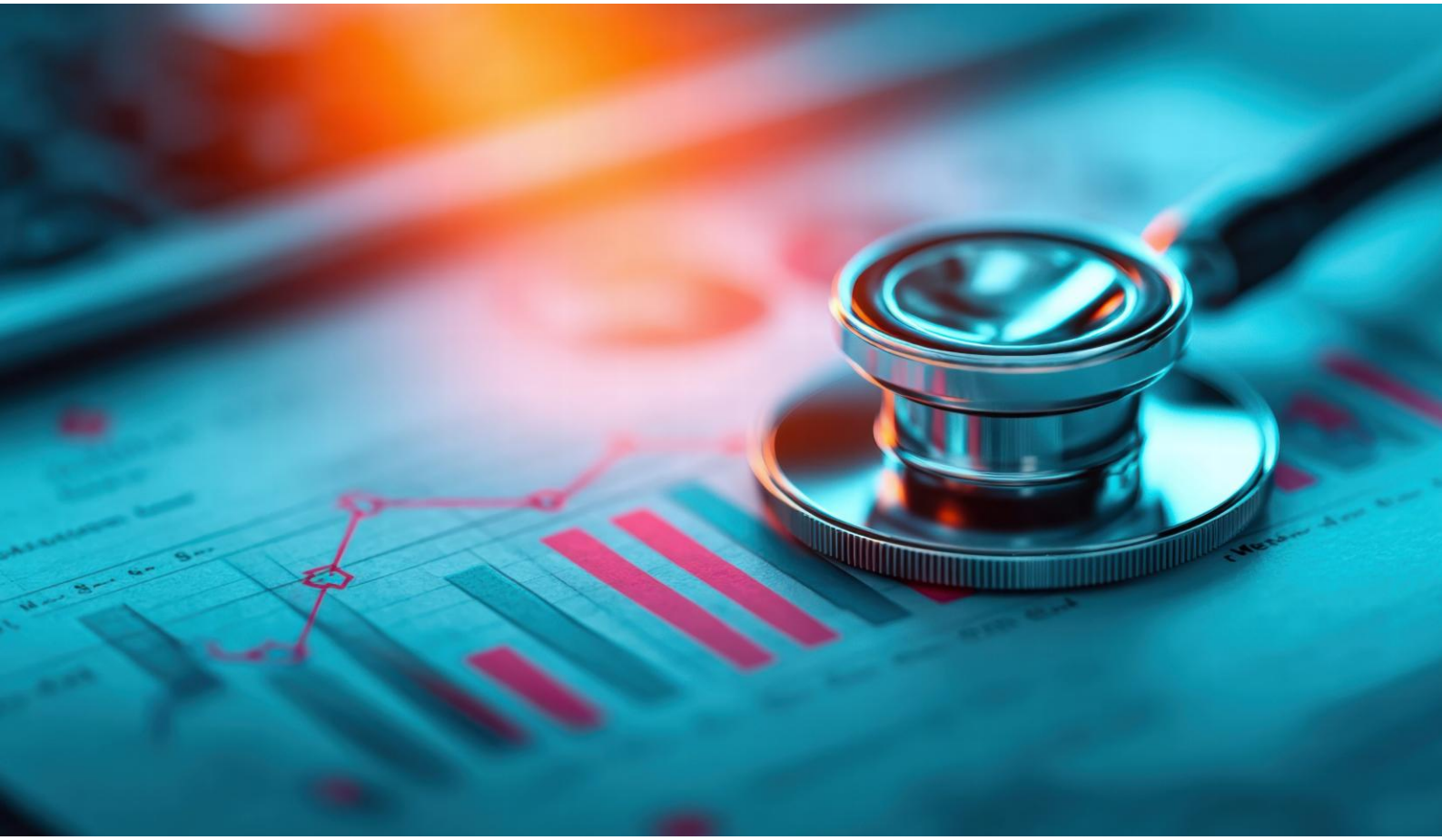
NZIER
NEW ZEALAND INSTITUTE OF ECONOMIC RESEARCH



The economic contribution of clinical trials in New Zealand in 2025

NZIER report to Medicines New Zealand

November 2026

About NZIER

The New Zealand Institute of Economic Research (NZIER) is an independent, not-for-profit economic consultancy that has been informing and encouraging debate on issues affecting Aotearoa New Zealand for more than 65 years.

Our core values of independence and the promotion of better outcomes for all New Zealanders are the driving force behind why we exist and how we work today. We aim to help our clients and members make better business and policy decisions and provide valuable insights and leadership on important public issues affecting our future.

We are unique in that we reinvest our returns into public good research for the betterment of Aotearoa New Zealand.

Our expert team is based in Auckland and Wellington and operates across all sectors of the New Zealand economy. They combine their sector knowledge with robust economic logic, models and data, and an understanding of the linkages between government and business to help our clients tackle complex issues.

Authorship

This paper was prepared at NZIER by Sarah Hogan and Daniel Hamill.

It was quality approved by Jason Shoebridge.

The assistance of Sarah Spring (NZIER), Tanya Baker and Jennifer Lei (Medicines New Zealand) is gratefully acknowledged.

How to cite this document:

NZIER. 2026. The economic contribution of clinical trials in New Zealand in 2025. A report for Medicines New Zealand.

Registered office: Level 13, Public Trust Tower, 22–28 Willeston St Wellington
Auckland office: Level 4, 70 Shortland St, Auckland
Postal address: PO Box 3479, Wellington 6140
Tel 0800 220 090 or +64 4 472 1880 | econ@nzier.org.nz | www.nzier.org.nz

© NZ Institute of Economic Research (Inc). Cover image © Dreamstime.com
NZIER's standard terms of engagement for contract research can be found at www.nzier.org.nz.

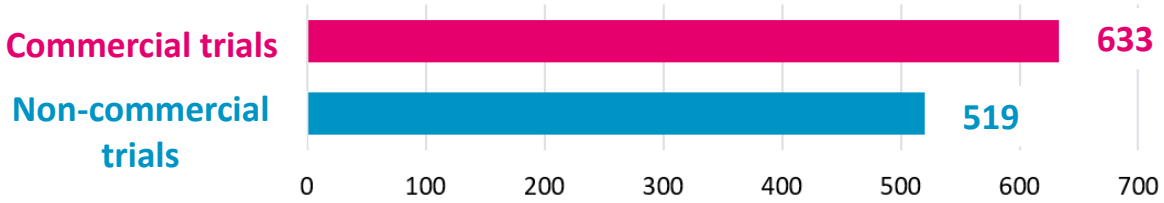
While NZIER will use all reasonable endeavours in undertaking contract research and producing reports to ensure the information is as accurate as practicable, the Institute, its contributors, employees, and Board shall not be liable (whether in contract, tort (including negligence), equity or on any other basis) for any loss or damage sustained by any person relying on such work whatever the cause of such loss or damage.

Clinical Trials in New Zealand: Key Points

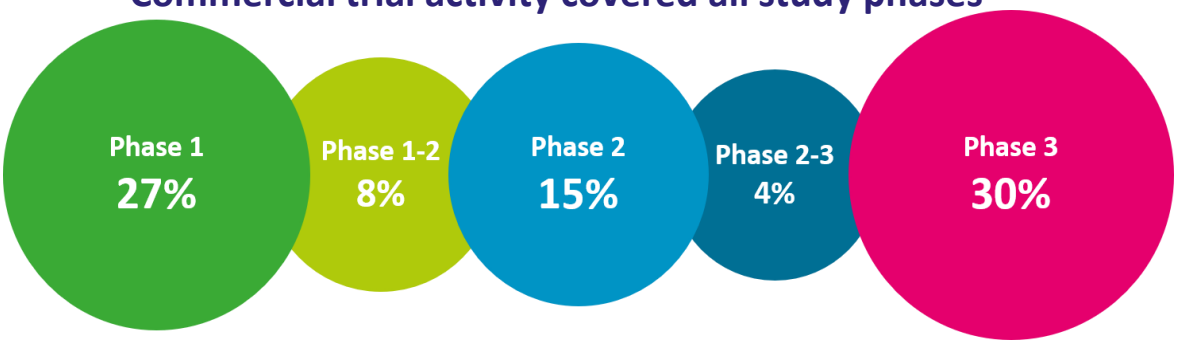
- Clinical trials provide earlier access to innovative treatments and care, attract foreign investment and support economic activity across New Zealand.
- We analysed clinical trials data, conducted a detailed sector survey, and interviewed key players across the sector to estimate of the value of clinical trials to New Zealand and develop a robust understanding of the challenges and opportunities.
- New Zealand hosted 644 commercial and 521 non-commercial trials between 2022 and 2026, with a total of 1,152 trial approvals in the four years 2022 to 2025. An estimated 250 trials were active in 2025.
- Global sponsorship brings substantial foreign investment. 94 percent of commercial trials had a global sponsor (versus only 19 percent of non-commercial trials).
- The sector has important strengths, including an experienced workforce, recognised expertise, high-quality trial delivery and data, and relatively fast approval processes.
- However, New Zealand risks falling behind. The sector is fragmented due to a lack of institutional support for public–private and limited government promotion and investment. Meanwhile, other countries—particularly Australia—are actively improving their incentives, infrastructure and international promotion.
- Medicines funding settings weaken New Zealand's attractiveness by increasingly requiring sponsors to fund medicines in both trial arms and extend compassionate access due to lack of funding for standard of care medicines and poor market access.
- Clinical trials have important economic impacts: They generated $556.6 million in domestic expenditure in 2025, with $318.2 million spent on supplying industries, $197.1 million paid in sector wages, $41.3 million paid to trial participants.
- The sector directly employs around 1,500 highly skilled New Zealanders. Commercial trials employ nearly 1,100 and non-commercial trials employ over 400.
- As a result, clinical trials contributed $763 million to GDP in 2025. Commercial trials accounted for $438.4 million of this (57.5 percent). Beyond the 1,500 jobs in the clinical trials sector, economic activity associated with clinical trials supported an additional 3,500 jobs across other industries.
- NZIER recommends that government: explicitly recognise clinical trials as a source of foreign investment employment and economic activity, and support them through improved R&D incentives and active international promotion; establish a national clinical-trials coordination function to strengthen public-private collaboration; ensure regulatory and ethics approval functions are adequately funded to maintain fast, consistent and efficient processes; and address the poor market access challenge for medicines to continue attracting this important source of clinical trial activity.

New Zealand's clinical trials activity by the numbers 2022—2025

1,152 clinical trials approved



Commercial trial activity covered all study phases



In 2025 alone, there were an estimated 250 active clinical trials

138 Commercial trials

250 Clinical trials active 2025

112 Non-commercial trials

… driving $556.6m worth of domestic expenditure

$318.2m went to domestic supplying sectors

$238.4m went to communities

$118m chemical and pharmaceutical products

$55m hospitals and healthcare services

$46m specialised transport and logistics services

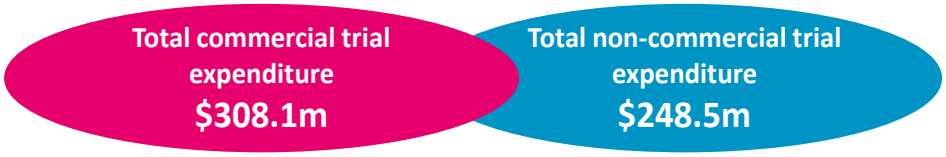
$41.3m paid to trial participants

$197.1m paid in wages to employees working in the clinical trials sector

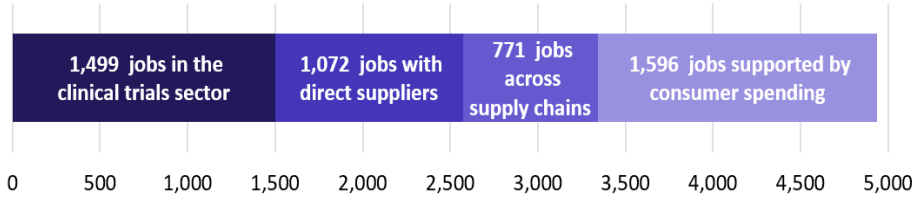
NZIER 2026

New Zealand's clinical trials sector value in 2025

Commercial trials contributed 55% of $556.6 million in domestic expenditure



Clinical trials supported nearly 5,000 jobs for New Zealanders



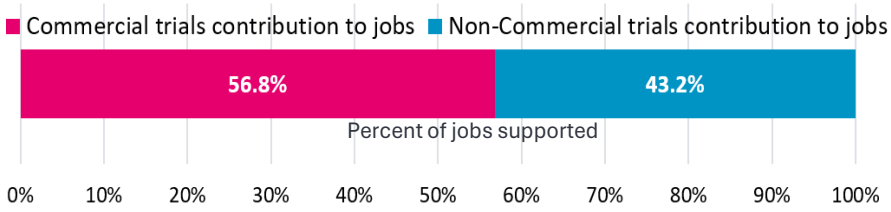
Including nearly 1,500 in the clinical trials sector



Clinical trials delivered over $50 million worth of health care through outpatient care alone



57% of jobs supported were due to commercial trials

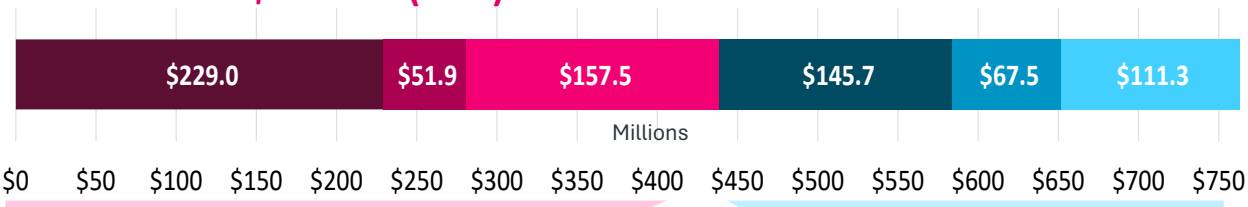


…and provided access to innovative medicines and vaccines that improve health outcomes and reduce system pressure



Clinical trials contributed $763m to GDP in 2025

$438.4m (57%) was from commercial trials



Commercial trial impacts
- Direct (in sector and direct suppliers)
- Indirect (wider supply chain)
- Induced (consumer spending)



Non-commercial trial effects
- Direct (in sector and direct suppliers)
- Indirect (wider supply chain)
- Induced (consumer spending)

NZIER 2026

Executive Summary

Clinical trials provide important health and economic benefits

Clinical trials support health care innovation, deliver direct health benefits to patients, and support economic activity within the sector and across the economy. For example, clinical trials were estimated to contribute €35.7 billion to the European Economic Area in 2025, and an Australian report estimated that clinical trials contributed approximately AU$1.6 billion to the Australian economy through direct expenditure or investment in 2022. Importantly, clinical trials, particularly commercial trials, have global sponsorship, which translates to direct foreign investment.

Previous New Zealand-specific insights have been limited, and the sector has seen significant change

A previous NZIER report identified $146 million in annual value driven by clinical trial activity between 2013 and 2018. However, this figure was recognised as an underestimate because of significant data limitations. Additionally, over the last few years the sector has experienced growth, a COVID bubble in which New Zealand attracted a higher-than-usual share of global trial activity, and significant sector restructuring including the amalgamation of the District Health Boards into Health New Zealand | Te Whatu Ora and major mergers and acquisitions that resulted in significant consolidation of commercial site businesses. All these factors indicate a need for a refreshed understanding of the sector.

This report fills an important gap using new data and insights

The research described in this report is based on publicly available data on trial activity in New Zealand, supplemented by an extensive clinical trials sector survey and interviews with a range of sector stakeholders, including businesses that provide supporting services to the sector. The survey respondents included sponsors, contract research organisations, non-commercial research organisations, sites and site networks, independent contractors, and Health New Zealand | Te Whatu Ora. The survey collected detailed confidential data on staffing, wage costs, trial-related financial flows, and expenditure on goods and services supplied by other industries. This enabled us to estimate employment and value added (contribution to GDP) resulting from commercial and non-commercial clinical trials in 2025 with minimal assumptions.

New Zealand attracts significant trial activity and foreign direct investment

Over the last four years, New Zealand has attracted 644 commercial trials providing health benefits to patients, substantial payments to healthy participants, employment, and economic spillovers to other industries, supporting broader employment and economic activity. In addition, there have been 521 non-commercial trials. Around 94 percent of commercial and 19 percent of non-commercial trials have a global sponsor, generating significant foreign direct investment to support employment and economic activity across a wide range of supplying industries. We estimate 250 clinical trials were active in 2025.

The New Zealand clinical trials sector has significant strengths but also faces risks

Our survey of sector players reveals that the strengths of the sector continue to be the capability to deliver high-quality trials with an experienced workforce, a relatively fast



approval process, and recognised expertise of key players. However, across the sector there are deep concerns that New Zealand is falling behind in the increasingly intense competition for global sponsors due to fragmented government support for the sector and a lack of public-private collaboration.

While New Zealand rates well for trial delivery and data quality, the strategic commercial value of conducting research here is often questioned. The limited medicines funding environment is a barrier to New Zealand's selection for trials, particularly for later-phase studies. Barriers to the R&D tax credit further exacerbate this.

Additionally, survey responses highlighted the risk that key strengths may not be maintained. In particular, sector players indicated that New Zealand's ability to attract clinical trials depends heavily on its fast and efficient approval processes, but maintaining this requires government recognition of the importance of speed and consistency and adequate funding to support this.

Increasing global competition for trials means relative attractiveness matters

Sector survey respondents and interviewees expressed significant concern that many other countries' governments have recognised the high value of clinical trials and global sponsorship and are actively supporting these activities.

Governments play a key role through tax incentives (often recognising clinical trials as core R&D investment) and through direct involvement in promoting their clinical trials sector to global sponsors, by increasing knowledge of the skills, systems, and capacity available, as well as building confidence in the regulatory and tax environment. Survey respondents emphasised that the credibility governments bring to the sector is key to maximising overseas investment.

> *"The Australian government really gets out there and promotes their clinical trials sector overseas. Our government doesn't do anything. We're on our own trying to attract this investment."*
>
> Sector survey participant

New Zealand is being outplayed by Australia, which has lifted its game

The Australian Government was noted in numerous comments for funding sector promotion through global trade missions under the Austrade Australian Clinical Trials Initiative (ACTI), as well as for building sector infrastructure and capacity. Australia explicitly recognises clinical trials as core R&D investment and offers a more generous tax credit designed for major trial sponsors. Government-supported incentives and promotion of the clinical trials sector are particularly important for small countries that may not be well-recognised internationally or compete for large-scale trials.

Clinical trial activity in 2025 generated $556.6 million in domestic expenditure

The value of clinical trials to the economy is a function of the associated domestic expenditure. Based on the detailed data from our sector survey, we estimate that in 2025:

- Total domestic expenditure associated with clinical trials amounted to $556.6 million.
- Commercial trials contributed $308.1 million to total trial expenditure.
- Wages paid to employees accounted for around $197.1 million of this expenditure.
- Participants in clinical trials benefited from over $41.3 million in payments.

- Supplying industries received a total of $318.2 million, including chemical and pharmaceutical products ($118 million), hospitals and other health services ($55 million), and transport, warehousing and logistics ($46 million).

Table 1 Clinical trials sector expenditure

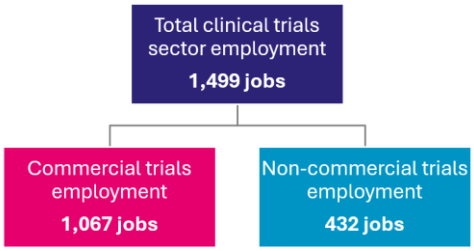
$ millions

Category of expenditure	Commercial trials	Non-commercial trials	All trials
Expenditure on supplying sectors	$138.3	$179.9	$318.2
Wages paid to sector employees	$140.3	$56.8	$197.1
Payments to trial participants	$29.4	$11.9	$41.3
Total	$308.1	$248.5	$556.6

Source: NZIER

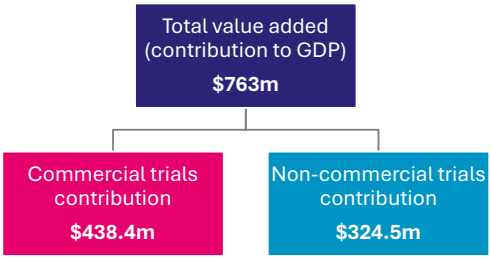
Clinical trials employ around 1,500 highly skilled New Zealanders

As a sector, clinical trials create substantial employment benefits. Commercial trials support nearly 1,100 jobs while non-commercial trials support over 400 jobs. With an average salary of over $120,000, the sector's employment value is substantial.



Clinical trials contributed $763 million to GDP in 2025 and nearly 5,000 jobs

As a result of clinical trial expenditure and employment, we estimate that clinical trials contributed approximately $763 million to New Zealand's GDP in 2025, with $438.4 million or 57.5 percent of this being associated with commercial trials.



Expenditure on supplying industries, wages paid to employees, and payments to participants support broader economic activity, including employment for New Zealanders both within and outside the sector. We estimate that clinical trial activity supported nearly 5,000 jobs in 2025, of which nearly 3,500 were in other industries.

Beyond economic benefits, patients receive over $50 million worth of health care

Survey data from respondents on the health care provided to patients participating in clinical trials provided insight into the health care received through participation in trials. While data on inpatient care were not detailed enough to value, the value of outpatient

visits and medicines alone amounted to approximately $50.6 million in 2025. In many instances, the investigational medicines and vaccines used by trial participants will have been specifically imported for clinical trial use and therefore do not contribute to GDP, except where the services of compounding pharmacies are used (the latter is captured in trial expenditure estimates).

Patients also derive additional benefit from receiving this health care – increased survival and quality of life as a result of having access to more modern treatment and high-quality care, which continues to be a significant driver of participation in trials.

Trial access benefits cannot be treated as a substitute for health system provision

Although New Zealand patients undoubtedly receive significant healthcare benefits from participation in research, the clinical trials sector should be seen as complementary to, rather than substituting for, health system provision. Approximately one third of trials conducted in New Zealand are early phase studies (phase 1 or phase 1-2), which are generally focused on the safety and pharmacokinetics of the investigational drug. Participants in early phase studies are commonly healthy volunteers rather than patients. Later phase studies do provide greater assurance of potential therapeutic benefits for enrolled patients, however the global market for later phase studies is highly competitive and sponsors have multiple considerations to weigh in determining study placement.

Post-trial market access challenges heighten the need for sponsor-funded compassionate access in New Zealand. Increasingly, sponsors must also fund medicines in both arms of trials because standard of care medicines required by trial protocols are not funded in New Zealand. In addition to increasing the cost of running a trial in New Zealand, the constrained New Zealand pharmaceutical funding environment contrasts poorly with countries where a company's clinical trial footprint can be viewed as a step on the strategic pathway to commercial launch. Gaps in New Zealand's public funding of medicines considered standard of care in comparable countries, particularly for later-line cancer treatments, may also mean that New Zealand patients are not eligible to be enrolled in some trial protocols because our patient population doesn't meet the study eligibility criteria.

Although New Zealand has a strong reputation for conducting high-quality clinical research, it is struggling to be seen as a credible destination for later-phase trials for ethical, clinical, and commercial reasons. This is due to a small population, a challenging environment for public funding of innovative medicines, and the rising financial costs and reputational risks associated with post-trial access to medicines.

NZIER recommends

Despite the concerns and risks facing the sector, sector players see the existing strengths of New Zealand's clinical trials sector as having the potential to support significant improvement with further investment. National coordination and collaboration are key to maximising the benefits of clinical trials for patients, the health sector, and the economy. Without them, there is a genuine risk that New Zealand will lose out on this significant source of foreign direct investment and the economic value it creates. Therefore, NZIER recommends that the government:

- Recognises clinical trials as a source of significant economic activity, foreign direct investment, employment, and health benefits to patients, and commits to supporting them through an enhanced R&D incentive and active promotion of the sector overseas.

- Establishes a national clinical trials collaboration and coordination function to ensure that opportunities to collaborate with private sponsors, contract research organisations (CROs) and trial sites/site networks are maximised.
- Assesses the funding of regulatory and ethics approval functions and ensures adequate funding to support consistent, efficient and fast processes continue.
- Establishes an inter-agency working group to develop solutions to the post-trial market-access challenge that limits New Zealand's attractiveness for clinical trials.

Contents

1 Clinical trials background and context 1
1.1 What are clinical trials? 1
1.2 Economic value of trials 2
1.3 Clinical trials provide a broad range of benefits 2
1.4 The clinical trials ecosystem 3
1.5 Increasing competition for clinical trials 4
1.6 Comparison of the Australian and New Zealand R&D tax incentives 5

2 Clinical trials in New Zealand 7
2.1 The New Zealand Health Research Strategy 7
2.2 Previous reports describe the opportunities and the challenges in the clinical trials sector 7
2.3 The sector has been through significant change since COVID 9
2.4 A smooth transition is critical 10
2.5 New Zealand clinical trials sector players 11
2.6 Flows of investment and expenditure associated with commercial clinical trials 17

3 Clinical trial activity in New Zealand 2022–2025 19
3.1 Data sources and methods 19
3.2 Results 19
3.3 Non-commercial trials 20
3.4 Commercial trials 22
3.5 Trends in clinical trials since 2022 30
3.6 Trial stage sequence analysis 34

4 Employment in the clinical trials sector 2025 37
4.1 Data sources and methods 37
4.2 Results 37

5 Economic contribution of clinical trials in 2025 39
5.1 Data sources and methods 39
5.2 Estimated expenditure on supplying industries 41
5.3 Estimated employment, wages and salaries, and payments to participants 41
5.4 Estimated economic contribution 42
5.5 Value of employment supported by clinical trials 44
5.6 Value of health care delivered 44

6 Sector insights on the current and future state of clinical trials 46
6.1 What has been, and still is, working well 46
6.2 Challenges in the sector and barriers to growth 47
6.3 Opportunities to do more or better in the current context 49

7 Sector spotlights 52
7.1 Sites and site networks 52
7.2 Supporting services 59

8 Conclusion and recommendations 74

9 References 77

Appendices

Appendix A Glossary of acronyms, abbreviations and terms 80

Appendix B Data and methods in detail 84

Appendix C Contributing sector organisations 91

Figures

Figure 1 Economic contribution of clinical trials in Europe 2025 2
Figure 2 The clinical trials ecosystem 4
Figure 3 Timeline of events since the publication of the New Zealand Health Research Strategy 2017–2027 11
Figure 4 Roles and responsibilities in a high-performing clinical trials sector 12
Figure 5 Main financial flows behind globally sponsored commercial clinical trials 18
Figure 6 Commercial and non-commercial shares of participants and trials 20
Figure 7 Non-commercial trials by global sponsorship and disease/condition focus 21
Figure 8 Number of commercial clinical trials by sponsor country of origin 22
Figure 9 Number of commercial clinical trials by phase and study type 23
Figure 10 Number of commercial trials by disease/condition focus 23
Figure 11 Number of commercial trial participants by disease/condition focus 24
Figure 12 Percentage of commercial trials and trial participants by phase 25
Figure 13 Number of phase 1 commercial trials, by disease/condition focus 25
Figure 14 Number of Phase 1-2 and Phase 2 commercial trials, by disease/condition focus 26
Figure 15 Number of Phase 2–3 and Phase 3 commercial trials, by disease/condition focus 27
Figure 16 Number of commercial generic or bioequivalence studies 28
Figure 17 Disease/condition focus by trial phase 29
Figure 18 Trial phase shares by disease/condition focus 29
Figure 19 Number of trial participants by disease/condition focus and trial phase 30
Figure 20 Number of commercial trials approved by year of approval 31
Figure 21 Number of commercial trials by phase 31
Figure 22 Number of non-commercial trials approved by year of approval 32
Figure 23 Number of commercial trial participants by year 33
Figure 24 Number of participants in commercial trials by phase 33
Figure 25 Number of participants in non-commercial trials by year 34
Figure 26 Sequences of stages for approved trials 34
Figure 27 Estimated trial stage by trial age 35
Figure 28 Number of people employed in the clinical trials sector 38
Figure 29 Effects of clinical trials expenditure 40
Figure 30 Expenditure on supplying industries by the clinical trials sector 41
Figure 31 Value of employment and participant payments in clinical trials sector 41
Figure 32 Total contribution of clinical trials to GDP 43
Figure 33 Employment effects of clinical trials 44
Figure 34 Total value of trial-related health care 45
Figure 35 Coverage of clinical trial sites in New Zealand 52

Tables

Table 1 Clinical trials sector expenditure viii



Table 2 Estimated number of commercial trials by stage and by year of approval.....36
Table 3 Economic impacts on supplying industries.....42
Table 4 Overall value-added contribution 2025.....43
Table 5 Acronyms and abbreviations.....80
Table 6 Trial phases and study types.....81
Table 7 Technical terms.....82

1 Clinical trials background and context

1.1 What are clinical trials?

Clinical trials are a critical step towards the development of new therapies and technologies. They can also provide a pathway for patients for whom existing treatments have failed, by enabling access to novel therapies that may be years away from being brought to market. However, their primary purpose is to assess the safety and efficacy of new medical therapies, vaccines, diagnostics, devices and other technologies and to provide robust evidence that will inform decisions on further investment and research and thus to eventually inform decisions on regulatory approval or funding.

> ***"The primary purpose of medical research involving human participants is to generate knowledge to understand the causes, development and effects of diseases; improve preventive, diagnostic and therapeutic interventions; and ultimately to advance individual and public health."***
>
> (Paragraph 7, World Medical Association's Declaration of Helsinki (2024))

Developing a new medicine or treatment is a high-risk endeavour. There are multiple stages and development phases that must be completed from basic science and drug discovery through to a marketable product. The risk of failure is present at each stage and phase. The research and development (R&D) process is marked by high failure rates and is time-consuming and costly.

Clinical research is increasingly complex not only in the science under investigation but also in the need for robust evidence to support the successful funding of treatments, and this complexity is consistent with a greater focus on outcomes that benefit patients.

Although international regulators are increasingly looking to real-world evidence and other sources, randomised controlled trials remain the "gold standard" for demonstrating the efficacy and safety of a new medicine.

