

A WHITE PAPER

The Future of Private Health Insurance and the effect on Public HealthCare in New Zealand

Strengthening the Private Insurance Pool, Building Private Healthcare Capacity, and Relieving New Zealand's Public Health System

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Executive Summary

New Zealand's private health insurance market is at a turning point. Medical inflation reached 14.5% in 2025, up from 7.4% the year before, and forecasts put employee medical plan cost growth at 18% in 2026 — well above the Asia-Pacific average of 11.3% and the global average of 9.8%. As insurers pass these costs through in double-digit premium increases, the policyholders best able to walk away — the young and healthy, who claim least — are doing exactly that. An estimated 80,770 people ended major medical cover in 2025 alone, and the annual policy termination rate has climbed from 7% (2022) to 9% (2025).

This is not a temporary rough patch. It is the early stage of a well-documented and, if left unaddressed, self-reinforcing process known as adverse selection: as lower-risk members leave, the remaining risk pool skews older and sicker, claims costs per remaining member rise, insurers increase premiums further to cover them, and the next wave of healthy members finds cover even less worth paying for. Australia lived through the full version of this cycle in the 1980s and 1990s, watching private cover collapse from roughly 80% of the population to just 30.3% by 1998, before deliberate tax and policy intervention rebuilt and then held coverage steady at 45–47% for the past 25 years.

This white paper sets out the case for New Zealand to act now, while the private market is strained but not yet broken, rather than waiting for a full-blown crisis and a much more expensive rebuild. Drawing on the experience of Australia, Ireland, Singapore, South Africa, the United States, India and the United Kingdom, it shows that:

- Governments that use tax policy — relief, credits, or targeted penalties for late entry — to keep healthy people inside the private risk pool can hold private coverage 15–20 percentage points higher than an unsupported market, and hold it there for decades.
- A larger, more stable pool of policyholders spreads risk across more premium-payers, which is the single most direct lever available to reduce or moderate the price of cover for everyone in it.
- Growth in privately funded patient volumes gives private hospitals and specialist groups the confidence and capital to invest — expanding facilities, recruiting specialists (including from overseas), and building clinical capability that New Zealand's public system cannot fund alone.
- Every patient treated privately is a patient who does not join the public waiting list — directly relevant to a public system that Health New Zealand itself is now trying to relieve by contracting out elective surgery to private providers.
- New Zealand does not need to invent this policy from nothing: the Financial Services Council has already put a costed, industry-backed proposal — an FBT exemption on employer-funded health and life insurance — in front of government as part of its 2026 election manifesto.

The paper recommends a package of measures rather than a single lever: an FBT exemption for employer-provided health insurance to protect and grow the workplace channel; a personal tax rebate or credit on individually purchased health insurance premiums, targeted to avoid simply subsidising people who would have bought cover anyway; and an age-based loading mechanism, modelled on Australia's Lifetime Health Cover or Ireland's Lifetime Community Rating, to directly counteract adverse selection by rewarding early and continuous membership. It also addresses the strongest counter-arguments — fiscal cost, distributional fairness, and the UK's experience of withdrawing a similarly-designed relief with

limited real-world effect — and explains why a well-targeted New Zealand scheme can avoid those pitfalls.

1. Introduction and Purpose

This white paper is addressed jointly to the New Zealand Government and to the private health insurance and private healthcare sector. It makes the case that a targeted tax incentive — whether structured as individual tax relief, an employer FBT exemption, or another form of subsidy — for holding private health insurance is not a cost to be resisted but an investment that pays for itself many times over in reduced pressure on the public health system, a more sustainable private insurance market, and a stronger, better-resourced private healthcare sector able to attract world-class specialists to New Zealand.

The paper is structured in six parts. Section 2 sets out the current state of the New Zealand private health insurance market and the adverse selection dynamic now visibly under way. Section 3 reviews how seven other countries have used tax policy to shape their private health insurance markets, and what happened when they did (or, in the UK's case, stopped). Section 4 sets out the specific case for New Zealand across three channels of impact: premium pool effects, private provider capacity and specialist recruitment, and relief of the public system. Section 5 sets out concrete policy options for consideration. Section 6 addresses the principal counter-arguments directly. Section 7 makes recommendations.

