



## Overview

New Zealand provides universal health coverage to permanent residents through a publicly funded system that's built on principles of access, equity, and collaboration. Funded through general taxation and overseen by the Ministry of Health (Manatū Hauora), the system offers a wide range of services, including inpatient and outpatient care, mental health care, long-term care, and prescription drugs.

The system performs well on several health indicators, including average life expectancy and maternal and infant health, but access gaps persist, particularly for the Māori community, Pacific peoples, and people on low incomes. About 37 percent of people have private insurance to help them pay for non-covered services and copayments.<sup>1</sup>

## Coverage and Access

### Background and History

New Zealand established one of the world's first universal health care systems with the enactment of the Social Security Act of 1938, which funded hospitals and aimed to provide free medical care for all citizens. Subsequent reforms defined the public health responsibilities assigned to the Ministry of Health (Health Act of 1956) and consolidated multiple hospital boards to enhance efficiency and accountability (Area Health Boards Act of 1983).<sup>2</sup>

In 1993, market-driven reforms introduced by the Health and Disability Services Act created competitive Crown Health Enterprises, which were autonomous, publicly owned entities, often comprising either one metropolitan hospital or a network of hospitals and associated services. However, these reforms fragmented the health care system, as the introduction of multiple purchasing and regulatory bodies led to the duplication of roles, poor coordination, and disjointed service delivery. These issues led to further restructuring in 1998, when the regional health authorities — government health purchasing bodies — were consolidated into the Health Funding Authority. This, in turn, was replaced in 2001 by 21 community-focused district health boards.<sup>3</sup>

### HEALTH SYSTEM BY THE NUMBERS

10%

Health care spending  
as a percent of GDP

82 years

Life expectancy at birth

100%

Public insurance coverage

More recently, the Pae Ora (Healthy Futures) Act of 2022 centralized health care under Health New Zealand (Te Whatu Ora), a single national entity that replaced the former district health boards. The Act also established the Māori Health Authority (Te Aka Whai Ora), a parallel entity intended to ensure health services meet the aspirations and needs of the Māori people and to support Māori leadership in health planning and delivery. Supporting structures included the Iwi–Māori Partnership Boards (IMPBs), designed to represent local Māori perspectives in health system design and performance, and the Hauora Māori Advisory Committee, which aims to include Māori voices at all levels of decision-making.<sup>4</sup>

This dual structure, however, was altered by the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill, which came into force in 2024. The bill disestablished the Māori Health Authority, transferring its functions to Health New Zealand and the Ministry of Health (*see Addressing Health Inequities*).<sup>5</sup>

In general, progress since the Pae Ora (Healthy Futures) Act of 2022 has been slow, according to health policy expert Robin Gauld, executive dean of Bond Business School and honorary professor at the University of Otago: “We’re now more than two years on, [from the Pae Ora (Healthy Futures) Act of 2022], and if you look at almost any aspect of the system, most of it is yet to see anything significant in terms of change.” Gauld notes that fragmented digital systems, workforce shortages, and ineffective institutional practices continue to limit reform efforts.

## The Role of Public Health Insurance

All permanent residents have access to a broad range of services that are funded by general taxation. The revenue primarily comes from Vote Health, which is a portion of public spending allocated to health services.<sup>6</sup>

Eligible residents are automatically covered and don’t need to enroll in any public insurance plan.<sup>7</sup>

### Services Covered by Public Health Insurance

The publicly funded system covers the following services:

- Preventive care
- Inpatient care
- Outpatient care
- Maternity care
- Mental health care
- Inpatient and outpatient prescription drugs
- Dental care (for children under age 18)
- Rehabilitative care
- Palliative care
- Home visits
- Assistive devices.<sup>8</sup>

Eye care is not covered under public health insurance.<sup>9</sup>

Hospital-based services (secondary and tertiary care) are available at little or no cost at the point of use for patients.<sup>10</sup> Additional funding comes from the Accident Compensation Corporation, a publicly funded no-fault insurance program that covers injury-related health services.<sup>11</sup>