The clinical research stage is generally the most expensive step because it involves multiple complex components and significant human resource input:

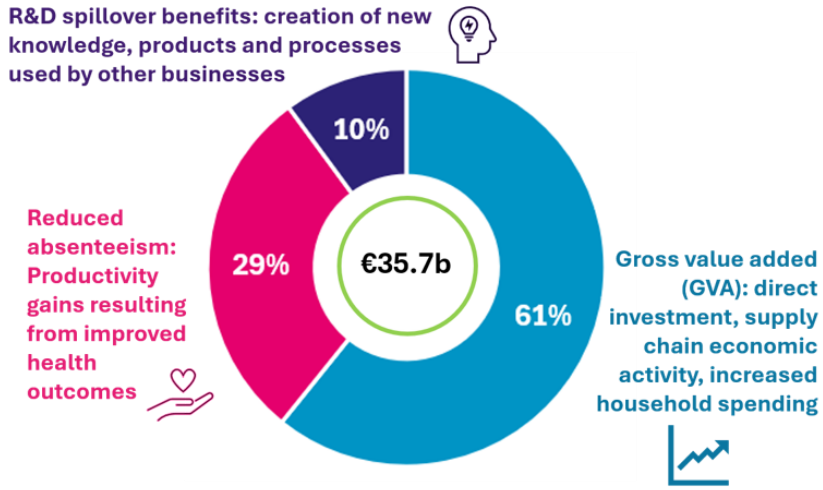
- Manufacturing and distributing investigational drugs.
- Recruiting, monitoring, and retaining human volunteers/patients.
- Intensive data management and regulatory compliance.
- Safety risk that presents legal, financial and reputational risk.

1.2 Economic value of trials

Clinical trials generate immediate and long-term benefits for patients, improve the effectiveness of health care systems, and drive economic activity with significant but often under-recognised value.

Internationally, several important reports have provided insight into the economic contribution of clinical trials, which were estimated to contribute €35.7 billion to the European Economic Area (EEA) in 2025, with 61 percent being gross value added, 29 percent being workforce productivity gains due to improved health, and 10 percent being spillover impacts of R&D to other firms.

Figure 1 Economic contribution of clinical trials in Europe 2025



Source: Frontier Economics (2026)

The report also identified over 165,000 jobs supported by clinical trials in Europe, including 45,000 clinical research jobs and over 120,000 jobs across other industries that result from clinical trial activity.

Additionally, an Australian report estimated clinical trials contributed approximately AU$1.6 billion to the Australian economy through direct expenditure or investment in 2022 (L.E.K. Consulting Australia 2024).

1.3 Clinical trials provide a broad range of benefits

Multiple previously published reports detail the broad range of benefits provided by clinical trials. These include:

- Benefits to trial participants: Trial participants may be patients gaining access to modern treatments that are more effective than the standard care provided in the public health system or healthy volunteers who are financially rewarded for participation. The form of benefits, therefore, can be gains in survival and quality of life, or financial gains to households that flow into communities through consumer spending.
- Benefits to the public health system: Clinical trials reduce the burden on the public health system by providing care and treatments at no cost to the taxpayer, including

often beyond the completion of a trial (through compassionate access programmes); may provide a source of revenue through the use of public hospital facilities and staff, contribute to capability and staff retention by involving staff in cutting-edge clinical care, contributing to the financial resilience of supporting industries like compounding pharmacies, laboratories, and specialist logistics services and helping them achieve scale efficiencies which benefit the public health system.

From a patient and public health system perspective, commercial trials are associated with the most immediate benefits. This is because commercial trials are more likely to study treatments rather than prevention or education interventions (Seidler et al. 2023).

An example of the scale of activity is provided by Aotearoa Clinical Trials (ACTT), New Zealand's largest public hospital-based clinical trial provider. ACTT operates fully integrated research units at Middlemore Hospital and Whangārei Hospital and runs trials across a wide range of therapeutic areas, from oncology, cardiology, and haematology to diabetes, paediatrics, respiratory health, renal care, and surgery. In 2025 ACTT:

- Worked on 77 clinical trials, of which 74 were commercially sponsored
- Conducted clinical trial activity at 26 public hospital departments
- Involved 88 investigators from public hospital departments
- Delivered care amounting to 4,151 outpatient visits, saving the public health system $1.45 million in services avoided
- Paid $409,000 in participant reimbursements to 637 participants.

ACTT provides an important example of how the benefits of clinical trials, including commercial clinical trials, to the public health system can be maximised through strong partnership that leverages the strengths and resources of both the commercial and non-commercial sector (Aotearoa Clinical Trials Te Kohinga Ora 2025).

1.4 The clinical trials ecosystem

The benefits of clinical trials are clear, but they are not simple or easy to generate.

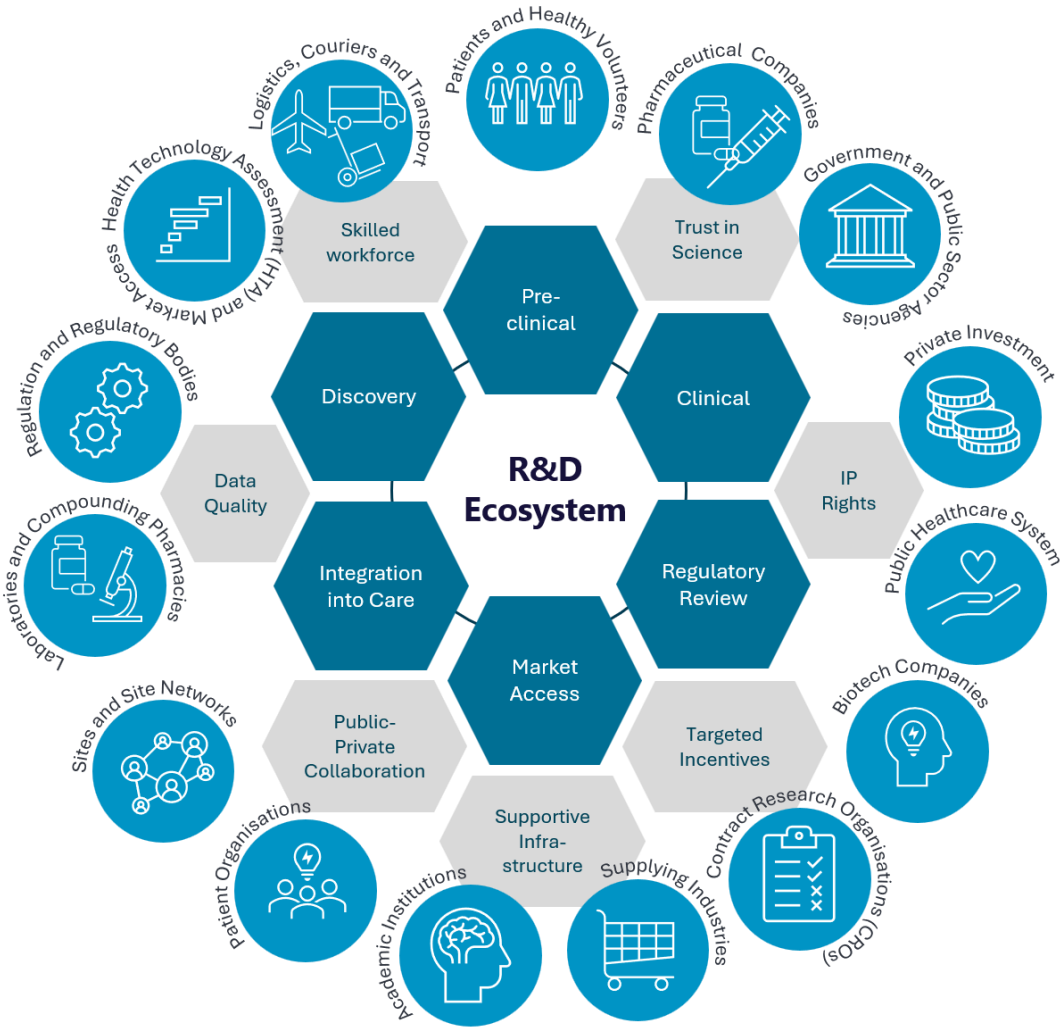
Internationally, the clinical trials ecosystem is complex and multi-layered. Some of the complexity relates to the wide range of stages across which clinical trial activity is relevant – from discovery to integration into care. These determine who and what is needed to support outcomes and value.

Multiple system enablers also help the clinical trials sector attract funding and participants, and conduct trials efficiently, safely and to a high standard of quality. These include intellectual property rights for commercial and non-commercial research and innovation, trust in science (by government, patients, and the general population), a skilled workforce to draw on, targeted incentives to attract investment, supportive infrastructure, quality data, and public-private collaboration to optimise the use of resources across the broader system.

The ecosystem supports a wide range of stakeholders in their respective roles and responsibilities, ensuring that opportunities for clinical trials are maximised, benefits reach patients, businesses, and the health system, and that the sector as a whole drives innovation and economic activity.

These are shown in Figure 2 below.

Figure 2 The clinical trials ecosystem



Source: NZIER based on IFPMA 2026

1.5 Increasing competition for clinical trials

While New Zealand has benefited from a strong track record of clinical trials and a clinical trials ecosystem that has evolved to provide a rich landscape of expertise, the recognised benefits of clinical trials have attracted the attention of many governments globally who are now actively working to increase their share, especially among global commercial sponsors.

Australia has lifted its game and is increasingly favoured over New Zealand

> "*The Albanese Government is investing in once in a generation reforms to improve health and medical research operations*." (Commonwealth of Australia 2025)

The Australian government has committed AU$750 million to boost clinical trial activity from 2022 to 2032. The investment being made by both federal and state governments reflects the recognition of clinical trials as a pillar of economic growth as well as a source of health care access.

In 2023, Australian Health Ministers agreed to the establishment of an Inter-Governmental Policy Reform Group (IGPRG) to provide policy and operational oversight of national health and medical research reforms (Commonwealth of Australia 2023). The IGPRG is responsible for delivering the broader policy programme including:

- A National One Stop Shop (NOSS) to minimise regulatory and administrative barriers to clinical trials and facilitate system navigation by global sponsors, with federal government funding of over AU$34 million. The NOSS will allow sponsors to interact with a single national digital platform that integrates ethics applications, governance approvals, site authorisation, trial registration and participant information. This is expected to deliver efficiencies that translate into accelerated site start-up times.
- The implementation of the National Clinical Trials Governance Framework (NCTGF) to embed clinical trial services into routine hospital accreditation across Australian health services
- A review of the National Standard Operating Procedures for Clinical Trials in Australia (National SOPs)
- Quality standards and an accreditation scheme for Human Research Ethics Committees.

Australia's R&D Tax Incentive, which pre-exists these reforms, is also a significant attraction for some sponsors.

1.6 Comparison of the Australian and New Zealand R&D tax incentives

There are a number of features of the Australian R&D tax incentive that make it more attractive to some trial sponsors than the New Zealand one (RSM 2024).

Higher maximum refundable benefit rather than tax credit

The refundable tax offset in Australia, which equates to 43.5 percent for most companies, nearly triples the base return rate offered by New Zealand's 15 percent tax credit. New Zealand does allow refunds for loss-making companies, but it caps the cash payout based on the amount of payroll taxes (PAYE/FBT) the company paid locally.

On the other hand, Australia has a maximum corporate turnover threshold for eligibility for the 43.5 percent offset (KPMG 2025). This threshold is set at AU$20 million. New Zealand has no maximum turnover limit.

These differences mean the Australian incentive is more attractive to smaller-scale sponsors such as early-stage biotech companies operating without active revenue: The ability to access cash rather than carrying forward tax credits is an important advantage.

Higher certainty

Under Australia's Clinical Trials Determination 2022, Phases 0, 1, 2, and 3 clinical trials notified under the Therapeutic Goods Administration (TGA) schemes are legally recognised as "Core R&D" and are therefore automatically eligible (AusBusiness Register 2026).

While New Zealand's R&D incentive is not based on an explicit definition of clinical trials as "core R&D" activity, expert assessment of the incentive indicates that wording differences in the eligibility rules and their application have allowed "a level of ease in accessibility that rivals not only Australia but any R&D Tax Incentive regime in the world" (RSM 2023).

However, because New Zealand requires clinical trials to establish eligibility on a case-by-case basis, this can create risk and additional administrative burden.

Lower and flexible overseas activity cap

Clinical trials are inherently global endeavours, particularly in small countries, and often require specialised laboratory processing, bioanalytical testing, or data management across borders. Australia permits these out-of-country activities to be subsidised under an approved Advance Overseas Finding, with no cap.

New Zealand enforces a hard 10 percent cap on total overseas R&D expenditure, penalising trials that require international supply chains or global specialised vendors.

Lower minimum spend requirement

Both countries have a minimum level of R&D expenditure within the tax year to be eligible for the incentive. And both countries allow for a waiver in cases where expenditure is lower, but the sponsor is using an approved or registered research provider.

However, where an approved or registered research provider is not being used, smaller trials (often early stage or pre-clinical pilot studies) are less likely to benefit under New Zealand's tax incentive due to the minimum expenditure of NZ$50,000 within the year, compared with the Australian minimum of AU$20,000 per tax year (RSM 2023).

2 Clinical trials in New Zealand

The full spectrum of clinical trial activity takes place in New Zealand, including all phases of the medicines development process (Phase 1 first-in-human trials to Phase 4 post-approval studies), as well as studies of medical devices, natural health products, and other interventions (diet, physiotherapy, etc.). This vast array of research means a complex and diverse ecosystem, as pictured previously in Figure 2, has developed in New Zealand. In this section, we focus on the existing landscape and the major players within the ecosystem.

2.1 The New Zealand Health Research Strategy

The New Zealand Health Research Strategy 2017–2027 clearly places clinical trials within a broader vision of an integrated health research and innovation system.

It clearly acknowledges the contribution of clinical trials to better evidence and health outcomes, workforce capability, health-system performance, equity, innovation and economic value. The strategy identifies embedding research more fully within clinical networks as a means of strengthening New Zealand's clinical research environment, including stronger industry collaboration, efficient and robust regulation, and collaboration across health agencies, researchers, clinicians and consumers.

However, this policy recognition has not been matched by sufficient implementation. Progress towards a nationally coordinated clinical-trials environment, supported by consistent infrastructure, processes, workforce development and equitable access, has remained slow and fragmented.

2.2 Previous reports describe the opportunities and the challenges in the clinical trials sector

Despite clear acknowledgement of the value of clinical trials and the need for system improvements led by government, reports published in the years following the release of the New Zealand Health Research Strategy show continued challenges and a lack of progress on system improvements that would help to protect and grow that value.

2.2.1 Previous NZIER report on the value of clinical trials

The 2020 NZIER report, *The value of clinical research with modern medicines in New Zealand*, commissioned by Medicines New Zealand, examined the economic contribution and wider health-system benefits of clinical trials conducted between 2013 and 2018.

Because the analysis focused only on trials reviewed and recommended for approval by the Standing Committee on Therapeutic Trials (SCOTT) (predominantly Phase 1–3 trials), the estimates were conservative for the sector as a whole. Nevertheless, the report concluded that clinical trials of new medicines made a material economic contribution:

- SCOTT trials directly contributed an average of approximately $146.3 million per year to GDP over 2013–2018 ($171.4 million in 2018).
- The sector directly employed an estimated 753 people in 2018.
- In 2018, the sector purchased approximately $44 million of inputs and supported a further 222 jobs in supplying industries.

The report recommended establishing a clinical trials network that brings together public- and private-sector clinical trial resources to strengthen trial infrastructure and New Zealand's reputation and attractiveness as a clinical trial destination. It also recommended improvements to data and reporting on clinical trials, as well as the regular publication of funding information to inform stakeholders of the benefits and opportunities afforded by non-commercial clinical trial research in New Zealand.

2.2.2 The Enhancing Aotearoa New Zealand Clinical Trials report

In 2019, two years into the period of the New Zealand Health Research Strategy, the Ministry of Health and HRC issued a request for proposals titled 2020 *Enhancing New Zealand's Clinical Trials RFP* (Health Research Council 2019). The stated purpose of the work being commissioned was to facilitate "a sustainable, nationally coordinated and equitable clinical trials enterprise". The research was required to:

- assess the strengths, gaps and needs in clinical trials systems and data infrastructure within the public health system
- review international evidence and best practice
- develop evidence-based recommendations to inform policy for New Zealand's clinical-trials infrastructure.

> "*Investment in clinical trials allows for efficient healthcare and provides health sector returns in excess of the dollars invested*."
>
> University of Auckland et al., 2022

Published five years into the 2017–2027 period relevant to the New Zealand Health Research Strategy, the resulting 2022 report (often referred to as the Liggins report) (University of Auckland et al. 2022) argued that realising the potential of clinical trials research is aligned with the Strategy and the New Zealand Health Research Prioritisation Framework, which was developed to support the implementation of the Strategy (Health Research Council of New Zealand, Ministry of Health, Ministry of Business, Innovation, and Employment 2019). The report identified a key goal of the project as developing "recommendations at a policy and system level to support the HRC and MoH in implementing policy that facilitates and develops a sustainable, nationally coordinated and equitable clinical trials enterprise in Aotearoa New Zealand".

The report argued that there is a strong case for significant investment in a national clinical trials infrastructure in Aotearoa New Zealand and recommended a nationally coordinated clinical trials infrastructure underpinned by Te Tiriti o Waitangi principles, co-governance with Māori, strengthened research leadership, and sustainable investment in workforce and support systems.

2.2.3 The Valuing Life Medicines Access Summits

The Valuing Life Medicines Access Summit, held in 2024 and 2025, is a multi-stakeholder forum focused on improving access to modern medicines and strengthening New Zealand's wider health innovation system. It brings together patient groups and advocates, clinicians, researchers, pharmaceutical and clinical research organisations, government officials, policymakers and academics to examine systemic problems and develop practical recommendations.

Clinical trials were discussed by attendees in both 2024 and 2025. Overall, attendees rated the current health of the clinical trials ecosystem at five out of ten in 2025. When asked to



compare the current ecosystem to the 2018 downturn, 43 percent considered it worse and only 3 percent considered it better. This was despite increased private investment following the COVID-era 'bubble'. With the end of the 10-year period of the New Zealand Health Research Strategy approaching (2027), attendees were increasingly concerned by the lack of progress and revealed strong sector alignment on the needed reforms:

- Attendees highlighted both strengths and weaknesses in the current clinical trials ecosystem and argued that while New Zealand's small population was a challenge, most barriers were amenable to reform. Proposed reforms were designed to address the fragmentation and underfunding of key parts of the ecosystem, which were leading to poor visibility and deterioration of New Zealand's global competitive position: Boosting and streamlining approvals with better resourcing, clear guidance and induction for ethics committee members, hospital-based regulatory and start-up expertise, and consideration of mutual recognition with Australia.
- Increasing workforce investment to improve recognition of critical trial staff and provide clearer career pathways and more secure employment. Succession planning for principal investigators and other research leaders was identified as particularly important because site selection depends heavily on experience.
- Stronger integration of clinical research into health-system planning, with trials embedded within health-system planning, horizon scanning, regulation, service delivery and medicines funding rather than treated as a stand-alone activity or a substitute for routine access to effective treatment.
- A national clinical trials network and capability registry covering public, private and commercial research to provide a single front door, improve coordination and visibility, and make New Zealand easier for sponsors to navigate.
- Public-private co-investment and risk-sharing, national diagnostic and genomic infrastructure, and stronger links between trials and national health priorities, particularly the needs of underserved communities.

Summit attendees emphasised that New Zealand still produces high-quality research, but without coordinated action and sustained investment its position as a competitive trial destination will continue to deteriorate.

2.3 The sector has been through significant change since COVID

When the New Zealand Health Strategy and the previous NZIER report were published, and when the Liggins Report was commissioned, the COVID-19 pandemic was yet to come. This means much of the documented evidence and planning for the sector reflected the pre-COVID landscape. With 2027 imminent, there is now a need for a renewed understanding of New Zealand's clinical trials sector, reflecting the significant changes that have occurred in recent years.

During COVID, New Zealand attracted more than its usual share of global clinical trials activity due to the effectiveness of pandemic restrictions, which permitted activity to go ahead relatively unhindered. In the years that followed, the sector underwent significant restructuring. In addition to the amalgamation of the District Health Boards into Health New Zealand | Te Whatu Ora, major mergers and acquisitions consolidated the commercial trial site companies. These are summarised in the table below.

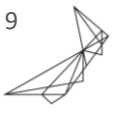


Table 1 Summary of commercial consolidation in New Zealand trial sites

Year	Change
2020	Christchurch Clinical Studies Trust and Auckland Clinical Studies merged to form New Zealand Clinical Research (NZCR)
2021	Lakeland Clinical Trials Group and Southern Clinical Trials Group combined as Pacific Clinical Research Network (PCRN), backed by Pencarrow Private Equity.
2023	NZCR acquired Optimal Clinical Trials, adding later-phase outpatient research to its early-phase base.
2024	NZ's P3 Research combined with Australian operators AusTrials and Holdsworth House to form Momentum Clinical Research.
2025	Momentum and PCRN merged. The combined network said it had more than 10 sites and could run trials from Phase 1 through Phase 4 across Australia and New Zealand.
2025–26	NZCR expanded into Australia through CMAX and Fusion. In August 2026, Advent announced an agreement to take a majority stake in NZCR Group; the transaction was expected to close in Q4 2026, so it was still pending at the time of the announcement.

Source: NZIER based on information from the NZCR and Momentum Clinical Research websites

A further change is planned in the research-funding system: the Government is making changes to how health research is funded and managed to "align funding with Government priorities, streamline processes, reduce duplication, and to make the system easier for researchers to navigate" (Ministry of Health 2025).

Under the new system, health research funding will shift from the Health Research Council (HRC) to Research Funding New Zealand (RFNZ), within a new Health and Society investment area. The Health Research Council will then be disestablished, with its functions shared across Research Funding New Zealand, the Ministry of Business, Innovation and Employment (MBIE), and the Ministry of Health.

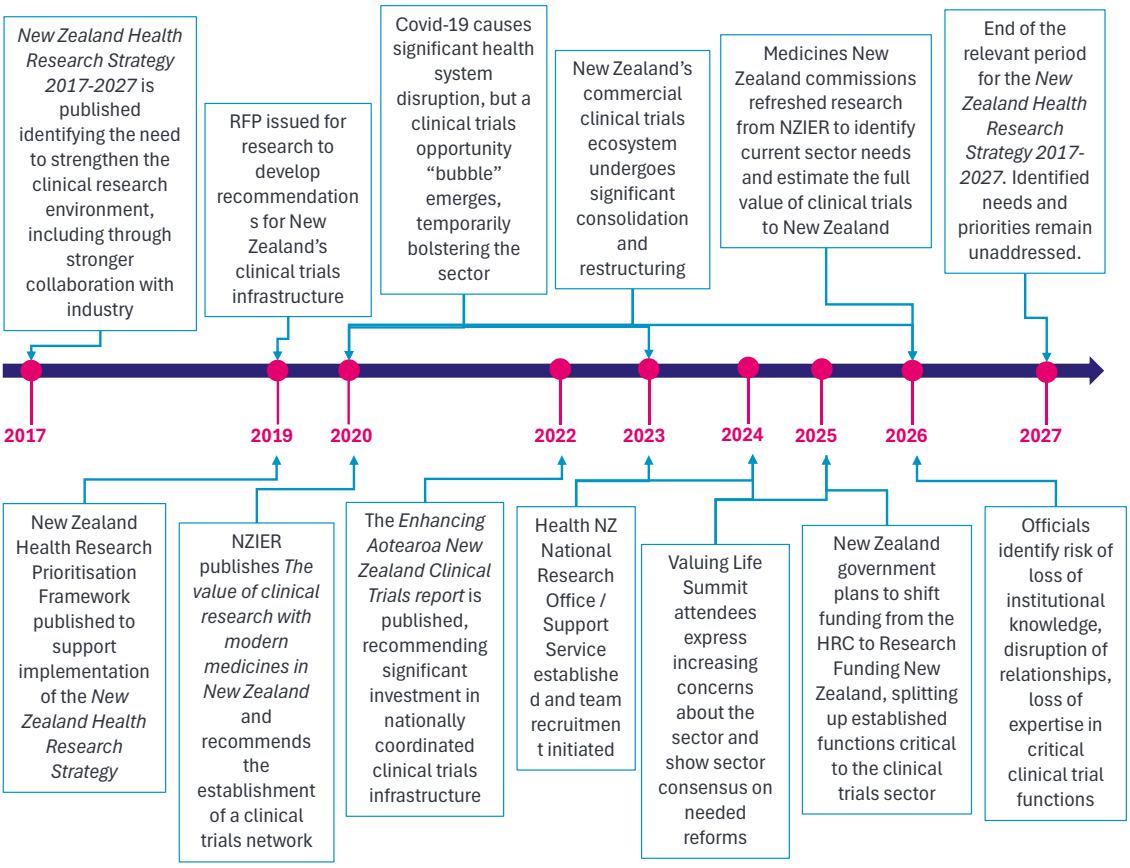
2.4 A smooth transition is critical

The change that will arise with the disestablishment of the HRC creates a material risk for the clinical trials sector, especially during the transition itself. Important functions will be split across several organisations: Health research funding decisions would move to RFNZ; funding administration would involve both RFNZ and MBIE; ethics functions would move to the National Ethics Advisory Committee; and scientific review for clinical-trial applications under the Medicines Act would move to the Ministry of Health and Medsafe. This creates a risk of loss of expertise and unclear responsibilities and processes.

Officials' own assessment identifies risks of losing institutional knowledge, disrupting research relationships, and losing expertise from assessment panels. Health New Zealand also raised the value of independent health-research expertise and the HRC's support for clinical, Māori and Pacific health research (MBIE 2026).

For clinical trials, continuity and certainty are system attributes that are critical to attracting global sponsors: grant decisions, ethics review and scientific review all affect whether research can proceed and how quickly it can begin, so implementation risks are material considerations for the sector.

Figure 3 Timeline of events since the publication of the New Zealand Health Research Strategy 2017–2027



Source: NZIER

2.5 New Zealand clinical trials sector players

Within the New Zealand clinical trials ecosystem, there are six key player groups. Although long established in New Zealand, the ecosystem is unfortunately not optimally connected and operates in piecemeal fashion. This becomes apparent when considering the New Zealand clinical trials sector against the roles and responsibilities shown in Figure 4 below.

Figure 4 Roles and responsibilities in a high-performing clinical trials sector



*New Zealand regulators include Medsafe, Environmental Protection Authority (EPA), National Ethics Advisory Committee (NEAC), Health and Disability Ethics Committees (HDEC).

**Sponsors include pharmaceutical/biotech/medical device companies, research institutes, charities, and universities.

Source: NZIER

2.5.1 Government and public sector agencies

In a high-performing clinical trials sector, government and public sector agencies play key roles in:

- **Funding:** This takes two main forms. First, central government and public-sector funding agencies fund regulatory and ethics functions. Adequate funding for these functions is critical to supporting a fast approval process – one of the key advantages that New Zealand's clinical trials sector has leveraged to attract global sponsors. Second, governments fund research, particularly early-stage research, providing a strong foundation for evidence development and the health research community.
- **Incentives and broader support:** Central government and public-sector funding agencies are uniquely placed to support the attractiveness of New Zealand's clinical trials sector by shaping incentives, such as through R&D tax credits, and supporting the international visibility of and confidence in the sector through a strong presence at international events where countries and suppliers market their capability and capacity to global sponsors.
- **Public-Private partnership:** High-performing clinical trials sectors enable public-private partnerships which may, over time, involve various combinations of public sector and private sector entities. Public-private partnership, and the optimisation of resources and opportunities this enables, requires both public and private sectors to agree on priorities, principles and processes to establish a consistent basis on which the barriers to and costs of collaboration are minimised. Collaboration between public and private entities can support patient recruitment into clinical trials from public health services, improving opportunities for participation by reducing access barriers and supporting more equitable outcomes.

Growing concerns in New Zealand are that the government and public sector agencies are not sufficiently supporting these critical ecosystem enablers, resulting in a piecemeal effect that undermines growth and value.

2.5.2 Regulators

Regulators are a subset of government and public sector agencies, but play a key role that is distinct from government and public sector funding agencies.

- Their responsibility is concerned with ensuring **quality and safety** through the setting of standards and requirements for clinical trials.
- They also support **speed of approvals** by ensuring efficient processes, although funding for adequate resourcing is also required.

New Zealand has a well-established reputation for efficient and robust ethics and regulatory approvals. This reputation has been built on the outcomes of the significant system reforms which ensued from the recommendations of the 2011 Health Select Committee Inquiry into clinical trials (*Inquiry into improving New Zealand's environment to support innovation through clinical trials* (Health Committee, Forty-ninth Parliament 2011)). These reforms, which included restructuring of the Health and Disability Ethics Committees (HDECs) and streamlining of regulatory pathways, were implemented in 2012 (New Zealand Government 2011) and have generally provided a high-level of systemic consistency. Unfortunately, with the currency of that Health Select Committee Inquiry slipping and likely



loss of institutional knowledge within the Ministry of Health, the sector has had to be very vigilant in recent years to ensure that systemic consistency has been maintained.

2.5.3 Patient and sector organisations and networks

Patient organisations play a key role in guiding and influencing research prioritisation, advising on study design, and supporting communication of information to patients who may benefit from participating in trials, enhancing trial participation generally as well as increasing the effectiveness of trial recruitment.

Research-focused clinical networks and groups, often allied to particular medical specialities, such as the Australasian Leukaemia & Lymphoma Group (ALLG) and the Australian and New Zealand Intensive Care Society Clinical Trials Group (ANZICS CTG), similarly play an important role in fostering collaborative research communities. These groups support the local research workforce, often providing practical, educational, and infrastructure support, including research training and mentoring, assistance with grant applications, databases and registries and strengthening partnerships with external research bodies both locally and internationally.

Patient and Sector organisations and networks are also important advocates for the value of clinical trials within the health system and play a significant role in advocating for the inclusion of New Zealand in international research trials.

Australian federal and state government investment has supported the establishment and scaling of dedicated national not-for-profit organisations that perform coordinating, intermediary and enabling functions across the health research, clinical trials and life sciences ecosystem. These include:

- the Australian Clinical Trials Alliance, the national peak body for clinical trials, which supports clinical trial networks, coordinating centres and clinical quality registries (Australian Clinical Trials Alliance 2026a, 2026b).
- AUScelerate, formerly MTPConnect, a life sciences innovation accelerator supporting the translation and commercialisation of biomedical and health technologies (AUScelerate, n.d.; Department of Industry, Science and Resources 2025).
- Omico, which coordinates a nationwide precision-oncology network that facilitates genomic screening, patient-trial matching and the delivery of biomarker-led cancer clinical trials (New South Wales Office for Health and Medical Research 2023; Omico, n.d.).

New Zealand suffers by comparison in terms of public resourcing for sector organisations, with the volunteer-led New Zealand Association of Clinical Research (NZACRes) assuming a broad scope of responsibility for fostering and supporting the wider clinical research ecosystem in New Zealand.