2. The Current State of Private Health Insurance in New Zealand

2.1 A market under real cost pressure

Around one in three New Zealand adults holds private health insurance — the New Zealand Health Survey has recorded coverage fluctuating narrowly between roughly 32% and 38% of adults over 2012–2025, with no sustained upward trend despite a growing, ageing population and a public system under widely reported strain. That plateau matters: it means the market has not been growing its risk pool even as the case for private cover — in terms of public wait times — has arguably strengthened. The market is now being tested by a sharp acceleration in claims costs.

Medical inflation — the rate at which the underlying cost of treatment rises — nearly doubled in a single year, from 7.4% in 2024 to 14.5% in 2025, according to AIA New Zealand. Aon's 2026 Global Medical Trend Rates Report forecasts New Zealand employee medical plan costs will rise a further 18% in 2026, compared with an Asia-Pacific regional average of 11.3% and a global average of 9.8% — meaning New Zealand employers and individuals are absorbing cost growth roughly double the international norm.

These pressures are visible insurer by insurer. UniMed reported more than 180,000 claims in the year to June 2025 — a 53% increase on the previous year — with average daily claims value rising from \$394,000 to \$612,000 and total claims approaching \$160 million. Southern Cross Health Insurance, New Zealand's largest insurer, reported claim numbers up 16% and total claim value up 14% in its last financial year, attributing losses to "an unusually high volume of claims alongside ongoing strain on the public health system" — and noting that members over 65 claim more than three times the amount claimed by members aged 35–49. The average health insurance claim paid per member has had a 75% increase since

2021. The practical result for members has been premium increases in the order of 10–30% a year for many policyholders, rising faster still for older members and those on comprehensive plans.

2.2 Cancellations, and the beginning of an adverse selection spiral

Rising premiums are already changing who stays insured. An estimated 80,770 people ended major medical cover in 2025, and the policy termination rate has risen from 7% in 2022 to 9% in 2025. This is precisely the pattern that international experience warns about, and it is worth stating the mechanism plainly, because it is the central problem this white paper proposes to solve:

1. Premiums rise to reflect increasing claims costs across the whole pool.
2. The policyholders most likely to cancel in response are those who feel they are "paying for nothing" — typically younger, healthier members who rarely claim and can more easily do without cover, or self-insure the risk.
3. As these lower-risk members leave, the remaining pool of policyholders is, on average, older or with health concerns/issues and carries a higher rate of claims.
4. Insurers must set the next round of premiums against this now higher-cost pool, pushing prices up again.
5. The cycle repeats, with each round shrinking the pool of policyholders and worsening its average risk profile — the dynamic economists call this adverse selection, and which in its extreme form is described as an insurance "death spiral."

New Zealand has not reached the extreme end of this spiral — but the ingredients are now all present: double-digit premium rises, an accelerating claims trend, a rising termination rate, and a striking gap in claims intensity by age (over-65s claiming more than three times as much as 35–49-year-olds) that shows exactly which members the pool most needs to retain and is least likely to. New Zealand is, in effect, at the point in the cycle where Australia was in the early-to-mid 1990s — well before its coverage collapsed to 30.3% by 1998, but on the same trajectory. Acting at this stage is materially cheaper and easier than rebuilding a market after it has broken, as Section 3.1 sets out in detail.

2.3 Consequences for the public health system

The consequence of a shrinking private pool is not merely a private-sector problem: every policyholder who cancels cover and later needs elective treatment becomes, by default, a claim on the public system instead. New Zealand's public system is already under acute pressure. Health New Zealand | Te Whatu Ora has responded by actively contracting out elective surgery to private hospitals and extending clinicians' hours specifically to cut waitlists — an acknowledgment that public capacity alone cannot meet demand, and that private capacity is a release valve the system now depends on. New Zealand also needs an estimated 1,800 additional full-time doctors overall, including well over 100 additional emergency medicine and intensive care specialists relative to comparable Australian benchmarks.

