

Unmet, unmeasured and unseen

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A growing number of New Zealanders are missing out on specialist healthcare. Senior medical and dental officers already know this because workforce constraints have been a lived reality for years and hard decisions are made daily about who can and cannot be seen. What does not match that experience is the story being told about improvement. “Milestones” and “targets” are being hit,¹ outsourcing is said to be working and yet access is tightening.

The pressure is not just in waiting lists. Referrals are not keeping pace with population growth and more are being declined. A growing number of patients never enter the system at all and languish in an under-resourced primary care sector. New analysis from the Association of Salaried Medical Specialists (ASMS) shows just how big that gap has become.² The data, obtained under the *Official Information Act 1982 (OIA)*, reveal this is not a temporary effect: it reflects a system trying to cope with a permanent workforce constraint by limiting access at the front door.

Health New Zealand – Te Whatu Ora does not know how many people are missing out on specialist care nationally

Health New Zealand – Te Whatu Ora does not collate or monitor trends in declined referrals for specialist care at the national level. This is a fundamental problem, because declined referrals are a critical indicator of unmet need for secondary care. Without this understanding Health New Zealand – Te Whatu Ora cannot accurately forecast, plan for and cost the services required to meet the needs of New Zealanders. Last year, its first costed health plan received a “fail” grade from the Controller and Auditor-General of New Zealand, who noted that *“I expected the Plan to be based on clear and reasonable assumptions about health needs and the expected quantity of service demand, the resources needed to provide those services, and the forecast cost of those resources. The Plan does not do this.”*³

Monitoring trends in referrals is also critical for assessing inequitable access to care between districts and between different specialities.⁴

Outsourcing risks exacerbating entrenched geographic inequities due to the distribution of private providers. Health targets that focus on elective treatment risk exacerbating inequitable access for patients who need medical rather than surgical treatment. Anecdotally, ASMS members report this is occurring, but without collating and interrogating referral data Health New Zealand – Te Whatu Ora is unequipped to monitor and respond.

A major driver of the 2022 health reforms was to address inequitable access to health services and achieve equitable health outcomes.⁵ This objective has not been realised, and calls for Health New Zealand – Te Whatu Ora to collect unmet-need data and improve the accuracy of its public reporting^{4,6} have not yet been acted upon.

Some districts, however, do collate referral rates. Under the *OIA*, the ASMS obtained data on referral rates from seven districts between 2023 and 2025: Auckland; Canterbury; Capital, Coast and Hutt; MidCentral; Lakes; and Southern.

...but data from some districts suggest the number of people missing out is growing

Data from these seven districts suggest more New Zealanders are missing out on specialist care than previously. Between 2023 and 2025 the population grew by 3.4%, but the total number of referrals only grew by 1.1%.² That referral numbers are not keeping up with population growth suggests general practitioners (GPs) may be holding back on referring. Media reports provide examples of several hospitals advising GPs to only refer patients in cases of emergency or expected cancer and changing thresholds for patient care based on capacity.⁷⁻⁹ Research also suggests that where GPs have knowledge and experience of services declining referrals, they may be less likely to refer patients even when there is a clinical need.¹⁰

When referrals were made, a substantial number were declined. Across the seven districts, 20% (112,348) of referrals for first specialist assessments (FSAs) were declined in 2025, up from 18.4% in 2023. If the data in the remaining 13 districts were similar, total declined referrals in 2025

would have been more than 255,000 nationally.² However, given Health New Zealand – Te Whatu Ora’s patchy data collection, the actual number of declined referrals nationally is unknown.

The health system is at capacity

Despite increased outsourcing, capacity to provide FSAs and treatment does not appear to have meaningfully improved. Health New Zealand – Te Whatu Ora’s reporting shows a total of 175,025 FSAs were delivered in 2024 compared with 174,943 FSAs in 2023.² The number of planned care treatments delivered in the year to December 2025 was just 2% higher than 2024, despite advice to the Minister of Health in January 2025 that *“An estimated additional 10-15% of activity in planned care is required to keep up with estimated growth and to progressively treat more patients who have already waited greater than 120 days.”*¹¹

There were 6,470 (7.6%) fewer people on the waiting list for elective treatment in December 2025 compared with December 2024, but this is in part due to 5,439 fewer people being admitted to the waiting list over the same period despite large backlogs of patients waiting for an FSA. Over the longer term, there has also been a substantial increase in the number and proportion of minor procedures being performed from the waiting list, suggesting minor procedures may be being prioritised over more complex cases to help bring waiting list numbers down.²

Capacity issues come as no surprise. The Planned Care Taskforce highlighted in 2022 that *“Staffing is the greatest challenge to improved planned care delivery”*.⁴ It also noted private hospitals appeared to have *“limited marginal capacity for*

inpatient elective planned care within all regions” with some districts having *“very few or no options to access private capacity locally to meet the waitlist needs”*. Similarly, the Health Workforce Committee warned that work suitable for private hospitals would tend to be less complex short-stay cases and raised the risk of perverse queueing, *“where next in line is not necessarily next treated”*.¹²