## Safety Nets

There are several programs designed to keep health care accessible, especially for people on low incomes. These include the Community Services Card, which subsidizes general practitioner (GP) visits and prescriptions for households on low to moderate incomes — for example, a single person earning an annual pretax income under NZD 35,997 (USD 21,764) or a four-person household earning less than NZD 93,364 (USD 56,447) a year.<sup>12</sup>

For residents who need frequent medical care, the High Use Health Card provides additional subsidies without income testing. The card supports individuals who have visited their GPs more than 12 times in a year.<sup>13</sup>

Prescription costs are reduced through the Prescription Subsidy Scheme. Once a household has paid for 20 new prescription items within a year, any further prescriptions are free for the rest of that period.<sup>14</sup>

Additional support includes the Disability Allowance, which provides financial assistance toward ongoing medical, household, and travel costs related to a health condition, and the Residential Care Subsidy, which helps people with limited income and assets to access long-term residential care.<sup>15</sup>

## The Role of Private Health Insurance

Voluntary private health insurance supplements publicly funded health care. About 37 percent of people have private insurance to help them pay for non-covered services and copayments.<sup>16</sup>

Private insurance often allows policyholders to bypass wait times in the public system and is commonly used to access elective surgeries (such as hip and knee surgeries), specialist consultations, and diagnostic services in the private sector. Coverage typically includes private hospital care, elective procedures, and services that aren't fully covered by the public system, such as adult dental care, physiotherapy, and some general practice visits.<sup>17</sup> Some people access policies through employer-sponsored programs; others purchase them individually.<sup>18</sup>

## The Role of Government

The government oversees health care policies, funding, regulation, and system performance. Each year, it sets the national health budget through Vote Health, the main source of funding for the health system. Administered by the Ministry of Health, this funding supports hospitals, community providers, public health initiatives, and infrastructure.<sup>19</sup>

Since 2022, health care planning and delivery have been centralized under Health New Zealand, which replaced the former district health boards. Health New Zealand oversees public hospitals and health centers and coordinates care with private and nonprofit providers to meet national objectives.<sup>20</sup>

Other government-supported entities include the following:

- **Pharmac** (Te Pātaka Whaioranga) oversees the selection, pricing, and subsidy of publicly funded medicines.
- **The Accident Compensation Corporation** funds treatment and rehabilitation for accident-related injuries.
- **The Health Quality & Safety Commission** (Te Tāhū Hauora) promotes patient safety and systemwide quality improvements.
- **Health Informatics New Zealand** champions digital health integration and innovation.
- **The Health Research Council of New Zealand** supports health research to inform evidence-based care.
- **The Health and Disability Commissioner** (Te Toihau Hauora, Hauātanga) protects patient rights and ensures ethical service delivery.<sup>21</sup>

## Integration and Care Coordination

New Zealand health policy emphasizes integrated health care to enhance patient outcomes and reduce fragmentation in care delivery. Initiatives such as the Integrated Health Care Framework for Pharmacists and Doctors are designed to encourage collaboration among health care providers.<sup>22</sup>

The System Level Measures (SLM) Framework facilitates coordination between primary care and district-level authorities and aligns local efforts with national health goals. This was incorporated into a broader framework for measuring the performance of New Zealand's health system.<sup>23</sup> "Smart hospitals," meanwhile, use digital technologies to improve transitions between primary, community, and hospital care.<sup>24</sup>

# Operations and Resources

## Overview of the Delivery System

The health care system is organized across three tiers funded through public subsidies and patient contributions:<sup>25</sup>

- **Primary care** is the first point of contact for most patients and is provided by GPs, nurses, pharmacists, and other community-based providers.
- **Secondary care** is accessed through referrals and is typically provided in hospitals or specialist clinics; these services include diagnostics, outpatient procedures, and mental health support.
- **Tertiary care** includes highly specialized, resource-intensive treatments, such as cancer care, organ transplants, and neurosurgery and is provided in major hospitals by multidisciplinary teams.