NZACRes' membership is open to all with an interest in clinical research, and membership is held on an individual rather than corporate basis. It is self-funded, with annual membership subscriptions currently set at $130 (including GST). As a non-profit run by volunteer officers from its membership, it provides an important 'neutral space' for cross-sector engagement between researchers and clinical research professionals from the public and private sectors. This enables co-design and collaborative solution generation and advocacy on priority issues for the wider clinical research ecosystem(New Zealand Association of Clinical Research 2026).

2.5.4 Trial sponsors

Trial sponsors may include pharmaceutical, biotechnology, and medical device companies and universities. They may also include non-profit research institutes and charitable organisations. They are responsible for:

- **Funding trials:** Sponsors directly provide the funding that enables clinical trials. They may engage the services of independent contractors and CROs, use commercial sites, and keep an arm's length from trial execution; however, they remain responsible for ensuring the trials are adequately resourced and collect the required data.
- **Commercialisation:** Commercial sponsors also seek to commercialise medicines, devices and other products that have been studied, enabling more effective health care to reach a broader patient population.
- **Knowledge translation:** Both commercial and non-commercial sponsors play key roles in knowledge translation and bridging the gap between research and clinical practice. This includes disseminating research findings, medical education activities, developing tools and guidelines, and collaborative engagements.

Sector feedback from commercial trial sponsors suggests that their experience of operating in New Zealand has been coloured by recurrent instances where engagement with public sector agencies and decision-makers has been lacking. The concern is that the relationship and connections are often transactional (sponsors are seen as payers rather than partners in research endeavours) and they have not been consulted on matters which may have a significant impact on their ability to sponsor research in New Zealand. There is a clear call for more collaborative approaches to be adopted.

2.5.5 Contract Research Organisations, sites, independent contractors and investigators

Contract Research Organisations (CROs), Non-commercial Research Organisations (NCROs), sites, independent contractors, and investigators manage the day-to-day execution of clinical trials.

In addition to their responsibilities for trial execution, these ecosystem players often champion New Zealand's inclusion in multinational studies. The commercial players – the CROs, private sites, and independent contractors – actively market New Zealand capacity and put New Zealand forward through global study feasibility bidding processes. They draw heavily upon both their track records for repeat business and wider business networks for new connections. In the case of investigators, their academic interests and professional clinical connections are often the entry point to trial participation.

New Zealand is currently fortunate to have a number of internationally renowned Key Opinion Leaders (KOLs) whose personal research reputations act as drawcards for sponsors. However, this strength will be lost as these experts retire.

CROs and NCROs are service providers with expertise in the design, planning, and management of clinical trials. Sponsors contract them to do this work, which often includes managing contracts with sites, investigators, and independent contractors. CROs operating in the New Zealand context may be affiliates of global CROs or smaller New Zealand-based services. Examples of global CROs with local offices and staff in New Zealand include Harvest Integrated Research Organization (HiRO), IQVIA and PPD Clinical Research Group – Part of ThermoFisher Scientific.



NCROs are non-profit entities that conduct research and provide trial-support and management services without a profit motive. They are often housed within universities, public health agencies, hospital networks, or independent non-profit research institutes and, unlike commercial CROs that primarily serve pharmaceutical, biotech, and medical device companies, NCROs frequently support academic investigators, public health research, and may have a research focus on specific disease areas (for example, cancers, rare disorders, intensive care research, and respiratory health). They rely heavily on public grants, charitable foundations, or academic endowments rather than corporate investor capital but may also undertake commercially sponsored studies. New Zealand examples include Aotearoa Clinical Trials, the Medical Research Institute of New Zealand, and the Malaghan Institute of Medical Research.

Once their services are commissioned by a sponsor, CROs and NCROs in New Zealand typically manage the full lifecycle of a clinical trial, completely overseeing the trial from end to end. They may help design the trial protocol, set recruitment targets, and conduct geographic feasibility assessments to identify the best-suited sites. CROs may leverage global and local networks to identify qualified clinics, train site staff, and set up contracts. They also design and manage patient recruitment strategies, coordinate patient recruitment with local doctors, and use advanced participant databases to find eligible volunteers and keep them engaged.

Trial sites

Trial sites provide the physical infrastructure and staffing to host trials. They can be part of the public sector, such as hospitals and outpatient clinics, or be primary care practices, or dedicated facilities run by private for-profit and not-for-profit organisations. Trials take place at multiple sites across New Zealand and at all levels of the public health system from primary care to intensive care as well as in private purpose-built research facilities. Many sites are part of extensive site networks allowing greater reach of trials to communities and enhancing participation opportunities.

Investigators

Investigators are qualified professionals – typically medically trained or other health professionals – who are responsible for leading and overseeing the research study at a specific site. They may be academics based at universities, clinicians working in the health sector, or research personnel employed by dedicated research units or sites. Research specialist medical roles are rare in the New Zealand public health system, and those roles that do exist are likely part-time. Instead, many medical practitioners who are investigators are participating in research as an “add on” to their public hospital clinical work (and teaching responsibilities if they have a joint academic appointment). For example, recent data from the annual Critical Care Resources Survey run by the ANZICS Centre for Outcome and Resource Evaluation (ANZICS CORE) (ANZICS 2026) shows that despite the significant contribution made by New Zealand intensive care units (ICUs) to internationally impactful critical care research, the health system funding available for research-specific lead clinician roles in New Zealand is very limited. Nine of the 10 units participating in the survey reported that they had FTE funding of between 0.0 and 0.2 for such roles.

As private site capacity has increased in New Zealand, opportunities have grown for medical practitioners seeking either research-focused employment or the chance to undertake funded research alongside their usual employment. Enhanced collaboration between public hospitals and private sector sites would increase opportunities for clinicians



interested in research and may offer financial benefits to both parties in the collaboration whilst offering opportunities for professional development and increased career satisfaction.

In both the public health system and private sites, investigators generally work in teams supported by other health and research professionals, including study nurses, clinical trial coordinators, and data managers. As with funded roles for medical practitioners, public health system funding for these critical research roles is scarce in New Zealand public hospitals; however, external funding, including grants, commercial trials, charitable donations, and University funding, plays a significant role in ensuring research is happening in our public health system. For example, survey data from the ANZICS-CORE indicates that there may typically be 0.5–0.6 hospital-funded FTE for ICU Research Coordinator Roles compared with 0.85–-3.03 independently funded ICU Research Coordinator FTE. Without these supporting professionals, research becomes largely infeasible.

The ecosystem crossover between commercial and non-commercial research is an important factor for research sustainability in New Zealand. The opportunities for doctors, nurses and other research professionals to engage with the broader spectrum of research are important for both career progression and security of employment. These are factors that appear to have been inadequately considered to date.

2.5.6 Supplying sectors and services

Supplying sectors and services are also critical to clinical trials, providing core services like laboratory, pharmacy and specialised logistics, as well as pharmaceutical and medical supplies. More general goods and services, such as cleaning, catering, insurance, IT services, transport, and others, also provide the necessary inputs to clinical trials. Purchases of goods and services to support clinical trials can involve both overseas and domestic suppliers, with sponsors, CROs and trial sites engaged in transactions to procure essential goods and services from a broad range of suppliers. Where these purchases involve domestic suppliers, there are direct economic impacts through the economic activity stimulated by this expenditure, indirect impacts across the supply chains that direct suppliers purchase from, and induced impacts via the consumer spending resulting from jobs that are supported within direct and indirect suppliers.

2.6 Flows of investment and expenditure associated with commercial clinical trials

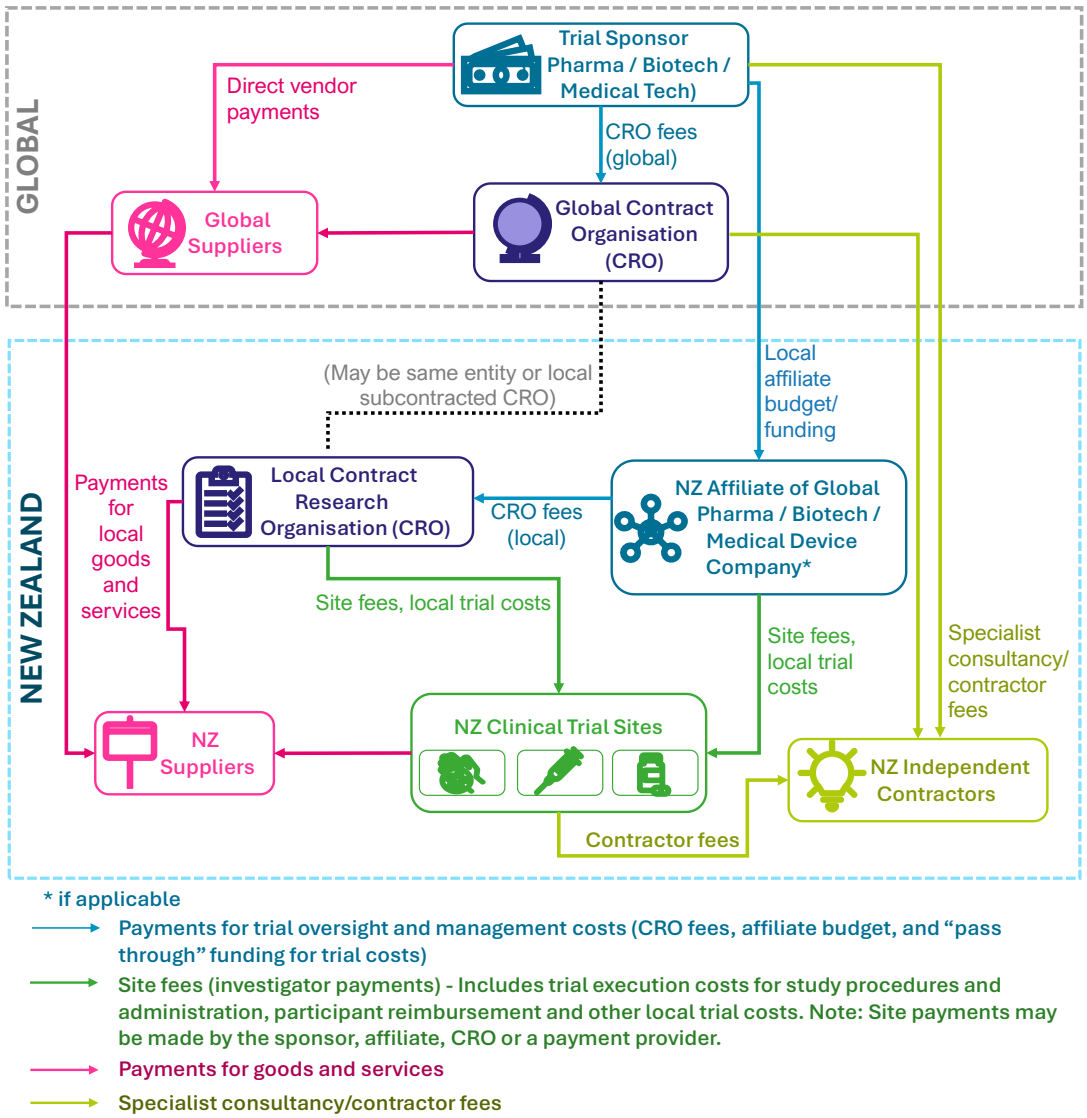
Unlike non-commercial clinical trials which generally represent domestic investment, commercial trials attract overseas investment. Trial sponsors are typically global pharmaceutical, biotechnology or medical technology firms which may or may not have a small-scale affiliate in New Zealand.

Due to the relatively small footprint of global sponsors in New Zealand, and also to the heavy data requirements of commercial trials, sponsors typically engage the services of CROs and independent contractors to manage clinical trials in New Zealand. Some New Zealand-based CROs are global or may be subcontracted to global CROs to undertake this work. Sponsor funding can flow entirely through the CRO, with funds to be passed through to sites to cover site fees and other costs incurred by sites, or sponsors may pay sites directly. Another flow of funds is from the sponsor, directly or via a global or local CRO, to

suppliers of goods, services and technology to be delivered to trial sites to support the execution of the trial.

These flows are described in Figure 5 below.

Figure 5 Main financial flows behind globally sponsored commercial clinical trials



* if applicable

- Payments for trial oversight and management costs (CRO fees, affiliate budget, and "pass through" funding for trial costs)
- Site fees (investigator payments) - Includes trial execution costs for study procedures and administration, participant reimbursement and other local trial costs. Note: Site payments may be made by the sponsor, affiliate, CRO or a payment provider.
- Payments for goods and services
- Specialist consultancy/contractor fees

Note: Illustrative model only. Financial flows vary by sponsor, CRO model and trial.

Source: NZIER

3 Clinical trial activity in New Zealand 2022–2025

3.1 Data sources and methods

This section presents a summary of the data sources used to describe clinical trial activity in New Zealand. A detailed description is provided in Appendix B.

Medicines New Zealand requested data extracts from the HDEC to support this project. Two datasets were provided that encompass the period 2022-2025, one describing non-commercial trials and one describing commercial trials:

- The non-commercial trials dataset described all non-commercial trials with "Review Date Received" from 21 January 2022 to 21 December 2025, and "Date of Final Status Decision" from 17 February 2022 to 20 January 2026 – approximately four years of clinical trials approved applications.
- The commercial trials dataset described all commercial trials with "Date Received" from 7 January 2022 to 24 December 2025, and "Date of Final Decision" from 11 February 2022 to 11 February 2026 – four years of clinical trials approved applications.

Medicines New Zealand supplemented the datasets with additional fields developed by analysing the formal title of the study, and protocol number and public registry reference identifiers (when available), and cross-referencing with other trial datasets.

Data limitations

While the data provides a rich picture of clinical trial activity in New Zealand, it has two important limitations:

- Because the HDEC dataset captures the status of trials as of the most recent status update, it does not allow for an accurate identification of trials' progression from approval to completion along a timeline.
- The non-commercial data does not identify the phase of most non-commercial trials.

3.2 Results

Clinical trial activity in New Zealand can be grouped according to the type of organisation or company sponsoring the trial –non-commercial or commercial sponsors.

Over the four years from 2022 to 2026, there were:

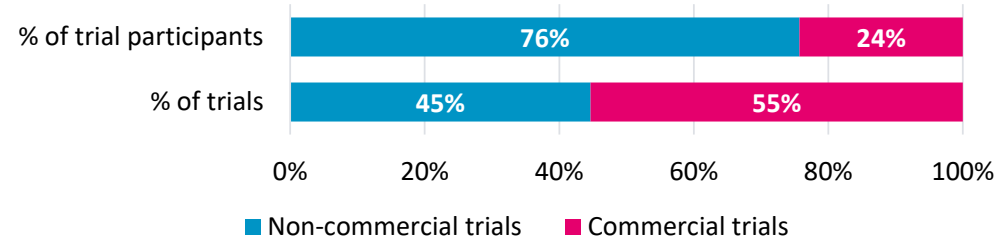
- 521 non-commercial trials, representing 45 percent of trials
- 644 commercial trials, representing 55 percent of trials
- 84,372 participants in non-commercial trials, representing 76 percent of all trial participants
- 27,060 participants in commercial trials, representing 24 percent of all trial participants

Therefore, while commercial trials dominate in number, non-commercial trials dominate in participants.



Figure 6 Commercial and non-commercial shares of participants and trials

2022-2025



Source: NZIER based on HDEC data

These differences mean that the average number of participants per trial is significantly higher for non-commercial trials (162) than for commercial trials (42). Overall, the average number of participants per trial is 95. The reason for the significantly higher number of participants in non-commercial trials cannot be determined from the HDEC data, as the rate of unspecified trial phase information is higher for non-commercial trials (81 percent versus 14 percent for commercial trials), leaving only 44 percent of all trials having a phase recorded in HDEC data.

However, it is well known that later phase trials have significantly larger numbers of participants on average and are more likely to attract non-commercial funding (such as from governments, universities, and charities). Additionally, larger commercial trials tend to be global multi-site trials, so New Zealand participants make up a small percentage of the total participants across all sites.

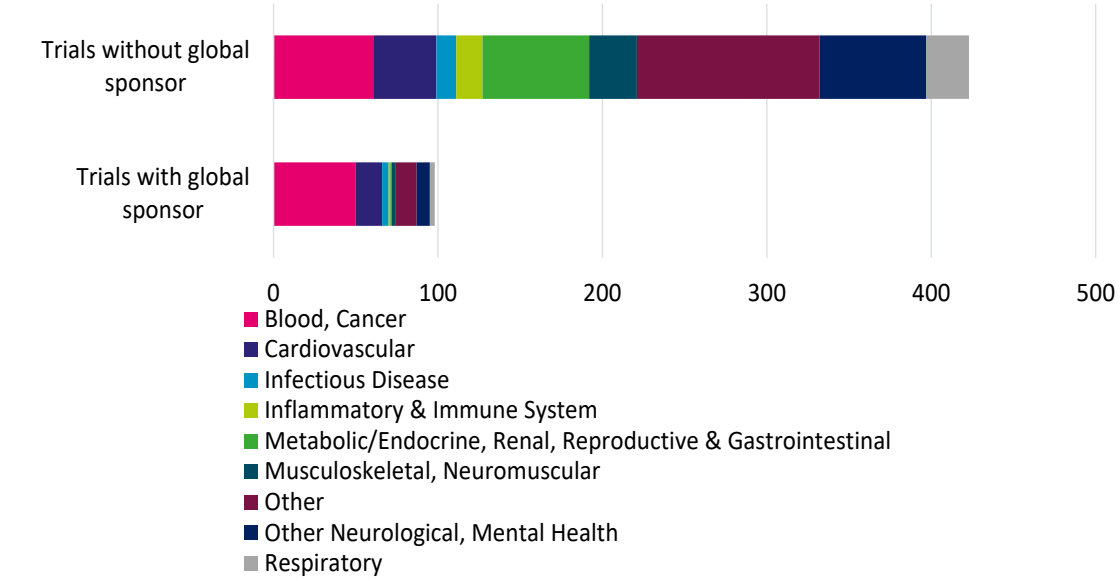
The HDEC non-commercial data contain national screening, diagnostic, service delivery, pragmatic and cluster-randomised studies. These types of trials recruit hundreds or thousands of New Zealand participants. For example, a hepatitis C testing study involved 15,300 participants and several of these types of studies enrolled 2,000–3,000 participants. A few of these very significant trials can skew the average trial size.

3.3 Non-commercial trials

Non-commercial trials covered a wide range of health conditions, including a high representation of blood and cancer, metabolic/endocrine, renal, reproductive and gastrointestinal, neurological and mental health, cardiovascular, and other conditions. While only around 19 percent of non-commercial trials have a global sponsor, more than half of these focused on blood and cancer (50 out of a total of 98 trials), a significantly higher representation than amongst trials that did not have a global sponsor (61 out of 423 trials). These results are shown in Figure 7 below.

Figure 7 Non-commercial trials by global sponsorship and disease/condition focus

2022–2025



Source: NZIER based on HDEC data

Participant numbers in non-commercial trials ranged from under 10 to over 15,000.

Global sponsors of non-commercial trials included:

- Universities and university-based research units around the world (e.g. Imperial College London, Monash University, University of Sydney Clinical Trials Centre (CTC),[1] King's College London, University of Newcastle, University of Michigan, Dalhousie University, the Child Health Research Centre at University of Queensland, University of Ottawa Heart Institute, University of British Columbia, University of Minnesota School of Medicine, etc.)
- Overseas hospitals and medical centres (e.g. Cardiology Department of Bern University Hospital, University of British Columbia's Children's Hospital, Amsterdam University Medical Centre, Unity Health Toronto, Mount Sinai Hospital, Royal Adelaide Hospital, Royal Children's Hospital, etc.)
- Foundations and non-profit research institutes (e.g. Stichting TRICALS Foundation, Centre for Heart Rhythm Disorders, Olivia Newton John Cancer Research Institute, Hunter Medical Research Institute, etc.).
- Trans-Tasman and overseas research groups/networks (e.g. Australia Australasian Leukaemia and Lymphoma Group, Australia and New Zealand Children's Haematology/Oncology Group (ANZCHOG), Australasian Leukaemia & Lymphoma Group (ALLG), Australasian Gastro-Intestinal Trials Group, Australia New Zealand Gynaecological Oncology Group (ANZGOG), Canadian Cancer Trials Group (CCTG), Breast Cancer Trials, etc.).

[1] Sometimes still referred to as the NHMRC Clinical Trials Centre. Established in 1988 as Australia's first national clinical trials centre, under the name NHMRC Clinical Trials Centre, the Sydney CTC was created to provide national leadership in the design, coordination and analysis of large, multi-centre clinical trials, addressing a growing need for rigorous, collaborative research to inform clinical practice across disciplines (University of Sydney n.d.).

3.4 Commercial trials

In total, there were 644 commercial trials run in New Zealand between 2022 and 2026.

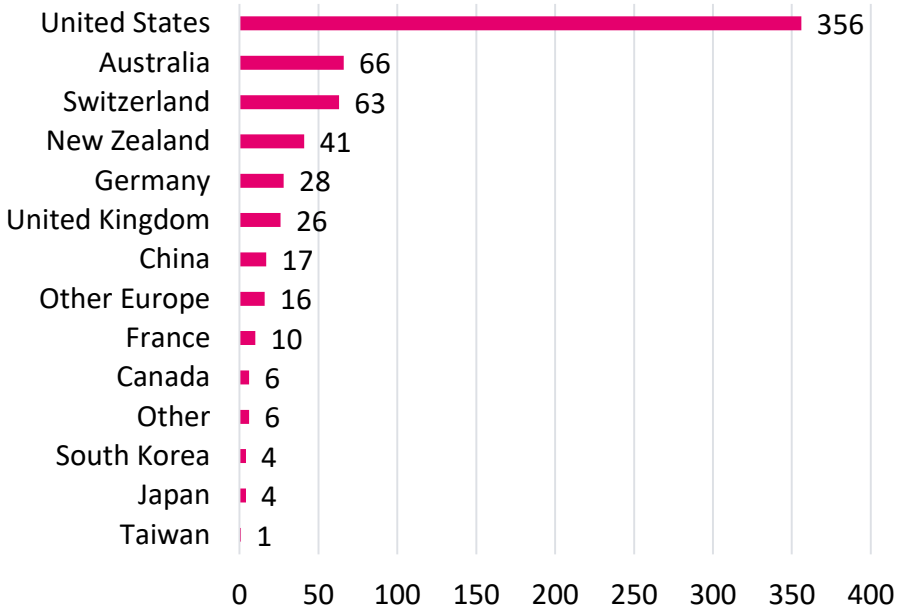
3.4.1 Global sponsorship of commercial trials

Global sponsorship of clinical trials is a source of foreign direct investment.

Of the 644 commercial trials, 603 (94 percent) had a global sponsor based overseas. The United States is by far the most common source of global sponsorship, sponsoring 356 trials (55 percent). This is followed by Australia and Switzerland. Very few trials had a sponsor based in China (17 trials), South Korea (4 trials), Japan (4 trials) or Taiwan (1 trial), suggesting New Zealand may be missing out on the growth in biotechnology in these countries. See Figure 8 below.

Figure 8 Number of commercial clinical trials by sponsor country of origin

2022–2025



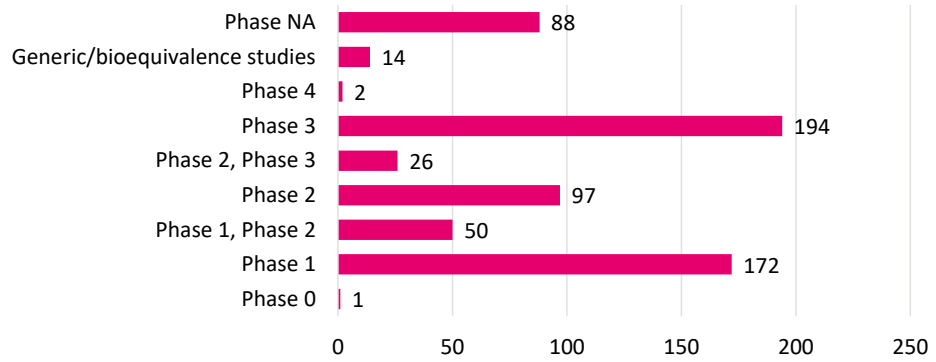
Source: NZIER based on HDEC data

3.4.2 Commercial trials overview

Phase 1 and phase 3 trials are the most common trial phases (see Figure 9 below).

Figure 9 Number of commercial clinical trials by phase and study type

2022–2025



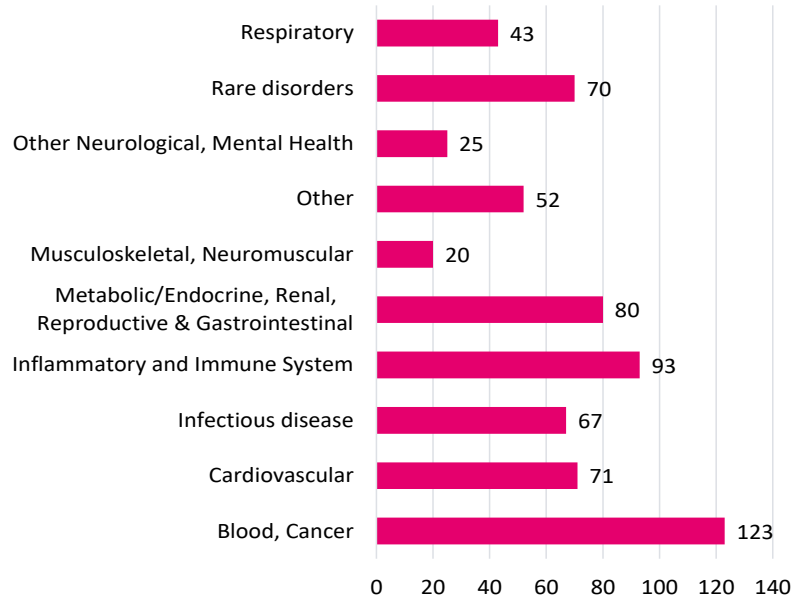
Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

Source: NZIER based on HDEC data

As shown in Figure 10 and 11 below, while blood and cancer trials dominate other trials in terms of the number of trials (123 trials over four years), infectious disease trials dominate in terms of the number of participants (11,205 participants over four years).

Figure 10 Number of commercial trials by disease/condition focus

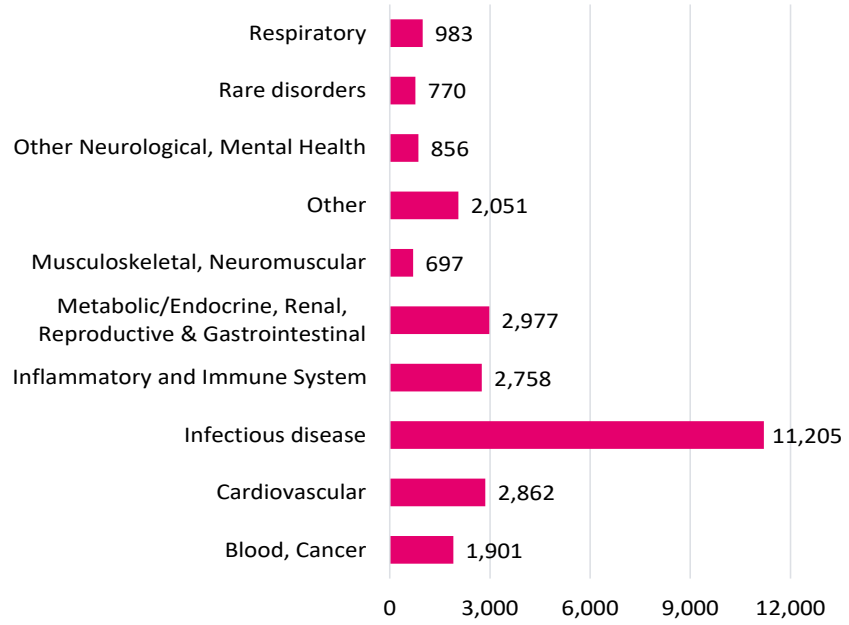
2022–2025



Source: NZIER based on HDEC data

Figure 11 Number of commercial trial participants by disease/condition focus

2022–2025



Source: NZIER based on HDEC data

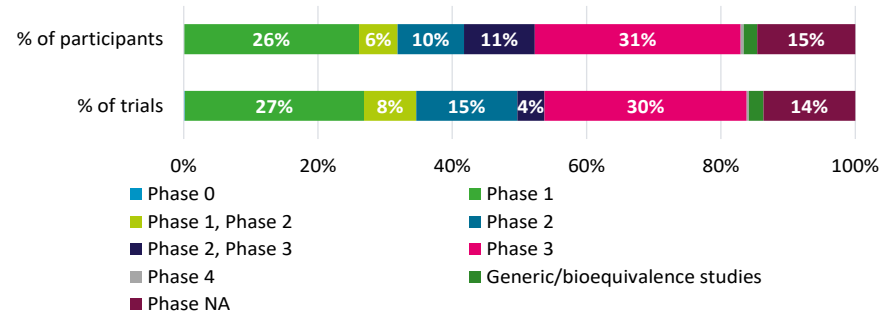
Over the four years from 2022 to 2025, the most common trials were single-phase, with phase 1 and phase 3 trials being dominant and relatively lower numbers of phase 2. Phase 4 trials were insignificant in number:

- There were 172 commercial phase 1 trials run with 7,066 participants, representing 27 percent of all commercial trials and 26 percent of all participants in commercial trials.
- There were 97 commercial phase 2 trials run with 2,675 participants, representing 15 percent of all commercial trials and 10 percent of all participants.
- There were 194 commercial phase 3 trials run with 8,298 participants, representing 30 percent of all commercial trials and 31 percent of all commercial trial participants.
- There were two commercial phase 4 trials run with 121 participants, representing less than one percent of trials and less than one percent of participants.