At the same time, the specialist workforce is already shifting toward the private sector on its own: between June 2022 and June 2024, private-sector specialist grew 9.6% compared with 4% growth in the public sector, with 15 of 36 medical specialities recording a net movement of specialists from public to private practice. In several specialities — including dermatology, oral and maxillofacial surgery, palliative

medicine and ophthalmology — New Zealand now has more specialists working privately than publicly. This shift is already happening; the policy question is whether New Zealand shapes it deliberately, with enough privately funded patient volume to make continued investment in private specialist capacity commercially sustainable, or lets it happen unevenly, unfunded, and without the patient volumes to justify it.

Sources: AIA New Zealand; Southern Cross Health Society; UniMed; Aon 2026 Global Medical Trend Rates Report; New Zealand Health Survey (Ministry of Health); RNZ; ASMS workforce analysis; Health New Zealand | Te Whatu Ora.

3. International Precedent: Tax Policy and Private Health Insurance

New Zealand is far from the first country to face this problem, and it does not need to design a solution from a blank page. The following review covers seven jurisdictions that have used tax relief, tax credits, tax exclusions, or closely related mechanisms (age-based loadings and community rating) to shape private health insurance markets — including one country, the United Kingdom, that withdrew such a relief, which offers an important cautionary lesson about design and targeting.

3.1 Australia — a cautionary tale, and the clearest fix

Australia's experience is the single most directly relevant precedent for New Zealand, because it is a story of the exact adverse selection cycle described in Section 2.2 playing out to its conclusion — and then being deliberately reversed by tax policy.

Following the introduction of universal public health insurance (Medicare) in 1975, private cover entered a long decline, falling from around 80% of the population to just 30.3% by 1998, as healthy members progressively opted out and the remaining pool became more expensive to insure — a decline that Australian academic research explicitly analysed as a case of "adverse selection and the decline in private health insurance coverage." Facing a private market in genuine danger of collapse and a public system unable to absorb the resulting demand, the Australian Government introduced three coordinated measures in 1999–2000:

- The Private Health Insurance Rebate — a government subsidy covering 25–35% of premiums, income-tested so it is worth more to lower and middle earners.
- Lifetime Health Cover (LHC) — a 2% premium loading for every year past age 31 that a person delays taking out hospital cover, up to a maximum 70% loading, removed after 10 continuous years of cover. This directly rewards joining (and staying) young and healthy, and penalises waiting until cover is "needed."
- The Medicare Levy Surcharge (MLS) — an extra 1–1.5% income tax charge on higher earners who do not hold private hospital cover, converting the choice to go uninsured from a pure saving into a net cost for those who can most easily afford cover.

The result was immediate and durable: coverage rebounded from 30.3% and has held steady in the 45–47% range for every year since 2000 — a quarter of a century of stability that a market left alone could not achieve on its own. Analysis of the individual levers shows LHC increased enrolment demand by around 9% at the critical age-31 threshold when first introduced, and the MLS lifted uptake among affected high earners from roughly 70% to 73% (singles) and 90% to 91% (families). Researchers are candid that no single lever is dramatic on its own — but combined, and sustained over decades, they converted a collapsing market into a stable one. The fiscal cost is real and worth stating plainly: the rebate cost the Australian government around A\$6.8 billion in 2021, equivalent to roughly 27% of the private health insurance industry's total premium revenue — a scale of public commitment that reflects how seriously Australia treats the alternative (a much larger cost shifted onto public hospitals).

"The policy has been effective at getting people to insure right before they turned 31, but has no effect for other ages... the carrots and sticks work, but don't contribute a huge

amount to overall demand on their own — it is the combination, sustained over time, that rebuilt the market."

— Austaxpolicy / Tax and Transfer Policy Institute analysis of Australian incentive policy

3.2 Ireland — Lifetime Community Rating and premium tax relief

Ireland combines tax relief on health insurance premiums (relief at the standard income tax rate, subject to a cap) with Lifetime Community Rating (LCR), introduced in May 2015 — a mechanism functionally very similar to Australia's LHC, applying a 2% premium loading for every year of age over 34 at which a person first takes out cover, for a maximum of 10 years. Ireland's market had suffered its own version of the adverse selection problem: coverage fell from 51% of the population in 2008 to 43% in 2014 following the financial crisis, as cost pressure pushed out marginal members.