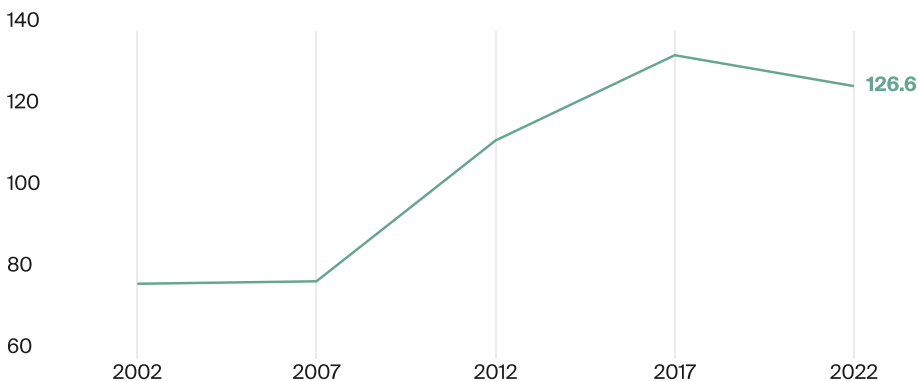
The three tiers of health care are provided by a collaborative network of public, private, and voluntary sector organizations:

- Public hospitals handle most emergency and complex care, while private providers focus on elective procedures.
- Community-based primary care is provided by independent practitioners, who typically receive public subsidies.
- Long-term care is mainly provided by private organizations, with significant public funding support.
- Nonprofit providers, including union-based and Māori- and Pacific-owned organizations (known collectively as the third sector), support primary care, mental health care, disability support, and community health promotion.<sup>26</sup>

Funding for primary care is capitation-based, with payments adjusted for patient demographics (age, sex, ethnicity, and socioeconomic status). Hospital funding is based on a diagnosis-related group model, which allocates resources based on each patient's condition and the complexity of their care.<sup>27</sup>

## Primary Care

### Number of GPs per 100,000 People, 2002–22



Source: The Global Health Observatory, [Medical doctor: generalist medical practitioners \(number\)](#), distributed by World Health Organization, accessed October 27, 2025. Numbers calculated using population data from World Bank Open Data [Population, total – New Zealand](#), distributed by World Bank Group, accessed November 5, 2025.

Most primary care is provided by GPs. Sixty-four percent of GPs work in self-owned clinics affiliated with primary health organizations that manage government subsidies.<sup>28</sup> These subsidies account for about half of GP income; the rest comes from copayments, Accident Compensation Corporation funding, and after-hours reimbursements.

There are 126.6 practicing primary care physicians for every 100,000 people. The Te Pae Tata | Interim New Zealand Health Plan 2022 proposes expanding the workforce, integrating nurse practitioners and paramedics, and improving telehealth and service consistency.<sup>29</sup>

## Outpatient/Specialist Care

Secondary care comprises specialist medical services accessed via referral from primary care providers. These services are provided in hospital outpatient clinics or specialist facilities and are free for eligible patients in the public system. In public health care, access is prioritized according to clinical urgency rather than ability to pay.<sup>30</sup>

Specialist areas include cardiology, dermatology, orthopedics, and mental health. In 2024, there were 140.2 specialist medical practitioners for every 100,000 people. Specialists often work across both the public and private sectors.<sup>31</sup>

Demand for specialist care has grown steadily over the past decade as New Zealand's population ages and chronic disease rates climb. Between 2020 and 2025, the specialist services industry expanded at an estimated compound annual growth rate of 1.8 percent.<sup>32</sup>

Long wait times are a concern. In 2024, 73 percent of New Zealanders reported that wait times for doctors' appointments were too long — a noticeable increase from 2023 (66%) and above the global average (67%). About half (49%) of the country believes long wait times are one of the biggest health system challenges.<sup>33</sup>

## Physician Education and the Workforce

New Zealand is facing physician shortages, particularly in rural areas and primary care settings. Although the number of doctors has increased by 5,000 over the past decade, only 260 are GPs and many are nearing retirement.<sup>34</sup>