(see Figure 12 below)

Figure 12 Percentage of commercial trials and trial participants by phase

2022–2025



Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

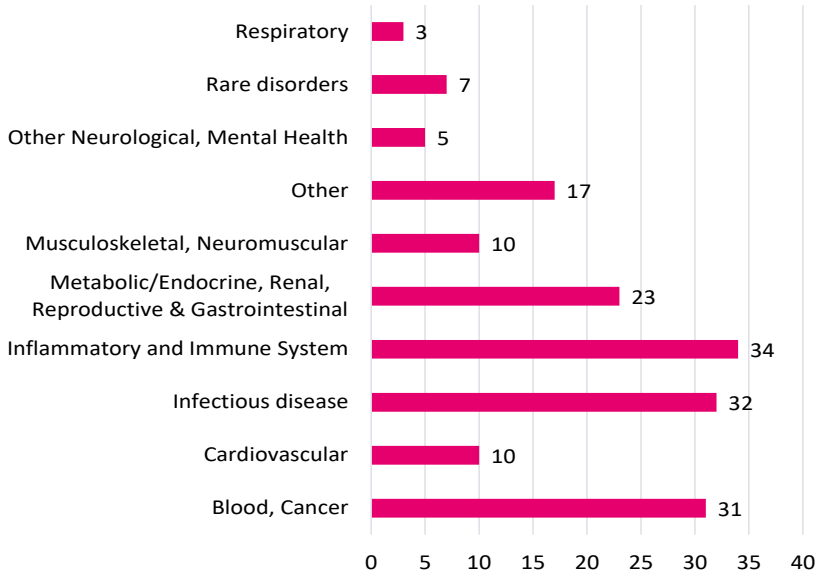
Source: NZIER based on HDEC data

3.4.3 Phase 1 trials

There were 172 Phase 1 commercial trials approved between 2022 and 2025. Phase 1 trials are sometimes also described as "first in human" studies and they are focused on determining the safety, dosing tolerability and pharmacokinetics of the investigational drug. They generally involve participants who are healthy volunteers. However, there are some higher-risk areas including cancer studies where it would be unethical to test the investigational drug on healthy volunteers, so the participants are patients with the relevant disease. Phase 1 commercial trials in the HDEC data set span a wide range of disease/condition focus areas, including both studies in healthy volunteers and studies in patients. The most strongly represented disease/condition focus areas were blood and cancer, infectious disease, and inflammatory and immune system conditions, together making up 97 of the 172 Phase 1 trials (see Figure 13 below).

Figure 13 Number of phase 1 commercial trials, by disease/condition focus

2022-2025



Source: NZIER based on HDEC data

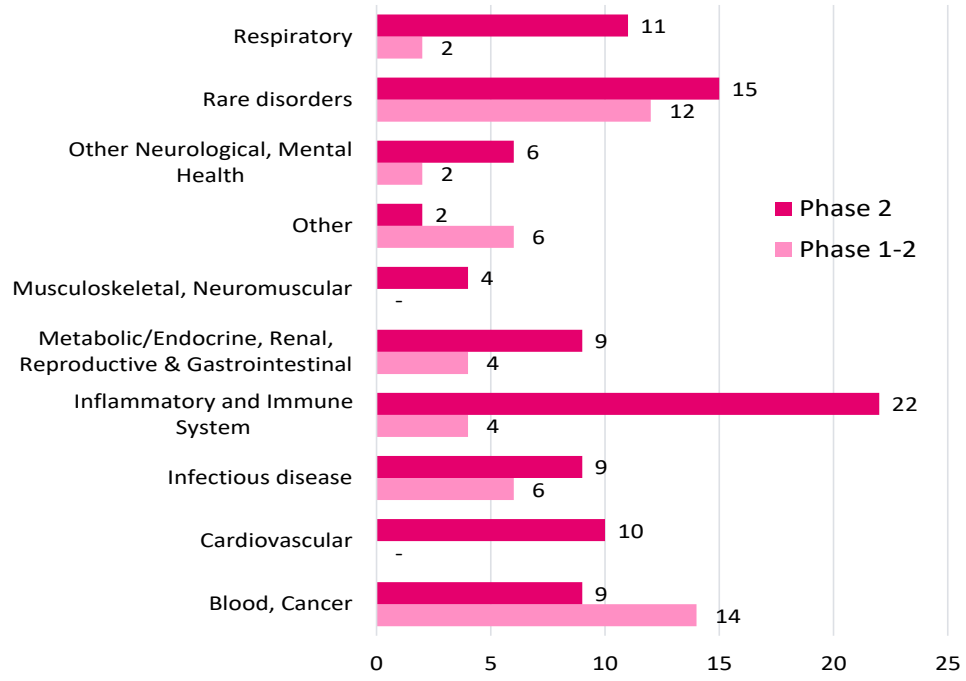
3.4.4 Phase 1–2 and Phase 2 trials

The HDEC dataset describes some commercial trials as spanning two phases. While there were fewer of these multi-phase trials (50 Phase 1–2 trials in total), blood and cancer featured strongly amongst these (with 14 Phase 1–2 trials compared with only 9 Phase 2-only trials) (see Figure 14 below). This was also a more common trial phase category than Phase 1 for rare disorders, with 12 rare disorders trials spanning Phase 1 and Phase 2, while only seven were purely Phase 1 trials. However, for rare disorders, purely Phase 2 trials were more common (15 trials).

Overall, inflammatory and immune system conditions have been the focus of the greatest number of Phase 2-only trials, followed by rare disorders. There were Phase 2 trials in every disease/condition focus area, but the significance of blood and cancer trials was lower in this phase, compared with Phase 1 and Phase 1-2 trials.

Figure 14 Number of Phase 1-2 and Phase 2 commercial trials, by disease/condition focus

2022–2025



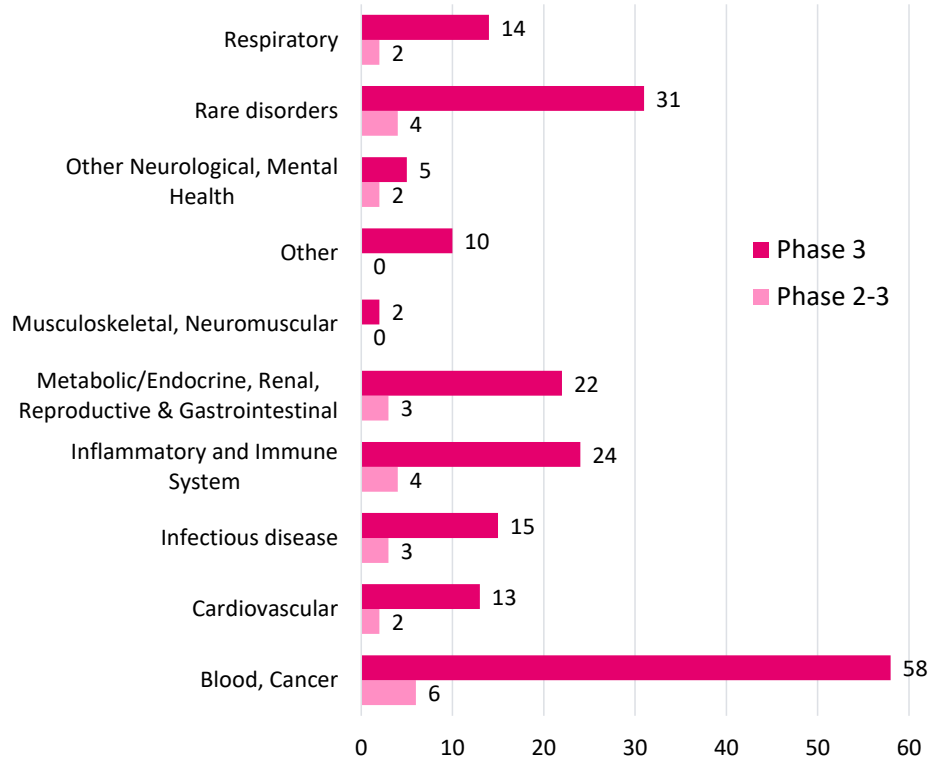
Source: NZIER based on HDEC data

3.4.5 Phase 2–3 and Phase 3 trials

As shown in Figure 15 below, there were few Phase 2–3 trials (only 26) compared with Phase 3 trials, of which there were 194. Blood and cancer was the most common focus area for trials in this phase category – both Phase 2–3 trials and Phase 3 trials. The number of rare disorder trials was highest in the Phase 3 category.

Figure 15 Number of Phase 2–3 and Phase 3 commercial trials, by disease/condition focus

2022–2025



Source: NZIER based on HDEC data

3.4.6 Phase 4 trials

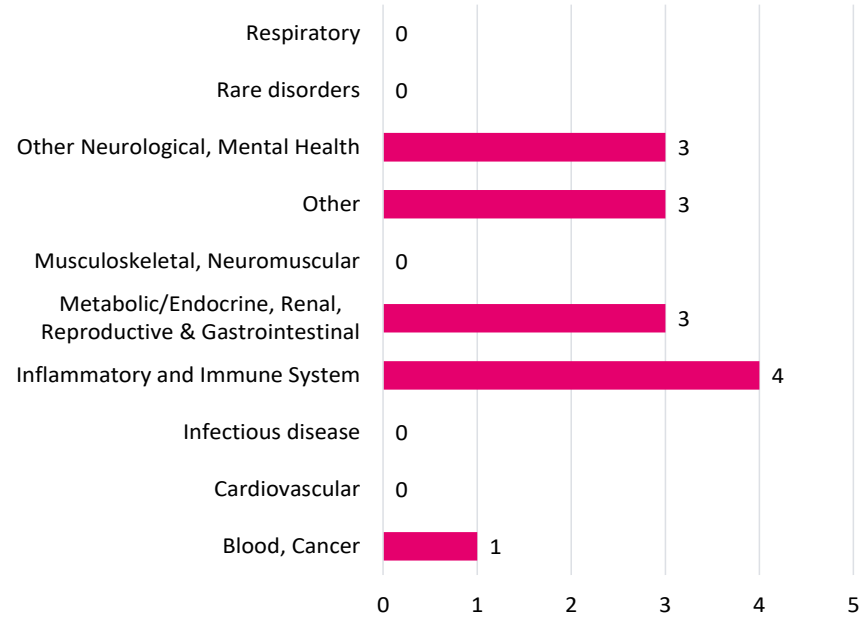
Only two Phase 4 trials occurred between 2022 and 2025. One focused on rare disorders and the other focused on metabolic/endocrine, renal, reproductive and gastrointestinal conditions.

3.4.7 Generic and bioequivalence studies

There were 14 generic or bioequivalence studies across the four years of data. Four were on inflammatory and immune system conditions, and three were in each of neurological and mental health conditions, metabolic/endocrine, renal, reproductive and gastrointestinal conditions, and other conditions. There was one study in the blood and cancer category (see Figure 16 below).

Figure 16 Number of commercial generic or bioequivalence studies

2022–2025



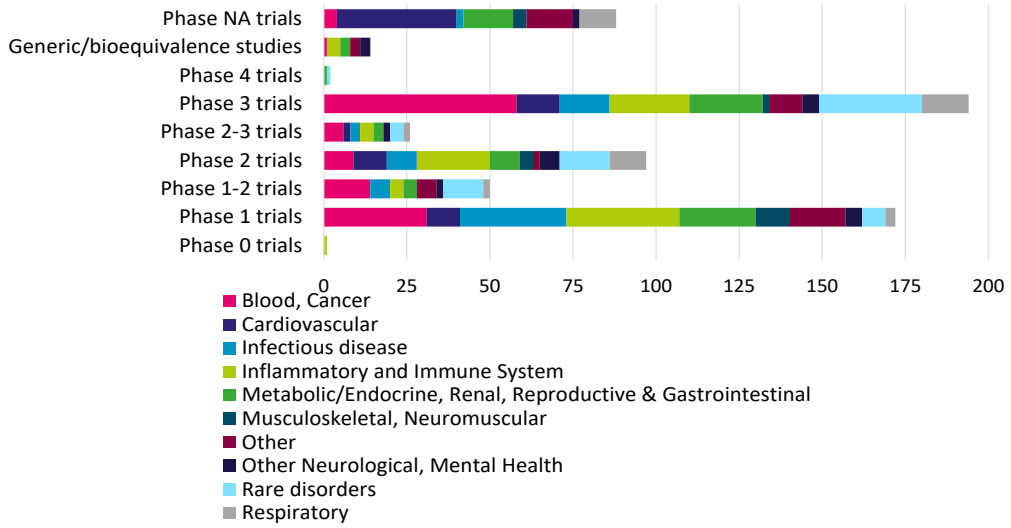
Source: NZIER based on HDEC data

3.4.8 Disease/condition focus of trials

Looking at commercial trials by disease/condition focus shows clearly that:

- Blood and cancer have been a major focus of clinical trials across Phase 1, Phase 1–2, and Phase 3, but were not a major focus of Phase 4 trials, generic/bioequivalence studies, or trials where the phase was not available or not applicable (e.g. due to not being medicines trials).
- Inflammatory and immune system conditions are an important focus area for all phases from 1 to 3 as well as generic/bioequivalence studies.
- The importance of infectious disease as a focus area decreases significantly in later-phase trials, compared to the pure Phase 1 trials.
- The most significant disease/condition focus for trials with no phase specified was cardiovascular disease.
- Only one Phase 0 trial was undertaken in New Zealand between 2022 and 2025. It focused on inflammatory and immune system conditions.

Figure 17 Disease/condition focus by trial phase

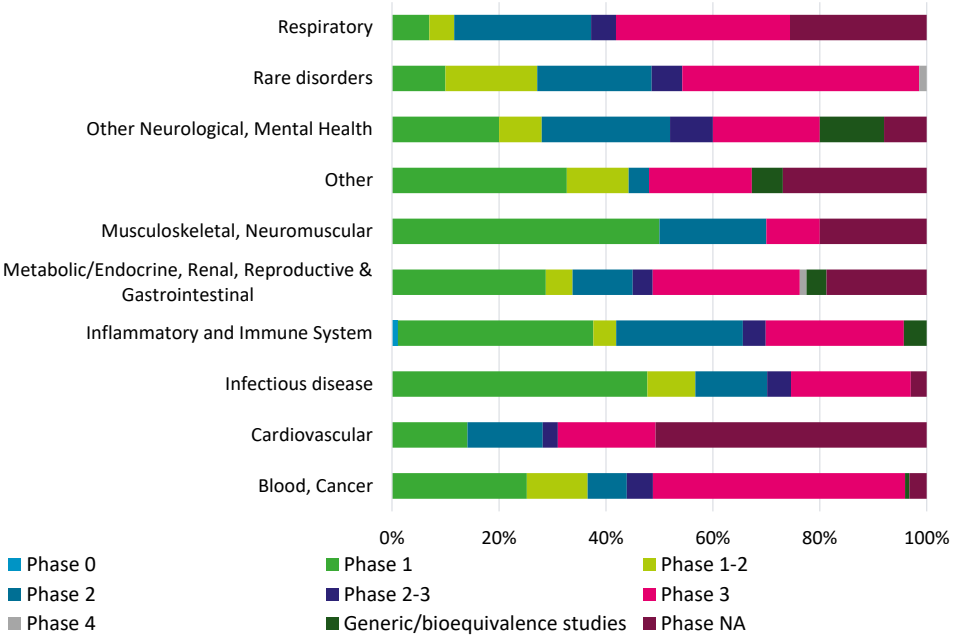


Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

Source: NZIER based on HDEC data

Some disease/condition focus areas have attracted a higher share of early-phase trials, such as musculoskeletal and neuromuscular conditions and infectious disease, whereas some disease/condition focus areas have tended to attract a higher share of later-phase trials, such as blood and cancer and rare disorders. Cardiovascular condition trials were the most likely to have no specified phase in the HDEC data (see Figure 18 below).

Figure 18 Trial phase shares by disease/condition focus



Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

Source: NZIER based on HDEC data

3.4.9 Commercial trial participants

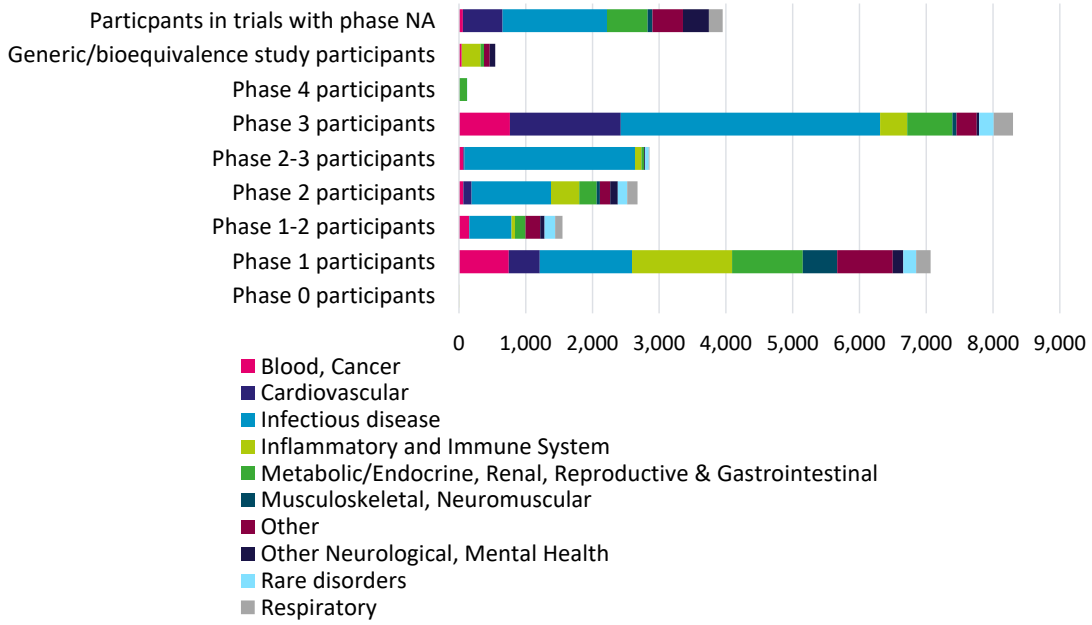
Looking at trial participants shows a different pattern from trials, with Phase 3 trials focusing on infectious disease being the most dominant block and putting Phase 3 trials in the number one place for the number of trial participants.

Infectious disease trials also attract high participant numbers in studies that span Phase 2 and Phase 3. The infectious disease condition category includes vaccine trials involving healthy volunteers and this accounts for the higher number of participants in these trials.

In comparison, blood and cancer trials are a less significant feature in terms of participant numbers, but this view shows that most blood and cancer participants participate in Phase 1 and Phase 3 trials.

Trials focusing on rare disorders are, unsurprisingly, less significant in terms of patient numbers than in terms of the number of trials.

Figure 19 Number of trial participants by disease/condition focus and trial phase



Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

Source: NZIER based on HDEC data

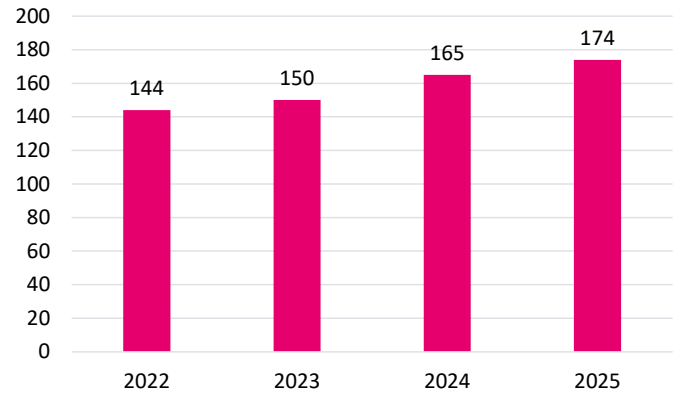
3.5 Trends in clinical trials since 2022

3.5.1 Commercial trials approved

As shown in Figure 20 below, there has been an increase in the number of commercial trials approved every year since COVID-19, with 174 trials approved in 2025, 30 more than in 2022 – an increase of 20.8 percent over 3 years.

Figure 20 Number of commercial trials approved by year of approval

2022–2025

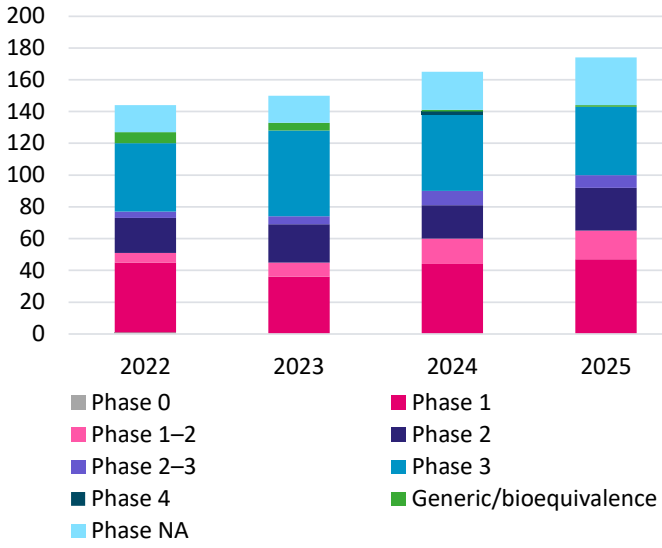


Source: NZIER based on HDEC data

Figure 21 below shows that the growth in commercial trials has largely been driven by growth in Phase 1-2 and Phase 2 trials, which increased by 17 trials from 2022 to 2025 – more than half of the overall increase in trial numbers. There was also a large increase in the number of trials where the phase was not available or was not applicable because they are not trials of medicines (for example surgical interventions, medical devices and diagnostics). Growth in Phase 1 trials was more subdued. At the same time, the number of generic and bioequivalence studies has decreased.

Figure 21 Number of commercial trials by phase

By year of approval, 2022–2025



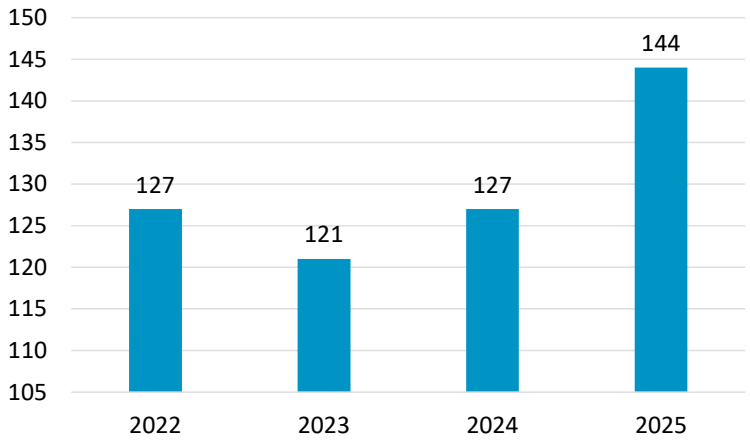
Note: Phase NA refers to studies where phase information is not available or not applicable, including medical device trials and surgical interventions.

Source: NZIER based on HDEC data

The growth in commercial trials over the 2022-2025 period exceeded the growth in non-commercial trials over the same period (see Figure 22 below) in both absolute and relative terms. After a slight drop in 2023, non-commercial trials returned to growth from 2024, reaching 144 trials approved in 2025. This translates into 17 more trials and a 13.4 percent increase overall since 2022.

Figure 22 Number of non-commercial trials approved by year of approval

By year of approval, 2022–2025



Source: NZIER based on HDEC data

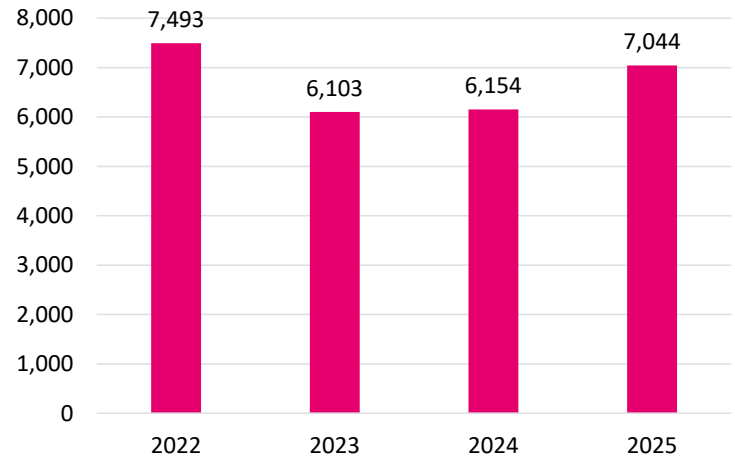
A high proportion of non-commercial trials had no study phase specified in the HDEC data, making it impossible to identify phase-related drivers of growth.

3.5.2 Trial participant numbers

Despite growth in the number of commercial trials, as shown in Figure 23 below, the number of participants in commercial trials has been lower every year compared with 2022, although there are signs of recovery, with the 2025 number being closer to the 2022 number and significantly above the four-year low in 2023. Changes in participant numbers may in part reflect changes in the therapeutic areas of focus including shifts in vaccine/infectious disease trial activity.

Figure 23 Number of commercial trial participants by year

By year of approval, 2022–2025

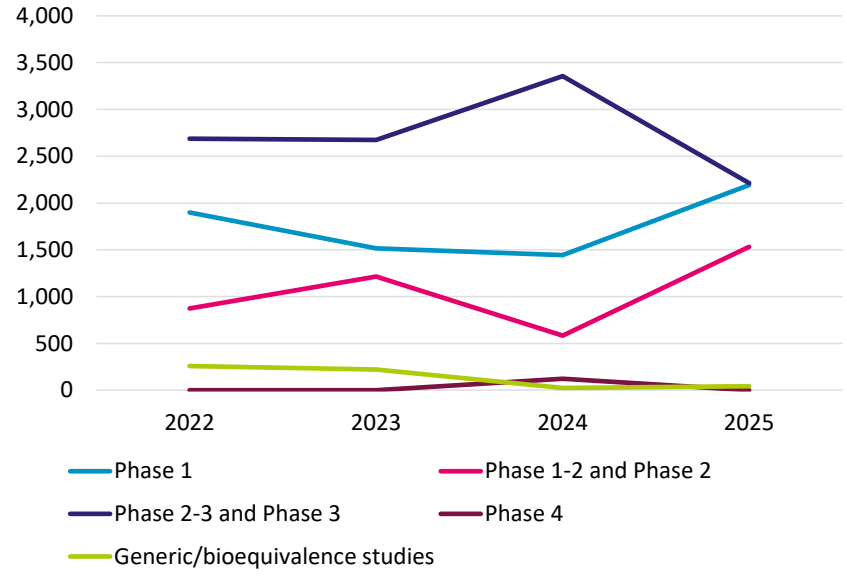


Source: NZIER based on HDEC data

Figure 24 below shows that the number of participants has been highest in every year in Phase 2–3 and Phase 3 trials, except in 2025, where the number of participants in Phase 1 trials was almost as high as the number in Phase 2–3 and Phase 3 trials.

Figure 24 Number of participants in commercial trials by phase

By year of approval, 2022–2025

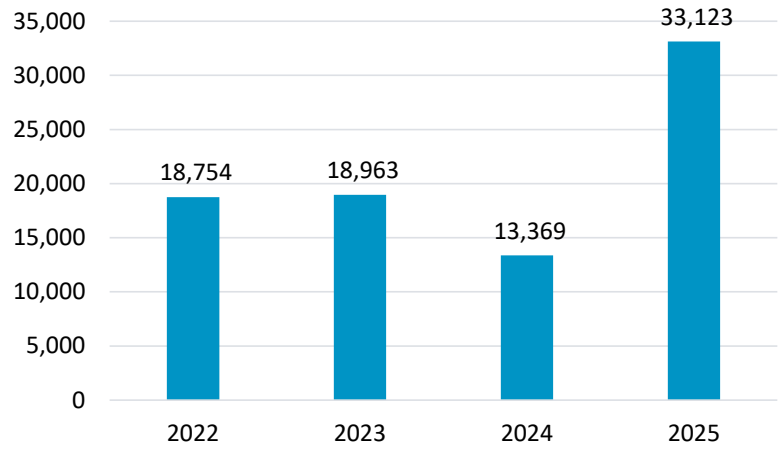


Source: NZIER based on HDEC data

Overall, the number of participants in non-commercial trials has been considerably higher than in commercial trials, and 2025 stands out with a much higher total than previous years.

Figure 25 Number of participants in non-commercial trials by year

By year of approval, 2022-2025



Source: NZIER based on HDEC data

The high proportion of non-commercial trials with phase not specified in the HDEC data prevents meaningful analysis of trends in participant numbers by trial phase.

3.6 Trial stage sequence analysis

Because the HDEC dataset represented a snapshot in time, it cannot directly provide information about the time that trials spend in each stage.

The stages described in the data are:

- Not yet recruiting
- Recruiting
- Active, not recruiting
- Completed
- Withdrawn
- Terminated
- Unknown.

To estimate the time spent in each stage, we first identified the stages that can be sequenced. This meant discarding trials with status recorded as withdrawn, terminated, and unknown. We confirmed with Medicines New Zealand that normally trials proceed in the sequence shown in the figure below.

Figure 26 Sequences of stages for approved trials



Source: NZIER

We then identified, based on the "age" of each trial and the stage recorded in the snapshot data, the time (in months) since the approval date, using April 2026 as the snapshot date (the date at which the status/stage was recorded).

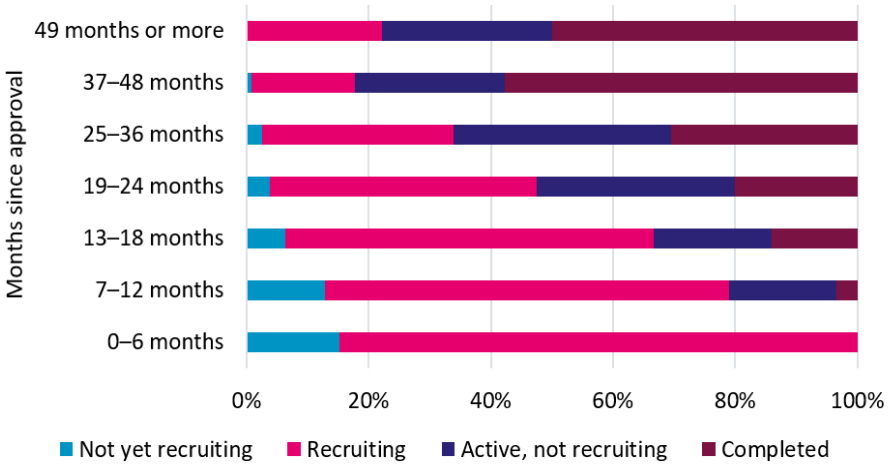
The analysis estimates trial status at each point in time using this process:

- Trials are grouped by their age since HDEC approval
- The observed status mix for each "age group" is calculated from the subset of trials in the "age group"
- The calculated status proportions are applied to the trials that had been approved at each year-end.

This showed that nearly 90 percent of trials were already recruiting within six months of approval, and the increasing share of trials at other stages as the trial age increased. Another notable insight is that around half of trials approved are completed by 3–4 years post-approval (see Figure 27 below).