LCR brought a meaningful number of people back into the pool — around 109,000 additional people aged under 60 took out cover between 2014 and 2017, including roughly 60,000 in the 40–59 age bracket specifically, the group whose entry age loading was about to bite. However, overall population penetration rose only about half a percentage point over the same period, illustrating an important lesson for New Zealand's design choices: an age-based loading mechanism reliably changes the timing and age-profile of enrolment — pulling forward decisions that would otherwise be delayed — but is not, by itself, a strong lever for growing overall market size. It works best paired with a genuine affordability incentive (as in Australia), rather than deployed alone.

3.3 Singapore — a savings-based hybrid model

Singapore's approach differs structurally from the tax-relief-on-premiums model: individuals are required to contribute to MediSave, a personal medical savings account, and receive tax relief on voluntary top-ups to that account, which can in turn be used to pay for approved private insurance (Integrated Shield Plans) and out-of-pocket costs. This is less a "buy insurance, get a tax break" incentive and more a compulsory-savings-plus-relief hybrid that blurs the line between public and private funding. It demonstrates that tax-advantaged personal healthcare accounts are a viable alternative or complementary lever to direct premium relief, though it would represent a more structurally significant change for New Zealand than the options set out in Section 5.

3.4 South Africa — a flat, equity-focused tax credit

South Africa's Medical Scheme Fees Tax Credit takes a different design approach again: rather than a percentage rebate on premiums (which is worth more, in dollar terms, to people paying for more expensive cover), it is a flat, non-refundable monthly credit per covered person — R364 per month for a single member and R728 for a member plus one dependant in 2025, with a smaller additional amount per further dependant. Because the credit is flat rather than proportional, it is deliberately designed to be equally valuable in relative terms to lower- and higher-income members, addressing a fairness critique that applies to several other countries' models (see Section 3.5). This is directly relevant to New Zealand's design choice in Section 5: a flat credit or capped rebate avoids disproportionately rewarding the wealthiest, most comprehensively insured members.

3.5 United States — the scale (and the risk) of an open-ended exclusion

The US excludes employer-paid health insurance premiums entirely from employees' taxable income and payroll tax. It is the largest single tax expenditure in the federal budget — an estimated US\$299 billion in 2022 — and is widely credited as a major reason most working Americans obtain coverage through their employer. It is also the clearest warning in this review about the risks of an *unlimited* incentive: because the exclusion is open-ended, it is regressive (a higher earner in a higher tax bracket saves more per dollar of premium than a lower earner) and is credited with encouraging progressively more comprehensive, lower-cost-sharing (and therefore more expensive) health plans over time, since the tax system effectively shields the "extra" cost from being felt directly by employees. The lesson for New Zealand is not to avoid an employer-based incentive — Section 5.2 recommends one — but to design it with a cap or a defined scope (an FBT exemption on a standard, sensibly-scoped policy, for example) rather than an unlimited exclusion.

3.6 India — Section 80D and closing a large protection gap

India's Section 80D of the Income Tax Act provides a direct income tax deduction for health insurance premiums paid for oneself, a spouse, children, and parents, with higher caps for senior citizens. It is deployed explicitly as a penetration-growth tool in a market where regulators have described the insurance "protection gap" as being as high as 70–80% of the population. While comprehensive before/after uptake data specific to Section 80D in isolation is limited (India's insurance growth reflects many simultaneous factors), it stands as a widely cited example of the simplest possible design — a straightforward premium deduction — being used as one tool among several in a deliberate national strategy to grow private cover.

3.7 United Kingdom — what happened when a relief was withdrawn

Between 1990 and 1997, the UK gave income tax relief on private medical insurance premiums specifically for people aged 60 and over, intended to keep older, higher-cost patients — and their demand — out of the NHS. When the incoming government abolished the relief in 1997, the Institute for Fiscal Studies found the real-world effect was modest: approximately 4,000 people dropped their private cover as a result, and the Exchequer saved about £135 million a year — a saving that comfortably exceeded the additional cost of the small number of people who returned to NHS care.