Forty-two percent of the workforce are international medical graduates — the highest proportion in the Organisation for Economic Co-operation and Development.<sup>35</sup> Retention is a challenge: just over 40 percent of international medical graduates leave within a year, and 75 percent leave within a decade.<sup>36</sup>

Medical education is concentrated at the University of Otago and the University of Auckland, which together produce 10.6 medical graduates for every 100,000 people.<sup>37</sup> Annual tuition ranges from NZD 20,000 to NZD 40,000 (USD 12,092 to USD 24,184).<sup>38</sup> A third medical school, proposed for the University of Waikato, is expected to produce an extra 120 graduates a year by 2031, with a focus on rural and general practice.<sup>39</sup>

The 2024 budget dedicated NZD 17 billion (USD 10 billion) to expanding training and strengthening workforce capacity.<sup>40</sup>

## Number of Medical Graduates per 100,000 People, 2021



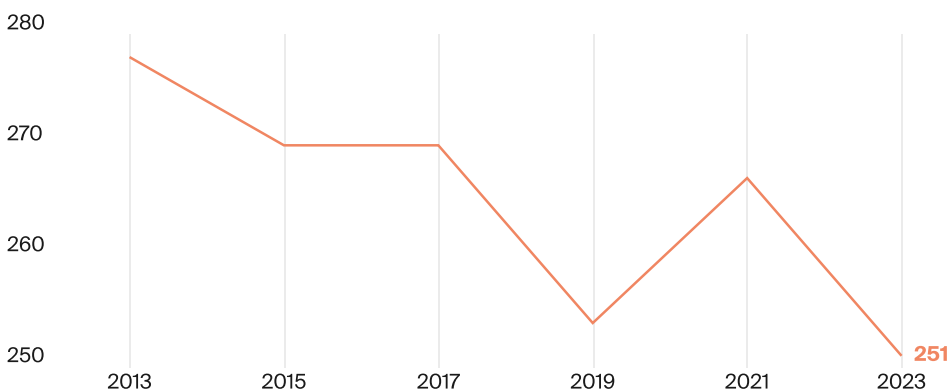
Source: Organisation for Economic Co-operation and Development, [Health at a Glance 2023](#) (OECD, November 10, 2023), 191. Note: numbers for New Zealand exclude overseas students, resulting in an underestimation.

## Hospitals

The hospital system is mostly public, funded by general taxation and managed centrally by Health New Zealand since July 2022. Public hospitals provide emergency, intensive, and elective care. Services are comprehensive and free for eligible patients.<sup>43</sup>

Private hospitals operate on a fee-for-service basis and are funded through out-of-pocket payments, private insurance, and Accident Compensation Corporation reimbursements for injury-related care.<sup>44</sup> These facilities focus on elective and nonemergency services, which means they can offer patients shorter wait times and more flexibility — but at a higher cost.<sup>45</sup>

## Number of Hospital Beds per 100,000 People, 2013–23



Source: The Global Health Observatory, [Beds, hospital Beds \(per 10,000 population\)](#), distributed by World Health Organization, accessed November 5, 2025.

### HOSPITALS BY THE NUMBERS

In 2023, there were **251 hospital beds per 100,000 people** (compared with an average of 537 across high-income countries).<sup>41</sup>

In 2025, there were **1,603 nurses per 100,000 people** (compared with an average of 434 across the Western Pacific in 2022).<sup>42</sup>

## Mental Health Care

Mental health care services are provided through Health New Zealand, private providers, and community organizations. Coverage includes anxiety, addiction, and maternal mental health, among other conditions.<sup>48</sup> GPs are the primary entry point for assessment, treatment, and referrals.<sup>49</sup>

Demand for mental health support has surged over the past decade. In the 2021–23 New Zealand Health Survey, 34.8 percent of adults reported symptoms of anxiety or depression, up from 25 percent in 2016–17. There has also been a sharp rise in mental distress and substance use among young adults (ages 15 to 24), prompting a nationwide response.<sup>50</sup>