Figure 27 Estimated trial stage by trial age

Percentage of trials in each stage based on time from HDEC approval, 2022–2025



Note: Because the movement of trials through phases is modelled based on observed status within trial cohorts, the modelling can result in some counter-intuitive results, such as the appearance of trials moving backwards in stages. This is due to the cohort basis of the model. For example, more trials appear to be completed in the 37–48-month cohort than in the 49+ month cohort. While counter-intuitive and impossible in reality, these effects were small and represent a minor shortcoming of the need to model trial stages due to the data not directly supporting this with time-stamped status updates.

Source: NZIER based on HDEC data

Based on this sequencing and the percentage of trials at each stage at each point in time, we estimate the number of trials that were in each stage at the end of each year. We estimate the number of trial participants in 2025 using the trial sequencing analysis and a proportionate approach. The results are shown in the table below.

Table 2 Estimated number of commercial trials by stage and by year of approval

	2022	2023	2024	2025	Total
Not yet recruiting	1	3	6	22	32
Recruiting	**17**	**38**	**80**	**118**	**253**
Active, not recruiting	**28**	**47**	**41**	**20**	**136**
Completed	73	44	25	8	150
Terminated or withdrawn	20	9	8	1	38
Status unknown	10	12	7	6	35
Total commercial trials	149	153	167	175	644

Source: NZIER based on HDEC data

Based on these results, we estimate that 138 commercial trials were active (118 recruiting and 20 active but not recruiting) in 2025.

Because non-commercial trial data usually does not identify the trial stage, we applied the same proportion to non-commercial trials, producing an estimate of 112 active non-commercial trials in 2025, for a total of 250 active trials overall.

4 Employment in the clinical trials sector 2025

4.1 Data sources and methods

This section presents a summary of the data sources and methodology for estimating employment in the clinical trials sector. More detail on our methods is provided in Appendix B.

The previous NZIER report on the value of clinical trials was constrained by data limitations: No direct data on employment in the clinical trials sector was available, so staffing and related costs had to be modelled. This was done by applying the staffing-to-participant ratio observed at Middlemore Clinical Trials to the sector as a whole. Staff costs were estimated based on assumptions.

For this report, therefore, a key improvement was the development and execution of an extensive sector survey to capture the staffing mix and costs of a wide range of sector players, including sponsors, CROs, independent contractors, sites/site networks as well as Health New Zealand | Te Whatu Ora and others. A complete list of organisations that participated in the survey is provided in Appendix C.

Most organisations provided detailed data, enabled by a strict data sharing agreement, including where needed, non-disclosure agreement (NDAs) signed between the participant and NZIER. NZIER project files were strictly locked down providing a high level of security for confidential data and all data was destroyed/deleted on project completion.

Total employment and total cost of salaries in the clinical trials sector was estimated for all sponsors, CROs, NCROs, sites and Health New Zealand | Te Whatu Ora.

Where organisations did not provide data on employment and/or salaries paid to employees:

- We extracted data from online sources such as annual reports and company information on LinkedIn, where employment headcount or FTEs are sometimes identified.
- Where no source of this information could be found, we imputed the number of employed staff from the available information provided and based on information provided by same-type organisations.

4.2 Results

Clinical trials require a broad and expansive workforce of highly trained professionals, including:

- Investigators, often medically trained
- Research nurses
- Study pharmacists
- Allied health and other health care professionals
- Laboratory specialists and technicians
- Clinical research associates/clinical monitors

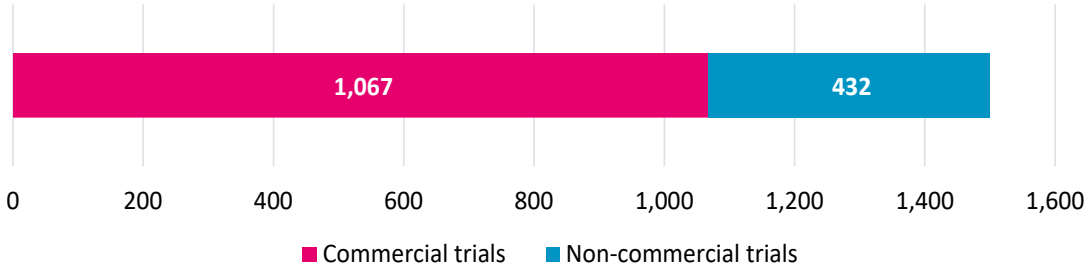


- Study start-up specialists
- Regulatory specialists
- Ethics specialists
- Contract managers
- Project managers and team leaders
- Quality assurance/audit experts
- Data managers
- Pharmacovigilance and patient safety specialists
- Trial statisticians
- Management staff
- Clinical trial assistants and other specialists
- Clinical trial support roles
- General and administrative staff

Based on the sector survey, asking sponsors, CROS, NCROs, sites and site networks and Health NZ | Te Whatu Ora about their FTEs under each of these roles and the salaries paid to staff in these roles, we estimate that:

- the clinical trials sector directly employs 1,499 people
- 1,067 people work in the commercial clinical trials sector
- 432 people work in the non-commercial clinical trials sector
- the average full-time salary of a person employed in the clinical trials sector is over $120,000
- The total value of wages and salaries paid was approximately $197 million in 2025.

Figure 28 Number of people employed in the clinical trials sector



Source: NZIER

5 Economic contribution of clinical trials in 2025

5.1 Data sources and methods

This section presents a summary of the data sources and methodology for estimating the economic contribution of clinical trials. More detail on our methods is provided in Appendix B.

HDEC data

Our estimates of economic contribution are based on clinical trial activity in 2025. We used the HDEC data to identify the number of commercial and non-commercial clinical trials that were likely incurring significant costs in 2025. These were identified as trials that were recruiting or active but not recruiting. The method to estimate the number of trials in these stages within 2025 and the number of participants associated with these trials was described previously (see sections 3.5 and 3.6).

Sector survey

The sector survey previously described (see section 4.1) provided four data inputs for the estimation of economic contribution:

- Number of people employed in the clinical trials sector
- Salaries paid to clinical trials sector employees
- Clinical trials sector expenditure on goods and services supplied by other industries
- Payments to healthy volunteers and patients recruited into clinical trials.

Imputed values

Most organisations reporting provided detailed and complete data or at least detailed data on some of the above categories. Where no data was provided, we imputed values based on the data provided by same-type organisations (e.g. sponsor data was used to impute missing values for other sponsors, CRO data was used to impute missing values for CROs, etc.) and the imputation was either on an average per trial or average per FTE basis.

Scaling to whole sector values

Because of the limited response to our survey from the wider non-commercial sector (although useful data was provided by two NCROs and Health New Zealand), we estimated non-commercial trial costs based on an assumption about trial complexity and resourcing intensity provided by Medicines New Zealand. The assumption was that non-commercial trial protocols require on average only half the labour inputs that commercial trials of the same size and phase require.

Payments to healthy volunteers

We estimated payments to healthy volunteers based on the share of participants in commercial trials with a healthy volunteer flag. In the absence of a similar indicator for non-commercial trials, the same share was applied to non-commercial trials. The value of payments applied to healthy volunteers was $5,000 per participant.

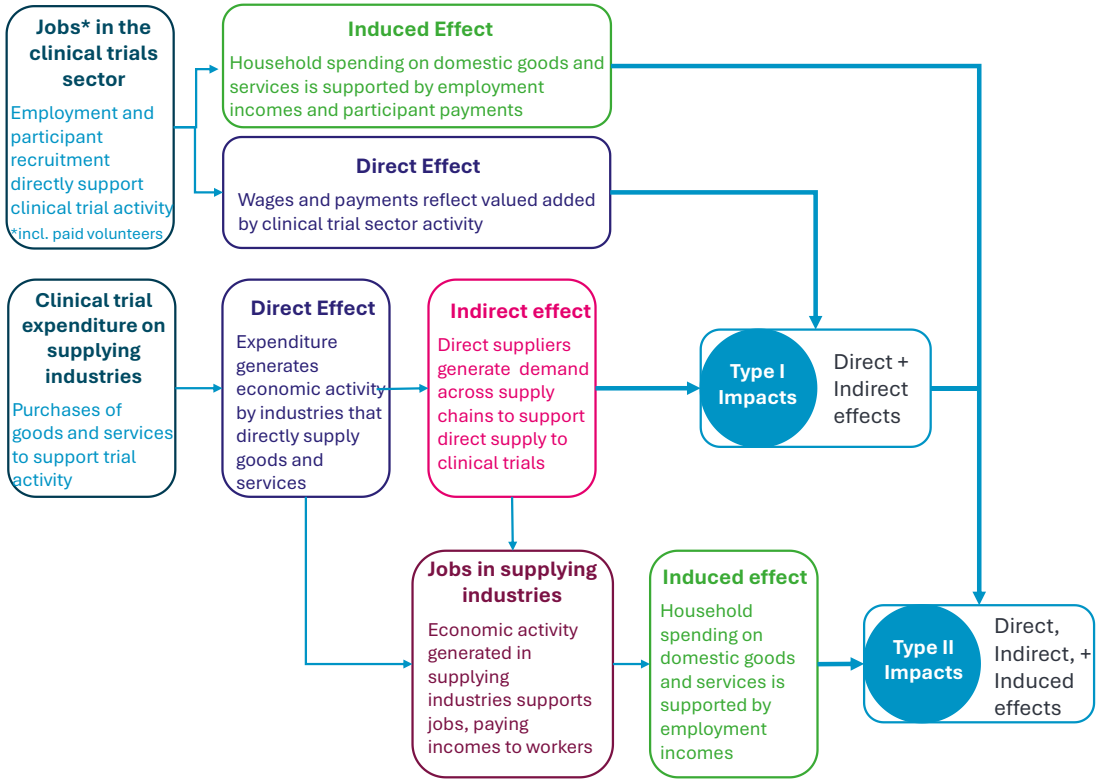


Estimation of economic contribution

Our economic contribution analysis estimates the economic activity supported by the clinical trials sector.

We developed an input-output (I-O) multiplier model using Stats NZ input-output data to estimate the direct, indirect, and induced economic impacts associated with clinical trials activity. The analysis distinguishes between direct, indirect and induced economic effects as shown in figure below.

Figure 29 Effects of clinical trials expenditure



*While paid volunteers are not counted as employment supported by the sector, the types of effects resulting from the payments they receive and subsequently spend are the same as those resulting from payment of wages and salaries to sector employees, so they are modelled the same way.

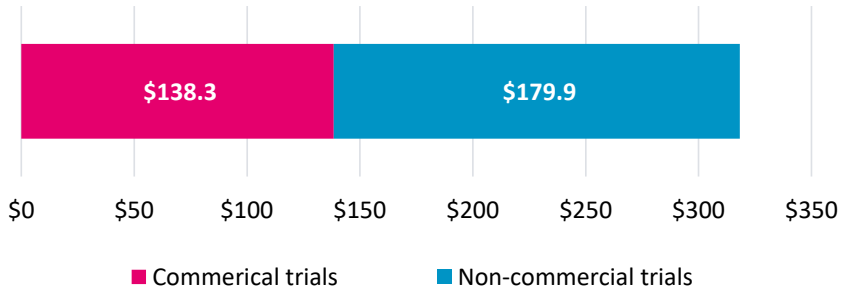
Source: NZIER

5.2 Estimated expenditure on supplying industries

Based on the survey data received, we estimate the clinical trials sector generated a total of $318.2 million in expenditure on supplying industries. This included $138 million from commercial clinical trials.

Figure 30 Expenditure on supplying industries by the clinical trials sector

2025, $ Millions



Source: NZIER

5.3 Estimated employment, wages and salaries, and payments to participants

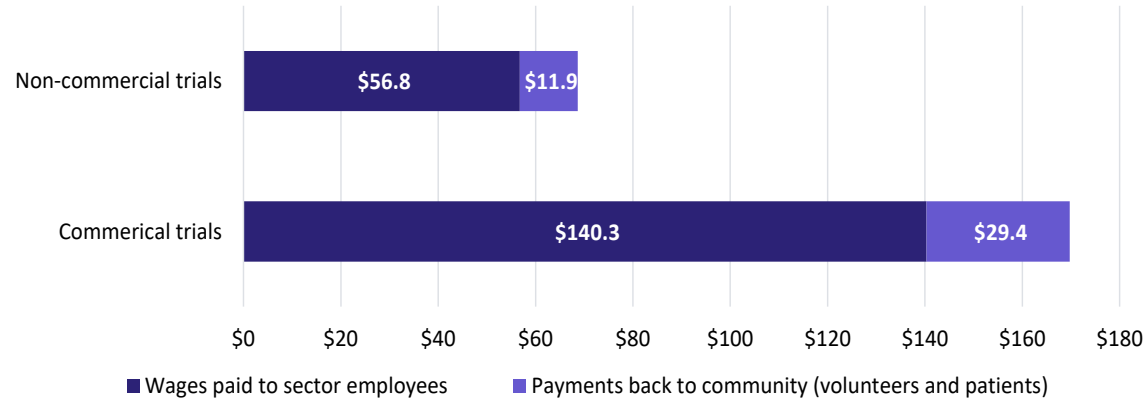
The clinical trials sector is estimated to employ nearly 1,500 people across commercial and non-commercial trials.

In total, the clinical trials sector is estimated to have paid $197 million in wages in 2025.

From an economic perspective, payments to participants play a similar role to wages, with a portion contributing to household spending and generating economic activity. In 2025, these amounted to $41.3 million. Figure 31 below shows the breakdown of wages and salaries and participant payments for commercial and non-commercial trials.

Figure 31 Value of employment and participant payments in clinical trials sector

2025, Millions



Source: NZIER

5.4 Estimated economic contribution

The economic contribution of clinical trials is presented below in two sections:

- economic contribution to other industries due to clinical trial expenditure
- total value added (contribution to GDP).

Together, and after capturing the direct, indirect and induced effects on economic activity, these provide an estimate of the value-added contribution of clinical trials – the contribution of commercial clinical trials to GDP.

5.4.1 Impact of clinical trial expenditure on supplying industries

Expenditure by the clinical trials sector on New Zealand suppliers supports economic activity both within the industries receiving this expenditure and throughout their domestic supply chains (supplying industries).

Table 3 presents the estimated Type I (direct and indirect) and Type II (direct, indirect and induced) impacts associated with this expenditure:

- Type I impacts in this table include the direct activity supported in supplying industries, and the indirect activity generated through their supply chains.
- Type II impacts in this table include Type I impacts as well as the induced effects generated when employees of the supplying industries whose employment is supported by clinical trial activity spend part of their income on goods and services. Under Type II impacts, industries supplying to consumers are also considered to be supplying industries.

Clinical trials generate over $800 million of gross output from supplying industries when both Type 1 and Type 2 effects are considered. Of this, $378 million is value added (supplying industries' contribution to GDP resulting from clinical trial activity).

Furthermore, clinical trial activity supports nearly 2,600 jobs across the economy, with over 1,800 in industries that supply goods and services directly or indirectly to the clinical trials sector.

Table 3 Economic impacts on supplying industries

2025

Measure	Direct	Indirect	Type I total	Induced	Type II total
Supply chain gross output value ($m)	$318.2	$258.1	$576.3	$227	$803.6
Supply chain value added ($m)	$136.3	$119.3	$255.6	$122	$378.0
Employment (number of jobs)	1,072.0	770.0	1,843.0	726.0	2,569.0

Source: NZIER

5.4.2 Total value-added or contribution to GDP

The total value-added contribution of clinical trials includes the value generated by expenditure on supplying industries as well as the value of clinical trials sector employment and other direct-to-consumer payments (payments to participants).

Table 4 combines these and shows that the total value added or contribution to GDP is approximately $763 million, including:

- $378 million via expenditure on supplying industries
- $385 million via payment of sector wages and payments to trial participants.

Table 4 Overall value-added contribution 2025

2025, $ millions

Source	Direct	Indirect	Type I total	Induced	Type II total
NZ supplier expenditure	$136.3	$119.3	$255.6	$122.3	$378.0
Clinical trials wages and payments to participants	$238.4	n/a	$238.4	$146.5	$384.9
Total value added	$374.7	$119.3	$494.0	$268.9	$762.9

Note: Clinical trials wages – value added doesn't have an indirect effect. This is explained in the methods in Appendix B.

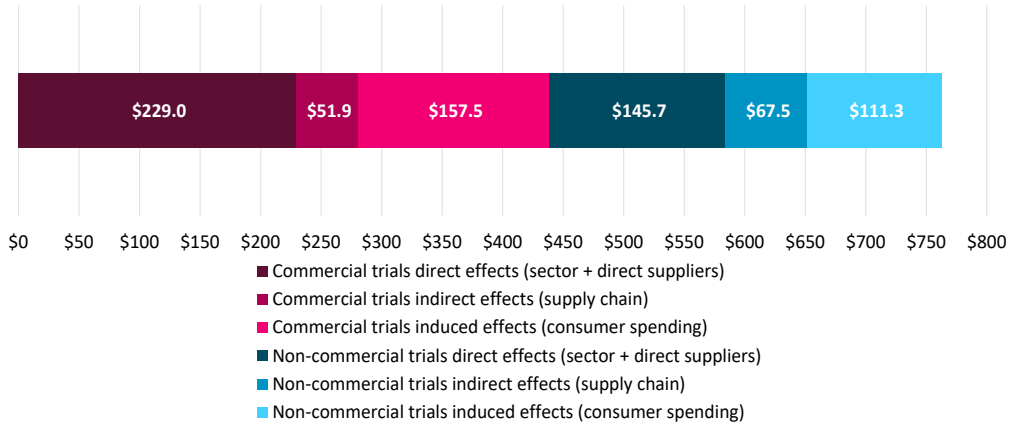
Source: NZIER

The commercial and non-commercial trial-related value added is shown by the contributing effect in Figure 32 below.

Commercial trials contribute a total of $438 million while non-commercial trials contribute a total of $325 million.

Figure 32 Total contribution of clinical trials to GDP

2025, $ Millions



Source: NZIER

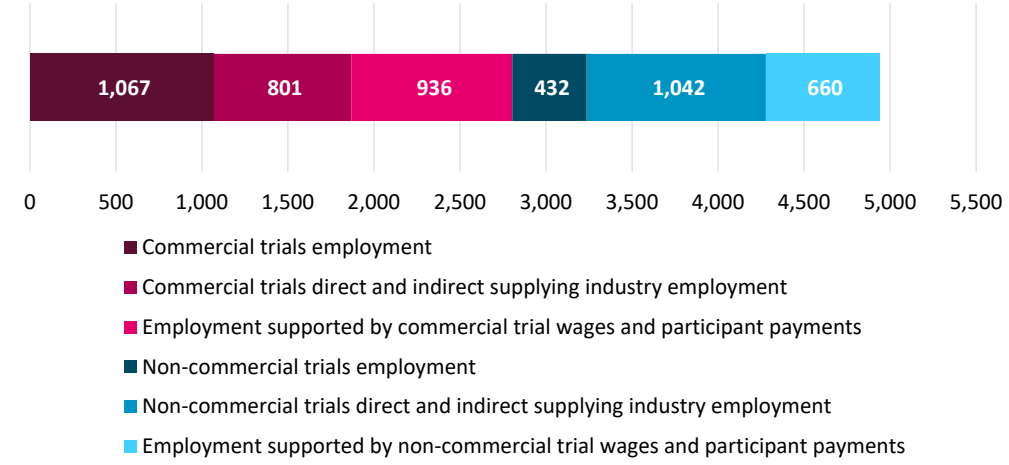
5.5 Value of employment supported by clinical trials

The total employment impact of the sector is shown in Figure 33 below. The amount of employment generated across the economy far exceeds the employment within the clinical trials sector:

- Commercial clinical trials employ 1,067 people, while non-commercial clinical trials employ 432 people.
- Commercial trials generate 801 jobs through expenditure on supplying industries, while non-commercial trials generate 1,042 jobs in supplying industries, through direct, indirect and induced effects of that expenditure.
- Payments of wages and participant payments in commercial trials generate 936 jobs in other industries through consumer spending alone, while payments of wages and participant payments in non-commercial trials generate 660 jobs.
- In total, clinical trials activity supports nearly 5,000 jobs across New Zealand, with nearly 1,500 directly working in the clinical trials sector and nearly 3,500 across other industries.

Figure 33 Employment effects of clinical trials

2025, Estimated number of jobs supported by clinical trials sector activity



Note: Jobs are measured as FTE for employment within clinical trials but as headcount in other sectors. Healthy volunteers paid to participate in trials are not counted as a form of employment.

Source: NZIER

5.6 Value of health care delivered

Clinical trials provide a range of health care services to patients and healthy volunteers ranging from routine screening to complex cutting-edge treatment.

The data collected as part of this research indicated that:

- Clinical trials provide an average of 5.5 outpatient visits per trial participant.
- Clinical trials in 2025 involved $50.6 million in medicines, vaccines and other pharmaceutical products.

Based on an outpatient cost of $541 per visit (The Treasury 2025), the total value of outpatient care delivered is estimated to be $2,975.50 per participant.

Because we do not know the reason for trials being terminated or withdrawn, or the timing, no health benefits are assigned to participants in these trials. This means our estimate is likely to be conservative. We assume that participants in trials that were in the active, not yet recruiting and completed stages by the end of 2025 received trial-associated health care benefits over the course of 2025.

This means health benefits were provided to a total of 253 participants in commercial trials. The total value of outpatient care delivered through clinical trials in 2025 was therefore approximately $752,802.

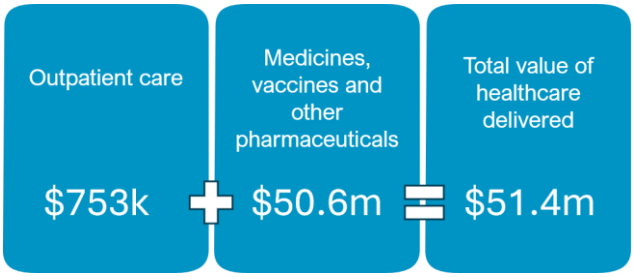
In total, therefore, including both the value of outpatient care and the value of medicines, vaccines and pharmaceutical products, the value of health care delivered through clinical trials in 2025 was approximately $51.4 million.

None of the health care components is included in the multiplier analysis. There are two reasons for this:

- medicines, vaccines and other pharmaceuticals used were imported
- the labour costs and other costs used to deliver outpatient care are captured in the trial-related expenditure categories.

Figure 34 Total value of trial-related health care

2025



Source: NZIER

6 Sector insights on the current and future state of clinical trials

This section describes qualitative feedback from sector organisations that participated in the sector survey. The responses are combined, anonymised, and where needed, supplemented by more detailed insights from the Valuing Life Summit in which many of the same sector players participated.

6.1 What has been, and still is, working well

Respondents pointed to the advantages of the clinical trials sector in New Zealand that have been features of the sector for many years:

- a fast approval process
- an engaged and ethnically diverse participant population
- a highly skilled workforce
- high-quality data.

This combination meant the sector had much to offer.

New Zealand can deliver high-quality clinical trials

Respondents strongly indicated that New Zealand has very credible, demonstrated clinical-trial capability. They pointed to experienced investigators, good clinical practice, reliable delivery and trusted data as genuine strengths. The Valuing Life Summit similarly identified pride in the quality of New Zealand trials and highlighted data quality as a recognised historical and current strength. Quality was noted by survey respondents as being the result of accumulated expertise, strong research culture, relationship building, strong systems and reputation. This was identified as an asset base to build on and to provide confidence in the value of investment in the sector.

Experienced and committed investigators remain a core asset

Respondents identified that the sector continues to benefit from skilled investigators and clinician-researchers with established local and international reputations. Survey respondents described investigators who are personally committed to research, willing to collaborate across academic, clinical and commercial work, and able to build broad research programmes spanning multiple therapeutic areas.

This strength, however, was also identified by some respondents as fragile, arguing that organisations can remain active and successful for four decades because of the reputation, persistence and collaborative orientation of a founder, but the degree of dependence of this source of organisational success was higher than it should be.

Existing capability spans a broad range of research

Survey responses identified experience and potential across Phase 1 research, oncology, haematology, vaccines, rare diseases, ophthalmology, musculoskeletal conditions, ageing, Alzheimer's disease, precision medicine, medtech, real-world evidence and advanced therapies. This breadth was noted as a strength in that it reduces reliance on a single therapeutic market and creates opportunities to connect hospital, specialist, primary and community settings.

Other capabilities included contract research, data management, biostatistics, pharmacovigilance, laboratories, logistics and manufacturing, although some noted these were under-developed and that investment was needed to build these areas further.

Willing participants and strong recruitment can make New Zealand competitive

Respondents reported that New Zealand can recruit well in appropriate studies and, in some cases, can even outperform other countries. Although New Zealand's population is small, there is a strong willingness to participate (noted as an ironic consequence of New Zealand's public health system not offering modern treatments in many areas). Strong relationships between investigators, sites and patient communities had been built to help offset the small country disadvantage.

The Valuing Life Summit also identified willing patients and recruitment speed as strengths worth protecting to ensure a continued competitive sector.

An additional attractive feature of New Zealand's population that was noted is that some patient populations may be less "treatment-saturated" than those in larger markets, possibly due to unmet need and limited funded lines of treatment. This can make New Zealand valuable for studies requiring participants who have not already received multiple therapies.

New Zealand offers a stable, trusted operating environment

Several survey responses identified New Zealand's stable institutional environment and reputation for credible research as advantages. Sponsors value confidence that trial data will be robust and that sites will operate within recognised ethical and regulatory standards. These attributes were noted as reducing risk for global study teams.

At the Valuing Life Summit, while there were calls for faster ethics and regulatory processes, these were consistently accompanied by emphasis on the need to retain the rigour and quality that has been a feature: speed should not come at the expense of ethical standards. Better resourcing, clearer guidance and stronger induction would ensure timely, consistent review while maintaining public and sponsor confidence.

6.2 Challenges in the sector and barriers to growth

Survey respondents were consistent in their identification of sector challenges and the ways in which these may present barriers to growth either for individual organisations or for the sector as a whole.

End-to-end start-up is too variable, often too slow, and getting worse

Start-up speed and predictability were identified as critical threshold conditions in global trial allocation. New Zealand's small population means it must compete through responsiveness and reliability and it has done this reasonably well in the past. But survey respondents described increasing delays or variability across regulatory and ethics review, locality assessment, Māori review, contracting, budgeting, institutional sign-off, staffing and site activation.

One survey respondent reported that some public-hospital sites took around four to six months to activate after central ethics and regulatory approval.



The Valuing Life Summit also described centralised ethics, the statutory regulatory timeline and national contracting templates as strengths supporting efficient start-up, while acknowledging that ethics review has become slow and inconsistent.

The survey was generally more negative about the full pathway and the current state, consistent with claims that this aspect has deteriorated further in recent months. Survey responses also highlighted that uncertainty can be as damaging as delays, and that it was increasingly difficult to provide credible activation dates – a key concern for sponsors.

Public-site capacity is a binding constraint

Public hospitals were noted as the bottleneck that contributed to significant delays in some cases. This was attributed to limited research capacity and a lack of protected time for trial work despite clinicians wanting to undertake trials. Some sites lacked key workforce, such as research nurses, coordinators, start-up specialists, pharmacy capacity, space or appropriate facilities.

Public-site constraints were shifting activity towards private sites. But some trials cannot be delivered without public hospital services.

Workforce shortages result from a lack of training pathways

The workforce challenge was identified as a consequence of a lack of training pathways in the public sector. Heavy reliance on the private clinical trials sector and global sponsors meant peaks and troughs that had to be managed, with negative consequences for job security.

Public-private partnership and collaboration is not supported

Survey respondents identified a need for greater public-private collaboration and genuine public-private partnership, but despite the clear benefits of this, the public sector is not supportive. Multiple respondents described Health New Zealand | Te Whatu Ora as unsupportive of clinical trials generally and uninterested in exploring partnership opportunities. Some respondents felt that decision-makers at Health New Zealand | Te Whatu Ora do not understand the value that clinical trials provide to patients or the health sector, hindering any attempts to optimise resources and maximise benefits through public-private partnership.

Gaps in funded standards of care reduce protocol feasibility

For later-phase international trials, the protocol may assume that participants can receive treatments or diagnostics that are standard overseas. Where those are not funded or routinely available in New Zealand, patients may be ineligible, the required comparator may be unavailable, or the protocol may be impractical. Some respondents noted that where sponsors have faced this problem, they face a choice between additional cost to run the trial in New Zealand, funding treatments in both arms of the study, or choosing another trial destination.

Delayed public funding and gaps between New Zealand treatment and international standards of care can leave sites without an appropriate comparator treatment and make some multinational trials impossible to conduct.

The problem was noted by some to be compounding over time. As health care advances are taken up overseas, a persistent funding gap in New Zealand renders an increasing share of trial protocols incompatible with New Zealand practice.

Post-trial market access creates ethical, operational and investment uncertainty

Market access for pharmaceuticals was noted as being very slow in New Zealand, and sponsors face an ethical dilemma when trials end, and sponsors are not confident that patients will ever gain access to funded treatment. This results in costs associated with ever-growing sponsor-funded compassionate access programmes and is increasingly taken into account in ethics reviews informing sponsor decisions about trial locations. Trials should improve pathways to innovation, but patients should not have to depend on participation in research to receive internationally accepted care.

Succession risk threatens both organisations and the wider ecosystem

A small number of responses noted that significant restructuring in the sector raises succession risk. Closures and mergers with larger global organisations that may not wish to maintain a presence in New Zealand could mean key experience, expertise, relationships, reputation and credibility are lost to the sector.

Costs and tax settings weaken the commercial proposition

Some respondents reported rising site costs or insufficient commercial return. New Zealand's R&D tax settings were perceived as less straightforward or less competitive than Australia's, for pharmaceutical companies in particular. While the incentive is also smaller than Australia's R&D tax credit, access barriers for pharmaceutical companies stood out as the major concern.

Global competition is growing, and other governments are backing their sectors

Countries in Asia and Europe are becoming more attractive trial destinations, and Australia provides a close comparator to New Zealand with greater scale and stronger incentives.

Survey respondents noted that the New Zealand government does not promote clinical trials globally in the same way that other countries, notably Australia, do. Governments play a key role in building sponsor knowledge and confidence in a country's clinical trials institutional settings, and this is all the more important for small countries like New Zealand where there may be important advantages, but these are not well recognised internationally.

6.3 Opportunities to do more or better in the current context

Survey respondents indicated that New Zealand cannot compete with large countries on population size alone, so the opportunity to increase attractiveness of the clinical trials sector in New Zealand lies in combining speed, quality, recruitment performance, trusted data, specialised capability and access to well-connected clinical networks.

Survey respondents strongly called for protecting existing strengths and building on them.

Use national coordination to make the small New Zealand system work more cohesively.

