

Performance first: why the economic success of our nation is dependent on the health of our people and why privatisation by stealth won't fix New Zealand's health system

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As New Zealand enters another election year, the *New Zealand Medical Journal's* editor rightly states that it will be the economy that will dominate the political debate, with health becoming a major secondary issue.¹ We agree but wish to point out that these two areas, health and the economy, are intimately related to each other and that the economic imperative for investing in health and healthcare as an investment in the nation's future is well founded.²⁻⁵

From an economic, social and equity point of view, New Zealand simply cannot afford to have so many of its citizens unable to access healthcare and not be in good health. That is an essential element in allowing us to be socially and economically productive and be the collective asset the nation needs.

Hence, a big question for this election should be the cost to the public finances and our economy of the current approach of cost containment and poor health planning that denies so many access to much needed health and healthcare services.

In the report *Managed Decline*,⁶ its author details those second-, third- and fourth-order fiscal consequences to the nation of so many being in poor health. The figures are staggering, such that should the status quo remain unchecked, by 2035 only 6.6% of adults in New Zealand will meet the World Health Organization definition of being in good health. That's a future we just cannot afford and an approach the author calls out as being fiscally reckless.

Instead of managing short-term costs, more attention needs to be placed on the economic value good health delivers by way of public policies to prevent harm from the social and commercial drivers of ill health, expanding and supporting our healthcare workforce and in the provision of publicly funded, publicly provided services.^{7,8}

We agree with the editor that, once again, health is framed as a contest of one-off promises for shorter waiting lists, better cancer care and more access to medicines; all necessary interventions, but as it stands this is simply the minister playing whack-a-mole to manage politically sensitive issues instead of planning for a sustainable health and healthcare system for the future.

As Professor Frizelle has argued, the real test of health policy is not aspiration but performance—whether people can access timely, affordable care in practice, and whether inequities are genuinely reduced.

International evidence should give us pause. Compared with countries such as New Zealand, the United States of America spends a far higher share of gross domestic product (GDP) on health than any other developed country yet performs poorly on life expectancy and in achieving good health outcomes.⁹ We have much to learn from the failures of their approach, notably the massive expense, inefficiencies and shocking inequities that are created by their fragmented approach to funding, planning and provision.

We recognise that not everything can be fixed by additional funding, but not much can be fixed without it and right now it is abundantly clear that a major boost of funding is urgently required in the next Budget and in each of those that follow until we have taken the necessary steps to put funding of our services on a stable and predictable footing for the future.

The alternative to expand public capacity and capabilities is critical as the Government actively promotes expanded private provision, justified as a pragmatic response to pressure in the public system. Private provision may offer short-term relief for individuals and those who can pay to bypass public waiting lists, but international

experience shows that, without strong public stewardship, privatisation by stealth will undermine system performance and population health, be more costly and increase inequity.^{10–15}

There are three predictable consequences. First, private expansion draws scarce workforce and infrastructure away from the public system, where need is greatest. In a country already facing critical shortages of doctors, nurses and allied health professionals, shifting capacity does not solve the problem. It redistributes it,¹⁶ usually away from rural communities and lower-income populations. Second, incremental privatisation normalises a two-tier system, where access to timely diagnosis and treatment increasingly depends on income rather than clinical need. Once this becomes embedded, public waiting lists lengthen,¹⁷ preventable harm increases and trust in the system erodes. Third, highly privatised systems cost more overall without delivering better population outcomes. The United States of America is not only an outlier because it spends too much. It is also because fragmentation drives inefficiency, duplication and inequity.⁹ New Zealand should not mistake higher private activity for improved system performance.

These are not ideological objections. They are practical everyday concerns. A fragmented health system struggles to coordinate care, reduce waiting times or address entrenched inequities, particularly when workforce constraints are already binding.

From a Te Tiriti o Waitangi perspective, the risks are even more pronounced. Māori already experience delayed diagnosis, reduced access to specialist care and poorer outcomes across multiple conditions, including cancer, cardiovascular disease and mental health.^{18–22} Incremental privatisation threatens to exacerbate these inequities, not resolve them. Te Tiriti obligations require the Crown to actively protect Māori health, ensure equitable outcomes and partner with Māori in governance and service design.²³ A two-tier system, where those with means bypass public pathways while others wait longer for care, is fundamentally incompatible with these obligations. Fragmentation weakens accountability for equity and shifts risk onto individuals and whānau least able to absorb it.

New Zealand's relatively strong health outcomes have not been achieved by solely chasing high spending as a percentage of GDP. They have

been built on a predominantly public, universal system that pools risk, supports prevention and enables access based on need. As fiscal pressures tighten and workforce shortages deepen, protecting the capacity of public provision becomes even more important.

This does not mean the system should stand still. As the *Journal's* editor notes, performance will be judged on whether Health New Zealand – Te Whatu Ora can restore access to primary care, reduce waiting times and improve equity. That requires sustained investment in general practice, integrated models of care, workforce development and genuine Māori partnership, not the quiet expansion of private alternatives that leave structural constraints untouched.

If election year health debates are to be credible, they must confront trade-offs honestly. Earlier cancer screening, better access to medicines, strengthened mental health services and improved primary care all require capacity and workforce. That means addressing pay equity across health professions, particularly in nursing, midwifery and allied health, where chronic undervaluation of predominantly female and Māori workforces undermines recruitment, retention and professional sustainability. In a globally competitive labour market, failure to resolve pay equity is not a fiscal saving but a direct contributor to workforce loss. Promising delivery without addressing these structural workforce constraints fuels public scepticism and undermines trust.

The test for voters is therefore straightforward. Does the Government's direction of travel strengthen the public system at scale, or does it shift pressure onto individuals and households while leaving the underlying causes of delay and inequity unresolved and our economic future in jeopardy?

Outcomes and equity, not ideology or spending headlines, must be the benchmarks of success. Sustained privatisation risks eroding both at precisely the moment when New Zealand needs coherence, confidence and courage in health policy.

The challenge for political leaders is clear. Stop treating private provision as an easy release valve for public system failure. Be honest about limits, deliberate about choices and explicit about delivery. If this election is to mark a genuine reset, health must be judged not by promises made or pathways outsourced, but by fair, timely care delivered for all New Zealanders.

COMPETING INTERESTS

DG is a board member for NorthAble, Fisher & Paykel Healthcare Foundation and Health Coalition Aotearoa. DG reports stock/stock options (managed funds) for Milford Asset Management and Forsyth Barr. LW is chair, Tūwharetoa Iwi Māori Partnership Board.

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