This is an important counter-example, and this white paper treats it honestly rather than ignoring it (see also Section 6). The lesson is not that tax relief for health insurance "doesn't work" — it is that a relief targeted narrowly at people who, for the most part, would have kept their cover anyway (i.e. it did little to change *behaviour* at the margin) delivers a poor return on its fiscal cost. Unlike Australia's LHC or Ireland's LCR, the UK's relief carried no mechanism that specifically rewarded early or continuous enrolment, and so did little to combat adverse selection or grow the pool — it mostly subsidised existing decisions rather than changing new ones. New Zealand's design should learn directly from this: an effective incentive needs to be structured to change behaviour at the margin — keeping people who would otherwise leave, and bringing forward people who would otherwise delay — not simply to reward existing policyholders.

3.8 Summary of international lessons for New Zealand

Country	Mechanism	Effect on coverage
Australia	Premium rebate (25–35%) + age-based loading (LHC) + tax surcharge for high earners without cover (MLS)	Rebuilt coverage from 30.3% (1998) to a stable 45–47%, held for 25+ years
Ireland	Premium tax relief + Lifetime Community Rating (age-based loading)	+109,000 members (2014–17) but only +0.5pp overall penetration — reshapes age profile more than market size
Singapore	Compulsory MediSave + tax relief on voluntary top-ups	High universal engagement with tax-advantaged personal healthcare funding
South Africa	Flat monthly tax credit per member (not proportional to premium)	Improves equity of incentive across income levels
United States	Full tax exclusion of employer-paid premiums (uncapped)	Anchors employer-based coverage for most of the population, but regressive and inflates plan cost over time
India	Section 80D income tax deduction on premiums	One tool among several targeting a large (70–80%) protection gap
United Kingdom	Premium tax relief for over-60s (withdrawn 1997)	Only ~4,000 people dropped cover on withdrawal — poorly targeted relief has limited effect either way

Read together, these seven cases point to a consistent design principle that this white paper carries into Section 5: the most effective incentives are the ones that specifically change enrolment behaviour at the margin — rewarding people for joining young and staying continuously covered, and imposing a real cost on delaying — rather than simply making existing cover somewhat cheaper for people who would have bought it anyway. Australia and Ireland succeeded because their mechanisms did this; the UK relief did not, and achieved little when removed.

4. The Case for Tax Relief on Health Insurance in New Zealand

The international evidence in Section 3 supports a case for New Zealand that runs across three connected channels of impact, plus the fiscal dimension that ties them together.

4.1 Channel one: a larger risk pool spreads cost and moderates premiums

This is the most direct and mechanically simple effect, and it follows straightforwardly from how insurance pricing works. A health insurance premium reflects the expected claims cost of the pool divided across all the people paying into it, plus insurer costs and margin. When healthy, low-claiming members leave the pool (Section 2.2), the same total claims cost is divided across fewer, higher-risk people, so the average premium must rise. The reverse is equally true and equally direct: the greater the uptake of cover, the more members there are to spread the pool's costs across, and the more the premium per member is moderated — both because the total cost is divided more ways, and because new entrants drawn in by a tax incentive skew toward exactly the younger, healthier profile the pool most needs (as Australia's LHC data and Ireland's LCR data both demonstrate directly — age 30–59 entrants were the specific group each mechanism was designed to attract, and did attract).

New Zealand's own market illustrates the downside of this dynamic already under way: a termination rate that has risen from 7% to 9% in three years, concentrated (by the economic logic of who cancels first) among lower-claiming members, is placing exactly the wrong kind of pressure on the premium base for everyone who remains. A tax incentive that reverses even a modest share of that churn — or, more powerfully, that grows the pool beyond its current 32–38% adult coverage plateau — works directly against the mechanism driving today's premium increases. Every percentage point of additional adult population brought into private cover is tens of thousands of additional premium-payers sharing a cost base that is currently being divided among a shrinking group.

4.2 Channel two: patient volume funds private provider capacity and specialist recruitment

Private hospitals and specialist practices are, like any business, capacity-constrained by the confidence they have in future patient volumes and revenue. A larger, more stable base of insured, fee-paying patients gives private providers the operating cash flow and the confidence to make exactly the kind of long-horizon investments New Zealand's healthcare system needs: new operating theatres and diagnostic equipment, expanded ward capacity, and — critically — the ability to recruit and retain highly qualified specialists, including from overseas, by offering the caseload, remuneration, and career prospects that attract them.