Several survey respondents and Valuing Life Summit participants noted that small scale can be an advantage if organisations are well connected and integrated. A national network could make capacity visible, route opportunities to appropriate sites, coordinate referrals, share specialist expertise and reduce duplication. The Summit proposed a national clinical trials network and registry covering public and private sites, universities, contract research organisations, sponsors, non-governmental organisations, clinicians, patients and



communities. The idea of a national network was also brought up in multiple survey responses with reference to the discussion at the Summit.

A single front door to reduce barriers for international sponsors

The concept of a single front door would make New Zealand easier for international sponsors and non-commercial collaborators to navigate. It need not centralise every operational decision. Its value would come from providing authoritative information, directing enquiries, coordinating feasibility, identifying capability and escalating cross-system barriers. A registry or national capability platform could show active trials, research-ready sites, therapeutic expertise, specialist services and recruitment pathways. For participants and clinicians, it could improve visibility of trial opportunities. For sponsors, it could reduce the cost and uncertainty of country and site feasibility. For government, it could improve understanding of activity, capacity and gaps.

Horizon scanning to identify investment needs

While survey respondents did not describe a role for horizon scanning, multiple respondents pointed to discussion at the Valuing Life Summit about gaps in the existing system. Participants at the Summit noted that horizon scanning is the most important additional system function needed. A coordinated horizon-scanning function could identify emerging therapies, technologies and trial designs before they reach New Zealand. It should assess unmet need, likely standards of care, diagnostic and genomic requirements, workforce implications, infrastructure needs, regulatory questions, potential budget impacts and post-trial access issues. This would allow New Zealand to be a fast follower by identifying areas aligned with national needs and existing capability and preparing the relevant parts of the system in advance. Horizon scanning would also connect trials more clearly to eventual patient access.

Investment in early phase and specialised research

Survey respondents identified opportunities to develop stronger early-phase and specialised research niches. Early-phase research was identified as less constrained by differences in funded standard care than later-phase comparator trials. New Zealand's data quality, investigators, willing participants and private-site capability could support further Phase 1 growth. Some respondents indicated that specialisation could compensate for scale, and that this had been demonstrated. Survey responses point to oncology, haematology, vaccines, rare disease, precision medicine, medtech, and real-world evidence as areas of deep specialisation in New Zealand.

Rare disease research was noted as an area that would benefit from stronger national coordination and referral networks. Although patient numbers are necessarily small, a well-connected national system would better identify eligible participants and reduce geographic barriers to participation.

Increase Māori, Pacific and rural participation

Some survey respondents identified a need for more participation by Māori and Pacific peoples. This was noted as requiring early partnership, culturally appropriate engagement, trusted local providers, attention to data governance and practical support for transport, time and whānau involvement. Rural participation was also raised as an area where improvement is needed.

Use public-private partnerships to expand capacity and share risk

Survey responses strongly emphasised that the public and private sectors are interdependent but that the system to support this does not exist in New Zealand. It was felt that institutional arrangements were needed to support greater collaboration and ensure consistent, efficient processes.

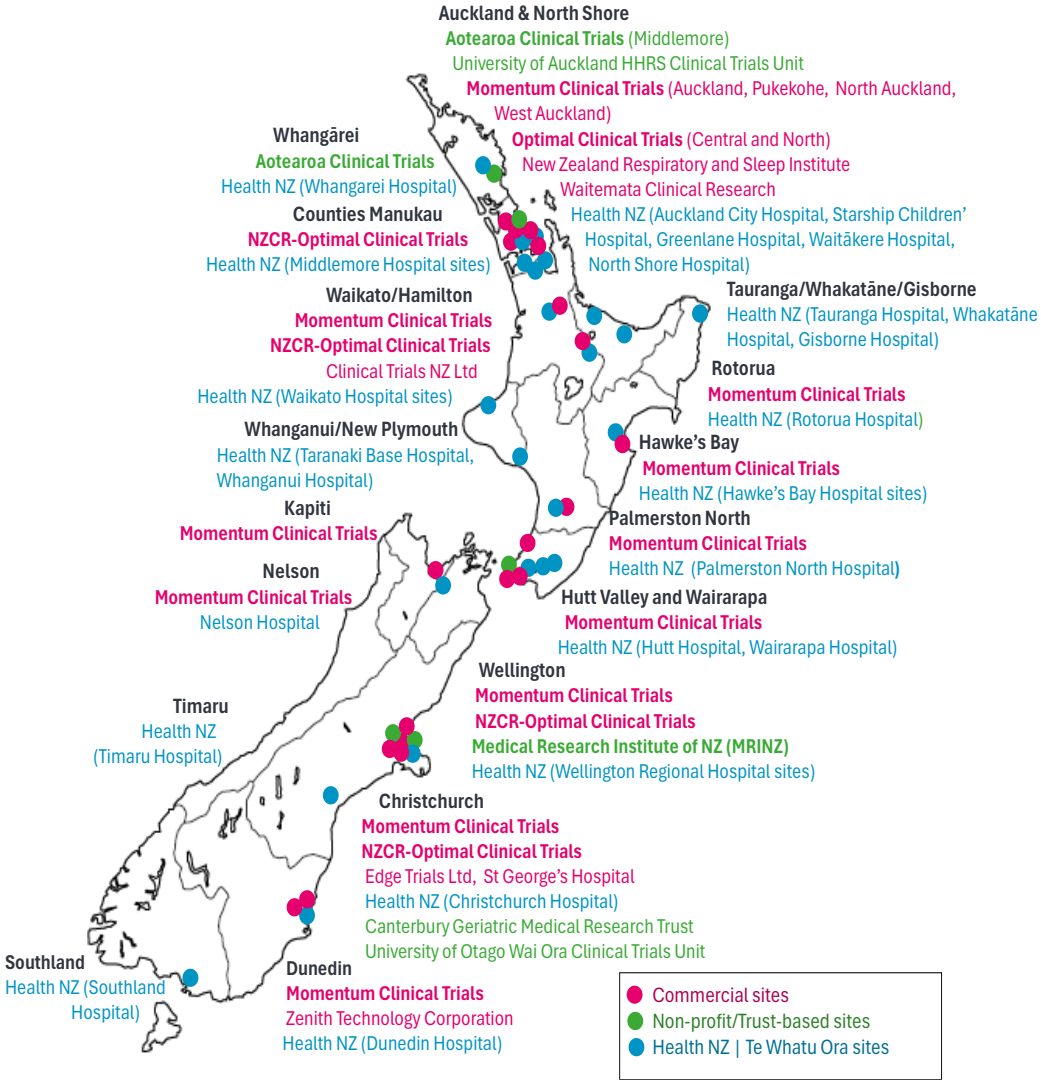
7 Sector spotlights

In this section, we spotlight several key players in New Zealand's clinical trials ecosystem, including insights from interviews with some of them.

7.1 Sites and site networks

Sites and site networks play a critical role in providing physical facilities and staff for the execution of clinical trials. For a small country with a small population, New Zealand has extensive geographic coverage, including by commercial sites, which have extended from major cities into regional centres to improve recruitment. New Zealanders across most of the country can participate in trials locally, minimising travel and time requirements. This also means better access to the modern treatments trials provide for Māori and rural New Zealanders whose access to public health services is often more limited.

Figure 35 Coverage of clinical trial sites in New Zealand



Note: Sites captured may not represent all clinical trial sites in New Zealand, particularly commercial sites. Site locations were extracted from HDEC data, our sector survey, and information on public sector agency websites.

Source: NZIER

As shown on the map above, Momentum Clinical Research and New Zealand Clinical Research (NZCR)/Optimal Clinical Trials are the two major players in commercial sites, with site networks spanning multiple regions.

7.1.1 Momentum Clinical Research

Momentum Clinical Research operates specialised research facilities across New Zealand and Australia that handle clinical trials from Phase 1 (first-in-human) to Phase 4.

Momentum was formed in 2024 when New Zealand's long-running P3 Research Ltd merged with the Australian operations AusTrials and Holdsworth House to create a unified trans-Tasman research model. In September 2025, Momentum merged with Pacific Clinical Research Network (PCRN), another large New Zealand network of private clinical trial sites.

Now with over 10 sites across the region, Momentum delivers end-to-end trials from Phase 1 first-in-human to Phase 4, combining centralised efficiencies with strong local site leadership for fast, reliable studies that expand community access to innovative treatments.

The single-contract system offers sponsors a "one contract, multiple sites" framework, cutting down administrative bottlenecks and smoothing budgeting across different clinics. The service offering is backed by a combined participant database of over 200,000 individuals and centralised recruitment and in-house outreach teams that accelerate patient enrolment and improve trial retention.

New Zealand locations span the North and South Islands:

- **Auckland (Takapuna, Silverdale, West Auckland & Pukekohe),** including Momentum's flagship facility in Takapuna. This facility, situated within 2km of North Shore Hospital, is co-located within a medical complex including general practice and radiology providers and was purpose-built as an advanced facility equipped for early-phase and Phase 1 inpatient trials.
- **Waikato, Rotorua and Palmerston North locations:** increasing access to trial participation for communities that traditionally have limited access, including people living rurally and Māori.
- **Wellington region locations (Wellington central, Upper Hutt and Kapiti):** Wellington - providing comfortable space for overnight or extended patient assessments close to Wellington Regional Hospital. The Upper Hutt facility, located in the Upper Hutt Health Centre, brings outpatient and chronic condition studies into the primary care setting
- **Nelson, Christchurch and Dunedin locations:** Momentum's strong South Island presence expands access to diverse communities and provides a range of site facility capacity for different outpatient trial types. For example, the purpose-built Dunedin site includes facilities to enable extended day stays.

Trials hosted by Momentum have covered a wide range of therapeutic areas, including respiratory studies on chronic conditions like COPD, bronchiectasis, and asthma, therapies for hypertension, cardiovascular disease, and type 2 diabetes, treatments for severe eczema, psoriasis, and coeliac disease, and studies on migraines, chronic pain, and healthy volunteer vaccine safety evaluations.

Our interview with Momentum revealed that the clinical trials ecosystem faces significant challenges that are likely affecting the ecosystem's structure and may impair New Zealand's

overall capacity to run trials in the coming years. Interviewees indicated that the current concerns are multifactorial:

- **New Zealand's Constrained Pharmaceutical Funding Environment/Market Access Limitations.** Reduced demand for services due to large pharmaceutical companies beginning to withdraw from clinical trials in New Zealand, driven by challenges in market access. This was identified as a major challenge with two dimensions:

  > *"It's not only in terms of the ethical concerns of ending a trial and withdrawing access to an effective medicine without being able to offer patients any realistic hope of funded access in the near future. It's also due to the standard-of-care medicines required in trial protocols. They are increasingly not funded medicines in New Zealand, so sponsors have to fund both arms".* (Sector Survey Participant)

  This increases the costs to sponsors of running trials in New Zealand, both during and after the trial. Momentum reports that the CROs they engage with are experiencing reduced demand in the New Zealand market as a result of this issue and are seeing those trials go to other countries instead.

- **Changing trial profiles and sponsorship mix:** Sponsors are still bringing trials to New Zealand, but this is more likely due to the need to use New Zealand to boost recruitment for difficult-to-recruit trials. This has shifted the mix of trials CROs are being asked to manage. This was estimated to be shifting from 85 percent of trials for big pharmaceutical sponsors around 2 years ago, to more like 45 percent now. Biotech sponsors are now a more dominant source of trial sponsorship, now representing 55 percent of CRO business. Biotechnology companies primarily sponsor phase 1-2 trials with lower patient numbers. The shift from in-house R&D by big pharmaceutical companies to outsourcing this to biotechnology companies is also partly driving the shift to biotechnology as trial sponsors.

  Revenue per unit of labour has been reduced because of the change in trial mix. Because there is now proportionately more early-phase trial work, there is a more intensive and complex process to find participants who can be randomised into a study. This puts a lot of pressure on margins.

- **A less attractive R&D Tax Incentive compared with Australia.** The New Zealand R&D tax incentive further reinforces the shift from big pharmaceutical company sponsors to biotechs. The Australian R&D incentive is much more attractive to the big pharmaceutical companies, who are now increasingly choosing Australia.

- **New Zealand Trade and Enterprise support is lacking**. Attracting clinical trials is being left up to the site networks and CROs, in contrast to other countries, such as Australia, where the government is actively supporting the sector.

  > *"Other governments seem to recognise the value of clinical trials much more and they're out there trying to attract investment, talking to sponsors, and making sure their domestic capability and regulatory settings are recognized and understood. When we go to road shows overseas, we see the Australian federal government – even state governments. They have a really strong presence. But we're there on our own representing New Zealand."* (Sector Survey Participant)



A lack of visible government support doesn't inspire the same confidence as when a government gets behind it. Australian federal and state governments are doing a great job of promoting the R&D tax incentive they offer as well as promoting all the regulatory, capability and other benefits they offer. In comparison, the benefits of running trials in New Zealand are not well recognised internationally. Given that this investment supports New Zealand jobs, adds value to the health sector, provides opportunities for patients and volunteers, supports economic activity across other sectors, and generates tax revenue, the government really ought to take an active role.

- **Untapped value of public-private system collaboration in New Zealand**. Momentum considers that there are opportunities for partnership and collaboration between private research sites and Health New Zealand that could increase New Zealand's capacity to undertake trials and expand geographic access for patients outside of major urban centres. However, these opportunities currently remain untapped. Improvements to Health New Zealand's decision making and contracting pathways focusses on facilitating public-private collaboration would have the potential to increased trial activity and the value of physical trials to the public health system:
  - For example, if a trial requires specific hospital-based assessments and the capacity needs to be made available across multiple hospitals, including public and private, or if referrals to the trial depend on patients coming through who are currently being treated in the public health service, requiring a strong referral pathway, a collaborative model would make it easy and fast to arrange.
  - A simple, centralised and consistent process supporting collaboration through contracting-in investigators who work in the public system would facilitate collaboration compared through the common approach of contracting public system investigators through their private practice on an individual basis.
  - Genuine openness and a culture of collaboration is essential. Momentum has had discussions with large public hospitals in Australia where there is real openness to collaboration for training, sharing resources, establishing and supporting referrals, etc. While Australian hospitals are not all supportive, and there is no centralised process, they run independently and this means it is possible to work with those who are open and pro-active about collaboration. Because New Zealand's decision-making processes about public health system-private clinical trial collaboration sit centrally, it is critical that decision-makers recognise the value of public-private collaboration.

  Momentum sees a significant opportunity for greater collaboration between Health New Zealand, the National Clinical Trials Group and established private clinical research providers. While Momentum has not directly pursued a formal partnership with Health NZ, it has experienced the flow-on effects of current operating arrangements and decisions on clinical trial delivery and access.

  A more integrated approach, recognising the complementary capabilities and capacity of public and private providers, could significantly improve trial efficiency, expand patient access and attract greater international investment. Momentum would welcome the opportunity to contribute to developing practical partnership models that leverage existing infrastructure, clinical expertise and recruitment capabilities across the country.

- **Workforce capacity and employment sustainability challenges. Momentum indicated that workforce and sustainability challenges are significant in the New Zealand clinical trials landscape:** Momentum highlighted that changing trial demand, workforce constraints and the costs associated with maintaining specialist clinical research capability are creating significant sustainability challenges across the sector. Without a coordinated approach to attracting investment, developing workforce capability and enabling collaboration, New Zealand risks losing valuable clinical research capacity and expertise. Equally, these challenges present an opportunity to establish a stronger, more connected and sustainable national clinical trials ecosystem that supports investment, employment and improved patient access

Momentum's observations regarding workforce capacity and employment sustainability were supported by insights shared by other stakeholders.

7.1.2 New Zealand Clinical Research Group (NZCR/Optimal Clinical Trials)

New Zealand Clinical Research Group (NZCR Group) is a private, physician-led clinical research organisation that today operates clinical-trial sites across New Zealand and Australia running under four brands – NZCR and Optimal Clinical Trials in New Zealand, and Fusion and CMAX in Australia.

NZCR was formed in mid-2020 by the merger of two well-established and highly regarded early phase research sites - Christchurch Clinical Studies Trust which was founded in 1999 as the first early phase unit in New Zealand and Auckland Clinical Studies which was founded in 2006. The merger of these two significant early phase research units, each with substantial capacity for in-patient-based early phase studies, has provided a solid base for capturing early phase business from a diverse range of international sponsors and scientific collaborations in cutting-edge fields such as *in vivo* gene editing.

Optimal Clinical Trials founded in 2012 by a husband-and-wife team of general practitioners has over the years built a very substantial community base for outpatient (Phases 1b–4) studies in the Auckland area. In the years they have been operating they have undertaken studies in over 20 therapeutic areas but have become particularly established in vaccine studies, chronic conditions including metabolic disease, dermatology and rheumatology trials and studies in older people. Whilst working with a range of sponsors and CROs, it is notable that NZCR Group sites (NZCR and Optimal sites) have been recognised as high-performing sites by the global CRO PPD Clinical Research Group – part of ThermoFisher Scientific and selected as PPD Select Network Partners in New Zealand. NZCR's acquisition of Optimal Clinical Trials in 2023 has resulted in a full offering across the entire clinical development lifecycle, combining NZCR's recognised Phase 1 leadership with Optimal's later phase specialisation.

NZCR/Optimal operates under 2 guiding principles:

- a physician-led, specialised early phase trial site
- an over-riding commitment to deliver excellent research.

NZCR/Optimal conducts clinical trials on behalf of pharmaceutical companies, biotechnology companies and CROs, offering extensive pharmacy, laboratory and regulatory services, medical expertise, and recruitment.

Combined with experience across a wide range of therapeutic areas and the expertise of 19 principal investigators, NZCR/Optimal reaches a diverse population and offers rapid

recruitment from a database of over 140,000 participants. NZCR/Optimal reports that it has completed more than 800 trials, including more than 140 first-in-human studies dosing more than 17,000 participants.

Through its leadership and its work with respected principal investigators, specialist clinicians, research nurses, study coordinators, pharmacists, laboratory staff and other research professionals, NZCR/Optimal has built deep expertise over more than two decades. This means NZCR/Optimal offers a depth of operational capability that is very attractive to trial sponsors and CROs and that allows it to leverage strong relationships with internationally renowned investigators to attract both large and complex trials.

Increasingly, its Phase 1 work has involved more complex trials, and this distinguishes it from other Phase 1 units around the world and allowed it to develop this as a competitive advantage from what was a unique value proposition 25 years ago. NZCR/Optimal has sites in the four largest cities in New Zealand:

- **NZCR Phase 1 units in Christchurch and Auckland**, with 81 inpatient bed capacity across the two sites, including eight private suites, and separate outpatient facilities with clinical beds, two laboratories and two pharmacies;
- **NZCR Outpatient sites in Hamilton and Wellington**, including two laboratories;
- **Optimal Clinical Trials Outpatient sites in Auckland Central and North Shore** with 30 outpatient beds, two laboratories and two pharmacies.

NZCR/Optimal's facilities are purpose-built research units, offering medicine and sample storage, laboratory-processing capability and equipment for safely monitoring participants after dosing. These facilities are particularly important for early-phase trials, where participants may need to remain in a research unit overnight or for several days and be monitored closely.

With over 375 FTE, and hosting approximately 59 clinical trials in 2025, the NZCR/Optimal group now has sufficient scale and capability that some services it offers overlap with CRO functions, offering sponsors an integrated service.

NZCR/Optimal is optimistic about its own growth opportunities and is planning to open a new Auckland site of over 4,000m2 and 65 new confinement beds in late 2027. It is also expanding its North Shore footprint and expects to do the same in Wellington in the next 12 months.

The interview with NZCR/Optimal identified three key areas that warrant attention to ensure New Zealand sustains its current market position and is positioned for growth:

- **Public-Private collaboration**

Despite being a major player with a strong outlook, NZCR/Optimal finds that public-private collaboration is lacking in New Zealand, as there are no institutional arrangements to support this. Collaboration between the health system and private entities is negotiated on a case-by-case basis and depends more than it should on relationships between individuals, which often also means careful selection of the few within the public system who are open to collaboration. It's NZCR's view that collaboration would be beneficial for all. This is because early-phase work is essential to build relationships with sponsors, but hospitals generally are not able to do early-phase work, so dedicated sites like NZCR/Optimal's are essential in this space to build the relationships and secure sponsor's confidence for later-phase work.



- **Improved marketing and a NZ Inc-type approach**

NZCR/Optimal sees marketing as the main mechanism for attracting trials – more so than R&D incentives, although it notes Australia has used its R&D incentive as an effective marketing tool, highlighting to foreign sponsors its relative ease of access compared with the New Zealand equivalent. They are also very supportive of New Zealand presenting a unified value proposition through a collaborative approach to international marketing efforts, such as the New Zealand Trade and Enterprise coordinated New Zealand BIO Tech Pavilion at the BIO 2026 International Convention in San Diego.

> *"One of the strongest signals from the week was the value of showing up collectively. When companies, research organizations, and industry partners tell a broader New Zealand story together, it helps amplify the scale, capability, and credibility of the entire ecosystem."* (New Zealand in North America 2026)

- **Rapid approvals**

Above all, the speed of the approvals process is a critical strength to maintain in New Zealand. Faster start-up timelines can make a country more attractive for sponsors deciding where to place studies, as the approvals and recruitment of the first participant is crucial for unleashing funding from global investors who make milestone-based payments (sometimes known as First-Patient-In funding). The importance of quick start-up is important for all trials but particularly for later phase trials which require larger numbers of patients to be recruited and thus are generally run as multicentre global trials on a competitive recruitment basis.

When studies are run using a competitive recruitment model, sites that are approved faster and can begin recruiting faster are potentially able to recruit a larger share of the overall recruitment target for the study than sites which start later. As sites are primarily paid on the basis of per participant fees, which are contracted for using a per-participant per-visit or per-procedure structure, the ability to recruit a larger share of the overall study recruitment target translates to a larger share of the global study budget.

In New Zealand's case, starting later may potentially mean missing out on the chance to recruit at all if countries with large populations that are motivated to join trials (e.g. China, Mexico, etc.) get to start recruitment earlier and fill the study quota quickly. This has a significant bearing on the financial viability of trial participation at a site and country level. NZCR/Optimal is concerned about the potential for insufficient government funding of ethics and regulatory approvals capacity to erode New Zealand's strength in approval timelines. This could mean New Zealand misses out on a significant source of investment from a decision to trim costs.

NZCR/Optimal emphasised that speed of approvals and start-up is absolutely critical and that clinical trial activity in New Zealand would decline dramatically if sponsors lost confidence in it

Takeaways from key site networks and other site stakeholders

Sector interviews, the sector survey, and interrogation of the HDEC data set all demonstrate that the business of running trials can be somewhat "lumpy". This is hard to manage in a small country with skill shortages and poor connections between key parts of the sector ecosystem. Overseas, there tends to be big government grants for clinical research and these help to smooth the demand by providing a solid base of revenue, making it easier for sites, CROs, and NCROs to operate, but New Zealand's public funding of health research has historically compared poorly with other developed countries.

Government support is needed for the ecosystem to thrive and grow:

- Ensuring that New Zealand continues to offer robust systems for regulatory and ethical approvals to support efficient study start-up timelines is key to our national value proposition.
- Going forward, New Zealand also needs to better capture available international opportunities for foreign investment.
- Trial sponsorship predominantly originates from the USA. New Zealand is missing out on the opportunities presented by Asia's biotech boom.
- The association of New Zealand to Pillar II of Horizon Europe, the European Union (EU)'s key funding programme for research and innovation should be maximised for broader cross-sector benefit. With a contestable budget for health research of €8.2billon, Cluster 1 (Health) of Pillar 2 of this European initiative presents a significant opportunity for New Zealand clinical researchers.
- A "NZ Inc" marketing approach is urgently needed and better connection across the New Zealand clinical research ecosystem and collaboration between public and private sectors facilitated by a national clinical trials collaboration and coordination function could greatly increase New Zealand's ability to grow sustainably.

7.2 Supporting services

The clinical trials ecosystem is complex and includes a wide range of supporting services industries that are less visible to sector outsiders but critical to the day-to-day execution of clinical trials and New Zealand's ability to attract clinical trials and global sponsors. Key players in this space are diverse and include human-capital intensive companies such as CROs that offer specialised project management, scientific, and regulatory expertise through to businesses that are capital-intensive asset heavy service providers such as laboratories and sterile compounding and manufacturing facilities.

To better understand the role of these support service providers and their perspectives on the New Zealand clinical research sector, its challenges and opportunities, information was gathered from public sources, the sector survey and interviews with companies/organisations involved in key service areas for the sector:

- CROs and Specialist Consultants/Contractors – IQVIA, PPD Clinical Research Group – Part of ThermoFisher Scientific, HiRO and new entrants in the sector Bubble Clinical Research and Sapro.
- Laboratories – Awanui Laboratories and Hugh Green Technology Centre at the Malaghan Institute.
- Compounding pharmacies/services – Slade Health.
- Specialised logistics services – Cencora World Courier.

Our research revealed a highly sophisticated and developing set of supporting services enabling clinical trials in New Zealand and supporting high value employment and economic activity.

7.2.1 Contract Research Organisations and specialist consultants/contractors

Clinical trials are highly complex undertakings that are governed by stringent regulatory and ethical standards. In addition to local regulatory and ethical requirements, clinical trials must be conducted in accordance with the International Council for Harmonisation Good Clinical Practice (ICH GCP) guideline, which establishes internationally recognised standards for protecting the rights, safety, and well-being of trial participants and ensuring the integrity and reliability of clinical data. Successful execution of a trial thus requires careful planning and project management, and robust systems of oversight to ensure that ICH-GCP compliance requirements have been met. Some trial sponsors elect to undertake these responsibilities themselves; others may choose to contractually delegate some or all of these responsibilities to a CRO or to a specialist contractor/consultant.

A CRO is a specialised service provider that offers outsourced specialist management and expert operational support for clinical trials. CROs range from small, niche local providers to large multinational companies that offer a comprehensive range of services including study design, site management, monitoring of trial conduct, data management, biostatistics, pharmacovigilance, and regulatory submissions. They serve as the primary connection between the sponsor and the clinical trial sites. By outsourcing to a CRO, sponsors can run complex, compliant global trials without needing a strong presence at every trial location.

Additionally, as clinical trials become increasingly data-intensive and operationally complex, larger-scale CROs can provide the infrastructure, experience, human resources, and quality systems needed to manage risks, maintain compliance, and deliver studies efficiently. They are particularly useful for smaller sponsors, such as Biotech firms that may not have the in-house capability to bring new therapies to market, and they offer larger sponsors greater flexibility in managing varying resourcing demands across product development lifecycles.

In New Zealand, although some Sponsor companies rely on in-house employee resources for local trial management and oversight, it is very common that CROs or contracted specialist consultants will be involved. CROs offer a particular value in the New Zealand context because many commercial sponsors have little to no footprint in New Zealand. For similar reasons, there is an increasing number of specialist contractor/consultants working in this space – often these people are former employees of sponsors or CROs.

CROs operating in the New Zealand context may be affiliates of large global CROs or smaller companies that may be contracted to either the sponsor or the Global CRO. Once their services are commissioned, CROs in New Zealand typically manage the full lifecycle of a

clinical trial, completely overseeing the trial from end to end, from necessary regulatory/ethics approvals through to “last patient last visit” and database lock.

Dependent on their service offerings and the nature of the trial concerned, they may help design the trial protocol, perform geographic feasibility assessments to determine which sites are best suited for the trial, set up contracts, train site staff, and design and manage patient recruitment strategies. CROs can also be important advocates for New Zealand as a research destination. By participating in global feasibility bids for studies and leveraging global company and local networks to identify qualified clinics and appropriate Principal Investigators, CROs operating in New Zealand can drive trial work to New Zealand.

Consequently, CROs operating in New Zealand are key employers of clinical research personnel supporting the conduct of commercial clinical trials.

Based on data from the sector survey, approximately 30 percent of the highly skilled New Zealanders working on commercial clinical trials are working in this space for CROs or as contractors or consultants.

Major Global CROs – with long-established New Zealand operations

IQVIA

IQVIA is one of the world’s largest CROs. Formed in 2016 through the merger of IMS Health and Quintiles, IQVIA integrates health data, advanced analytics and technology with end-to-end clinical development and trial delivery capabilities.

IQVIA’s New Zealand operations work closely with its Australian and broader Asia-Pacific teams and employ Clinical Research Associates and other clinical research professionals in New Zealand. This enables IQVIA to support coordinated clinical development strategies and trial delivery across Australia and New Zealand, while drawing on broader regional and global capabilities.

The 2025 New Zealand clinical trial activity reported by IQVIA in this survey was commercially funded and included medicine trials across Phases 1 to 4, including first-in-human studies. IQVIA also offers global capability in medical devices, cell and gene therapies, digital health, diagnostics and other interventions, which can be deployed to support relevant opportunities in New Zealand.

IQVIA’s global scale and breadth of expertise also extend to screening, diagnostics and non-drug, non-device interventions, including digital health, digital therapeutics, in-vitro diagnostics (IVD) and related evidence-generation and compliance support. These activities are not currently prominent in New Zealand but represent potential areas for future sector expansion.

IQVIA also has expertise in trial designs and research approaches including adaptive designs, decentralised and hybrid trials, registry studies, pragmatic studies and other real-world study designs. Its real-world evidence capability covers New Zealand and includes prospective observational research, patient registries, retrospective research, electronic health record (EHR) and database studies, and other non-interventional approaches.

As a major global CRO with a diverse client base, deep technical expertise and well-established operations in New Zealand, IQVIA helps to strengthen the country's clinical research workforce. Its Australia and New Zealand Clinical Research Associate (CRA) training programme provides structured learning and practical experience for people

entering the profession. With experienced clinical research professionals in strong demand, the programme represents a significant investment in New Zealand's future capability.

PPD Clinical Research Group – Part of ThermoFisher Scientific

PPD Clinical Research Group (PPD) is a global CRO that has extensive and long-established operations in both Australia and New Zealand, which began with the establishment of an office in Australia in 1997. Over the last 3 decades, PPD has established its presence in Australasia and has built a combined team of approximately 450 clinical research professionals. In recent years, they have been commissioned to undertake over 400 studies in New Zealand across a diverse range of study phases and therapy areas, including Early Phase, vaccines, gene therapies, oncology and rare disease studies. Responding to this significant level of local activity, the New Zealand team now numbers over 50 and includes a diverse range of professional clinical research roles in addition to CRAs.

