

# Privatisation by stealth, design or default? The future of New Zealand's health system

Erik Monasterio, Shamubeel Eaqub

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## ABSTRACT

New Zealand's health system is under sustained pressure, with worsening access to primary and specialist care, widening inequities and declining public confidence. In this context, there is an emerging but largely unarticulated shift towards increased reliance on private provision and private financing. This editorial examines whether this represents privatisation by design, default or drift, and considers the likely consequences. Evidence from New Zealand and comparable health systems suggests that increased privatisation is associated with higher costs, reduced equity and no consistent improvement in outcomes. Rising private insurance costs, outsourcing of elective services and public-private partnerships risk undermining the sustainability of the public system while failing to address the fundamental drivers of demand, particularly chronic disease and unmet need in primary care. These trends disproportionately affect Māori, Pacific peoples and low-income populations, raising concerns regarding Te Tiriti o Waitangi obligations. An alternative approach is proposed, centred on sustained investment in primary care and prevention, a clearly defined core package of publicly funded services and a cross-party health accord to ensure policy stability. The future of New Zealand's health system will depend on deliberate choices about equity, access and the role of the public sector.

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Aotearoa New Zealand's health system is at a critical inflection point. Despite repeated reform efforts and sustained political attention, confidence in access, equity and system performance continues to decline. The founding principles of the 1938 *Social Security Act*—universal access, care based on need, and fairness—are increasingly under strain. What is emerging is not a single, clearly articulated policy shift, but a pattern of change that raises an important question: is New Zealand moving towards privatisation of healthcare by design, by default or simply by drift?

Recent data highlight the scale of the problem. In 2022/2023, more than one-third of New Zealanders reported being unable to access a general practitioner when needed, and over 5% were unable to access hospital specialist services. These figures are substantially worse than those seen in many comparable Organisation for Economic Co-operation and Development (OECD) countries and reflect a system under sustained pressure.<sup>1</sup> The burden of unmet need is not evenly distributed. Māori, Pacific peoples, those on lower incomes and individuals with serious mental illness continue to experience disproportionately poor access and outcomes.<sup>1</sup>

These realities are increasingly normalised.

Clinicians and patients alike are exposed to repeated accounts of delayed care, avoidable harm and system failure.<sup>2</sup> Over time, this risks creating a sense of inevitability—that deterioration is unavoidable and beyond meaningful intervention. Such a mindset is dangerous. It discourages clinical advocacy and weakens the collective will required to pursue structural reform.

Against this backdrop, there is a gradual but discernible shift in how healthcare is delivered and funded. This includes increasing reliance on private providers for publicly funded services, longer-term contracting with private hospitals and growing dependence on private health insurance and out-of-pocket payments.<sup>2</sup> While each of these developments may be justified individually as pragmatic responses to system pressure, their cumulative effect is to reshape the structure of care.

International evidence, however, does raise concerns about this direction. The United States of America, often cited as a predominantly privatised system, spends nearly twice as much per capita on healthcare as other OECD countries, yet performs poorly on measures of access, equity and health outcomes.<sup>3-5</sup> Higher expenditure does not guarantee better care when access is mediated by ability to pay.

In New Zealand, the expansion of private health insurance reflects both consumer response and system failure. Approximately 37% of the population now holds insurance, but coverage is highly inequitable, with significantly lower uptake among lower-income groups.<sup>6</sup> Premiums are rising rapidly, far outpacing general inflation, and increase steeply with age. The consequence is a structurally unstable model: individuals accumulate insurance during their working years but are forced to relinquish it when health needs increase. Many then return to the public system, adding further strain.<sup>7,8</sup>

Private insurance also offers incomplete protection. Pre-existing conditions—often those most relevant to older populations, including cancer, cardiovascular disease and degenerative musculoskeletal conditions—are frequently excluded. This creates a two-tier system in which those with the greatest need face the greatest barriers to access.<sup>9</sup>

The increasing outsourcing of elective procedures to private providers presents additional risks. While such arrangements may reduce waiting times in the short term, they risk entrenching long-term dependence on private capacity. More complex care and complications remain within the public system, while training opportunities and workforce development are diminished. Over time, this risks eroding public sector capability.

Similarly, proposals to expand infrastructure through public-private partnerships warrant careful scrutiny. Evidence from the United Kingdom and across OECD countries suggests that such models are frequently associated with higher long-term costs and limited efficiency gains.<sup>10,11</sup> Rather than alleviating fiscal pressure, they may exacerbate it.

The implications extend beyond hospital services. Under-resourcing of specialist mental health services has contributed to the increasing criminalisation and incarceration of individuals with serious mental illness and intellectual impairment. This represents a profound system failure, shifting responsibility from healthcare to the justice sector, with significant ethical, legal and economic consequences.<sup>12-14</sup>

At a broader level, the shift toward privatisation does little to address the fundamental drivers of health demand. Chronic diseases, strongly influenced by social determinants, account for the majority of healthcare expenditure.<sup>15</sup> Delayed access to primary care and preventive services results in more advanced disease at presentation,

higher treatment costs and poorer outcomes. This is both clinically inefficient and economically unsustainable.

The consequences for equity are substantial. Māori and Pacific populations, along with those on lower incomes, experience disproportionate barriers to care. These inequities are not incidental but reflect structural features of the system. They are also inconsistent with the Crown's obligations under Te Tiriti o Waitangi to actively protect Māori health and ensure equitable outcomes.<sup>1,12,13</sup>

If current trends continue, universal health-care risks becoming nominal rather than real. Access will increasingly depend on a combination of public rationing and private purchasing power. Such a trajectory is likely to increase overall system costs, worsen inequities and erode public trust.

An alternative approach is both necessary and achievable. Health should be understood not as a fiscal burden but as an investment in national productivity and wellbeing. Evidence consistently demonstrates that investment in health—particularly in primary care and prevention—yields substantial economic returns.<sup>16</sup> Early intervention reduces downstream costs, improves workforce participation and enhances societal wellbeing.

Central to this approach is policy stability. The frequent turnover of health leadership and repeated structural reforms have contributed to fragmentation and uncertainty. A cross-party health accord, insulated from electoral cycles, would provide a foundation for sustained investment and long-term planning.<sup>17</sup>

Reform should prioritise strengthening primary care, ensuring access to a clearly defined core package of publicly funded services and delivering measurable improvements in equity. Universality must be reframed around equity rather than uniformity, recognising that those with the greatest need require proportionately greater investment.

The current trajectory—whether driven by intent, necessity or inertia—risks reshaping New Zealand's health system in ways that are difficult to reverse. The evidence is clear. The choices are political. The consequences will be enduring.

The question is not whether change is required, but whether it will be deliberate, equitable and sustainable—or whether it will continue to occur incrementally, without clear direction, until the defining principles of the system are irreversibly altered.

**COMPETING INTERESTS**

EM received payment to present at Ara Poutama Aotearoa – Department of Correction’s National Training Programme, September 2025. EM works as a private medico-legal report writer for NZ Criminal Courts, Coroner’s Court. EM is a member of the National and Binational Forensic Faculty, Royal Australian and New Zealand College of Psychiatrists (RANZCP), and chair of the Prison Mental Health Advisory Group RANZCP (both unpaid positions).

**AUTHOR INFORMATION**

Erik Monasterio: Consultant in Forensic and General Psychiatry, Orko Ltd.  
Shamubeel Eaquib: Chief Economist, Simplicity.

**CORRESPONDING AUTHOR**

Erik Monasterio: Consultant in Forensic and General Psychiatry, Orko Ltd. E: orko.mem@xtra.co.nz

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