This is not a hypothetical mechanism — it is already visible in New Zealand's workforce data. Private-sector specialist grew 9.6% between 2022 and 2024, more than double the 4% growth rate in the public sector, and New Zealand now has more specialists working privately than publicly in several fields, including dermatology, ophthalmology, oral and maxillofacial surgery, and palliative medicine. That shift is happening on the back of today's constrained private insurance base of roughly one in three adults. A tax incentive that grows that base — and, just as importantly, makes the growth durable and predictable rather than subject to the boom-bust cycle of an adverse-selection-driven market — gives private providers the confidence to plan multi-year specialist recruitment and capital investment, rather than

reacting year to year to premium volatility and membership churn. Sourcing specialists internationally is expensive and competitive; New Zealand competes for the same clinicians as Australia, the UK, and other developed health systems, and a visibly growing, well-funded private patient base is a material factor in that competition.

4.3 Channel three: relieving the public health system

Every patient who is treated through privately funded care is, definitionally, a patient who does not add to public hospital demand or public waiting lists — and New Zealand's public system is currently managing demand it cannot fully meet on its own. Health New Zealand | Te Whatu Ora's own response — actively contracting elective surgery out to private hospitals and extending clinical hours specifically to cut waitlists — is a direct, current, and official acknowledgment that private capacity is not a luxury alternative to the public system but an operational release valve the public system is actively relying on. New Zealand's projected shortfall of roughly 1,800 full-time doctors, and specific gaps of 105 emergency medicine specialists and 57 intensive care physicians relative to Australia, describe a public system that has more demand than capacity across a wide front.

A larger private insurance base, sustained by tax policy rather than left to erode through adverse selection, is one of the few levers available that reduces demand on the public system at the same time as it grows the supply-side capacity (private specialists, private hospital beds) available to absorb patients the public system contracts out to it — a genuine two-sided relief, not merely a cost shift. This is the throughline connecting all three channels: more members (4.1) funds more private capacity and specialists (4.2), which absorbs more demand that would otherwise fall on the public system (4.3), which is exactly the outcome Health New Zealand is already trying to engineer through direct contracting — a tax incentive achieves the same policy goal on an ongoing, structural basis rather than through ad hoc contracts.

4.4 The fiscal case: cost against what alternative?

Any tax relief or subsidy carries a fiscal cost, and this paper does not understate that — Australia's rebate costs approximately A\$6.8 billion a year. But the relevant policy question is never whether an incentive has a cost; it is whether that cost is smaller than the cost of the alternative it displaces. The alternative to a well-insured private sector is not "no cost" — it is the full cost of treating the same patients through the public system, which is New Zealand's highest-cost, most capacity-constrained care pathway, at a time when Health New Zealand is already paying a premium to contract private capacity on an ad hoc basis simply to manage current waitlists. A modest, well-targeted tax incentive that keeps or brings tens of thousands of additional New Zealanders into privately funded care should be evaluated against the marginal cost of the public system treating those same people — including the wider economic cost of extended workforce absence while people wait for treatment — not evaluated in isolation as a stand-alone fiscal cost.

5. Policy Options for New Zealand

This section sets out four complementary policy options, informed directly by the international review in Section 3. They are not mutually exclusive — the strongest package, consistent with Australia’s multi-lever success, combines several of them.

5.1 A fringe benefit tax (FBT) exemption for employer-provided health insurance

New Zealand employers who pay for staff health insurance currently do so as a taxable fringe benefit, which increases the effective cost of providing cover well above the headline premium. The Financial Services Council (FSC) — the industry body representing New Zealand’s insurers and fund managers — has already put this proposal directly to government, calling for an FBT exemption on employer-funded health and life insurance in its manifesto for the 2026 election, citing exactly the medical cost inflation figures set out in Section 2.1. This is, in effect, a live and industry-supported version of the option this white paper recommends, and government does not need to originate the policy design from scratch — only to evaluate and adopt a proposal already on the table.

