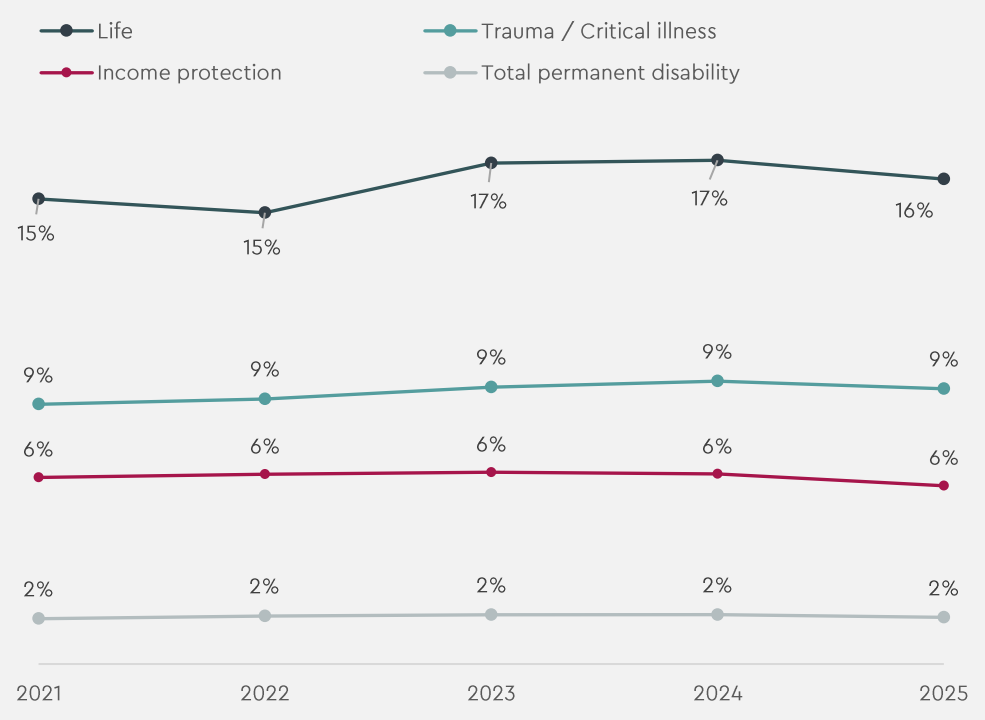
There is a small market for life insurance in New Zealand

33%

of Kiwi are covered by life insurance

FSC data shows that in 2025, 33% of New Zealanders had life insurance, falling from 35% in 2024. In terms of the type of products that Kiwi are using, life (term or accidental death insurance policies) was the most common, with trauma/critical illness the next most common (Figure 14). Only 6% have income protection insurance.

Figure 14. New Zealander's mix of life insurance products has remained broadly the same, in the last five years



Source: Financial Services Council Life insurance member dataset

Notes: Data for year ending 31 December.

Some members have multiple life insurance products and will be counted in each product category

Employers also play a substantial role in life insurance coverage

12%

of life insurance holders access insurance through employer schemes

Employers also play a key role in life insurance cover with about 12% of people accessing life insurance through group cover in 2025.[b]

[b] As provided by Financial Services Council.

KEY PUBLIC POLICY CONSIDERATIONS

Private insurance complements and supplements current system settings

The key public policy considerations are the potential impact of greater use of insurance and whether it improves access, equity, and outcomes for New Zealanders. The summary case for and against is set out below, informed by desktop review of the evidence.

The primary case for private insurance:

- Private health insurance could expand total system capacity by creating a parallel funding stream, reducing pressure on public waiting lists, and may correlate with greater elective surgery throughput than New Zealand's more constrained public system.
- It could offer greater consumer choice over timing and use of specialists, provide some fiscal relief as populations age, and allow those willing to pay to access faster care without (in theory) disadvantaging others.

This is considered alongside the primary case against private insurance:

- Greater use of private insurance could compromise equity by creating differential access based on ability to pay, and in workforce-constrained systems like New Zealand, the central argument is that every hour a specialist spends in private practice is an hour not available to public patients.
- Greater dependence on insurance could increase the risk of adverse selection, may require substantial public subsidy (usually via the tax system) to remain viable, and could generate administrative overhead that doesn't exist in single-payer systems.
- There is also some concern that greater use of insurance may allow private providers to "cherry pick" elective work while public hospitals retain complex cases, emergencies, and teaching burdens.

We assess choices against policy criteria

Policy criteria:

- Efficiency
- Equity
- Fiscal sustainability
- Feasibility

Overall, the judgement is whether a policy change would improve health outcomes in New Zealand across four key criteria:

1. **Efficiency** – Does increasing the role of private health insurance as a funding source expand total system capacity and reduce waiting times, or just redistribute access?
2. **Equity** – What are the distributional effects? Who benefits, who's unaffected, who might be worse off (for example, through workforce diversion)? How does this intersect with broader population health objectives?
3. **Fiscal sustainability** – What is the net cost to the Crown after accounting for any offset in public utilisation? Is this good value compared to alternatives?
4. **Feasibility** – Political economy, implementation complexity, path (what would have to change)? What could we learn from others?

The case depends significantly on the counterfactual.

If the alternative is the funding isn't spent on health at all, expanding private cover through insurance would likely lead to better overall health outcomes.

If the alternative is equivalent investment in public capacity (as a fiscal opportunity cost) then the policy argument shifts, and the case for direct public investment yields more health gain per dollar than subsidising private insurance.

Because of the forecast constrained fiscal environment and the growing health burden. considering the case for greater use of private insurance in the health care system is an option worth exploring.

EFFICIENCY

Private insurance allows people to access a wider range of health services than they would otherwise, and services to suit need, preferences, and perceived quality and outcomes. Does increasing the role of private health insurance as a funding source expand total system capacity and reduce waiting times?

Some studies find better health outcomes, more timely care, reductions in waiting time, and improvements in service quality are derived from greater access to private insurance

A matched sample (by demographic and clinical characteristics as well as hospital characteristics) study of private and public funded patients undergoing percutaneous coronary intervention[c] in New South Wales, Australia found that private patients had lower rates of in-hospital mortality than public patients. Researchers also examined length of stay and rates of hospital-acquired complications and found no significant differences between the two groups. Notably, remoteness and relative socioeconomic disadvantage were also considered and did not account for the difference between publicly funded care and private insurance care.

This is in line with an older study into private health insurance by the OECD that indicated that private health insurance can lead to better access to more timely care and improve the quality of life of those who would otherwise have lengthy wait times for treatment.[22]

A more recent study into wait times in Victoria, Australia concluded that a one percentage point increase in private health insurance coverage led to about 0.34 days (or 0.5%) reduction in waiting times in public hospitals on average.[23] However, the researchers warned that while the result is statistically significant, its practical effects are small. The effect of increases in private health insurance coverage leads to increases in private patients and reduces the volume of public patients. As specialist physicians in Australia (and New Zealand) work across public and private sector, this means that specialist physicians allocate more time to treating private patients, reducing their availability in public settings. This aspect is further discussed in the section on fiscal sustainability starting from page 25.

Another study in Australia concludes that private health insurance is correlated with improved health, but this was mostly due to healthier people purchasing private hospital insurance.[24] The researchers also note the limiting factor of specialists working in both the private and public sectors.

Improvements in health service quality (but also increases in prices consumers pay) have also been found in a couple of studies, based on reforms that introduced more competition in the health services market.[25,26] Arguably in New Zealand's health landscape those studies are not comparable as private health insurance access and use tend to lead to faster access to care, but don't usually lead to greater choice in provider. We do not canvas those studies further for this report.

[c] Percutaneous coronary intervention (PCI) is a minimally invasive procedure used to treat narrowing of the coronary arteries of the heart found in coronary artery disease.

But other research findings are mixed

The OECD's older study found no clear evidence that waiting times are reduced in the public health system due to more private health insurance.[22] That same study found only weak evidence that private health insurance is related to delivery of high-quality care. The OECD go on to state that this is partly a function of policy settings, for example, regulatory and financial incentives for insurers to influence quality of care, consumers wanting access to individual choice, and insurers not wanting to add other sources of influence on decisions over appropriateness of care.

A recent Australian study found that, in the context of encouraging private health insurance to reduce pressure on the public healthcare system, the use of premium subsidies and tax penalties doesn't have substantial effects for high-income earners – as insurance premiums are a relatively small fraction of income and rebate reductions would not cause financial stress.[27] The researchers recommend targeting private health insurance benefits toward lower income earners as a more efficient way to reduce government expenditure. There are important behavioural lessons to be learnt here (and in other studies[28]) in designing any private insurance intervention:[27]

- General consumer inertia. People tend to set-and-forget and don't update their policies over time.
- Tax penalties and rebates, and insurance price differences, can be difficult to understand so that individuals won't necessarily choose plans and prices, and apply for rebates and subsidies, that would benefit them.
- Rebates that are tagged to retirement age tend not to influence take up of private health insurance.[28] The rebates become a wealth transfer to older people who already have insurance.

There are concerns that private health insurance leads to cost-shifting

A couple of studies in New Zealand conclude that private health insurance leads to more cost in the public health care system. Using data from the New Zealand Health Survey, Blumberg[29] concludes that private health insurance imposes a cost of $40 million to $100 million on the health system (in 2006 dollars).

A more recent study found that a small proportion of private health insurance-funded care led to a subsequent admission to a public hospital within seven days of discharge – 2%.[30] While this is a small percentage, the researchers estimated that this would amount to an additional $11.5 million in cost to the public system, with a median cost of $2,800 per event. This is consistent with other studies which indicated that cost-shifting is relatively small.[22]

Researchers in the US examined the interactions between public health insurance, private individual health insurance, and employer-provided health insurance.[31] They highlighted that designing insurance, labour market, and health policy should not be done in isolation. By integrating policies through sharing of risk, their modelling suggested that public costs would be reduced and households would benefit.

The paper recognised that different groups of people are largely separated into different insurance risk pools:

- Higher-skill, higher-income workers tend to be in employer-funded plans

- Lower-income workers and non-workers are more likely to be on Medicaid (in New Zealand this would be equivalent of no private health insurance and using public healthcare)
- Individual insurance bought though Accordable Care Act exchanges for those in between (private health insurance).

The policy tested was cross-subsidising or partially cross-subsidising employer-funded plans and private health insurance plans, so heathier and less healthy people were pooled together more evenly. The model found that:

- Most households would be better off
- Government spending on health insurance falls, even while households benefit
- The share of uninsured people falls slightly
- Full-time employment rises slightly.

Insurers also offer preventative interventions which can reduce demand for public health care services

There are considerable methodological issues in isolating the effects of insurance on preventative health care and health outcomes.[32] This is because people without insurance differ from those with insurance on many characteristics including demographics, health behaviours, socio-economic status, propensity to use healthcare, and health status.