PPD's team in New Zealand manages clinical trials on behalf of a range of trial sponsors including pharmaceutical and biotechnology sponsors, and medical-device manufacturers. Through the company's comprehensive full-service model, they can provide operational services encompassing study start-up, regulatory and ethics submissions, site selection, contracting, clinical monitoring, project management, data services and pharmacovigilance. In more than two decades of operating in New Zealand, PPD has worked with independent private, public-hospital, and university researchers and sites. They have now built relationships with over 30 New Zealand sites, meaning they have full geographic reach around New Zealand and can support strong trial recruitment.

Globally, PPD has established the PPD Select Network Partners & Preferred Sites program, which is a network of high-performing clinical research sites. The network aims to connect these trial sites with pharmaceutical and biotech sponsors to speed up trial execution through streamlined operational processes. The New Zealand site service providers, NZCR Group, Momentum Clinical Research and Aotearoa Clinical Trials have been selected for this program in recent years.

PPD was acquired in 2021 by ThermoFisher Scientific, a global American life sciences and biotechnology company with a broad base of providing scientific goods and services including analytical instruments, laboratory equipment, software, consumables, and pharmaceutical contract manufacturing and development services for small molecules and biologics. Through the acquisition of PPD, ThermoFisher Scientific can now offer a comprehensive suite of services across the clinical development spectrum − from scientific discovery, to assessing safety, efficacy, and health care outcomes, to managing clinical trial logistics, to the development and manufacturing of the drug product.

In New Zealand, in addition to its scientific supply business, ThermoFisher Scientific operates advanced biomanufacturing facilities in both the North and South Islands. This complements the sizeable clinical research service operation PPD built in New Zealand before its acquisition. This gives the company a distinctive local footprint that connects New Zealand's broader healthcare and biotechnical sector including public hospitals, laboratories, Universities, researchers and private trial sites with a global life-sciences and pharmaceutical-development network.

Boutique CROs – Emerging and Specialist Players with strong New Zealand connections

Harvest Integrated Research Organization (HIRO)

Harvest Integrated Research Organization Australia-New Zealand (ANZ), usually referred to as HiRO or Harvest IRO, has evolved from Pharmaceutical Solutions Limited (PharmaSols), a New Zealand business established in 2000. PharmaSols' business developed around delivering Phase 1–4 trials in Australia and New Zealand for overseas biotechnology, pharmaceutical and CRO clients. As a relatively small, regionally specialised CRO, it formed strong relationships with investigators and research sites.

PharmaSols was acquired in 2021 by HiRO, a Shanghai-based CRO. HiRO itself was a relative newcomer, established in September 2020 with at that time an Asia-Pacific focus and offices in China, Taiwan, and the Philippines. It's acquisition of PharmaSols in 2021, gave HiRO an established ANZ operation with experience, expertise and critical regional relationships.

Since the acquisition of PharmaSols, HiRO's global operations have evolved significantly by diversifying and growing rapidly. In the last 5 years, they completed further strategic acquisitions of two speciality US-based CROs and an EU-based CRO and relocated headquarters to the USA. They now have over 500 staff across 85 countries and have delivered around 1,600 trials globally, building on 30 years of accumulated or acquired organisational experience.

The HiRO ANZ operation is headquartered in Auckland, with the ANZ team also located in Wellington, Tauranga, Christchurch and several Australian cities. Their New Zealand-based team of approximately 23 personnel has significant depth of experience across trials in diverse therapeutic areas including cardiovascular, oncology, blood diseases, endocrine and metabolic conditions, respiratory disease and neurology. They are a commercial, full-service CRO and can manage all or selected components of a clinical trial, including everything from:

- Pre-trial work such as feasibility
- Country-selection advice
- Protocol and trial-design support
- HDEC ethics and Medsafe regulatory submissions
- Clinical project management, site monitoring and close-out
- Investigational-product and specialist-logistics coordination
- Quality assurance and audits
- Data management and biostatistics
- Full medical package - monitoring, drug safety and medical writing.

HiRO's clients span biotech, pharmaceutical, and medical device sponsors, as well as other CROs, and they can also act as the New Zealand local legal sponsor for globally sponsored clinical trials when the global sponsor has no legal entity presence in New Zealand.

HiRO is an active advocate for conducting trials in the ANZ region with the HiRO ANZ team participating in the New Zealand Trade & Enterprise and Australian Delegations at the BIO2026 International Convention in San Diego, along with other life sciences conferences.

As part of a larger company, they can also market as part of an integrated global operating model under the HiRO Linkage, combining common systems, standard operating procedures, governance, data definitions and cross-regional teams. This dual-track marketing approach combined with a significant base of repeat ANZ business has ensured that HiRO continues to have a strong business base in Australasia.

New entrants in the sector

Filling a niche in the broader CRO support services sector are independent consultants (often sole traders) and emerging boutique CROs. These service providers often cater to small-to-midsize biotech companies and niche medical device developers, and can provide more flexible, specialised, and individualised client-focused service models. Their smaller scale means they can support clients that require tailored operational support, closer senior-level involvement, and more cost-effective delivery models than may be feasible for larger global CROs to offer. By emphasising personalised service, strong sponsor relationships, and agile clinical trial delivery, boutique CROs are marketing themselves in a way that complements rather than competes with larger multinational CROs.

Examples of businesses operating in this space are Bubble Clinical Research Services (Bubble CRS), a New Zealand-based boutique CRO and SAPRO, an Australian boutique CRO which has established a presence in New Zealand.

Whilst these businesses are relatively newly established, they both emphasise the depth and breadth of experience of their teams as key to their service offering. As smaller organisations, they can add value by providing high-quality expertise whilst maintaining organisational flexibility. Their more flexible business models and diverse sponsor client base from the biotech and device sectors also provide greater opportunity to engage with private specialists and smaller research sites, thus supporting a diversified site landscape.

These new companies have also been adept and active in building their profiles and marketing local capability through sector events. Bubble CRS's involvement with the inaugural NZACRes-led New Zealand pavilion exhibition at the 2026 ARCS Australia Annual Conference is an example of this activity and suggests both confidence in the market opportunities available to specialist CRO providers and the value of presenting a united New Zealand front.

Ecosystem insights from the CRO perspective

The CROs participating in our research identified key factors for sustainability and success in New Zealand, including predictable, efficient study start-up processes; timely and consistent ethics and regulatory review; and access to adequately resourced research-ready sites. Strong collaboration among sponsors, CROs, sites, and the wider health system is essential to improve delivery certainty and support long-term sector growth. Additionally, a skilled and sustainable clinical research workforce, including investigators, research nurses, study coordinators, and start-up specialists, is critical.

Barriers and challenges in the current New Zealand clinical trials landscape were identified as:

- A lack of dedicated research resourcing and capacity in public hospitals to initiate and conduct clinical trials at a pace that is competitive internationally. As a result, study start-up timelines can be affected by variability across sites in contracting, budgeting, and operational readiness.

- While relatively fast, HDEC approval timelines and review consistency are less predictable than in some European comparator markets, which can reduce New Zealand's competitiveness for global trial placement because predictability is a key concern that interplays with speed in global sponsor considerations of trial placement.
- Limited Pharmac funding for critical standard-of-care medicines and diagnostics can sometimes exclude New Zealand patients from eligibility for certain trials, particularly in Phase 2 and 3 Oncology and Haematology trials, unless sponsors are willing to fund the comparator treatment as well, which they often aren't willing to do.
- Workforce capacity constraints and variable site research infrastructure across the country can limit the sector's ability to scale efficiently and respond quickly to new opportunities.

Success factors from the CRO perspective

CROs said factors that would likely affect sector sustainability and success in New Zealand are the need for continued investment in site capability, streamlined contracting and budgeting processes, and broader access to funded standard-of-care medicines and diagnostics to support New Zealand's attractiveness as a clinical trial destination.

New Zealand's existing strengths, including high-quality data, experienced investigators, a stable operating environment, and a diverse patient population, provide a strong foundation for the value that would be derived from continued improvements in system enablers.

7.2.2 Other supporting services

Other supporting services include a wide range of services operating behind the scenes of the large sponsors, sites and CROs and providing both critical services to the clinical trials sector as well as the broader health sector and beyond.

Prominent amongst these supporting services are laboratories, compounding pharmacies/services, and specialist logistics services. To better understand the roles of these providers and their perspectives on the sector, its challenges and opportunities, we conducted interviews with:

- Awanui Laboratories
- Hugh Green Technology Centre at the Malaghan Institute of Medical Research
- Slade Health
- Cencora World Courier

Our interviews revealed a highly developed set of supporting services enabling clinical trials in New Zealand and supporting high-value employment and economic activity.

Spotlight on laboratories

Clinical trials use both local laboratories and central laboratories.

A central laboratory is a large-scale, highly specialised laboratory facility (or a strictly harmonised global network) contracted to process, analyse, and store all biological samples

collected across every single clinical site involved in a multi-centre or multinational trial. Central laboratories play a key role in supporting clinical trials by providing technical standardisation of trial sample analysis. In addition to providing analysis and testing of trial participant samples through standard laboratory panels, they may also set up and validate new assays to support innovative research approaches, including testing for novel biomarkers. In addition to providing standardised analysis processes, central labs commonly provide end-to-end support for specimen management. This can include the provision of pre-packed protocol- and study visit-specific standardised collection kits to study sites, comprehensive systems for labelling and tracking of samples, through to reporting of results to sites and data integration of lab results into study databases.

Currently there are no laboratories providing central laboratory services for commercial trials in New Zealand, and trial samples are routinely shipped to Australia and Asia (e.g. Singapore and China), and sometimes further afield for central lab analysis. In a small and geographically distant country like New Zealand, local laboratories play an important connecting role between research sites, central laboratories, and the needs of study sponsors for quick turnaround of key study laboratory results.

Awanui Laboratories

As New Zealand's largest network of pathology and laboratory diagnostic services, with more than 150 collection centres across major cities and provincial areas, Awanui plays an important role in supporting clinical trials throughout New Zealand. Clinical trials are an important and strategically aligned activity for Awanui, complementing its core diagnostic laboratory business and drawing directly on its extensive laboratory infrastructure, specialist expertise, established logistics network and national reach. These capabilities are particularly valuable in supporting trial accessibility for patients in regional New Zealand and enabling consistent service delivery across multiple trial sites.

Depending on factors such as site capacity, trial design and testing requirements, Awanui's involvement in commercial and non-commercial clinical trials can vary considerably. Its services include the pre-analytical management of clinical trial samples, including collection, stabilisation, centrifugation, storage, packaging and transportation. For studies where rapid turnaround is critical, Awanui provides expedited sample processing and analysis, including testing to determine patient eligibility and safety monitoring in early-phase trials. This includes routine pathology testing as well as access to more specialised testing where required.

Awanui's broad national coverage is a significant advantage for both commercial and non-commercial clinical trials. Awanui supports public hospital-based trials, private clinical research organisations such as NZCR and Momentum, university-led research, and larger multi-site studies involving 80 or more participants.

An important strength of the Clinical Trials Network established by Awanui (see text box) is the standardisation of laboratory testing platforms, methodologies and quality systems, which supports consistency and comparability of results across locations. This is particularly valuable for multi-site clinical trials, where reliable and standardised testing is essential to maintaining data integrity and

Awanui has established a dedicated **Clinical Trials Network**, bringing together clinicians, laboratory leaders, quality and safety specialists, and business managers to coordinate services and promote consistent processes nationally.

meeting study protocols. This coordinated approach has supported public health research such as the SHIVERSII (Southern Hemisphere Influenza and Vaccine Effectiveness, Research and Surveillance) study, as well as hospital-based and early-phase trials with more complex operational and analytical requirements.

Awanui has also invested in information technology capabilities and systems to meet the requirements of clinical trials, including data collection, data quality, traceability and reporting, with flexibility to accommodate trial-specific protocols and information requirements. National electronic ordering capability is also available through Awanui, supporting efficient and consistent test requesting and information management across participating sites. These capabilities, combined with established laboratory quality management systems, provide an important foundation for meeting the operational, data integrity and reporting expectations of clinical trial sponsors and research organisations.

Clinical trials also give Awanui opportunities to develop and apply advanced laboratory technologies and specialist analytical capabilities, with benefits extending into its wider diagnostic services. In particular, early-phase and more complex studies can support innovation, technical development and the introduction of new testing methodologies. For example, Awanui has been involved in developing and providing analytical services for biomarkers associated with new medicines. Clinical trial testing is generally integrated into existing laboratory operations, enabling Awanui to leverage established expertise and infrastructure while providing staff with opportunities for professional development, exposure to emerging technologies and a wider variety of work.

While Awanui does not operate a single dedicated central laboratory for clinical trials, it believes its integrated national network of laboratories, specialist testing capabilities and established logistics infrastructure can collectively meet a broad range of clinical trial requirements, including those involving more complex or specialised testing. The ability to coordinate testing across multiple laboratories, supported by standardised platforms, quality systems, information technology and sample transportation arrangements, provides an alternative to a traditional single-site central laboratory model. Awanui considers this integrated network approach a particular strength in New Zealand, offering flexibility, geographic accessibility and the ability to support multi-site trials through coordinated service delivery. Although some highly specialised testing is currently referred to overseas laboratories, Awanui sees opportunities to expand the range of clinical trial testing undertaken domestically by leveraging and further developing capabilities within its existing network.

Clinical trials represent an important and attractive area of activity for Awanui, strongly aligned to its core business and opportunities to contribute to the growth of the clinical research sector. The fee-for-service funding model supports appropriate resourcing and commercial sustainability, while participation in trials provides opportunities to strengthen technical capabilities, develop new services and build relationships with research organisations and pharmaceutical sponsors. Awanui has a dedicated Product Manager for Clinical Trials to support business development and coordination across its network, reflecting its commitment to this area. Awanui sees clinical trials as an area with ongoing potential and would welcome initiatives to strengthen New Zealand’s attractiveness as a destination for clinical research. With its national laboratory network, standardised testing platforms, established logistics infrastructure and investment in clinical trial-specific systems, Awanui considers itself well positioned to support future growth in clinical trials and an expanded range of testing services within New Zealand.



Hugh Green Technology Centre at the Malaghan Institute

An initial investment in 2010 from the Hugh Green Foundation (then the Hugh Green Charitable Trust) was the necessary stimulus to spearhead the establishment of the Hugh Green Technology Centre (HGTC) at the Malaghan Institute of Medical Research in Wellington. The HGTC remains within the Malaghan Institute, but with further investments from the foundation in 2019 and 2023, the centre has evolved considerably from its beginnings in terms of technical capacity, expertise and broader operational objectives.

The HGTC is now a leading biomedical research technology hub in New Zealand and is considered to be a centre of excellence for advanced research bioanalytics using flow cytometry.

From its philanthropically funded base providing analytical services to support the Malaghan Institute's own research, the HGTC is now making initial forays into providing bioanalytic services to support researchers and clinical trials from around New Zealand, including commercial trials. Currently, the centre is accredited by International Accreditation New Zealand (IANZ) to ISO/IEC 17025 for whole blood processing to peripheral blood mononuclear cells (PBMCs), serum, plasma and genomic DNA (gDNA). In 2025, they were vendor-qualified for PBMC isolation by Crux Biolabs, a leading Australian bioanalytic laboratory, enabling trans-Tasman partnership and collaboration and potential commercial opportunities.

The HGTC advises that they are now aiming to increase their service offering for trials by working towards accreditation for flow cytometry. As a result of the significant philanthropic investment there has been in equipment and technical development, the HGTC states that they are now the leading facility in New Zealand for flow cytometry. They consider that offering flow cytometry services is a natural fit for the centre's commercial offerings, building on existing capacity and expertise while complementing the work they do to support the Malaghan Institute's own research.

Achieving the necessary accreditation to offer commercial flow cytometry services will be a key milestone for the HGTC in moving to a more financially sustainable operating model. Alongside the technical challenges of entering the commercial market such as accreditation, the HGTC reports that, as a not-for-profit organisation, getting to grips with business development has been a core focus. Key challenges include understanding the size and nature of their customer base, marketing themselves, pricing their services, and managing long lead times for study contracts.

In 2026, the HGTC is moving to expand the team to further support their commercial and collaborative endeavours. They were an active participant in the New Zealand Trade and Enterprise showcase at the BIO 2026 International Convention in San Diego, which has supported exploring options in New Zealand and overseas. They are also looking ahead and considering adding genomics, histology, high-throughput cytokine analysis or bioimaging capabilities as part of their highly specialist niche offering.

Success in these endeavours will not only benefit the HGTC but will also fill a niche in New Zealand for local specialist laboratory offerings. By removing the need to ship samples internationally, it will reduce transit risks that can compromise sample quality and offer cost-saving benefits for other New Zealand researchers, including commercial research sites, that may otherwise have to send samples to Australia, Singapore or further afield for specialist analysis. From speaking with the HGTC, it is clear they are learning fast from their

experiences and are committed to pursuing commercial opportunities that support clinical trials through niche service provision as a specialist technical laboratory.

Spotlight on compounding pharmacies and services

A compounding pharmacy is a specialised pharmacy practice where pharmacists mix, alter, or combine medicines and raw chemical ingredients to create customised medicines and other pharmaceutical products tailored to specific needs of patients where mass-produced and existing commercial products are not available. This can involve preparing custom strengths, doses, or alternative formulations, as well as sterile admixtures for intravenous administration. While many standard pharmacies can perform basic extemporaneous compounding (such as mixing an oral liquid or cream), dedicated, specialised compounding pharmacies operate with advanced laboratories, precision equipment, and a more specialised staffing mix.

Compounding pharmacies are important to New Zealand's clinical trials sector due to the strong reliance on compounding for early-phase trials. During these early stages of the development of new medicines, the pharmaceutical compound may only be available as a raw powder or might not yet be optimised in terms of solubility, stability, or other properties. Compounding provides a suitable formulation to be administered to trial participants while ensuring appropriate product quality and adherence to trial dosage protocols.

Compounding helps early phase trials avoid significant direct and time costs by allowing them to bypass manufacturing processes and regulatory requirements for manufacture of a finished drug. Countries with supportive regulatory environments and compounding capability are ideal contexts for early phase trials, enabling them to start and progress more quickly and allowing formulations to be refined over the course of a trial, providing an efficient route to developing an optimal formulation. At the same time, because compounding enables the preparation of customised formulations for individual study participants, it ensures that each participant receives their most appropriate dose of the investigational medicine.

Specialist compounding services also have a key role in the larger-scale production of sterile admixtures of medicines for intravenous infusion, including for clinical trials. Sterile admixtures are preparations created under aseptic conditions by adding the active treatment(s) (such as a chemotherapy drug or antibiotic) to a larger volume of a base fluid such as normal saline. Historically, hospital pharmacies would have undertaken compounding to prepare sterile admixtures; however, with the need to increase production efficiency in the face of health system pressures, and the high costs of running aseptic clean rooms along with the health and safety issues arising with cytotoxic substances, there has been a widespread shift internationally to outsourcing this work.

Centralised batch production of compounded admixtures by large-scale, specialist compounding manufacturers is now standard practice internationally. The preparation of medicines for infusion in both public hospital and private clinic/private hospital settings is commonly undertaken by specialist, large-scale compounding facilities in New Zealand. This is particularly true with respect to the preparation of cancer medicines and applies to both medicines used for routine clinical care and medicines used in clinical trials.

In addition to the costs of staffing and facilities, compounding services must meet stringent quality standards. They are tightly regulated under the Medicines Act 1981 and the Medicines Regulations 1984 to ensure clinical safety, with regulatory oversight including licensing managed by Medsafe. These quality and regulatory compliance requirements are costly. There is a limited number of companies with facilities licensed to manufacture sterile preparations in New Zealand (Medsafe 2026) and with facilities that are suitable for the complexity of clinical trials and able to accommodate protocol-specific capacity requirements.

The additional revenue from clinical trials is attractive to compounding service providers and this has led to companies offering trial compounding services from both North and South Island facilities. A viable compounding services sector is important for the public health system, particularly hospitals, as the ability to tailor precise, individualised dosages or delivery mechanisms for specific patients, and meet demand for the production of sterile admixtures, directly supports more complex patient care.

Slade Health

One Medsafe licensed compounding service provider operating in New Zealand is Slade Health (Slade). Slade is part of ICON Oncology Group, a significant provider of cancer care in Australasia. In New Zealand, Slade is the preferred provider of compounding services to Health New Zealand | Te Whatu Ora Auckland. Slade also provides services to other Health New Zealand | Te Whatu Ora hospitals and to some private hospitals. The team at Slade's Auckland facility are experienced in compounding medications for Phase 1–4 studies, primarily in oncology and haematology.

Slade can ship medications to sites outside of the Auckland region by working with validated logistics firms with expertise in safe and secure cold chain or ambient transport of medications. Their system of national clinical trial co-ordination ensures relevant quality criteria have been met for the compounding of the investigational products, and that they can support the administrative work necessary for clinical trials, including documentary requirements for manufacturing, storage accountability and temperature control.

Slade is licensed in New Zealand by Medsafe and by the Therapeutic Goods Administration in Australia, as required for compounding manufacturers. Licensing and the compliance cost burden it presents were identified as a barrier to entry in both New Zealand and Australia and a reason why there are not many compounding manufacturers in either country. Slade is currently supporting 47 clinical trials in New Zealand and has seen growth in trials, up from 22 in 2022. In New Zealand, staffing to provide this service consists of one manager, one coordinator and one pharmacist.

Fees charged for a clinical trial will be determined on a case-by-case basis to ensure that they meet the operational costs of each study. Aseptic preparation fees are charged for each item of the study medicine/investigational product prepared. Slade indicated that

compounding service providers may also charge an establishment fee per trial site, an annual fee per trial, storage fees, and a completion fee per trial for documentation.

At the end of a trial, patients typically are able to continue on the relevant medication free of charge. This is "compassionate supply" of the treatment by the trial sponsor whilst it is not available through the public health system. One of the costs to sponsors is the compounding fee to prepare the medicine for the patients. The fee is charged to hospitals/clinics, who then pass on the cost to the sponsor. They noted that the duration of compassionate supply may be quite lengthy – it is not uncommon for former trial patients to be receiving compassionate supply for years. This is due to New Zealand's constrained pharmaceuticals funding environment.

Slade identified that access to medicines not funded in New Zealand is a major benefit to patients participating in trials but also indicated that there can be challenges in providing access to trials to regional patients. This is in part due to the lack of local public hospital pharmacist resourcing and capability or experience regionally. Slade does support regional work where possible, but this requires coordination and collaboration with regional hospitals, which is not always feasible if the hospital lacks clinical trial pharmacist resources.

Spotlight on specialist logistics services providers

Few people realise how much clinical trials rely on complex, specialised logistics. However, specialised logistics service providers are critical to clinical trials because unlike most commercial supply chains, logistics services supporting clinical trials require the equipment and capability to manage highly sensitive, irreplaceable payloads. Four critical requirements make these service providers highly specialised in the needs of clinical trials:

- Fine-tuned cold chain management: Many modern clinical trial materials, such as biological samples (blood, tissue), vaccines, and investigational medicines, are highly temperature-sensitive. This means they must be kept within strict, validated temperature ranges (ambient temperatures down to deep-frozen cryogenic states). Even minor temperature fluctuations can degrade a sample and damage trial data integrity.
- Time-critical process windows: Biological samples are highly perishable and often have a narrow 'viability window' (frequently 24 to 96 hours) from the moment they are drawn at a clinic to when they must be processed at a local or central laboratory.
- Strict regulatory accountability: Agencies like Medsafe and international bodies require a continuous, legally auditable chain of custody. Logistics providers must often supply continuous digital tracking data proving that experimental drugs remained stable and secure through transit.
- Navigation of customs complexities: the sensitive nature of clinical trial biological samples and clinical trial supplies, including medicines, vaccines, radiopharmaceuticals, genetically modified organisms, and hazardous substances, can present challenges in terms of international and domestic customs clearance, regulatory documentation, and express freight coordination. Expertise and efficient systems for customs brokerage and freight forwarding are essential to ensure that administrative oversights and errors do not lead to delays.

With trial design becoming more patient-centric, the role of specialised logistics services is increasing. For example, in some decentralised clinical trials, where study medicines are sent directly to the patient's home, a trained logistics professional can handle doorstep delivery. The same professional can also pick up temperature-controlled bio-samples right from the participant's home for shipment to the central lab.

Although the provision of specialist biomedical logistics services for clinical trials is complex, it is a commercially valuable business sector. It's clear that companies operating in this space take a very active approach to clinical trial focused business development, and they are common exhibitors at industry and academic life science conferences.

Data and insights gathered for preparation of this report indicate that there are four main specialist biomedical logistics providers serving the clinical trials sector in New Zealand and that this is sought-after business, with trial-related activity a primary driver for some of these international business operations having a footprint in New Zealand.

Cencora and World Courier

Cencora is one of the premier global providers of specialised biomedical logistics services. It operates within the clinical trial space through their prominent specialty logistics subsidiary, World Courier. World Courier handles a wide scope of study logistics in New Zealand for commercial trials including shipment of study medications and biological samples, it also supplies services to support non-commercial and academic research. A key focus for World Courier's business in New Zealand is the international shipment of biological samples from commercial trial sites to central laboratories – generally in Australia and Singapore.

New Zealand presents a challenging logistics problem for clinical trials due to our geographic isolation and small scale which results in reliance on overseas central laboratories. This means logistics services must handle domestic operations and coordinate the export of samples to massive hubs offshore. This involves the use of specialty packaging with advanced thermal shippers (using liquid nitrogen or dry ice) designed to hold a precise temperature for days to ensure they can safely outlast long-haul Pacific flights and unexpected flight delays. World Courier also provides experience and capability for navigating customs and New Zealand's strict biosecurity requirements for imports.

World Courier operates from a base in Auckland with 14 FTE working across customer service and operations, sales, and finance, and has specialised agents in Christchurch where they also have heavy infrastructure with fridges and freezers to store samples and supplies.

While major trial sites are located in Auckland and Christchurch, notably the early phase research units and cancer-focused research sites which generate significant volumes of samples, World Courier also provide logistics services supporting trials running at sites around New Zealand. New Zealand has a strong ecosystem of clinical research occurring at commercial sites in provincial cities, Health New Zealand public hospitals, and other research institutions, and ensuring the participation of patients living in more distant, rural regions is important.

In terms of trends in the sector, World Courier sees Phase 1 trials as a growth area in New Zealand but is concerned that the Australian R&D tax incentive is much stronger than New Zealand's. They say clients have been lost to Australia because of this.

World Courier also sees a trend towards smaller trials involving medical devices and other health technologies (other than medicines). According to World Courier, as the logistics arrangements for sample shipment are typically made by CROs rather than sites, in response to smaller trials they are seeing the emergence of some smaller “boutique” CROs. These organisations are well positioned to support studies that may be less aligned with the operating models or scale priorities of larger CROs, and who require an end-to-end logistics service. This echoed concerns raised by Momentum Clinical Research about smaller device and biotech trials and the cost challenges for larger CROs. However, World Courier did also comment that some New Zealand sites are reaching a size and scale where evolution of their business model is occurring, and this may mean they become a customer base in their own right.

8 Conclusion and recommendations

Clinical trials generate substantial health and economic benefits for New Zealand, providing access to innovative treatments and high-quality care, strengthening healthcare innovation, attracting foreign investment and supporting broader economic growth.

Our sector survey, interviews with key players, data analysis and modelling have generated important evidence-based insights that demonstrate how these benefits are delivered, quantify the value to New Zealand, and point to key areas of concern that must be addressed if this value is to be protected and strengthened.

Sector strengths attract significant clinical trial activity and global investment

- New Zealand attracts considerable trial activity. Over the past four years, New Zealand hosted 644 commercial and 521 non-commercial trials. An estimated 250 trials were active across New Zealand in 2025.
- Global sponsorship brings investment into New Zealand. Around 94 percent of commercial trials and 19 percent of non-commercial trials had global sponsors.
- The sector retains important competitive strengths. These include an experienced workforce, recognised expertise, high-quality trial delivery and data, and relatively fast approval processes.

Clinical trials generated $556.6 million in domestic expenditure in 2025…

…comprising:

- $318.2 million spent on goods and services from supplying industries
- $197.1 million spent on sector wages and salaries
- $41.3 million paid to trial participants
- Of the total $556.6 million in domestic expenditure, over half ($308.1 million) was associated with commercial trials.

The sector directly employs around 1,500 highly skilled New Zealanders

- Commercial trials employ nearly 1,100 people
- Non-commercial trials employ nearly 400 people
- Average salaries exceed $120,000, an indicator of the level of expertise in the sector.

Clinical trials contributed approximately $763 million to GDP in 2025

- Commercial trials accounted for $438.4 million, or 57.5 percent of the total contribution to the sector.
- Overall, clinical-trial activity supported nearly 5,000 jobs across New Zealand, including around 3,500 in other industries.
- Beyond economic value, participants in clinical trials received at least $50.6 million in outpatient care and medicines alone, as well as health benefits resulting from innovative treatments and vaccines and access to care.

But the value proposition for global sponsors is declining

New Zealand's clinical trials sector is facing significant risks driven by international and domestic factors:

- **The sector is fragmented, and opportunities to add value continue to be missed.** Public-private partnership would optimise the use of resources and expertise and ensure equitable patient access to the best available treatment; however, no institutional arrangements to support this have been implemented. Health New Zealand is a large, complex and risk-averse organisation, and the relatively new 'national team' that supports research across public hospitals lacks a clear blueprint that recognises the value of both the public and commercial parties for mutually beneficial collaboration. As a result, collaboration between the public health system and private players continues to be negotiated on a case-by-case basis depending heavily on individual relationships.
- **Government promotion of and investment in the sector are limited**. Other countries – particularly Australia – are actively improving incentives and infrastructure and engaging in strong international promotion of their clinical trials sectors, recognising the intensity of global competition for this investment. New Zealand's strengths are not well recognised internationally and require active promotion to continue attracting investment.
- **Medicines funding settings further undermine New Zealand's attractiveness**. Sponsors may need to fund medicines in both trial arms and provide extended compassionate access, as standard-of-care and post-trial treatments are not publicly funded. This raises trial costs and reduces New Zealand's strategic value, particularly for later-phase trials.
- **Barriers to accessing the R&D tax credit and a reduced value** compared to other trial destinations add to the New Zealand disadvantage.
- **Increasingly, speed of approvals is uncertain, and there are new risks.** While approval processes have been relatively fast, timelines are increasingly variable and public sector restructuring introduces a risk of loss of expertise, clear responsibility and adequate funding for these critical functions.