An FBT exemption operates on the employer channel specifically, which matters because employer-provided cover is typically extended to whole workforces — including younger, healthier employees who might not otherwise purchase cover individually — making it a particularly effective channel for improving risk pool composition (see Section 4.1) rather than only subsidising people who were going to buy cover regardless. It also directly addresses the employer cost pressure documented in Section 2.1 (18% forecast cost growth in 2026), which is already causing employers to scale back group schemes exactly when growth is most needed.

5.2 Individual tax relief or rebate on health insurance premiums

A rebate or deduction against premiums paid by individuals for their own private health cover, modelled on Australia’s income-tested rebate or South Africa’s flat monthly credit. Two design choices matter, drawing directly on the international review:

- Flat credit versus percentage rebate: a flat credit per covered person (as in South Africa) is more equitable across income levels than a percentage rebate (as in Australia, or the uncapped US exclusion), which disproportionately rewards people who can already afford the most comprehensive cover. A flat or capped structure also limits fiscal exposure in a way an open-ended exclusion does not (Section 3.5).
- Targeting new and younger entrants: because the UK experience (Section 3.7) shows that relief given indiscriminately to all existing policyholders has limited effect on behaviour, a rebate structured to matter most for the decision to *join or stay* — rather than simply reducing the cost of cover people already hold — is likely to deliver a materially better return on fiscal cost.

5.3 An age-based loading or community rating mechanism

New Zealand could adopt a mechanism directly modelled on Australia’s Lifetime Health Cover or Ireland’s Lifetime Community Rating: a modest premium loading applied to people who first take out cover later in life, removed after a period of continuous membership. This is the single most targeted tool in the

entire international review for combating adverse selection specifically, because unlike a general subsidy it works by directly changing the economics of *when* someone chooses to join — rewarding early enrolment and continuous membership, and imposing a real cost on waiting until cover is "needed." Given that this mechanism does not itself require government expenditure (it is a market design rule enforced through the insurance and tax system rather than a subsidy), it is a natural complement to options 5.1 and 5.2 rather than an alternative to them, closely mirroring the combined approach that produced Australia's 25-year run of stable coverage.

5.4 A targeted, means-tested option

For government concerned about the fiscal cost or distributional fairness of a universal incentive, a smaller and more targeted alternative is a means-tested credit or rebate available only below a defined income threshold, or a credit weighted toward first-time policyholders and young adults specifically — directly targeting the demographic (see Section 4.1 and 4.2) whose enrolment does the most to improve the risk pool and fund provider growth, while limiting the cost of subsidising people who would already hold cover regardless of any incentive.

Option	Primary channel	Fiscal profile
5.1 FBT exemption (employer)	Grows whole-workforce risk pools; directly offsets employer cost pressure	Forgone FBT revenue; no direct outlay
5.2 Individual premium rebate/credit	Affordability for individually purchased cover	Direct fiscal cost; scalable via cap or means-test
5.3 Age-based loading (LHC/LCR style)	Directly counters adverse selection by rewarding early/continuous enrolment	No direct fiscal cost — a market design rule
5.4 Targeted/means-tested credit	Concentrates impact on young adults and lower-income entrants	Lower and more predictable fiscal cost

6. Addressing the Counterarguments

6.1 "Tax relief for health insurance mainly subsidises people who would buy cover anyway"

This is exactly the flaw the UK experience (Section 3.7) exposes, and it is a legitimate concern for any poorly targeted design. The response is design, not abandonment: as Section 5 sets out, mechanisms that specifically reward new and continuous enrolment (an age-based loading, per Section 5.3) or that target new entrants and younger adults (Section 5.4) are structured precisely to avoid this failure mode, and Australia's and Ireland's data show these mechanisms measurably change enrolment timing and composition rather than simply subsidising existing decisions.

6.2 "It is fiscally regressive — wealthier people are more likely to already hold insurance"

This is a real risk with an uncapped, proportional relief (as the US exclusion, Section 3.5, demonstrates starkly). It is directly addressed by choosing a flat credit rather than a percentage rebate (South Africa's model, Section 3.4), or a means-tested option that concentrates the benefit on lower- and middle-income New Zealanders for whom the incentive is most likely to be the deciding factor in taking out cover at all (Section 5.4).