In the US, various randomised controlled trials (RCTs, seen as the gold standard of methods in programme evaluation) on the effect of the expansion of public health insurance programmes (such as Medicare, Medicaid, and the Affordable Care Act) provide insight into insurance's impact on (preventative) healthcare usage and health outcomes. One such study examined the impact of coverage on the previously uninsured and found strong evidence that public health insurance increased the use of some preventative services (such as cholesterol screening, Pap tests, prostate-specific antigen screening, and mammography) and improved self-reported health.[33]

A study of rural and low-income adults in the US also found that public health insurance led to increases in preventative care.[34]

A systematic review of chronic disease prevention programmes implemented by private health insurers found that preventative interventions fell into four categories:

- Financial incentives
- Health coaching
- Wellness programmes
- Group medical appointments.

While the peer reviewed literature from the US, South Africa, Australia, and Germany varied in the types of outcome measures used and to determine the effects of different types of interventions, most studies reported improvements in outcomes such as increase in healthy eating, physical activity, and lower hospital admissions. The main moderator of outcomes was duration of the programmes, that is, interventions that were longer (at least 2 years) had better outcomes and outcomes were sustained for longer, than those that were shorter in duration.[35]

EQUITY

35% of adults or

1.5 million

adults have access to private health insurance

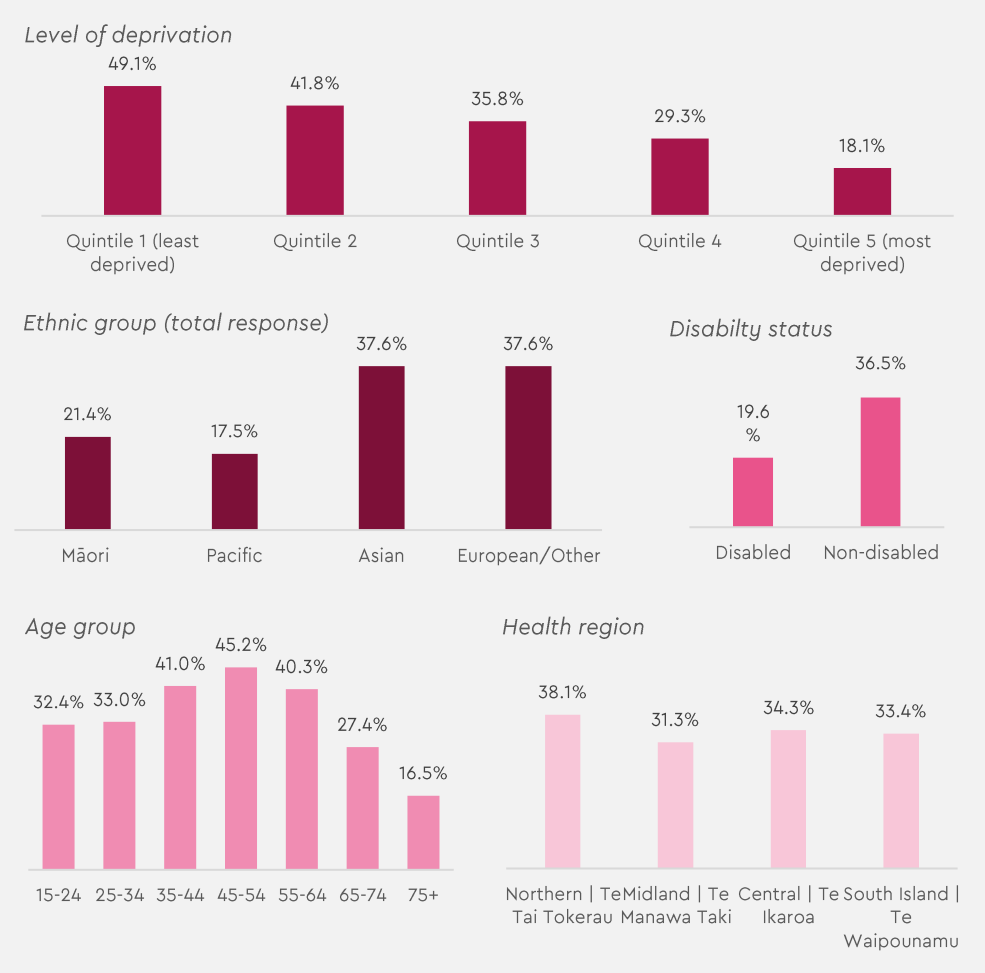
Private insurance enables many Kiwi access to privately funded health services

In countries that have private health insurance markets, a key challenge is access to coverage. Higher-risk and low-income individuals face difficulties accessing and affording policies, in the absence of, or with little, regulation.[22]

But the privately insured tend to be higher educated, have higher incomes, be European, and middle-aged

People living in the least deprived neighbourhoods were more likely to have private health insurance than people living in the most deprived neighbourhoods (49.1% vs 18.1% for adults) (Figure 15).[8]

Figure 15. Those with private health insurance tend to be older, richer, and European or Asian



Source: Ministry of Health (2025) *New Zealand Health Survey*[8]

There may be labour productivity benefits to private insurance

TDB Advisory's[36] report for Health Funds Association of New Zealand noted that private health insurance can lead to faster return-to-work benefits which flow on to have increased incomes for individuals, lower rates of absenteeism and increased output for employers, as well as higher tax revenue for government. At the time (2016) these benefits were estimated in total savings of $101 million per annum. The

return-to-work benefits do not just stem from private health insurance but also life insurance. Life insurances (including income protection, trauma, and disability insurance) provided financial buffers that enable beneficiaries to return to work sooner than they would otherwise without insurance (see box below, for an example of an Australian life insurer's efforts in product development and improving return-to-work outcomes).

Understanding the lived experience of return-to-work for cancer survivors to inform life insurance products

Hannover Life Re has a research collaboration with Griffith University's Centre for Work, Organisation and Wellbeing (WOW) (Queensland, Australia). The two organisations released in 2004 a scoping review of return-to-work of cancer survivors from Griffith University.[37]

A study in 2018 of lost productivity due to cancer in Australia estimated that Australia's GDP is reduced by approximately $1.7 billion due to the estimated number of Australian adults of working age with cancer who were not in the labour force.[38]

The scoping review examined 320 peer-reviewed journal articles published between 2013 and 2023 to understand what would support better return-to-work outcomes for cancer survivors, particularly the development of insurance products and services that could be tailored to their needs.

A study in the US of the National Health Interview Survey from 2008 and 2017 focused on the return-to-work and financial outcomes of patients who had sustained trauma requiring hospitalisation.[39] Other than shorter length of hospital stay and higher education level, private health insurance was associated with higher rates of return-to-work. Financial resilience and stability appear to play a role in return-to-work.

The use of community rating and zero-rating regulatory tools level the affordability playing field

A key feature of Australia's private health insurance industry settings is that it is community rated. This means that the same premium is charged for the same product regardless of individuals' characteristics, for example, health, age (or other risk factors), or likelihood to claim. Insurers also can't refuse to insure an individual for pre-existing conditions. A system of risk equalisation underpins community rating. Because insurers are not allowed to risk rate premiums, risk equalisation partially compensates insurers with a riskier demographic profile by redistributing money from those insurers paying less than average benefits to those paying higher than average benefits.[40]

But community rating risks adverse selection, so Lifetime Health Cover (LHC) was introduced to the Australian system in July 2000. This penalises people who take up private health insurance after age 31. The combination of LHC as well as the Medicare Levy Surcharge and community rating has led to more people taking up private health insurance at younger ages.[41]

Community rating or zero-rating is also used in Ireland and South Africa.

Private insurance providers have reported improved health outcomes for Māori

In 2018, nib partnered with Ngāti Whātua Ōrakei to provide universal insurance for all hapū members – Tohu Toi Ora programme, including:

- Automatic coverage for members' pre-existing conditions
- No co-pay, reducing financial burden
- A range of services such as primary care, specialist care, and cover for major surgical and medical treatment in private hospitals.

From research nib commissioned from Nicholson Consulting, in 2020, Toi Ora could lead to:

- 321 fewer avoidable hospitalisations for iwi members,
- 657 more iwi members with access to primary healthcare, and
- 15 fewer iwi members with cancer.[42]

ImpactLab[43] estimated a social return on investment of $2 for every $1 spent in 2023 on Toi Ora – creating $10 million in social value.

The research on whether private health insurance hinders or supports equity is also mixed

The Treasury warns that moving towards higher private contributions could impact on people on low incomes or those with chronic health conditions and reduce access to primary healthcare which can shift costs to more expensive parts of the health system.[2] In Australia, there were concerns from those living rurally in incentivising private health insurance as they could not easily access the services.[44]

While community rating in Australia levels premium prices for all, there are still out of pocket payments. Various studies and reports note that for Australian private health insurance, policies can contain excesses, co-payment, and exclusions.[45] Additionally, those insured often must cover gap payments and the average gap payment has increased to levels that have been deemed to be unaffordable.

A New Zealand study finds that privately funded surgery did not take demand off the public system

In New Zealand, a study evaluated equity of provision of surgery for those receiving elective joint replacement, prostatectomy, or cataract surgery through private and public channels.[46] The study noted geographical disparities, that is, regions with lower rates of publicly funded surgery had higher rates of privately funded surgery. But high private provision was not associated with better access to publicly funded surgery. That is, the assumption that more surgery done privately takes demand off the public system did not hold. The researchers do note that there is a limited supply of doctors and nurses in New Zealand and elsewhere, and this has been found to be the most significant factor in waiting times.

Studies in the US find that expanding public healthcare insurance coverage to priority groups improves use and health outcomes

Various studies in the US have found impacts on equity. While caution is warranted as the public healthcare system differs considerably, it does give insight as to what might occur when private health insurance access is expanded to more vulnerable communities. Using difference-in-differences analysis (that is, looking at the average difference between outcomes before and after treatment of a treatment group

compared to a control group), a few studies have found that health insurance improved access to care, self-reported health, and reduced mortality. Importantly effects were stronger in low-income counties and in minority groups.[32]

Using other research method approaches, positive effects were found for US low-income and rural adults accessing private health insurance, such as large increases in service use – outpatient visits and inpatient stays, but no effect on emergency department use.[34]

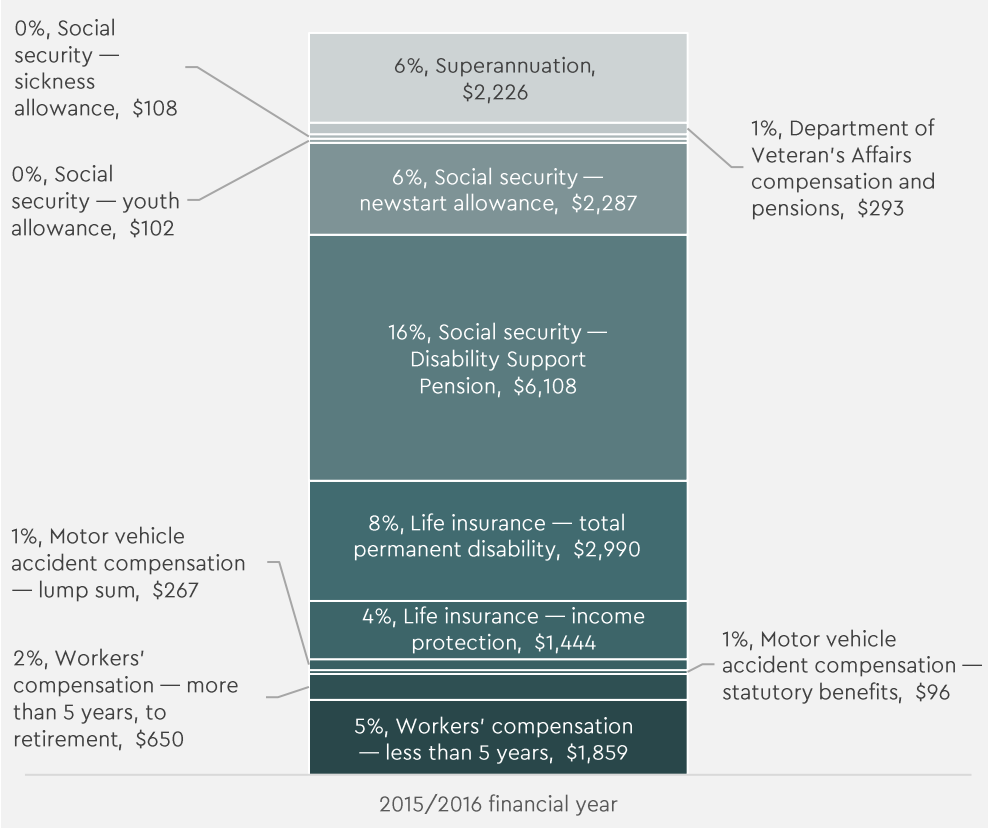
FISCAL SUSTAINABILITY

The research shows that the answer isn't clear cut as to the fiscal effect of private insurance.