Many commercial players are responding to the changing landscape

- **Many pharmaceutical companies are shifting trial activity**, or indicating they plan to do so, to Australia or elsewhere.
- **The changing composition of clinical trial work makes New Zealand a high-cost market for global firms**. With an increasing share of clinical trials focused on biotechnology and smaller, more complex trials (instead of medicines), the costs of operating in the New Zealand market for critical trial sector organisations like CROs are increasing. With these players also experiencing transformational changes from major mergers and global acquisitions, the shifting composition of trials and the cost consequences for their New Zealand operations introduce a risk of loss of capacity from the New Zealand market.
- **Sector players are losing hope of sector challenges ever being addressed.** Many commercial sector players indicate significant structural challenges in engaging with the research governance processes at Health New Zealand, resulting in costs, fatigue,



and reconsideration of the value of operating in the New Zealand context when alternative trial destinations provide simpler, easier, and more supportive environments.

- **Major sector consolidation and restructuring risks loss of capacity and capability**. Over the last few years, the commercial sector has experienced significant consolidation. The loss of smaller players and sector diversity is noted as exposing a significant historical weakness in the New Zealand workforce training pipeline and increasing the risk of loss of critical capability and capacity.

NZIER recommends

Despite the concerns and risks facing the sector, sector players see the existing strengths of New Zealand's clinical trials sector as having the potential to support significant improvement with further investment.

National coordination and collaboration are key to maximising the benefits of clinical trials for patients, the health sector, and the economy. Without it, there is genuine risk that New Zealand will continue to miss out on opportunities and increasingly lose access to this significant source of foreign direct investment and the economic value it creates.

Therefore, NZIER recommends that the government:

- Recognises clinical trials as a source of significant economic activity, foreign direct investment, employment, and health benefits to patients, and commits to supporting them through an enhanced R&D incentive and active promotion of the sector overseas.
- Establishes a national clinical trials collaboration and coordination function to ensure opportunities to collaborate with private sponsors, CROs and trial sites/site networks are maximised.
- Assesses the funding of regulatory and ethic approval functions and ensures adequate funding to support consistent, efficient and fast processes continue.
- Establishes an inter-agency working group to develop solutions to the post-trial market access challenge that limits New Zealand's attractiveness for medicines trials.

9 References

ANZICS. 2026. *Critical Care Resources Survey*. https://www.anzics.org/index.cfm//advocacy/core-icu-registries/registry-datasets/critical-care-resources-ccr/.

Aotearoa Clinical Trials Te Kohinga Ora. 2025. *Annual Report 2025. Driven to Make a Lasting Difference to the Health of All New Zealanders.* https://www.aotearoatrials.nz/files/dmfile/ac_trials_ap2025_web.pdf.

AusBusiness Register. 2026. "Clinical Trials in Australia: R&D Tax Incentive for Biotechs." https://ausbusinessregister.com.au/clinical-trials-australia-rd-tax-incentive/.

AUScelerate. n.d. *What We Do*. https://auscelerate.org/what-we-do/.

Australian Clinical Trials Alliance. 2026a. *About ACTA*. https://clinicaltrialsalliance.org.au/about-acta/.

Australian Clinical Trials Alliance. 2026b. *Funding and Support*. https://clinicaltrialsalliance.org.au/about-acta/funding.

Commonwealth of Australia. 2023. *Eminent Australian to Lead One Stop Shop Clinical Trials Reform Group*. Media Release. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/eminent-australian-to-lead-one-stop-shop-clinical-trials-reform-group?language=en.

Commonwealth of Australia. 2025. *$13.6 Million to Cement Australia's Status in World-Class Clinical Trials*. Media Release. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/136-million-to-cement-australias-status-in-world-class-clinical-trials.

Department of Industry, Science and Resources. 2025. *Industry Growth Centres Initiative Ends*. https://www.industry.gov.au/news/industry-growth-centres-initiative-ends.

Frontier Economics. 2026. *The Economic Impact of Industry Clinical Trials across Europe*. https://efpia.eu/media/zdzg0bey/the-economic-impact-of-industry-clinical-trials-across-europe.pdf.

Health Committee, Forty-ninth Parliament. 2011. *Inquiry into Improving New Zealand's Environment to Support Innovation through Clinical Trials*. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE5289159.

Health Research Council. 2019. *2020 Enhancing New Zealand's Clinical Trials RFP*. https://www.gets.govt.nz/HRC/ExternalTenderDetails.htm?id=22098120&utm.

Health Research Council of New Zealand, Ministry of Health, Ministry of Business, Innovation, and Employment. 2019. *The New Zealand Health Research Prioritisation Framework. Maximising the Benefits of Health Research for New Zealanders.* https://www.hrc.govt.nz/sites/default/files/2020-01/NZ%20Prioritisation-Framework-FA-web_0.pdf.

IFPMA. 2026. *Enabling Innovation: The R&D Ecosystem for Medicines and Vaccines*. Position Paper. https://www.ifpma.org/publications/enabling-innovation-the-rd-ecosystem-for-medicines-and-vaccines/.

KPMG. 2025. “Global R&D Incentives Guide.” https://kpmg.com/kpmg-us/content/dam/kpmg/pdf/2021/global-rd-incentives-guide.pdf?

L.E.K. Consulting Australia. 2024. *Australia’s Clinical Trials Sector. Advancing Innovative Healthcare and Powering Economic Growth.* Report for MTPConnect. https://auscelerate.org/wp-content/uploads/2025/07/MTPConnect-2024-Australias-Clinical-Trials-Sector-Report.pdf.

MBIE. 2026. *Transitioning Health Research Funding from the Health Research Council to Research Funding New Zealand*. https://www.regulation.govt.nz/assets/RIS-Documents/Regulatory-Impact-Statement-Future-of-health-research-funding-decision-making-and-allocation.pdf.

Medsafe. 2026. “Licensed Medicine Manufacturing Sites.” May 4. https://www.medsafe.govt.nz/regulatory/licensed.asp.

Ministry of Health. 2025. “Changes Ahead for Health Research Funding.” December 3. https://www.health.govt.nz/news/changes-ahead-for-health-research-funding.

New South Wales Office for Health and Medical Research. 2023. *$25 Million Boost to Support Those Living with Hard-to-Treat Cancers*. https://medicalresearch.nsw.gov.au/about/news/2023/25-million-boost-to-support-those-living-with-hard-to-treat-cancers.

New Zealand Association of Clinical Research. 2026. *About Us*. https://nzacres.org.nz/about-us/.

New Zealand Government. 2011. *Government Will Streamline Clinical Trial Applications*. https://www.beehive.govt.nz/release/government-will-streamline-clinical-trial-applications.

New Zealand in North America. 2026. *New Zealand Biotech Is Back on the Global Stage—and Making a Strong Impression.* LinkedIn post. https://www.linkedin.com/feed/update/urn:li:activity:7476327775176400896/.

NZIER. 2020. *The Value of Clinical Research with Modern Medicines in New Zealand*. A report for Medicines New Zealand.

Omico. n.d. *About Omico*. https://omico.org.au/about-us.

RSM. 2023. “2023 Guide to the R&D Tax Incentives across Australia and New Zealand –Definitions | RSM Global.” March 21. https://www.rsm.global/insights/2023-guide-rd-tax-incentives-across-australia-and-new-zealand-definitions.

RSM. 2024. “A 2024 Guide to the R&D Tax Incentives across Australia and New Zealand – Key Considerations | RSM Global.” August 12. https://www.rsm.global/insights/2024-guide-rd-tax-incentives-across-australia-and-new-zealand-key-considerations.

Seidler, Anna Lene, Melina L. Willson, Mason Aberoumand, et al. 2023. “The Changing Landscape of Clinical Trials in Australia.” *Medical Journal of Australia* 219 (5): 192–96. https://doi.org/10.5694/mja2.52059.

The Treasury. 2025. “CBAx Spreadsheet Model.” October 31. https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model.

The World Medical Association. 2024. “Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Participants.” https://www.wma.net/policies-post/wma-declaration-of-helsinki/.

University of Auckland, Liggins Institute, and University of Otago. 2022. *Enhancing Aotearoa New Zealand Clinical Trials*. https://www.auckland.ac.nz/content/dam/uoa/auckland/liggins/docs/HP8537%20-%20LIG_Clinical%20Trials_FINAL_v6.pdf.

University of Sydney (About Us. Sydney Clinical Trials Centre Excellence in Trials. Impact in Health.). n.d. “Our History.” https://www.sydney.edu.au/medicine-health/our-research/research-centres/sydney-clinical-trials-centre/about-us.html.

Appendix A Glossary of acronyms, abbreviations and terms

Table 5 Acronyms and abbreviations

Acronym/Abbreviation	Definition
ACTI	Australian Clinical Trials Initiative.
ACTRN	Australian New Zealand Clinical Trials Registry Number; an identifier for a trial registered with ANZCTR.
ACTT	Aotearoa Clinical Trials Trust
AI	Artificial intelligence
ALLG	Australasian Leukaemia and Lymphoma Group.
ANZ	Australia and New Zealand
ANZCHOG	Australia and New Zealand Children's Haematology/Oncology Group
ANZGOG	Australia New Zealand Gynaecological Oncology Group.
ANZCTR	Australian New Zealand Clinical Trials Registry
AUD	Australian dollar
CCTG	Canadian Cancer Trials Group
CGM	CGM Research Trust
COPD	Chronic obstructive pulmonary disease
CRO	Contract research organisation; a provider contracted to manage or support clinical trials
EEA	European Economic Area
EHR	Electronic health record
EPA	Environmental Protection Authority
FBT	Fringe benefit tax
FDI	Foreign direct investment
FTE	Full-time equivalent; a measure of staffing that converts hours worked into the equivalent number of full-time roles.
GB	Generic/bioequivalence study
GDP	Gross domestic product
gDNA	Genomic DNA
HDEC	Health and Disability Ethics Committees
HGTC	Hugh Green Technology Centre
IANZ	International Accreditation New Zealand
ICH-GCP	International Council for Harmonisation Good Clinical Practice; the international guideline for trial conduct and participant protection.
ICMJE	International Committee of Medical Journal Editors
IFPMA	International Federation of Pharmaceutical Manufacturers & Associations
I-O	Input-output; as in an input-output model or table.
ISRCTN	International Standard Randomised Controlled Trial Number; a trial registration identifier.



Acronym/Abbreviation	Definition
IVD	In vitro diagnostic; a test performed on samples such as blood or tissue outside the body.
MRINZ	Medical Research Institute of New Zealand
NCRO	Non-commercial research organisation
NEAC	National Ethics Advisory Committee
NIH	National Institutes of Health (United States)
NLM	National Library of Medicine (United States)
NOSS	National One Stop Shop; Australia's proposed national platform for navigating clinical-trial applications and approvals.
NCTGF	National Clinical Trials Governance Framework
NZACRes	New Zealand Association of Clinical Research
NZCR	New Zealand Clinical Research
PAYE	Pay As You Earn; New Zealand's system for deducting income tax from employees' pay.
PBMC	Peripheral blood mononuclear cell
PK	Pharmacokinetics; the study of how a medicine is absorbed, distributed, metabolised and eliminated by the body.
R&D	Research and development
SCOTT	Standing Committee on Therapeutic Trials
SHIVERS II	Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance
TGA	Therapeutic Goods Administration (Australia)
WHO	World Health Organization

Table 6 Trial phases and study types

Phase / Study type	Description
Phase 0 trial	An exploratory, first-in-human study using very small doses to gather preliminary data on how an investigational product behaves in the body before larger clinical trials.
Phase 1 trial	A study that primarily evaluates the safety, tolerability, dosing, and pharmacokinetics of the investigational medicine, usually in a small number of healthy volunteers.
Phase 2 trial	A study in patients with the target condition that assesses the pharmacodynamic effects of the investigational medicine, further evaluates safety, and helps determine the optimal dose.
Phase 3 trial	A large-scale study that compares an investigational medicine with standard treatment and/or placebo to confirm its efficacy and safety in the intended patient population.

Phase / Study type	Description
Phase 4 trial	A post-marketing study conducted after regulatory approval to monitor long-term safety, effectiveness, and use in broader or different patient populations.
Generic/Bioequivalence Study	A study that compares the pharmacokinetic profile of a generic medicine with its reference branded product to demonstrate equivalent bioavailability and support regulatory approval.

Table 7 Technical terms

Term	Definition
Adaptive trial design	A trial design that allows specified changes to aspects of the study as evidence accumulates, while following a pre-planned process.
Bioavailability	The extent and rate at which an active ingredient becomes available in the body. Bioequivalence studies compare this between a generic and an established medicine.
Commercial trial	A trial sponsored or funded by a commercial organisation, commonly to develop a medicine, device or other product.
Compassionate access	Continued or special access to an investigational or unfunded treatment for patients who may benefit, often after a trial ends.
Comparator treatment	The treatment a trial's investigational product is compared with, such as a placebo or standard-of-care treatment.
Decentralised or hybrid trial	A trial that conducts some or most activities away from a central research site, for example through home visits or remote assessments. A hybrid trial combines remote and site-based activities.
Direct economic effect	The additional output or value added in industries that directly supply goods or services to clinical trials.
Displacement	The possibility that trial-related activity replaces other economic activity, rather than adding to total activity.
Early Access Protocol trial	A follow-on study that can provide continued access to a medicine after a Phase III trial while collecting further safety or tolerability information.
Efficacy	How well an intervention produces its intended effect under the conditions of a study.
Gross output	The total value of goods and services produced. It includes the value of intermediate inputs, so it is not the same as value added or GDP.
Indirect economic effect	Additional output or value added among suppliers to the industries that directly serve clinical trials; the supply-chain effect.
Induced economic effect	Further economic activity generated when workers supported by trial-related activity spend their wages.
Investigational product	The medicine, vaccine, device or other intervention being studied in a trial.
In vitro / in vivo	In vitro refers to work conducted outside a living organism, such as in a laboratory dish; in vivo refers to work conducted in a living organism.
Input-output model	An economic model that uses data on relationships between industries to estimate how expenditure flows through suppliers and the wider economy.
Marginal propensity to consume	The share of an additional dollar of income that households spend rather than save.



Term	Definition
Multiplier	An estimate of the wider economic activity associated with an initial change in expenditure, through supply chains and household spending.
Non-commercial trial	A trial primarily conducted for research or public-health purposes, rather than commercial product development.
Observational study	A study that observes participants or health outcomes without assigning participants to an intervention.
Pharmacovigilance	The monitoring and assessment of medicine safety, including the detection and reporting of adverse effects.
Pragmatic study	A study designed to assess how an intervention works in routine health-care settings.
Randomised controlled trial	A study in which participants are assigned by chance to different groups, such as an intervention group and a control group.
Real-world evidence	Evidence about the use or effects of interventions drawn from routine health-care data or studies outside conventional clinical trials.
Standard of care	The usual treatment or care provided to people with a particular condition.
Type I impacts	The combined direct and indirect effects of expenditure on supplying industries.
Type II impacts	Type I impacts plus induced effects from household spending.
Value added	The value created by production after subtracting the value of intermediate inputs; it is the measure used to calculate an industry's contribution to GDP.

Appendix B Data and methods in detail

B.1 The HDEC dataset

The base raw dataset for this report was provided as an Excel file by the Secretariat of the Health and Disability Ethics Committees (HDEC) at the New Zealand Ministry of Health. It consisted of the 642 trial applications approved by the HDEC for which the application submission process, resulting in a final approval, was initiated and/or completed during the period from 1 January 2022 to 31 December 2025 and which had at least one New Zealand site.

The requirements for trials that require HDEC approval are established in the Standard Operating Procedures for Health and Disability Ethics Committees Version 3.0 (December 2019). All applications submitted to the HDEC for approval of a trial are under the auspices of a lead New Zealand site (i.e., there must be at least one New Zealand research site participating in the study for the application to be made), and the submission is made under the authorisation of the designated Coordinating (Chief) Principal Investigator for the study in New Zealand.

The HDEC data set did not include declined applications, or any applications which were provisionally approved and for which the further information required by HDEC remained outstanding as of 31 December 2025.

Fields captured and augmented in the HDEC data

The fields captured in the HDEC dataset were augmented by matching each included trial with the registration for the trial in one of the following three publicly accessible online trial registries:

- ClinicalTrials.gov (https://clinicaltrials.gov/). ClinicalTrials.gov is a registry of privately and publicly funded clinical studies conducted worldwide. It is maintained by the U.S. National Library of Medicine (NLM) at the National Institutes of Health (NIH). ClinicalTrials.gov meets all standards set by the International Committee of Medical Journal Editors (ICMJE) and WHO requirements for trial transparency.
- The Australian New Zealand Clinical Trials Registry (ANZCTR) (https://www.anzctr.org.au/Default.aspx). The ANZCTR is a registry that lists clinical trials being conducted across Australia, New Zealand, and globally. It accepts both interventional and observational studies across all medical fields, including drugs, surgery, devices, and lifestyle interventions, and is managed by the NHMRC Clinical Trials Centre at the University of Sydney. It is recognised as a Primary Registry by the World Health Organization International Clinical Trials Registry Platform (WHO ICTRP) and meets all standards set by the ICMJE.
- The ISRCTN (https://www.isrctn.com/). The ISRCTN is the UK's clinical study registry. It is international in scope but aims to include all interventional and non-interventional clinical studies occurring in the UK; studies occurring outside the UK may also be included in it. It is recognised by the WHO as a primary clinical study registry and meets all standards set by the ICMJE.

The following fields were added to the HDEC dataset after extraction using a combination of AI-generated matches (multiple rounds of matches were run to allow for cross-matching to the three different registries) and manual collection:

- NCT/ACTRN/ISRTC Number (i.e. trial registry reference registration number)
- Registry sponsor
- NZ City/Site
- Study status
- Study target enrolment (overall trial target, not NZ-specific). Data extracted from online registries
- Condition category
- Study phases.

The augmented data set included some rows where it was not possible to match the trial identifier in the HDEC raw data set (i.e., protocol number and/or formal title) to a registration in one of the 3 trial registries.

Sponsor country origin

Sponsor country origin was generated using as primary reference the "HDEC Global Sponsor" (secondary reference is the Registry Sponsor field) to ascertain the name of the originating Sponsor company and publicly available information concerning the location of the company headquarters.

Number of New Zealand sites

The number of site locations for each trial was counted based on entries in the NZ City/Site field. In instances where the registration was not complete (or the trial protocol ID from HDEC could not be matched with a registry entry) the filler “UNK” for unknown has been added; however, the number of New Zealand sites has to be a minimum of 1.

Estimated patient numbers

Maximum number taken from the field HDEC_Target_NZ_Number when a range was entered. In instances when a study was in parts, the target numbers for each part were added to get a total maximum target number.

Healthy Volunteers

Identified from the study title (HDEC_Formal_Title) field using Excel formula and keyword searches (Healthy; Volunteer; Volunteers)

Study status

There are 7 status codes –

- Recruiting (the trials which had a registry category of “Enrolling by Invitation” have had their status reassigned to the broader category code of “Recruiting”)
- Active not recruiting
- Completed. The trial has been completed.
- Unknown (these were blank fields in the original dataset, and no information was available from other registries).

- Terminated (the study stopped early, reason for termination unknown, e.g. may have reached primary endpoint early or a safety issue may be encountered, etc.).
- Withdrawn. The application was withdrawn and the trial did not occur.
- Not yet recruiting – there are a few entries with this status even though they were approved some time ago (e.g. in 2022). This may reflect a failure to maintain and update the registration.

Condition category

Medicines New Zealand conducted a manual curation of trials into one of 10 therapeutic area groups/categories based on the most common groupings and intersecting therapeutic areas.

The 10 categories include the catch-all category of "other".

In instances where more than one condition category was assigned as per online registries (E.g. a trial for cystic fibrosis could have three condition categories assigned – Respiratory/Oral and Gastrointestinal/Human Genetics and Inherited Disorders), a decision was made to select the category considered most relevant.

Trials for rare health conditions that meet the population prevalence based definition of being a rare disease were categorised as rare disorders

If the condition category could not be data matched and extracted from the online registry, the report category was assigned based on manual review of the full study registration details, information in the study title, and other publicly available information about the trial and the investigational product.

There were a small number of trials for which a primary therapeutic area could not be assigned, and these trials were categorised as other.

Study phases

If this information could not be automatically extracted from the online registries via data matching it was obtained by review of the study title, the full registration information, and other publicly available information.

Note:

GB = generic/bioequivalence study;

Not applicable = non-pharmaceutical trial (predominantly medical device)

There are a number of trials which span more than one phase as they are trials in parts (e.g. Part A is phase 1 and then Part B is phase 2).

Limitations

Two key limitations remain that could not be dealt with by any additional data source:

- Lack of detail in the HDEC dataset to accurately identify trials' progression from approval to completion along a timeline.
- Lack of detail in the HDEC non-commercial data to identify the phase of most non-commercial trials.



B.2 Data and methods for estimation of employment and economic contribution

This section presents a summary of the data sources and methodology relevant to the estimation of the sector employment estimates and economic contribution of clinical trials.

The data used to identify employment in the clinical trials sector came from an extensive sector survey.

Most organisations provided detailed data, enabled by a strict data-sharing agreement, including, where needed, non-disclosure agreements (NDAs) signed between the participant and NZIER. NZIER project files were strictly locked down, providing a high level of security for confidential data and all data was destroyed/deleted on project completion.

Clinical trial activity in 2025

Our estimates of economic contribution are based on clinical trial activity in 2025. We used the HDEC data to identify the number of commercial and non-commercial clinical trials that were likely incurring significant costs in 2025. These were identified as trials that were recruiting or active but not recruiting. The method to estimate the number of trials in these stages within 2025 and the number of participants associated with these trials was described previously (see Section 3.6).

Clinical trial costs

The sector survey previously described provided four data inputs for the estimation of economic contribution:

- Number of people employed in the clinical trials sector
- Salaries paid to clinical trials sector employees
- Clinical trials sector expenditure on goods and services supplied by other industries
- Payments to healthy volunteers and patients recruited into clinical trials.

Most organisations reporting provided detailed and complete data or at least detailed data on some of the above categories. Where no data was provided, we imputed values based on the data provided by same-type organisations (e.g. sponsor data was used to impute missing values for other sponsors, CRO data was used to impute missing values for CROs, etc.) and the imputation was either on an average per trial or average per FTE basis.

Employment and salaries

Total employment and total cost of salaries in the clinical trials sector were estimated for all sponsors, CROs, NCROs, sites and Health NZ.

Where organisations did not provide data on employment and/or salaries paid to employees:

- We extracted data from online sources such as annual reports and company information on LinkedIn, where employment headcount or FTEs are sometimes identified.
- Where no source of this information could be found, we imputed the number of employed staff from the available information provided and based on information provided by same-type organisations. For example, for sponsors, we assumed that the FTE count would be equal to the average number of FTE per trial sponsored by that

sponsor, based on the HDEC data. Sites and CROs were treated separately but using the same calculation: dividing the total expenditure for organisations not providing FTE count by the average expenditure per FTE for those same-type organisations providing complete information. Salary costs were calculated by applying the average salary per FTE indicated by same-type organisations that provided this data.

Expenditure on goods and services from other industries

Expenditure on supplying sectors was estimated on a spend-per-trial basis for sponsors, and on a spend per FTE basis for CROs and sites/site networks. This was applied to participants who reported no costs in this section of the survey. No assumption was made to impute values for cost categories where participants reported zero costs or left blanks while reporting non-zero costs in other categories. That is, we assumed all participants who reported any costs in this section of the survey reported a complete set of costs.

Payments to trial participants

The number of healthy volunteers participating in trials was estimated based on the healthy volunteer flag added to the HDEC dataset of commercial trials. The number of New Zealand participants in trials with the healthy volunteer flag from 2022 to 2025 amounted to 31 percent of all participants. This share was then applied to participants in non-commercial trials. The resulting estimated total number of healthy volunteers was then scaled using the share of trials estimated to be active (recruiting or active but not recruiting in 2025).

Most CROs and sites provided detailed information on payments to healthy volunteers and patients who participate in trials. We excluded payments to patients because survey respondents indicated that these were intended only to cover costs of travel and accommodation and other costs associated with participation. Payments to healthy volunteers, however, were identified as significant but also varying significantly both within trial phases and across trial phases. We excluded high outliers as likely to be highly unusual and calculated an average participant payment to be applied to all healthy trial participants estimated for 2025.

Estimation of non-commercial trial costs

To estimate expenditure on non-commercial trials, we applied an assumption about trial work intensity and scaled FTE costs accordingly. The assumption was that non-commercial trials require on average only half the labour inputs that commercial trials of the same size and phase require. This assumption was indicated by Medicines New Zealand and informed by its sector insights.

We calculate the FTEs involved per equivalent-participant-scaled trial based on the total commercial FTEs reported through the survey for 2025 and the 2025 commercial trials and number of participants in the HDEC dataset for which any of the reporting organisations were identified in the sponsor or site fields.

Similarly, we scaled our estimate of Health NZ's clinical trials workforce as a function of its reported proportion of commercial trials and the same assumption regarding trial intensity.

Non-commercial trials are also assumed to incur similar expenses through expenditure on goods and services from supplying sectors. These expenses were estimated based on the expenses reported by survey respondents and scaled to reflect the same intensity assumption as the FTEs. This may mean these expenses have been conservatively estimated if many expenses are fixed costs or a function of the number of participants rather than the



number of staff. However, in the absence of expenditure data for non-clinical trials, this consistent and more conservative assumption was preferred.

Modelling

Our economic contribution analysis estimates the economic activity supported by the clinical trials sector.

We developed an input-output (I-O) multiplier model using Stats NZ input-output data to estimate the direct, indirect, and induced economic impacts associated with clinical trials activity. The model uses the Stats NZ input-output tables for the year ended March 2024. The analysis distinguishes between direct, indirect and induced economic effects. The precise interpretation of these effects differs across the two expenditure channels described below.

Economic value or value added comes from two main sources in the clinical trials sector:

- Employment in the clinical trials sector and trial participation by healthy volunteers result in payment of wages and salaries, and participant payments represent the value added by clinical trials activity, and as such are **direct effects**. We do not apply an industry multiplier to these wages for **indirect effects** because doing so would require assuming a production structure for the clinical trials sector, which is not represented separately in the Stats NZ input-output tables. However, both of these generate consumer spending. The effects of consumer spending in generating economic activity within industries supplying goods and services to consumers (and their supply chains) are known as **induced effects**.
- Expenditure on supplying industries which generates output and employment in other industries
  - The **direct effect** on supplying industries is the resulting additional output from those industries that directly supply goods and services to the clinical trials sector.
  - The **indirect effect** on supplying industries is the resulting additional output from those industries that do not directly supply goods and services to the clinical trials sector, but that supply goods and services that are needed to generate the output of industries supplying goods and services directly (supply chain effects).
  - The **induced effects** are the result of the additional employment supported by activity taking place within direct supplying industries and across their supply chains as a result of clinical trial expenditure. This additional employment is associated with wages paid to New Zealanders who then spend some of their wages on domestic goods and services, generating further economic activity.

  The results are presented as the standard Type I and Type 2 impacts used in economic contribution assessments (see Figure 29 in section 5.1).

Limitations

The following limitations apply to the data and methods used to estimate economic contribution of clinical trials:

- To avoid over-burdening survey participants with a highly detailed data request, we only requested expenditure data on industries we expected to be more significant areas of expenditure. This means expenditure estimates are likely to exclude some categories of expenditure. That said, we did ask whether there were any other

important categories of expenditure, and none of the survey respondents indicated that there were any.

- In some cases, survey respondents combined some categories of expenditure and reported a total amount of expenditure for more than one category. In these cases, we assigned all expenditure reported this way to the category that had the lowest economic multiplier to ensure no overestimation. This means there is likely some underestimation of economic contribution.
- Incompleteness of survey data: There was variation in the respondents' ability to report some cost information since some participant types (e.g. sponsors) do not manage the day-to-day execution of trials. However, detailed trial cost data was supplied by CROs, and sites and detailed employee and salary data were supplied by most respondents in most categories. Additionally, the survey provided data on financial flows between sector players, including fees that may be passed through from CROs to sites. While some values had to be imputed, the use of this method was supported by detailed data from multiple other same-type organisations and adequate information for scaling to the organisation whose data needed to be imputed.
- A lack of data from the full range of organisations involved in non-commercial trials: While we collected data from non-commercial contract research organisations, Health NZ, and sites that support both commercial and non-commercial trials, we did not collect data from universities and other non-commercial entities involved in clinical trials.
- Lack of detail in the HDEC dataset as previously described (see Section 1 of this Appendix)

Input-output multiplier analysis is a widely used approach for estimating the flow-on effects of expenditure. However, the results should be interpreted as estimates of the economic activity supported by clinical trials expenditure under the structural relationships represented in the input-output tables, rather than as a forecast of how the economy would dynamically adjust to a change in clinical trials activity.

The analysis is subject to several limitations:

- No displacement – the analysis does not consider the potential for displacement of economic activity from other industries that may occur due to economic activity of one industry.
- Household consumption behaviour – induced effects are estimated using observed average relationships between household income and expenditure. The marginal propensity to consume out of additional income may differ from this average relationship.
- Treatment of clinical trials as a separate activity – clinical trials are not represented as a standalone industry in the input-output tables. Supplier expenditure and direct wages are therefore modelled separately rather than by applying a single industry multiplier to an estimated level of clinical trials output. As a result, the direct value-added estimate for the clinical trials sector captures compensation of employees but does not capture other components of value added, such as returns to capital.



Appendix C Contributing sector organisations

The organisations and individuals below provided critical data and insights for this report, including through the sector survey and interviews:

AbbVie

Adjutor Healthcare

Alexion

Aotearoa Clinical Trials Trust

AstraZeneca

Awanui Group

Baxter Healthcare

BeOne

BioOra

Bristol Myers Squibb (BMS)

Boehringer Ingelheim

Bubble Clinical Research Services

Cadwell Consulting

Cencora World Courier

CGM Research Trust

Douglas Pharmaceuticals

GSK

Harvest Integrated Research Organisation (HiRO)

Health and Disability Ethics Committees, Ministry of Health

Health New Zealand | Te Whatu Ora

Hugh Green Technology Centre at the Malaghan Institute

Human Health Research Services Platform/University of Auckland

IQVIA

Malaghan Institute of Medical Research

Marken (UPS Healthcare Precision Logistics)

Medical Research Institute of New Zealand (MRINZ)

Merck Group

Momentum Clinical Research

Merck, Sharp & Dohme (MSD)

New Zealand Association of Clinical Research (NZACRes)

Novotech

New Zealand Clinical Research Group (NZCR and Optimal Clinical Trials)

Professor Paul Young & Australian and New Zealand Intensive Care Society Clinical Trials Group

PPD Clinical Research Group – part of ThermoFisher Scientific

Roche

Sapro CRO

Slade Health

Syneos Health

Takeda

Waitemata Clinical Research