In 2019, the government allocated NZD 1.9 billion (USD 1.1 billion) to mental well-being and launched Kia Manawanui Aotearoa — a 10-year strategy focused on early intervention, community-based care, and the integration of mental well-being into public policy. By 2023, primary mental health and addiction services had been established in more than 400 general practice sites, along with dedicated services for Māori and Pacific peoples, LGBT+ communities, and young people. Telehealth tools such as Groov, Small Steps, and Headstrong, meanwhile, complement traditional mental health services by providing accessible, self-guided support for people with mild symptoms or those seeking early intervention.<sup>51</sup>

Despite these efforts, mental health continues to be seen as an issue. In 2024, over half of New Zealanders (58%) listed mental health as a top health concern. Women were more concerned about the issue than men, though the latter were more likely to cite substance abuse as one of the biggest health problems.<sup>52</sup>

New Zealand has a greater number of psychiatrists and mental health professionals relative to its population than many high-income countries, but access to care is uneven across the country.<sup>53</sup> In 2021, 85 percent of psychiatrists reported that people needing specialist treatment were often unable to access the right care due to resource constraints, while 13 percent said they were sometimes unable to do so. These access problems reflect workforce shortages, limited inpatient capacity, and long wait times, among other systemic issues.<sup>54</sup> In addition, Māori and Pacific peoples are underrepresented in the mental health workforce.<sup>55</sup>

There are no data available for the number of mental hospital beds.

## Long-Term Care and Social Support

The long-term care system provides a mix of publicly funded and privately delivered services for individuals who can no longer live independently. Under the Residential Care and Disability Support Services Act 2018, long-term residential care is available in rest homes, dementia units, and psychogeriatric facilities.<sup>56</sup>

Eligibility for subsidized care is based on age and income. Adults over age 65 and people ages 50 to 64 without dependent children are eligible. Subsidy amounts are determined through clinical need and financial means assessments; individuals with more assets contribute more toward their care costs.<sup>57</sup>

### MENTAL HEALTH CARE BY THE NUMBERS

There were **14 psychiatrists per 100,000 people** in 2023 (compared with an average of 8.6 in high-income countries in 2020).<sup>46</sup>

In 2020, there were **117 mental health professionals per 100,000 people**, much higher than the average of 62 in high-income countries.<sup>47</sup>

Nearly all aged residential care is delivered by the private sector. Fifty-seven percent of funding in 2022–23 came from Health New Zealand and 43 percent from resident fees.<sup>58</sup> Services include medical and home care, respite care for family caregivers, and palliative care for terminally ill patients.<sup>59</sup> Health New Zealand continues to support hospital and community-based end-of-life care.<sup>60</sup>

Workforce shortages limit access. As demand for long-term care rises with the aging population, problems with staffing, affordability, and equitable access grow more acute.<sup>61</sup> Since 2023, however, family members have been eligible for compensation for home care, which has helped broaden the pool of paid caregiving staff. The reform allowed family caregivers to be employed through official support service providers and to be paid to deliver the same standard of care as formal caregivers.<sup>62</sup>

## Cost and Affordability

### Health Care Spending Overview

New Zealand spends 10 percent of its gross domestic product (GDP) on health care, placing it above the average for high-income countries.<sup>63</sup> Total health expenditure was USD 25.2 billion, or about USD 4,820 per person, in 2022.<sup>64</sup>

Public funding accounts for most spending. The government contributes 81.3 percent (USD 20.5 billion), out-of-pocket payments account for 11.6 percent (USD 2.93 billion), and voluntary spending, such as private insurance, covers 7.1 percent (USD 1.78 billion).<sup>65</sup>

In 2022, government health care spending per capita was USD 3,920, with an average out-of-pocket spend of USD 560 and an average prepaid private spend of USD 341.<sup>66</sup>

### Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory, [Current health expenditure \(CHE\) as a percentage of gross domestic product \(GDP\) \(%\)](#), distributed by World Health Organization, accessed November 5, 2025.