Australian data and research suggest that life insurance has a role in individual financial resilience which can have positive flow on benefits to Crown accounts

In Australia, an examination of the expenditure related to work disability finds that life insurances bear significant costs and are complementary to public expenditure (Figure 16).[47] While social security accounts for 23% of total income support, life insurance is the second largest category at 12% or $4.4 billion. The researchers noted that life insurance systems were the next largest to social security in terms of both volume and expenditure. Life insurance providers also offered services that were available through the public system, such as return-to-work, help finding a job or employment, and case management.

Figure 16. Estimated total expenditure on income support, AUD$ millions, 2015/16



Source: Collie et al [47]

NMG Consulting argues that life insurance should be considered a community good where there are second-order benefits to friends, family, business partners, and co-workers. These are realised through the avoidance of strain on support networks and social connections due to death, disability, or illness. Because benefits are only realised to their potential if there is scale, but the population is generally under-insured, it is stated that government should have a role in provision.[48]

Bringing these two strands together, MetLife Australia has articulated the value that individuals, the economy, and government receives from life insurance.[49] The

framework used in this industry-led work is helpful when analysed within a New Zealand context:

- **Individuals:** improved health, work, and financial security.
  - Financial security: life insurance premiums are significantly less than how much individuals would need to save to reach $500,000 of cover. Income protection payments provide households with payments over and above social security disability benefits.
  - Work: income protection claims include return-to-health and rehabilitation tools to support recovery. The study's data found that between 2018 and 2020, claims that were referred to a programme with an external occupational rehabilitation provider had the following outcomes:[49]
    - 35% of customers returned to work (note that under ACC, in January 2026 35.7% of clients returned to work or independence within 28 days. ACC has a target to increase this to 37% by the end of the calendar year[50]).
    - 55% of customers achieved an upgrade in work certification from their GP
    - 70% of customers achieved an improvement in their functional/health status.
  - Work: High return-to-work rates also means improved salaries and wages and KiwiSaver balances.
- **Economy:** the life insurance industry helps economic growth and contributes to a country's GDP. In 2025, the broader finance and insurance industry in New Zealand comprised 5.6% of New Zealand's GDP – almost $16 billion – more than the agriculture, forestry, and fishing industry.[51] Various quantitative studies have shown strong relationships between life insurance and economic growth[52,53], that hold even in the periods after severe economic crises. One study suggests that for OECD countries, a 1% increase in life insurance premia raises real GDP by 0.06% per year.[Lee et al, 2013, as cited in 53] In another study, a 1% increase in total insurance penetration led to a 4.8% increase in economic growth per year.[Han et al, 2010, as cited in 53]
- **Government:** high return-to-work rates from life insurance mean that costs are diverted from unemployment benefits, disability support payments, and potentially from ACC. In New Zealand, MoneyHub, using 2025 claims data from LifeDirect, found that 32% of income protection insurance claims over 2025 were for mental health conditions.[54,54] While musculoskeletal injuries are still the leading cause of claims (38%), mental health claims are not far behind. This indicates that life insurances may be stepping in for both government social and health expenditure.

Private health insurance can also alleviate some of the fiscal pressure on government

In Australia, 2018 industry data showed that private health insurance paid for almost two-thirds of non-emergency surgery, 90% of day admissions for mental health care and 50% of all mental health admissions, 70% of joint replacements, 60% of chemotherapy, and 88% of retinal procedures.[55] The regulation impact statement accompanying private health insurance reforms in Australia in 2018 indicated that

without initiatives to improve the affordability and accessibility of private health insurance, there would be:

- Increased demand for services in the public hospital system
- Greater pressure on Commonwealth and state funding for public hospitals
- Impact on funding levels under the National Health Reform Agreement
- Implications for contributions to public hospitals required from taxpayers.[55]

More recent analysis (2025 by the Australian Medical Association) identified that Australian private health insurance providers and private hospitals were responsible for more than two in every three planned surgeries, and two out of every five hospital admissions.[56]

The Members Health Fund Alliance, representing 80% of Australia's private health insurers, have estimated that the funds contribute more than $21.8 billion to Australia's national GDP.[57] This includes covering the cost of 6.4 million hospital bed days, 510,000 elective surgeries, and 37.8 million episodes of extra services such as dental, optical, physiotherapy, and psychology.

In New Zealand, the last assessment (in 2016) of the economic contribution of the private health insurance sector concluded, conservatively, that fiscal savings generated by the sector were around $390 million per annum, which included regulatory costs of a private insurance market.[36] TDB Advisory concluded that:

> **[Private health insurance], on balance, benefits New Zealanders.** These benefits arise through **reduced waiting times** and increased output through **fewer days off work, wider health coverage, greater consumer choice and the avoided deadweight cost of taxation (approximately $77 million per annum).**

Some research suggests that it does not reduce public expenditure

The older OECD (2004) study concluded that private health insurance had "not significantly assumed financing burdens from the public sector".[22(p15)] More recently, the Australian Medical Association's (AMA) 2025 Private Health Insurance Report Card states that the private health insurance market is "increasingly failing to deliver value for money"[56(p4)] and insurance premiums have risen significantly, outpacing inflation and wage growth. Insurance premiums are rising while coverage is narrowing – with most policies containing exclusions. In response, Private Healthcare Australia indicated that health insurers are paying out more than ever before, and the average premium rise has been below the rate of health inflation against a backdrop of specialists charging more.[58]

Some arguments against incentives and penalties for private insurance highlight the fiscal cost of these policies, and that the effects may be better stimulated through investing directly in public healthcare. Yang et al (2024)[23] state that while the Australian incentives appear to have led to a statistically significant decrease in wait times, the expenditure involved in policy interventions may achieve greater outcomes through more public healthcare investment.

Other analysis using OECD data finds that, holding everything else constant, there were no efficiency gains in transitioning from a government-based healthcare service to compulsory insurance managed by private providers.[59] In that study, efficiency was defined as levels of performance from an age-adjusted per capita healthcare budget. The evidence from the study suggested that increasing government funding in healthcare was associated with higher efficiency, rather than transitioning from one policy to the other.

In New Zealand, outsourced elective treatments as a proportion of public-funded treatments has risen over time – from 8.5% in 2011/12 to 19% in 2025/26.[60] Health NZ has panels in place for the delivery of 16 clinical specialties and elective treatment interventions – including surgical, radiology, endoscopy, ophthalmology, and cardio procedures – within private clinics.[60] These contracts enable public hospitals to meet demand and support meeting elective targets.

To date, there has been no analysis undertaken of whether these private contracting arrangements are providing value for money over and above expanding public hospital provision.[60]

Studies of private health insurance preventative programmes have found reductions in healthcare utilisation and cost

A systematic review of chronic disease prevention programmes provided by private health insurers found a few studies that specifically examined healthcare cost:[35]

- A US study of integrated medical crisis counselling straight after a distressing diagnosis (that is, cancer, heart attack, diabetes) found, compared to a standard care control group, overall less mental healthcare utilisation and therefore diversion of costs from the public healthcare system.[61] There were small sample sizes so the results are exploratory. Diabetes patients who received medical crisis counselling had medical costs in the follow-up period that were double those of standard care patients. But this was offset by savings for the cancer patient group: over a six-month period the standard care group used almost $1,000 more in incremental mental health costs alone. It was also hypothesized that over a longer term the costs associated with diabetes patients in the treatment group would decrease.
- An economic evaluation of an online self-management programme for people living with one or more chronic conditions that was part of a Pennsylvania, US employer's group insurance plan found that the intervention saved US$757 per participant.[62] Modelling and including programme costs led to a return on investment of almost $10 for every $1 spent after one year of using the programme.
- A 4-year wellness and disease prevention programme in Hawaii found savings of $350 per participant per year.[63]

But others find no differences

In Australia, the Bupa Australia trial analysed over 15,000 adults with private health insurance that had a diagnosis of heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, or low back pain and who were predicted to have high-cost claims over the following 12 months who received health coaching, versus a control group (that received standard care) of almost 9,000 people.[64] The analysis found that the intervention group had higher total healthcare costs than the control group of AUD$66, but this was not statistically

significant. However, there was some evidence that the rate of same-day only admissions were lower in the intervention group, especially for those with diabetes. The researchers also note that the intervention was relatively small in frequency compared to other similar trials, that is, there were on average about 3 contacts over a 12-month period. Most other health coaching trials suggest at least 12 or 14 sessions to produce significant health outcomes.

ACC's financial position is under pressure

The Accident Compensation Scheme is under financial pressure. More people are taking longer to return to work and independence. ACC spent $8.1 billion on rehabilitation, treatment, and compensation in 2024/25, up $4.9 billion from 10 years ago. Under current trends, ACC could have an overall funding gap of $26.3 billion by 2030.[65]

It is estimated that ACC comprises just under half of New Zealand's private healthcare spending (Table 1).

Table 1. Estimates of private healthcare spending by category, 2024

Category	Amount (NZ$ billion)
Private health – 2024	**$14.80**
Individuals	**$6.90**
Out-of-pocket expenses	$4.90
Medical insurance claims (not premiums)	$2.00
Employers (excluding employer subsidies)	**$0.80**
Wellness programmes	$0.80
ACC	**$7.00**
Claims by individuals – treatment and rehabilitation	$4.00
Claims by health providers (on behalf of individuals)	$3.00

Source: Westpac[66], based on Treasury, Health NZ, ACC, and Westpac

Currently, ACC is intertwined with private health so that any changes to ACC case management methods, or the way it funds and contracts for rehabilitation and treatment services can have significant flow-on effects on public health provision and private health insurance. For example, in relation to mental health, a recent survey of private psychologists (approximately 30% of all practising psychologists) found that 53% conducted ACC assessments.[67] Older surveys indicated that 21% of clinical psychologists held contracts with ACC and 48% are employed in the public health system.[68] ACC contracts also tend to offer higher pay than Health NZ.[69]

Any potential further role for private health provision should be considered within this broader system dynamic.