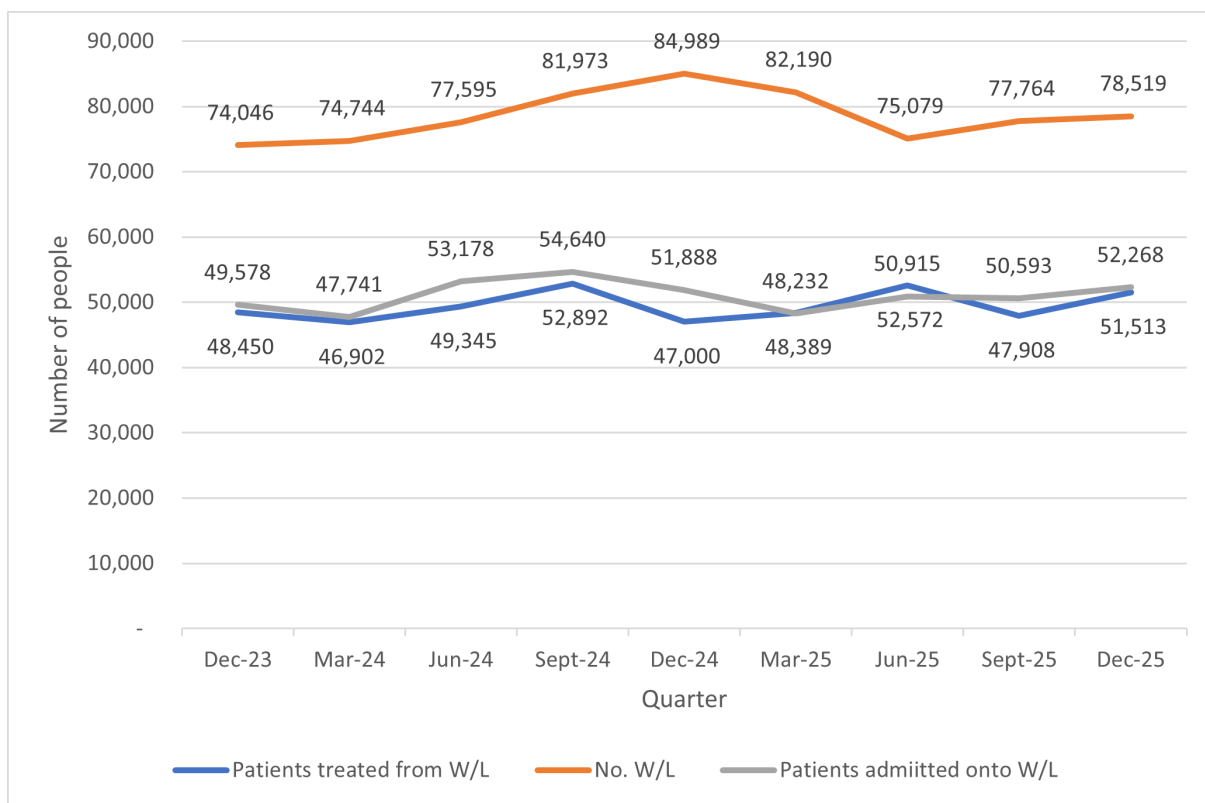
No meaningful plan to address senior medical officer shortages

Although staffing is the critical factor limiting capacity for specialist care, Health New Zealand – Te Whatu Ora has no coherent plan to meaningfully increase the senior medical officer (SMO) workforce. In 2024 it identified an estimated shortfall of 1,140 SMOs based on vacancy data.¹³ The same year, it lost control of its finances and responded by implementing hiring freezes and strict, centralised control of recruitment. In 2026, recruitment remains slow and overly centralised, and workforce planning does not appear to include budgeting to increase capacity.

Because SMO full-time equivalent (FTE) has not increased in line with demand for healthcare, the real SMO shortfall will be far greater than the estimated 1,140 FTE. An ASMS survey of clinical directors across almost 300 services indicates services are working with 32% fewer SMOs than needed to operate safely and meet patient need.

The Waikato Medical School is one small step in the right direction, but it will not come close to fixing the entrenched shortage of hospital-based specialists. Without a plan to address SMO workforce capacity, unmet need for secondary care will continue to grow.

Figure 1: Elective treatment waiting list (W/L): total patients waiting, patients admitted and patients treated*.



Source: Data on patients treated from the waiting list and patients on the waiting list are from Health New Zealand – Te Whatu Ora Quarterly Health Target Factsheets 2026. Data on patients admitted to the waiting list were obtained from Health New Zealand – Te Whatu Ora under the *Official Information Act 1982*.

*“Patients admitted” is the number of patients admitted to the waiting list in each quarter. “Patients waiting” is the total number on the waiting list.

COMPETING INTERESTS

At the time of writing, all three authors were employed by the Association of Salaried Medical Specialists.

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