## Pharmaceutical Spending

Pharmaceutical spending in New Zealand accounts for a smaller share of total health expenditure than in many high-income countries. In 2023–24, the combined pharmaceutical budget was NZD 1.81 billion (USD 1.09 billion).<sup>67</sup> This represents about 6.8 percent of total health spending.<sup>68</sup> The lower spending reflects a focus on cost-efficiency, led by Pharmac, the national agency responsible for assessing, negotiating, and funding medicines within a fixed budget.<sup>69</sup>

Prescription copayments are capped at NZD 5 (USD 3) per item from approved providers, but children under age 14, seniors over age 65, and Community Services Card holders do not have to pay this copayment. Additional protections include the High Use Health Card, which reduces out-of-pocket costs for frequent users of medicine.<sup>70</sup>

Subsidized medicines are available to eligible residents, and prescriptions from non-approved providers incur higher copayments — NZD 15 (USD 9) for adults and NZD 10 (USD 6) for people ages 14 to 17 — to encourage people to use public services.<sup>71</sup>

## Cost Sharing and Out-of-Pocket Spending

The universal health system provides extensive public coverage, but some services still require copayments or out-of-pocket spending. As of 2023, out-of-pocket payments accounted for 12.6 percent of total health expenditure, below the average across high-income countries (18%).<sup>72</sup> Despite this, in 2024, a small majority of New Zealanders (67%) believed that good health care was unaffordable for many in the country.<sup>73</sup>

There are no public sector deductibles, but copayments are commonly applied to the following:<sup>74</sup>

- **GP visits:** Patients typically pay between NZD 15 and NZD 50 (USD 9 and USD 30), depending on the practice and whether they are enrolled. Children under age 14 are exempt. Fees are lower for holders of the Community Services Card and the High Use Health Card, and those visiting practices affiliated with the Very Low Cost Access program.
- **Prescription medicines:** These are capped at NZD 5 (USD 3) per item, with exemptions for children under age 14. Households that fill 20 prescriptions in a year qualify for a Prescription Subsidy Card, which waives further charges until the following year.
- **Dental care:** This is fully funded for individuals under age 18. Adults pay the full cost, except in some emergency situations that are managed by public hospitals.

Caps and subsidy programs help reduce the financial burden for low-income and high-use patients. However, private services, such as specialist consultations and elective procedures, are paid entirely out of pocket or with private insurance.<sup>75</sup>

## Percentage of Health Care Spending That Is Out of Pocket, 2022



Source: The Global Health Observatory, [Out-of-pocket expenditure as a percentage of current health expenditure \(CHE\) \(%\)](#), accessed November 18, 2025.

## How Are Costs Contained?

In its 2024 budget, the government allocated an additional NZD 5.7 billion (USD 3.4 billion) over four years to manage cost pressures, with another NZD 5.5 billion (USD 3.3 billion) earmarked for the budgets in 2025 and 2026. This increase reflects a 6.2 percent cost-pressure adjustment, well above the 2.2 percent inflation forecast for the same period.<sup>76</sup>

Initiatives funded through government budgets include support for emergency department security, expanded breast screening, training for new medical professionals, and funding for critical infrastructure projects.<sup>77</sup>

Health spending is comparatively high compared with other high-income countries, both per capita and as a percentage of GDP, reflecting the expense of maintaining a comprehensive, largely publicly funded health system.<sup>78</sup> Cost-containment strategies, such as centralized procurement, pharmaceutical pricing controls, and capitation-based funding, are helping to manage expenditure across the system.<sup>79</sup>

# Quality and Outcomes

## Health Outcomes

In 2021, average life expectancy was 82 years — 80.4 years for men and 84 years for women — which aligns with the average across high-income countries (80 years).<sup>88</sup> However, Māori and Pacific peoples experience shorter life expectancy than non-Māori and non-Pacific peoples. In 2022, average life expectancy for Māori women was seven years shorter than for women of European ethnicities, while it was eight years shorter for Māori men than for their European counterparts. For Pacific peoples, life expectancy was lower by six years for both women and men than for their European counterparts.<sup>89</sup>