But insurers are facing increasing cost of provision

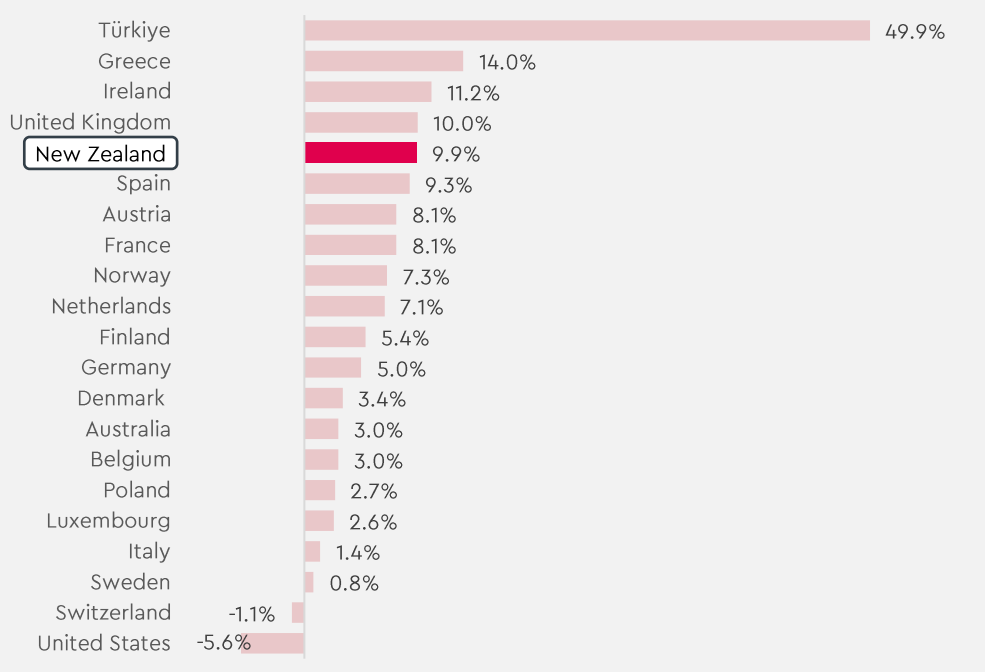
Private insurers use several mechanisms to manage costs:

- Preferred providers

- Co-payments
- Coverage for preventative care
- Risk-rated premiums
- Negotiating lower prices as have bargaining power due to scale.

There have been large price rises for health insurance policies across the OECD, often exceeding inflation rates.[20,66] This includes New Zealand which saw the price of health insurance policies grow by 9.9% over 2024 (Figure 17).

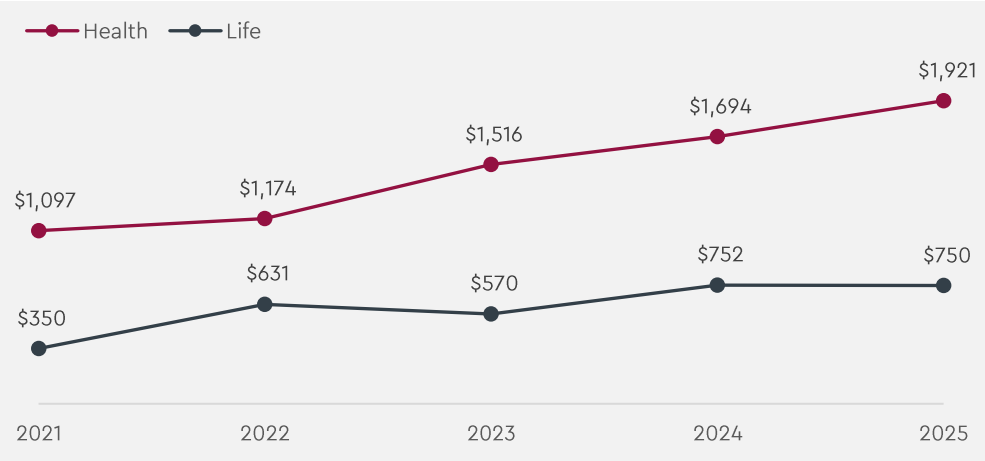
Figure 17. New Zealand's nominal growth rate of the price of health insurance policies in 2024 was one of the highest



Source: OECD. (2025). Global insurance market trends 2025.[20]

Industry data shows that both health and life insurers are also paying out more in claims (Figure 18). The average health insurance claim paid out in 2025 is almost double that in 2021.

Figure 18. New Zealand health and life insurers are paying out more than ever before – average claims paid per member

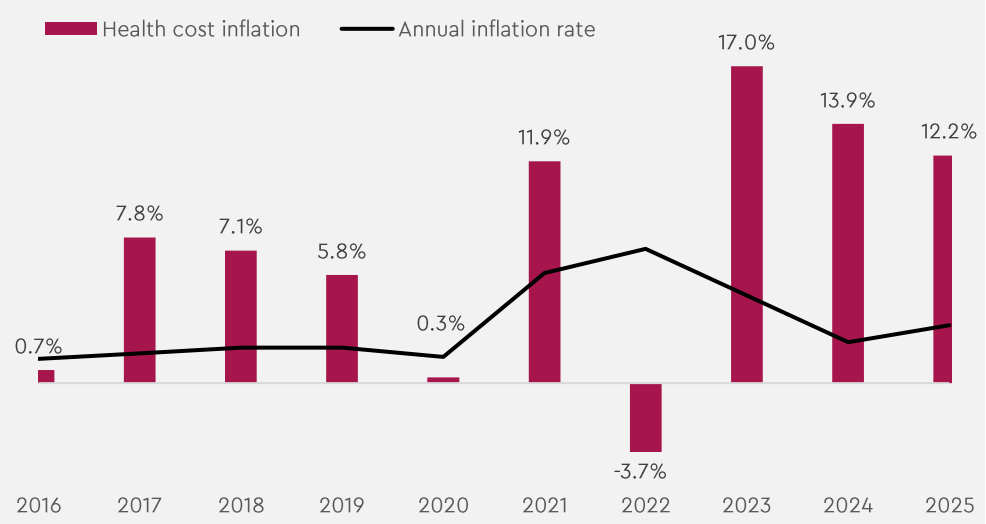


Source: Financial Services Council Health insurance member and Life insurance member dataset

Notes: Data for year ending 31 December

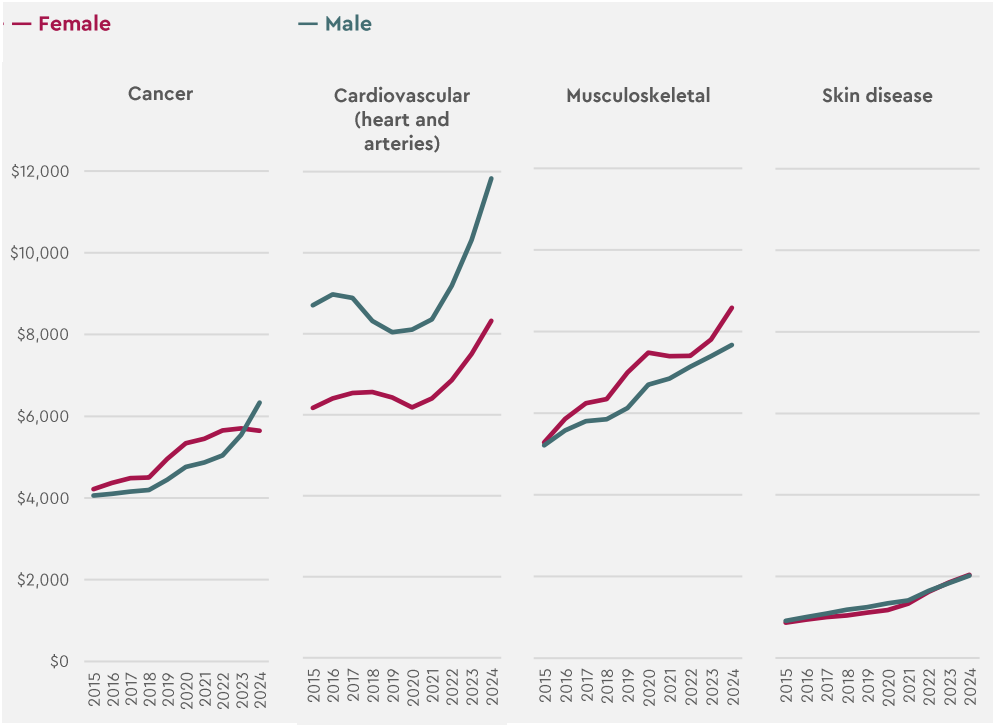
Industry-supplied information indicates that the prices for health products and services have increased at a faster rate than general inflation, driven by procedure price inflation and increasing utilisation (Figure 19 and Figure 20). In recent years, utilisation, which combines volume increases as well as a shift toward higher-priced procedures, has contributed two-thirds of health cost inflation with increases in both incidence rates and claiming frequency. While underlying drivers of health cost inflation vary by specialty, common themes are growing incidence rates and awareness of underlying conditions, worsening of underlying health and lifestyle trends, an ageing population, investment in new equipment and technology, and a general shift from the public to the private health sector.

Figure 19. Southern Cross Medical Care Society health cost inflation, 2016-2025



Source: Southern Cross Medical Care Society and Stats NZ Consumers price index
Note: Annual inflation rate refers to annual change for the December quarter

Figure 20. Average cost of selected procedures over time, 2015–2024



Source: AIA; December 24 CPI rates

It is important that these cost pressures are well understood and evidenced in any future system. Currently, the cost of treatment is largely a function of contracting arrangements and negotiated pricing between purchasers and providers, with outcomes that often reflect limited supply and constrained negotiating leverage. Industry input also indicated there is also significant cost variation between private sector providers for broadly comparable treatments. Relatedly, industry feedback suggests that more expensive treatments and procedures are sometimes favoured over lower-cost alternatives, without clear evidence of better patient outcomes. This points to a potential misalignment between price, clinical value, and what the system is ultimately paying for.