6.3 "The public health system should be prioritised for public funding, not private insurance subsidies"

This paper's central argument, set out in Section 4.3, is that these are not competing uses of the same funding — a well-designed incentive reduces net demand on the public system by keeping care in the private sector that the public system would otherwise have to fund and deliver itself, at higher marginal cost and with less spare capacity. Health New Zealand's own current strategy of paying private hospitals directly to take on public elective surgery demonstrates that government already accepts this logic operationally; a tax incentive achieves a structurally similar outcome — more patients treated privately — without requiring case-by-case contracting, and without the public sector bearing 100% of the cost of that private capacity.

6.4 "The UK tried something like this, and it didn't achieve much"

This is addressed directly and honestly in Section 3.7 rather than omitted: the UK's experience is genuine evidence that a poorly targeted relief achieves little, and this paper treats it as the strongest available caution on design rather than dismissing it. The specific lesson — that a relief must be structured to change enrolment behaviour at the margin, not simply subsidise existing policyholders — is built directly into the recommendations in Section 7, which favour mechanisms with a clear behavioural lever (the FBT exemption's effect on whole-of-workforce enrolment; the age-based loading's direct effect on enrolment timing) over an undifferentiated blanket relief of the kind the UK withdrew.

7. Recommendations

This white paper recommends that government and the private health insurance and healthcare sector jointly progress the following, sequenced to build the strongest possible evidence base while managing fiscal exposure:

- 7.1** Adopt the FBT exemption for employer-provided health and life insurance, as proposed by the Financial Services Council, as the first and lowest-friction step — it requires no new subsidy mechanism, directly offsets the employer cost pressure already documented in Section 2.1, and grows the risk pool through whole-of-workforce enrolment, which improves pool composition (Section 4.1) at minimal design risk.
- 7.2** Commission a costed design study for an age-based loading mechanism modelled on Australia's Lifetime Health Cover or Ireland's Lifetime Community Rating, given this is the single most targeted and lowest fiscal-cost tool available for directly counteracting adverse selection (Section 5.3), and does not require ongoing government expenditure.
- 7.3** Trial a capped or flat-rate individual tax credit for personal health insurance premiums, targeted at new entrants and/or means-tested, with a sunset and review clause — avoiding the open-ended fiscal exposure of the US model (Section 3.5) and the poor targeting of the UK's withdrawn relief (Section 3.7).
- 7.4** Establish joint government–industry monitoring of coverage rates, termination rates, claims trends, and specialist workforce distribution (building on the data already tracked by the New Zealand Health Survey, insurers, and ASMS) so that the impact of any incentive introduced can be measured against Australia's and Ireland's benchmarks and adjusted accordingly — a discipline that international evidence suggests has been essential to the durability of successful schemes.
- 7.5** Explicitly link any incentive package to public system relief targets, so that the policy is evaluated — and can be publicly justified — against the same objective Health New Zealand is already pursuing through private-sector contracting: measurable reduction in elective surgery wait times and public system demand.

8. Conclusion

New Zealand's private health insurance market is showing the early, well-documented signs of an adverse selection cycle: accelerating claims costs, double-digit premium increases, and a rising rate of policy cancellation concentrated among exactly the lower-risk members the pool most needs to retain. Left unaddressed, the international evidence reviewed in this paper — most starkly Australia's collapse to 30.3% coverage in 1998 — shows where this trajectory leads, and how expensive and disruptive it is to reverse once a market has actually broken.

New Zealand has the advantage of acting before that point, informed by decades of international experience about what works (targeted, behaviour-changing incentives like Australia's three-lever model and Ireland's Lifetime Community Rating) and what does not (broad, undifferentiated relief of the kind the UK withdrew with little consequence). A tax incentive for health insurance — whether through an employer FBT exemption, individual tax relief, an age-based loading mechanism, or a combination —

offers a rare policy alignment: it can grow and stabilise the private insurance pool, fund the private healthcare sector's capacity and its ability to attract world-class specialists to New Zealand, and directly relieve a public health system that is already, by its own actions, relying on private capacity to meet demand it cannot meet alone. Government and industry have a shared interest in getting this right, and a genuine opportunity to act while the cost of acting is still relatively low.

References and Sources

This white paper draws on the following sources, current as at August 2026. All figures should be verified against primary sources before formal submission, as insurer, government and industry data are updated regularly.

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