Managing chronic disease and addressing rising mental health concerns are additional challenges. Low-income groups, individuals with disabilities, and rural communities face barriers due to costs, lack of transportation, and workforce shortages.<sup>90</sup>

## Addressing Health Inequities

Inequities in access to care and overall health have persisted across ethnic, geographic, and socioeconomic lines. An uneven distribution of wealth underpins these differences. In 2020–21, the top 20 percent of households held 62 percent of total net wealth, while the bottom 20 percent held just 1 percent. This imbalance is further reflected geographically: In regions such as the Gisborne District (Tairāwhiti), the Northland Region (Te Tai Tokerau), and Whanganui, over 40 percent of the population lived in the most socioeconomically deprived areas.<sup>91</sup>

Individuals living in these areas have shorter life expectancies. For women, there was a nine-year gap in life expectancy between those living in the least deprived areas and their counterparts in the most deprived areas. Child mortality was also affected, with rates in the most deprived areas consistently about three times higher than those in the least deprived areas. Māori and Pacific peoples were disproportionately affected, being two to three times more likely to live in highly deprived areas than would be expected if deprivation were evenly distributed.<sup>92</sup>

Health inequities extend beyond life expectancy. Mortality rates for cardiovascular disease, for instance, were highest in Te Manawa Taki, at 105 for every 100,000 people, compared with 91 for every 100,000 in the northern region. Access to care also varies: in 2022–23, 89 percent of northern residents lived within 30 minutes of care, compared with 72 percent of residents of Te Manawa Taki. In that region, 68 percent of Māori people lived within the same distance of care.<sup>93</sup>

Several health system reforms in 2022 prioritized equity as a core objective, such as the creation of the Ministry of Disabled People (Whaikaha). Rather than delivering health services directly, the Ministry works in partnership with the disabled community and Māori organizations to influence how the wider health system responds to the needs of people with disabilities. It aims to support cross-government coordination, promote accessibility, and embed the Enabling Good Lives approach into the system. This approach seeks to give people with disabilities and their families more choices and greater control over their lives.<sup>94</sup>

## HEALTH OUTCOMES BY THE NUMBERS

In 2021, average life expectancy was **82 years – 80 years for men and 84 years for women**.<sup>80</sup>

The top three causes of death in 2021 were:

- Ischemic heart disease: **100 deaths per 100,000 people**
- Alzheimer’s disease and other forms of dementia: **67 deaths per 100,000 people**
- Stroke: **46 deaths per 100,000 people**.<sup>81</sup>

The maternal mortality rate was **7 deaths per 100,000 live births** in 2023 (compared with 35 on average in the Western Pacific).<sup>82</sup>

The infant mortality rate was **4 deaths per 1,000 live births** in 2023 (compared with an average of nine across the Western Pacific).<sup>83</sup>

In 2021, the share of the population with mental health disorders was **18 percent** (compared with an average of 16% in high-income countries).<sup>84</sup>

The suicide rate was **13 per 100,000 people** in 2023, higher than the average of 11.8 per 100,000 people across high-income countries in 2021.<sup>85</sup>

Guns were responsible for **1.64 deaths per 100,000 people** in 2023, compared with 0.95 in Australia.<sup>86</sup>

**34 percent** of adults were affected by obesity in 2024.<sup>87</sup>

There are no recent data available for the avoidable mortality rate in New Zealand.