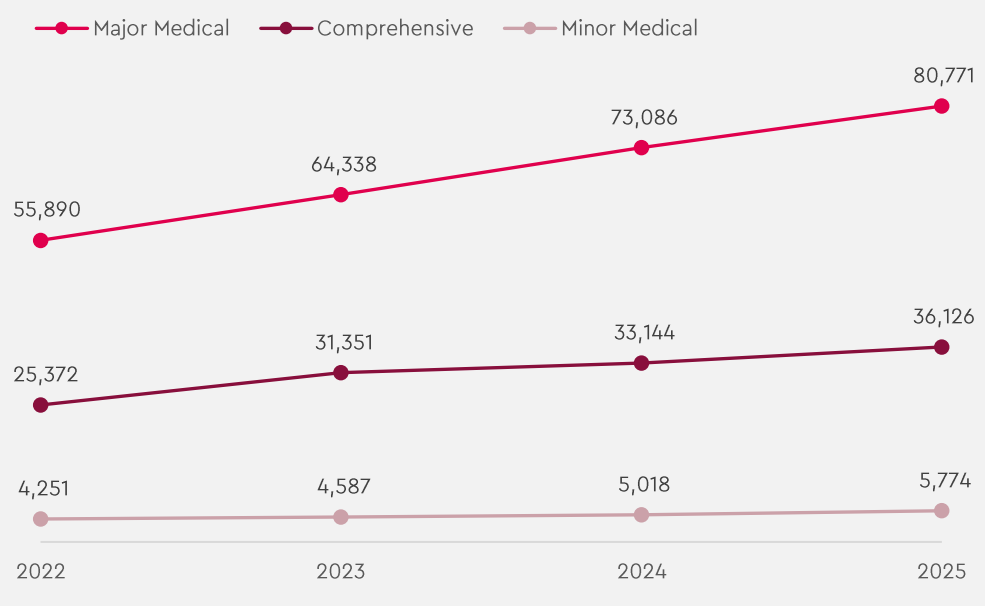
And New Zealand consumers face these increased costs

Escalating costs and claims are being passed on to New Zealanders.

Consumers are experiencing escalating premiums, and some are making the decision to forego cover

Data from FSC finds that in 2025 9% of those who had health insurance made the decision to terminate their cover. This is 2% more than those that terminated cover in 2022. The proportions of those terminating health cover by type of plan have broadly remained the same (Figure 21). The sector indicates that while terminations have increased, the greater movement has occurred in consumers trying to keep cover going by changing to plans with lower premiums, increasing excesses, and removing benefit options.

Figure 21. More people are terminating their health insurance cover – number of people ending cover by product

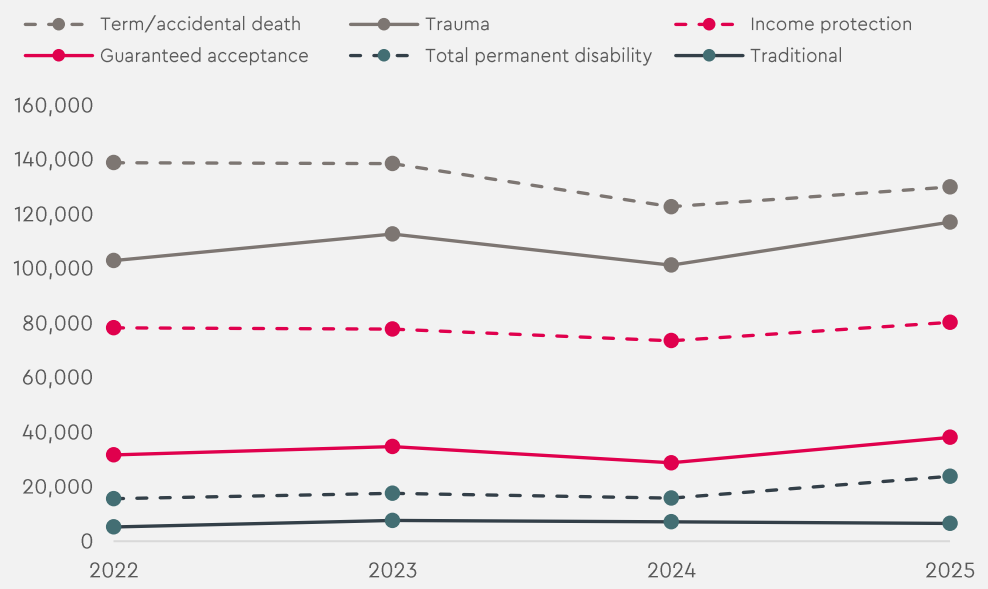


Source: Financial Services Council Health insurance member dataset

Notes: Data for year ending 31 December. Includes lapses, surrenders, and cancels

New Zealanders are also terminating life insurance cover but not to the same extent as health insurance cover (Figure 22).

Figure 22. Some New Zealanders are foregoing life insurance, but the number of people has not risen to the same extent as health insurance terminations



Source: Financial Services Council Life insurance member dataset

Notes: Data for year ending 31 December. Includes lapses, surrenders, and cancels

Term/accidental death – covers that provide a lump sum payment in the event of the death of the insured life.

Trauma – covers that provide a lump sum payment in the event of a predefined illness or trauma event.

Income protection – covers that provide for a regular payment in the event of the insured life being considered (totally or partially) disabled in accordance with the policy definitions. Includes redundancy covers.

Guaranteed acceptance – policies with no underwriting which usually have a return of premiums if death occurs in early years, possible with full benefits payable on death by accident.

Total permanent disability – cover that provides a lump sum payment in the event of the insured life being considered totally and permanently disabled in accordance with the policy definitions.

Traditional – bundled or unbundled life insurance policies with combined savings and risk cover and benefits payable on death or (for endowment) on a specific date.

Excludes credit insurance due to small numbers, and most credit insurance products have since exited the New Zealand market.

Private insurance supplements, complements, and overlaps with public healthcare

As private insurance is intertwined with public healthcare, the effects of private health insurance policy changes, and thus their fiscal impacts, are difficult to isolate. Various research comments that understanding the effects is inherently complex because:

- As commented in research mentioned earlier, specialists work across the public and private health systems which means that private health initiatives will always be constrained by the limited supply of specialists and doctors.[46, 23]
- Surgeons and specialists have a considerable amount of bargaining power.[36,58]
- If the goal is to reduce public hospital utilisation, there are many factors that influence this including population change and demand-related factors.[44] In Australia, the public hospital system is available to those that have private health insurance so those with private health insurance will still use the public system, especially for emergencies and complex care.
- If the goal is to reduce wait times, this is also difficult to assess.[44] This relates to specialists working across both the private and public sectors, but also to other health policies that directly fund initiatives to reduce wait times in the public health system.

Why has New Zealand not gone down this path historically, and what would have to change? What could we learn from others?

Our ability to directly replicate policy settings from other jurisdictions is constrained as they sit within broader health, fiscal, and tax policy contexts. However, how others have fared, and learning from (unintended) consequences and policy evaluations, can provide signals for what might work in New Zealand, and what won't work.

As discussed in the previous section, the nature of private and public health being so dependent on each other means that policy effects and impacts and effects are difficult to evidence. McDonald and Duckett (2017)[44] state that Australia had not undertaken an inquiry into the direct and indirect costs of its private health insurance regulatory framework and the costs of other options – such as direct payment to private hospitals or additional funding to the public healthcare system.

More recent theoretical papers have sought to understand how a managed competition model could work, making the best of both private and public healthcare systems.

What about a different model? A conceptual framework for integration of public healthcare and private health insurance

Academics in Australia, The Netherlands, and Italy examined how countries, like Australia, Chile, Ireland, South Africa, and New Zealand where mixed private-public systems operate, could be integrated to either a national health service (as in the UK, Italy, and Spain) or social health insurance (such as in Germany and the Netherlands).[70] These models could increase system efficiency, equity, sustainability, and resilience.

Case studies of Australia and Switzerland are provided in the next section.

The academics propose 13 preconditions for efficiency and equity, adapted from previous work by Van de Ven et al (2013) (Table 2).[71]

There has been discussion in New Zealand about the outcomes within the "Bismark system" based on the German and Swiss models. This model funds healthcare through compulsory payroll contributions from employers and employees, channelled through competing regulated insurers, ensuring universal coverage while allowing consumer choice among providers. The analysis related to these systems tend to show good access and outcome evidence, but cost, complexity of implementation and equity gaps make direct New Zealand application less certain, requiring further analysis.

Table 2. Preconditions linked to the goals of efficiency and equity

1	Free consumer choice of insurer	Establishes choice as a fundamental element of competition to motivate responsiveness of the market and competition in price and quality. There should be no barriers to underwriting, waiting periods, and tie-in products. Facilitators should be available like open enrolment, easy switching, and enough insurers in the market. Mediating regulation, such as contract length, can help balance choice and ensure correct pricing by insurers.
2	Consumer information and market transparency	Highlights the need for transparent information on price, quality and other aspects of medical services/products to be made public to avoid competition based on quality skimping. Transparency and comparability of insurance products through a standardised benefit package is needed to allow value-based comparisons and prevent choice overload.
3	Risk-bearing buyers and sellers	To achieve efficiency, insurers and providers should bear financial responsibility for their respective roles. For this, payment schemes should transfer risk to providers, while insurers enforce contracts. Subsidies should align with product price differences. Individuals should bear some risk through cost-sharing, referral mechanisms or prior authorisations to reduce moral hazard.

4	Contestable markets	Requires removing unnecessary entry and exit barriers for the provider and insurance markets. Barriers in provider markets (e.g. subsidies, capital investments, long training times for physicians) limit competition, while barriers in insurance markets (e.g. prudential requirements) are needed to protect consumers but may hinder entry. Balancing regulation is crucial for market efficiency and consumer protection.
5	Freedom to contract and integrate	So that insurers can perform their third payer/purchaser functions. This implies that contracting should be free within certain regulations that prevent free market failures. Insurers and providers should have freedom to (selectively) contract, negotiate prices, establish payment mechanisms and integrate vertically for efficiency, while competition regulation should balance potential anti-competitive effects. Providers should be free to set up an insurer, and insurers should be free to provide care through their own healthcare facilities.
6	Effective competition regulation	The need for, and measures to, stop anticompetitive practices such as cartels, the abuse of dominance and mergers and takeovers that are not considered in consumers' best interests. In the context of healthcare markets where the geographic definition of the appropriate sub-market is unclear, competition policy is complex.
7	Cross-subsidies without incentives for risk selection	Emphasis should be placed to ensure affordable premiums for all income and risk groups. Various measures can be implemented, such as subsidies based on income through external or internal arrangements, premium rate restrictions (community rating) and risk adjustment to address risk selection incentives. Overall, the regulator needs to calculate accurate payments. Premium-related subsidies can also be employed for specific groups facing high premiums to avoid shortcomings. Additionally, ex-post compensations and risk-sharing mechanisms such as proportional risk sharing, reinsurance, risk corridors and high-risk pools can be considered, although they may reduce incentives for cost containment. While tax-based contributions have been seen as the ultimate way of achieving progressive contributions, several challenges exist: • They might be subject to capture. • Other options to achieve income solidarity are for premiums to be income related (in whole or part). • A tax on income can have similar repercussions as income-related contributions in terms of market distortions (that is, a tax on labour). Some key differences are that income-related contributions are typically proportional to income, and a progressive income tax system would make tax paid as a proportion of income increase as income increases. • In implementing community rating, risk selection by consumers (that is, adverse selection) may also be a problem which requires regulatory solutions. • The risk equalisation scheme could become susceptible to lobbying (as it will distribute potentially large amounts of funding), increasing the importance for a solid governance framework in this area. • Feasibility (for example, related to data availability) may hinder potential risk equalisation models.
8	Cross-subsidies without opportunities for free riding	All individuals should be covered, and people that avoid paying cross subsidies should be mitigated. Alternatively, it will lead to opportunistic behaviours (for example, taking insurance when about to incur medical expenses or individuals may choose to underinsure while healthy and insure/over insure while sick). The main signal for potential for free riding mentioned is the possibility to opt out of mandatory basic coverage. Additional tools can ensure free riding is minimised: a mandate to pay a solidarity contribution; establishing a basic benefit package; allow for premium rating, considering the trade-off between "increasing efficiency and reducing incentives for risk selection by insurers" and equity; and directing premium subsidies to those who otherwise might opt out (for example, low-risks), with some loss of efficiency.
9	Effective quality supervision	Consumers should be protected against poor quality service delivery by both insurers and, particularly, by medical providers. Reimbursement

		arrangements, on-going quality assessment and the publishing of performance league tables are specific tools to achieve this. The measurement of quality is not straight-forward and requires a well-resourced quality supervisory institution.
10	Guaranteed access to basic care	This guarantee may be given by government, insurers, employers or another "third-party". It could be the responsibility of insurers (as the purchasers of care) to ensure timely access without using provider availability as an excuse, by providing adequate solutions (e.g. transport services, or flexibility to contract with new or different providers) to meet demand.
11	Basic benefit package	To ensure a minimum standard of care to all. Government needs to outline a standard package of services that should be covered by all insurers in the system. The benefit package should be comprehensive to maximise access and minimise complementary and supplementary markets that might undermine the principles of equity and efficiency in the primary market. Insures can offer non-medical "luxury" for those willing to pay. Health technology assessment and health economic evaluation is required in deciding what should be included. The package would need to be carefully selected so that the total cost of delivering healthcare doesn't become unmanageable.
12	Affordable out-of-pocket payments	The cost-sharing design should not be excessive, and should capture the insureds' ability to pay, establishing a progressive design. Several tools are available, including co-payments, co-insurance rates, deductibles and safety nets (out-of-pocket limits).
13	No conflict of interest by the regulator	The functions of governance/stewardship need to be separated from those of insurance and provision, and the institutions established need to have clear goals that are not conflicting. Conflicts between the regulation tasks should be avoided: (a) defining and updating the basic benefit package; (b) access guarantee; (c) revision of product characteristics (e.g. cost-sharing and product architecture, premiums, premium increases); (d) contracts (e.g. provider payments, tariffs) if otherwise market failures would occur; (e) defining and managing the subsidies and risk equalisation payments; (f) financial supervision of the insurers and providers; (g) quality and safety assurances; and (h) competition supervision and consumer protection.

Source: Henriquez et al (2025)

These pre-considerations are a disaggregated set of the assessment criteria used in this report: efficiency, equity, financial sustainability, and feasibility. In terms of feasibility, the paper sets out some potential pathways to moving from a mixed public-private health system to a managed competition model.

In assessments of whether the healthcare systems in Belgium, Germany, Israel, the Netherlands, and Switzerland meet the first 10 pre-conditions, none were able to fully meet the conditions.[72,71] Further, there was limited progress in the last 10 years (between 2012 and 2022) to meet the preconditions.

CASE STUDY

Australia

KEY FEATURES

- Dual public and private healthcare system
- Universal public health insurance, Medicare
- Three initiatives to encourage take-up of private health insurance:
  - Medicare levy surcharge (MLS)
    - Tax on higher income earners who do not hold appropriate hospital insurance.
  - Private Health Insurance Rebate
    - Income tested and age-related rebate.
    - Maximum rebates are around 30% of health insurance premiums in a year.
  - Lifetime Health Cover
    - A payment on top of premium for every year aged over 30 from when private hospital cover is taken out, for 10 years.
    - Maximum loading is 70%.
- 2025: 46% of Australians had private health insurance
- Premiums regulated under community-rating. Premiums are charged the same price for a given plan regardless of health status, age, gender of any other characteristic.
- The private health insurance rebate settings were worth around $7.1 billion in 2024/25.[73]

More recently there have been three waves of private health insurance reform.[74]

The Australian Government has committed to ensuring the sustainability of a private health insurance industry

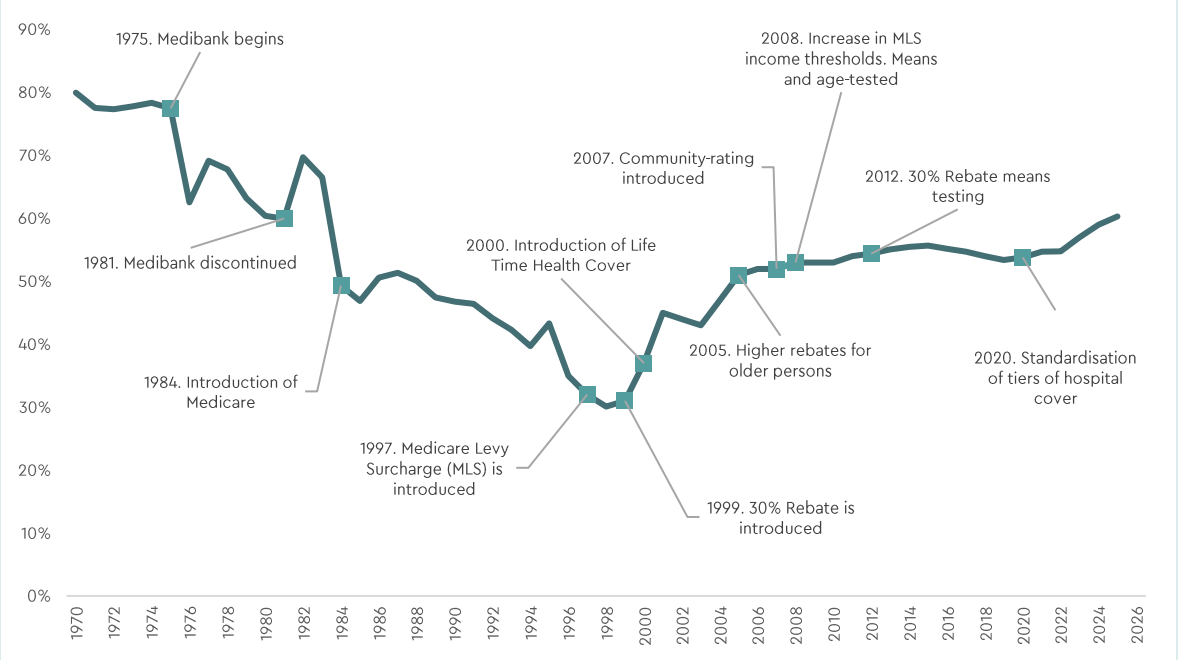
The Australian Government considers that a healthy and stable private health insurance system is essential for the stability of Australia's overall health care system.[55] Health policies encourage private health insurance cover to provide consumers with a greater choice of care options and relieve pressure on the state public hospital system.

Various policy changes over the years have sought to increase the proportion of the population that is covered by private health insurance. In 1970, private health insurance was at its peak with 80% population coverage, but started falling with the introduction of compulsory university health insurance, Medibank (the precursor to Medicare), in 1984 (Figure **23**).[75] Coverage rates continued to fall until 1999 when the 30% private health insurance rebate was introduced followed by Life Time Health Cover in 2000.

The point at which the rebates and subsidies for private health insurance came in are like the current rates of coverage experienced in New Zealand – approximately 30%.

First wave 2020	Second wave 2021-22 Budget	Third wave 2021/22 to 2025/26
Private hospital cover to be classified in four standard tiers (gold, silver, bronze or basic) Health insurers can offer: • Discounts for young people • Higher excesses for lower premiums • Improved access to mental health treatment Private Health Insurance Ombudsman powers strengthened to investigate complaints	Increasing the age of dependents Transparency of out-of-pocket costs Expanding home and community-based mental health and rehabilitation care Actuarial studies of incentives	Extension to the Medicare Levy Surcharge (MLS) and Private Health Insurance (PHI) Rebate for a further 2 years Review and enhance the Government's PHI Rebate Model Investigate private hospital default benefit arrangements Improvements to the certification process for admitting patients to hospital.

Figure 23. Proportion of the Australian population with private health insurance, 1970 to 2025



Source: Quinn, 2002; Australian Prudential Regulation Authority (APRA); Australian Bureau of Statistics, National Health Survey and Patient Experience Survey.

Notes: The numerator is number of individuals with private health insurance cover. This is higher than those used in other reports that focus only on those with private hospital cover.

Are the Australian policy settings efficient, do they improve equity, are they financially sustainable, and feasible?

Some of the settings have been less successful in stimulating change:

- Econometric modelling used by Kettlewell and Zhang (2024)[27] suggest that for high income earners there was little change – there was a small increase in take-up and higher premiums at which MLS kicks in. But there was no change at thresholds where the penalty is larger and the subsidy smaller. The researchers recommended targeting benefits toward lower income earners as a more efficient way to reduce government expenditure.
- Other modelling exercises have found that for older people, receiving higher rebates when they turn 65 and 70 years old made no difference to the take up of private health insurance.[28]
- In a review of the private health insurance government policies, McDonald et al (2017)[44] conclude that
  - the rebate is generous but has only been linked to a small increase in coverage
  - lifetime health cover did increase coverage but mostly for less expensive insurance products
  - MLS only had marginal effect on take-up.

But other research and reviews suggest that policies are having the desired effect:

- Nguyen and Worthington (2021)[76] note that there have been declining numbers of insurance holders even though there are various incentives and penalties in place. They found some evidence of adverse selection in the market, that is, unhealthy people who need healthcare are more likely to take out health insurance than healthy people. Adverse selection is one source of market failure and can make the insurance market inefficient. However, they also found more support for advantageous selection due to government policies as well as individual differences in preferences and attitudes towards risk.
- Yang et al (2024)[23] found that a one percentage point increase in private health insurance coverage led to a 0.5% decrease in wait times; however, they highlighted that this was in practical terms a small effect and the investment in private health insurance policy would be better directed to public healthcare investment.
- The government post-implementation review of introducing means testing and thresholds to the rebate and MLS concluded that the changes supported government financial sustainability by providing significant savings, the changes redistributed the rebate more equitably amongst higher and lower income earners, and coverage rates increased even though higher income earners received no or a reduced rebate under the policy changes.[77]