There was also the Pae Ora (Healthy Futures) Act 2022, which provided a legislative framework for achieving more equitable health outcomes by strengthening partnerships with iwi and Māori providers, addressing systemic bias, and investing in equity-focused services (see *Background and History*, and *Health Care Innovation*).<sup>95</sup> Included in the Act were initiatives such as Whānau Ora that promote culturally grounded, family-centered approaches to care, particularly for Māori communities (see *Health Care Innovation*). These include the use of trained navigators to help families access coordinated health and social services.<sup>96</sup> Public reporting on health outcomes and service access tracks progress and highlights where inequities persist.<sup>97</sup>

In 2024, however, the government urgently passed the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill (see *Background and History*).<sup>98</sup> According to the Ministry of Health, the amendment was intended to introduce an outcomes-based approach and prevent duplication of work, unifying everything under one entity.<sup>99</sup> Critics, however, say this violates the self-determination of Māori people — their right to freely determine their political status; pursue their economic, social, and cultural development; and maintain their own institutions and cultures.<sup>100</sup>

A tribunal held in 2024 found that the Amendment Bill breached the principles in the Treaty of Waitangi (the founding document of New Zealand): good government and partnership.<sup>101</sup> Its members asserted that the government chose to disestablish the Māori Health Authority, which was seen as a well-researched initiative codesigned by the community, in haste without consulting the Māori people.<sup>102</sup> A memorandum from the Ministry of Health, however, maintains that this amendment is intended to empower the Māori community and improve their health outcomes.<sup>103</sup> The health outcomes of this reform are as yet unknown.

## Innovation and Reform

### Health Care Innovation

In July 2025, the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill was introduced in Parliament (see *Addressing Health Inequities*). It has a number of aims, including amending the purpose, objectives, and function of Health New Zealand, which replaced 21 district health boards following the Pae Ora (Healthy Futures) Act 2022. Specifically, the Amendment Bill adds the delivery of effective and timely services to Health New Zealand's purpose. It also makes Health New Zealand responsible for infrastructure.<sup>104</sup>

Certain reforms have been met with criticism from Māori people. The Amendment Bill intends to change the roles and responsibilities of iwi Māori in the delivery of health services. Specifically, it changes the role of IMPBs to engage with local communities about health needs and removes the requirement for Health New Zealand to engage with IMPBs when setting investment priorities.<sup>105</sup> Critics argue that the reforms diminish the responsibility of the IMPBs from designing and implementing health care to an engagement and advisory role.<sup>106</sup>

To guide long-term change, the New Zealand Health Strategy of 2023 sets out a 10-year vision to improve health outcomes and reduce inequities.<sup>107</sup> It identifies six national priorities:

- Strengthening the community voice
- Enabling flexible and locally tailored care
- Investing in the health workforce
- Fostering a learning health system
- Building system resilience
- Developing cross-sector partnerships.<sup>108</sup>

## Health Care Technology

New Zealand's government has accelerated the digital transformation of health care to improve access, coordination, and patient outcomes — particularly for rural and underserved populations. Central to this effort is the National Health Index and a growing network of electronic health records (EHRs). EHRs are widely used in primary care and increasingly integrated across the health care delivery system. Initiatives such as GP2GP streamline record transfers between general practices, while the My Health Record platform gives patients direct access to their own data.<sup>109</sup>

Progress in digitization has been uneven, however, with inadequate infrastructure proving to be a barrier. The public health system relies on more than 4,000 fragmented information technology systems, many of which are outdated, poorly integrated, and limited in their capacity to promote data sharing and coordination.<sup>110</sup> Clinicians have also reported problems with system usability and limited engagement in digital service design.<sup>111</sup>

The EHR market, valued at NZD 514 million (USD 311 million) in 2022, is projected to grow to NZD 884 million (USD 534 million) by 2030.<sup>112</sup>

Digital health tools are also expanding beyond hospitals. A rollout of EHRs across the Department of Corrections (Ara Poutama Aotearoa) and the use of telehealth to reach remote communities illustrate efforts to close care gaps.<sup>113</sup>

*This profile reflects data as of January 2026. New or updated information may have become available since its release.*

## Notes

1. *Health Trends: Accessible and Affordable Healthcare*, (Financial Services Council of New Zealand, April 2024), <https://7422267.fs1.hubspotusercontent-na1.net/hubfs/7422267/FSC%20Corporate/Documents/Research%20Reports/FSC%20Insights%20%26%20Trends%20-%20Healthcare%20FINAL.pdf>.
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