CASE STUDY

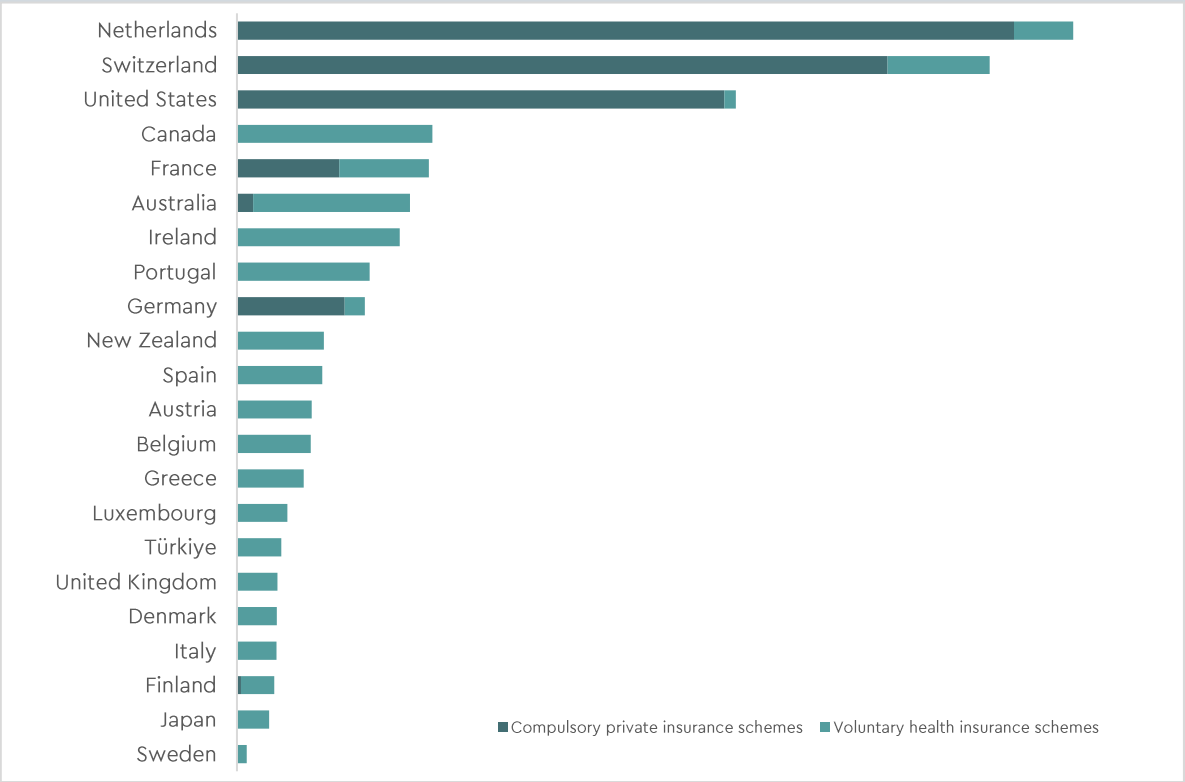
Switzerland

Health insurance policy settings

- Mandatory basic health insurance for all residents (*LAMal* in French or *KVG* in German)
  - Covers essential medical services such as doctor visits, hospitalisation, and prescribed medications.
- Individuals choose private insurers and plans, but pay premiums, deductibles, and make co-payments
  - All insurance providers must provide the exact same coverage. Providers cannot deny claims based on pre-existing conditions, etc.
  - Insurers compete for customers, offering identical benefits for the basic plan but varying in premiums and additional services.
  - Residents can also purchase voluntary supplementary insurance for services not covered by the basic plan, such as private hospital rooms, dental care, or alternative medicine.
  - Insurance premiums are paid monthly and vary based on factors like age, region, and insurer.
  - Patients pay out-of-pocket for part of their care through deductibles and co-payments. This ensures personal responsibility and cost control.
- Government provides subsidies (cash payments) to low-income individuals if premiums exceed 8% of their income.
- Switzerland does not require employers to contribute to premiums.[78]
- The healthcare system is highly decentralised and regulated.
  - Responsibilities are divided between the federal government, cantons, and municipalities. Cantons manage hospitals, regulate healthcare professionals, and oversee healthcare infrastructure.
  - Healthcare services are delivered by private doctors, clinics, and public or private hospitals. Patients have free choice of doctors and hospitals within the system.

Compared to Australia and New Zealand, Switzerland has a much higher share of private health insurance spending (Figure 24).

Figure 24. Private health insurance as a share of health spending, 2024 (or nearest year)



Source: OECD (2025) *Health expenditure and financing*[79]

Most of the commentary and studies highlight that Switzerland's out-of-pocket and private health insurance is relatively expensive

Switzerland's system is known for high-quality care, short waiting times, and excellent medical infrastructure. However, it is among the most expensive healthcare systems globally.

In a study of 11 countries[d] health insurance design, Switzerland stood out the most for rapid access – 93% of Swiss respondents received a same- or next-day appointment the last time they were sick.[78] The same study noted that lower income Swiss had much higher rates of out-of-pocket spending. However, low-income adults in Switzerland:

- had high confidence that they would receive high-quality care (which was also the case for New Zealand).
- were most likely to get fast access to care when sick (same or next day)
- were most likely to get fast access to specialists when needed (less than 4 weeks)
- were more likely to report short waits to see specialists compared to high-income Swiss adults.

Compared to other countries, Switzerland had relatively high deductibles and cost sharing. However, annual limits and exemptions and transparent pricing and billing mean that residents can plan for health costs. Pricing was also consistent across health service providers, for example, payments by insurers to doctors are the same within a geographic area.[78] But others note that public information on the prices of medical services is lacking.[72]

Switzerland's system was assessed in 2012 as to whether it met the preconditions mentioned earlier. At the time, Switzerland was found to have little "effective quality supervision", as adverse selection of insurers was not adequately considered and there was not sufficient transparent consumer information about the quality of care.[71,72] There were also weaknesses in "freedom to contract and integrate", "contestable markets", and "effective competition regulation".

The updated assessment in 2022 found that little had changed, other than the risk equalisation formula used had improved ("incentives for risk selection").[72] "Effective quality supervision" had also improved with nationwide monitoring of inpatient care with outcome measurement and monitoring results publicly available.

[d] Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United States, and the United Kingdom

CONCLUDING ANALYSIS

The 2025 Briefing to the Incoming Minister of Health by the Ministry of Health recognised that public spending on healthcare as a share of GDP is forecast to increase and New Zealand's spending is above the OECD average.[80] The Ministry indicated that there are options to address the affordability of the health system, such as "investigating a greater role for user pays healthcare or insurance, changing models of care, or increasing targeting services"[80(p8)].

This report canvasses some of the arguments for and against insurance playing more of a role in public healthcare. The arguments were weighed against a policy assessment framework of four criteria:

- Efficiency
- Equity
- Financial sustainability
- Feasibility.

The research and the experiences of similar jurisdictions are not clear-cut as to whether current system settings or an increased role for private insurance comes out best on the four criteria. However, given the constrained fiscal environment it would appear prudent for the Government to seek further advice as to what the potential impacts and trade-offs would be for more private insurance in the healthcare system in New Zealand.

In assessing policy changes, the following pre-conditions should be paid attention to:

1. Free consumer choice of insurer
2. Consumer information and market transparency
3. Risk-bearing buyers and sellers
4. Contestable markets
5. Freedom to contract and integrate
6. Effective competition regulation
7. Cross-subsidies without incentives for risk selection
8. Cross-subsidies without opportunities for free riding
9. Effective quality supervision
10. Guaranteed access to basic care
11. Basic benefit package
12. Affordable out-of-pocket payments
13. No conflict of interest by the regulator.

Endnotes

1. OECD. *Health at a Glance 2025: OECD Indicators*. OECD Publishing; 2025. doi:10.1787/8f9e3f98-en
2. The Treasury. *He Tirohanga Mokopuna - Long-Term Fiscal Statement 2025*. Te Tai Ōhanga - The Treasury; 2025.
3. The Treasury. *Te Ara Mokopuna - Treasury's 2025 Long-Term Insights Briefing: Sustainable and Resilient Fiscal Policy through Economic Shocks and Cycles*. Te Tai Ōhanga - The Treasury; 2025.
4. The Treasury. *He Puna Hao Pātiki: Investment Statement 2025 - November 2025*. Te Tai Ōhanga - The Treasury; 2025.
5. NZIER. *Building a Healthy Infrastructure: The Potential Scale of Investment in Crown-Owned Health Infrastructure over the next 30 Years*. New Zealand Institute of Economic Research; 2023.
6. NZIER. *Private Health Insurance: An Expanding Role in the Future of Health Care?* NZIER; 2014.
7. Retirement Commission. Financial resilience. Te Ara Ahunga Ora Retirement Commission. 2026. https://retirement.govt.nz/financial-capability/what-is-financial-capability/financial-resilience
8. Ministry of Health. Annual data explorer 2024/25: New Zealand Health Survey. Published online November 2025. https://minhealthnz.shinyapps.io/nz-health-survey-2024-25-annual-data-explorer/
9. OECD. *Promoting Health and Well-Being at Work: Policy and Practices*. OECD Publishing; 2022. doi:10.1787/e179b2a5-en
10. Government of the Netherlands. Standard health insurance. Government of the Netherlands. 2026. https://www.government.nl/topics/health-insurance/standard-health-insurance
11. Gerkens S, Merkur S. *Belgium: Health System Summary 2024*. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; 2024.
12. The Health Insurance Authority. *Health Insurance in Ireland: Market Report 2024*. The Health Insurance Authority; 2025.
13. B&A. *A Review of Private Health Insurance in Ireland 2023*. B&A; 2023. https://www.hia.ie/sites/default/files/2024-01/hia-consumer-survey-2023-final_0.pdf
14. Revenue. Medical insurance premiums. Revenue - Irish Tax and Customs. January 9, 2026. https://www.revenue.ie/en/personal-tax-credits-reliefs-and-exemptions/health-and-age/medical-insurance-premiums/index.aspx
15. Government of Canada. Premiums and contributions to insurance plans. Government of Canada. September 9, 2025. https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/payroll/benefits-allowances/benefits-allowances-chart/premiums-contributions.html
16. Finkelstein A. The effect of tax subsidies to employer-provided supplementary health insurance: evidence from Canada. *Journal of Public Economics*. 2002;84(3):305-339. doi:10.1016/S0047-2727(00)00155-9
17. Inland Revenue. Employer contributions to employee funds. Inland Revenue. April 28, 2021. https://www.ird.govt.nz/employing-staff/deductions-from-other-payments/fringe-benefit-tax/types-of-fringe-benefits/employer-contributions-to-employee-funds
18. Inland Revenue. Fringe benefit tax (FBT). Inland Revenue. June 17, 2025. https://www.ird.govt.nz/employing-staff/deductions-from-other-payments/fringe-benefit-tax
19. Leong J, Allott A. An overview of the life insurance sector in New Zealand. *Bulletin*. 2020;83(1).
20. OECD. *Global Insurance Market Trends 2025*. OECD Publishing; 2025. doi:10.1787/0d11ecf4-en
21. Financial Services Council. *Money & You: Valuing Belongings over Ourselves*. Financial Services Council NZ; 2025.
22. OECD. *Private Health Insurance in OECD Countries*. OECD; 2004. doi:10.1787/9789264007451-en
23. Yang O, Yong J, Zhang Y. Effects of private health insurance on waiting time in public hospitals. *Health Economics*. 2024;33(6):1192-1210. doi:10.1002/hec.4811
24. Baldwin E, Fooken J, Rowell D. Private health insurance and health in a healthcare system with comprehensive public insurance. *Empir Econ*. 2025;68(4):2009-2040. doi:10.1007/s00181-024-02680-2
25. Cooper Z, Craig SV, Gaynor M, Van Reenen J. *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*. National Bureau of Economic Research; 2018.
26. Cooper Z, Gibbons S, Jones S, McGuire A. *Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms*. Social Economics Research Centre; 2011:F228-F260. doi:10.1111/j.1468-0297.2011.02449.x
27. Kettlewell N, Zhang Y. Financial incentives and private health insurance demand on the extensive and intensive margins. *Journal of Health Economics*. 2024;94:102863. doi:10.1016/j.jhealeco.2024.102863
28. Kettlewell N, Stavrunova O, Yerokhin O. Premium subsidies and demand for private health insurance: results from a regression discontinuity design. *Applied Economics Letters*. 2018;25(2):96-101. doi:10.1080/13504851.2017.1299094
29. Blumberg L. *The Effect of Private Health Insurance Coverage on Health Services Utilisation in New Zealand*. Fellowships Office, Fulbright New Zealand; 2006.
30. Penno E, Sullivan T, Barson D, Gauld R. Private choices, public costs: Evaluating cost-shifting between private and public health sectors in New Zealand. *Health Policy*. 2021;125(3):406-414. doi:10.1016/j.healthpol.2020.12.008
31. Aizawa N, Fu C. *Interaction of the Labor Market and the Health Insurance System: Employer-Sponsored, Individual, and Public Insurance*. National Bureau of Economic Research; 2021.
32. Wallace J, Sommers BD. Health insurance effects on preventive care and health. *American Journal of Preventive Medicine*. 2016;50(5):S27-S33. doi:10.1016/j.amepre.2016.01.003

33. Allen H, Baicker K, Finkelstein A, Taubman S, Wright BJ, the Oregon Health Study Group. What the Oregon Health Study can tell us about expanding Medicaid. *Health Affairs.* 2010;29(8):1498-1506. doi:10.1377/hlthaff.2010.0191

34. Burns ME, Dague L, DeLeire T, et al. The effects of expanding public insurance to rural low-income childless adults. *Health Services Research.* 2014;49(S2):2173-2187. doi:10.1111/1475-6773.12233

35. Wanni Arachchige Dona S, Angeles MR, Hall N, Watts JJ, Peeters A, Hensher M. Impacts of chronic disease prevention programs implemented by private health insurers: a systematic review. *BMC Health Serv Res.* 2021;21(1):1222. doi:10.1186/s12913-021-07212-7

36. TDB Advisory. *Assessing the Net Impacts of Private Health Insurance.* TDB Advisory Limited; 2016.

37. Chan XW, Khaw J, Esterhuizen M, Khalil W. *Return-to-Work of Cancer Survivors: A Scoping Review*. Griffith University; 2024. doi:10.25904/WPHA-Y071

38. Bates N, Callander E, Lindsay D, Watt K. Labour force participation and the cost of lost productivity due to cancer in Australia. *BMC Public Health.* 2018;18(1):375. doi:10.1186/s12889-018-5297-9

39. Neiman P, Taylor K, Sinco B, et al. Insult to injury: National analysis of return to work and financial outcomes of trauma patients. *Journal of Trauma and Acute Care Surgery.* 2021;19(1):121-129. doi:10.1097/TA.0000000000003135. PMID: 34144560.

40. APRA. Private health insurance risk equalisation statistics. Australian Prudential Regulation Authority. March 31, 2025. https://www.apra.gov.au/private-health-insurance-risk-equalisation-statistics

41. Abhayaratna T. *Overcoming Adverse Selection Death Spirals in Private Hospital Insurance through Lifetime Health Cover: The Australian Experiment.* Tax and Transfer Policy Institute; 2024.

42. Ministry of Health. *Meeting with Nib Health Insurance.* Ministry of Health; 2025.

43. ImpactLab. Not just insurance, a pathway to whānau wellbeing. ImpactLab. March 26, 2025. https://www.impactlab.co.nz/resources/not-just-insurance-a-pathway-to-whanau-wellbeing

44. McDonald F, Duckett S. Regulation, private health insurance, and the Australian health system. *McGill Journal of Law and Health.* 2017;11(1):S31-S60.

45. Berardi C, Arija Prieto P, Henríquez J, Paolucci F. Preconditions for efficiency and affordability in mixed health systems: are they fulfilled in the Australian public–private mix? *HEPL.* 2025;20(2):144-159. doi:10.1017/S1744133123000336

46. Derrett S, Bevin TH, Herbison P, Paul C. Access to elective surgery in New Zealand: considering equity and the private and public mix. *Health Planning & Management.* 2009;24(2):147-160. doi:10.1002/hpm.978

47. Collie A, Di Donato M, Iles R. Work disability in Australia: An overview of prevalence, expenditure, support systems and services. *J Occup Rehabil.* 2019;29(3):526-539. doi:10.1007/s10926-018-9816-4

48. NMG Consulting. *Australia's Life Underinsurance Gap: Research Report.* NMG Consulting; 2022.

49. MetLife Australia. *Value of Life Insurance Report.* MetLife Australia; 2021. https://www.metlife.com.au/content/dam/metlifecom/au/images/thoughtleadership/Value-of-Life-Insurance-Report_20210622.pdf

50. ACC. *Turnaround Plan Monthly Report.* ACC; 2026. https://www.beehive.govt.nz/sites/default/files/2026-02/Monthly-Turnaround-Plan-January-2026.pdf

51. Stats NZ. Economic Indicators: National Accounts - SNA 2008 - SNE. Published online 2026. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.stats.govt.nz%2Fassets%2FUploads%2FGross-domestic-product%2FGross-domestic-product-December-2025-quarter%2FDownload-data%2Fgross-domestic-product-december-2025-quarter.xlsx&wdOrigin=BROWSELINK

52. Apergis N, Poufinas T. The role of insurance growth in economic growth: Fresh evidence from a panel of OECD countries. *The North American Journal of Economics and Finance.* 2020;53:101217. doi:10.1016/j.najef.2020.101217

53. ILO. *Insurance and Economic Development: Growth, Stabilization and Distribution.* International Labour Organization; 2016. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_emp/documents/publication/wcms_614874.pdf

54. MoneyHub. Mental health now causes 32% of income protection claims as back injuries & burnout top reasons NZers can't work. Published online February 28, 2026. https://business.scoop.co.nz/2026/02/28/mental-health-now-causes-32-of-income-protection-claims-as-back-injuries-burnout-top-reasons-nzers-cant-work/

55. Australian Government The Treasury. *Private Health Insurance Reforms.* Department of the Prime Minister and Cabinet; 2018.

56. AMA. *Private Health Insurance Report Card 2025.* Australian Medical Association; 2025.

57. Members Health Fund Alliance, Finity Consulting. *The Economic and Social Impact of the Members Health Funds of Australia.* Members Health Fund Alliance; 2024.

58. Dalzell S, Cockburn P. Value of private health insurance "eroding" as doctors urge reform. *ABC News.* December 5, 2025. https://www.abc.net.au/news/2025-12-05/private-health-insurance-eroding-as-doctors-urge-reform/106095198

59. Molander P. Public versus private healthcare systems in the OECD area– a broad evaluation of performance. *Eur J Health Econ.* 2025;26(7):1163-1173. doi:10.1007/s10198-025-01767-6

60. Pennington P. Health NZ sending more eye operations to private sector under long-term contracts. *RNZ.* April 12, 2026. https://www.rnz.co.nz/news/national/592126/health-nz-sending-more-eye-operations-to-private-sector-under-long-term-contracts

61. Koocher GP, Curtiss EK, Pollin IS, Patton KE. Medical crisis counseling in a health maintenance organization: Preventive intervention. *Professional Psychology: Research and Practice.* 2001;32(1):52-58. doi:10.1037/0735-7028.32.1.52

62. Schwartz SM, Day B, Wildenhaus K, Silberman A, Wang C, Silberman J. The impact of an online disease management program on medical costs among health plan members. *Am J Health Promot.* 2010;25(2):126-133. doi:10.4278/ajhp.091201-QUAL-377

63. Schwartz SM, Ireland C, Strecher V, Nakao D, Wang C, Juarez D. The economic value of a wellness and disease prevention program. *Population Health Management*. 2010;13(6):309-317. doi:10.1089/pop.2009.0070

64. Scuffham PA, Byrnes JM, Pollicino C, Cross D, Goldstein S, Ng SK. The impact of population-based disease management services on health care utilisation and costs: Results of the CAPICHe Trial. *J GEN INTERN MED*. 2019;34(1):41-48. doi:10.1007/s11606-018-4682-5

65. ACC. *Turnaround Plan to Deliver Better Outcomes for Injured New Zealanders: 2025/ 26*. ACC; 2025. https://www.acc.co.nz/assets/corporate-documents/Turnaround-plan2025-26.pdf

66. Clark P. *Healthcare in New Zealand: The Changing Role of the Private Sector*. Westpac; 2026. https://library.westpaciq.com.au/content/dam/public/westpaciq/secure/economics/documents/nz/2026/03/Research-Papers_100326-Healthcare_bulletin_10Mar26.pdf

67. Wall S. The overlooked workforce. Can private psychologists bridge the treatment gap in adolescent mental health? *Journal of the New Zealand College of Clinical Psychologists*. 2025;35(1):132-145. doi:10.5281/ZENODO.16744046

68. Psychology Workforce Task Group. *The Aotearoa New Zealand Psychology Workforce Survey*. Ministry of Health; 2016.

69. Drake L. Six Whanganui DHB psychologists join 600 union members in strike action. *Whanganui Chronicle*. October 31, 2019. https://www.nzherald.co.nz/whanganui-chronicle/news/six-whanganui-dhb-psychologists-join-600-union-members-in-strike-action/WUU2PVEX6PKPYZHKZJFMCU3F6U/

70. Henriquez J, Van De Ven W, Melia A, Paolucci F. The roads to managed competition for mixed public–private health systems: a conceptual framework. *HEPL*. 2025;20(2):110-125. doi:10.1017/S1744133123000373

71. Van de Ven W, Beck K, Buchner F, et al. Preconditions for efficiency and affordability in competitive healthcare markets: are they fullfilled in Belgium, Germany, Israel, The Netherlands and Switzerland. *Health Policy*. 2013;109:226-245.

72. van de Ven WPMM, Beck K, Buchner F, et al. Preconditions for efficiency and affordability in competitive healthcare markets: Are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Ten years later. *Health Policy*. 2024;146:105099. doi:10.1016/j.healthpol.2024.105099

73. Department of Health. *Private Health Insurance - Improving Affordability and Sustainability of Private Health Insurance*. Australian Government Department of Health; 2022.

74. Department of Health, Disability and Ageing. Private health insurance reforms. Department of Health, Disability and Ageing. 2025. https://www.health.gov.au/topics/private-health-insurance/reforms

75. Quinn C. *The Pasts and Futures of Private Health Insurance in Australia*. National Centre for Epidemiology and Population Health, The Australian National University; 2002. https://openresearch-repository.anu.edu.au/server/api/core/bitstreams/cd578835-f39c-4813-82a8-607060748926/content

76. Nguyen L, Worthington AC. Adverse selection in Australian private health insurance. *SSRN Electronic Journal*. Published online 2021. https://dx.doi.org/10.2139/ssrn.3884719

77. Department of Health. *Post-Implementation Review: Fairer Private Health Insurance Incentives*. Australian Government Department of Health; 2015.

78. Schoen C, Osborn R, Squires D, Doty MM, Pierson R, Applebaum S. How health insurance design affects access to care and costs, by income, in eleven countries. *Health Affairs*. 2010;29(12):2323-2334. doi:10.1377/hlthaff.2010.0862

79. OECD. Health expenditure and financing. Published online 2025.

80. Ministry of Health. *Briefing to the Incoming Minister of Health. Part A - Ensuring New Zealanders Have Timely Access to the Quality Health Services They Need*. Ministry of Health; 2025.

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