

The case for removing FBT on group insurance schemes

Employer-based insurance enables faster access to services for working people, reducing time away from work, maintaining productivity and lessening the caregiving burden on families

NZIER report to Financial Services Council

2026

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Key points

- As the New Zealand population grows and ages, there is increasing demand for support for injury, rehabilitation, trauma, income support and death. This rising demand imposes increased costs for the Government and the broader New Zealand economy.
- Hence, it is timely to reconsider the role of the private sector in funding this support. The growing incidence of self-funding for support services is a key vulnerability for uninsured households relying on public services.
- Ill health, injury and trauma create costs for individuals, employers and government:
 - For individuals, costs include treatment costs, reduced income, reduced hours, reliance on family care, debt, savings drawdown and reduced resilience.
 - For employers, costs include absenteeism, presenteeism, staff turnover, recruitment, training, reduced output and lower productivity.
 - For government, costs include health expenditure, mental health expenditure, ACC costs, income support, disability support and wider economic effects.
- Increasing employees' access to group life and health insurance schemes is a way for the private sector to take on a greater share of this funding. Participation in these schemes can increase household financial resilience by increasing households' ability to manage the impact of illness, injury, disability, death and income loss.
- Employer-based insurance enables faster access to services for working people, reducing time away from work, maintaining productivity and lessening the caregiving burden on families.
- Health and social services system performance is usually assessed based on equity and efficiency.
 - On *equity* grounds, productive workers should have rapid access to rehabilitation that prioritises return to work. Both ACC and private insurance costs are borne by the insurer and the insured, not the general taxpayer, so the benefits go to those who pay, with some positive externalities for the economy.
 - On *efficiency* grounds, the New Zealand health insurance market, in particular, is regarded as highly efficient
- New Zealanders are relatively under-insured, with respect to life insurance, compared with the OECD average.
- Employer-sponsored group insurance schemes are a practical way to increase insurance uptake because they pool risk across employees and can reduce premiums for individuals. Group schemes may also improve access for people who would otherwise find individual insurance unaffordable or difficult to obtain.
- However, the Fringe Benefit Tax (FBT) raises the cost to employers of providing group insurance, making schemes less attractive and likely suppressing uptake. Removing or reducing the FBT would lower the employer cost of providing group insurance and could increase the number of employees covered.



- We estimate that removing FBT from group life and health insurance schemes would reduce the annual tax take for the government by between \$210.7 million and \$234.5 million.
- Although the direct government savings from funding and delivering health and social services will not fully offset the lost FBT revenue, there are broader benefits, including household resilience, faster recovery times for individuals, stronger labour-force attachment, productivity gains, and reduced system-wide pressure.
- We estimate the benefits of increased uptake of group life and health insurance schemes for the broader New Zealand economy to be \$408.7 million. Resulting in a net benefit of between \$174.3 million and \$198 million. This includes the benefits of timely access to treatment and rehabilitation, which results in reduced absenteeism, presenteeism and staff turnover.



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1 Should Fringe Benefit Tax be applied to group insurance schemes?

Life, trauma, income protection and health insurance protect individuals and families by mitigating financial risks associated with illness, accidents and death, and by providing households with financial security against adverse events, thereby increasing financial resilience during crises.

New Zealanders are relatively under-insured for life insurance, compared with other OECD countries. This reflects the universal nature of government health and social service delivery in New Zealand, but government delivery is increasingly under strain. There is an opportunity to leverage insurance products to strengthen New Zealanders' financial resilience and improve their access to non-government health and social service providers.

Employer-sponsored group life and health insurance schemes provide an effective way to increase uptake across the population. By sharing the insurance risk across the employee group, these schemes can reduce the cost to the insured.

There are clear benefits for employers in providing insurance support for their employees. Reducing absenteeism, presenteeism, and staff turnover will increase output and productivity. However, the application of fringe benefit tax (FBT) to employer contributions imposes a considerable cost that offsets the potential benefits to the employer and employee.

Removing FBT from group insurance schemes would make them more attractive to employers. Increased uptake of group insurance schemes by employees would help New Zealand households improve their financial resilience and access health and social services more quickly. This could ease the demand for government-funded social and health services.

The Financial Services Council has asked NZIER to assess the potential impact of increasing the uptake of life and health insurance products by removing (or reducing) FBT on group schemes. This report reviews:

- The need to reconsider the public-private funding boundary for social services in New Zealand
- Why employee health, mental health and income resilience matter for the economy
- New Zealand's health and social support system
- Provides high-level estimates of the benefits of extending access to group insurance schemes; and
- Reviews the assumptions and risks underlying these estimates.



2 Rethinking the public-private funding boundary

“... a debate on longer term directions on the public-private boundary needs to be had particularly in terms of what are the best buys for limited public budgets.”
(OECD 2024, 24)

New Zealand’s health and support services are provided by the public and private sectors, but they are predominantly funded by the public sector. New Zealanders pay for some services out of pocket (see section 6). They are also largely expected to cover any shortfall in income that results from prolonged ill-health or other trauma.

Government resources are under pressure, and revenue growth is constrained. There are limited options to expand government services to meet rising demand and shocks, such as increased mental health needs, a pandemic or an ageing population. One option for the government is to keep increasing expenditure, but this is unsustainable, and more funding does not necessarily guarantee improved availability and delivery. Alternatively, government policy can focus on improving efficiency, reducing public funding or applying user charges. The last two options will fall on households, who are also facing rising costs.

New Zealanders are increasingly making ‘out of pocket’ (OOP) payments to fund health and social services. The options for making these payments are varied, including borrowing from family and friends, drawing on savings and KiwiSaver funds, selling off assets (such as the family home) and crowd-funding. Using savings and other assets reduces individuals’ and households’ financial resilience in the short and long term, especially for retirement.

Reassessing the boundaries between public and private spending is one way to increase funding options. This is also an opportunity to consider how the public and private parts of the social service and health systems intersect and the possibilities for delivering and funding services differently. Ultimately, this could give individuals and their families greater choice and autonomy in managing their well-being.

New Zealand’s hybrid health and social service system means the public-private boundary has always been somewhat blurred. The challenge is to better harness private sources of funding without making access to healthcare and related services income- or asset-dependent. Increasing individuals’ and households’ financial resilience by ensuring they have insurance for healthcare, trauma, income protection, and related risks is one approach. Life and health insurance products provide targeted savings vehicles for individuals and their families to manage their health and well-being needs. They help spread the cost and risk for the individual and avoid the need to draw on savings or other assets. This provides individuals and households with funds to choose and pay for services when they need them.



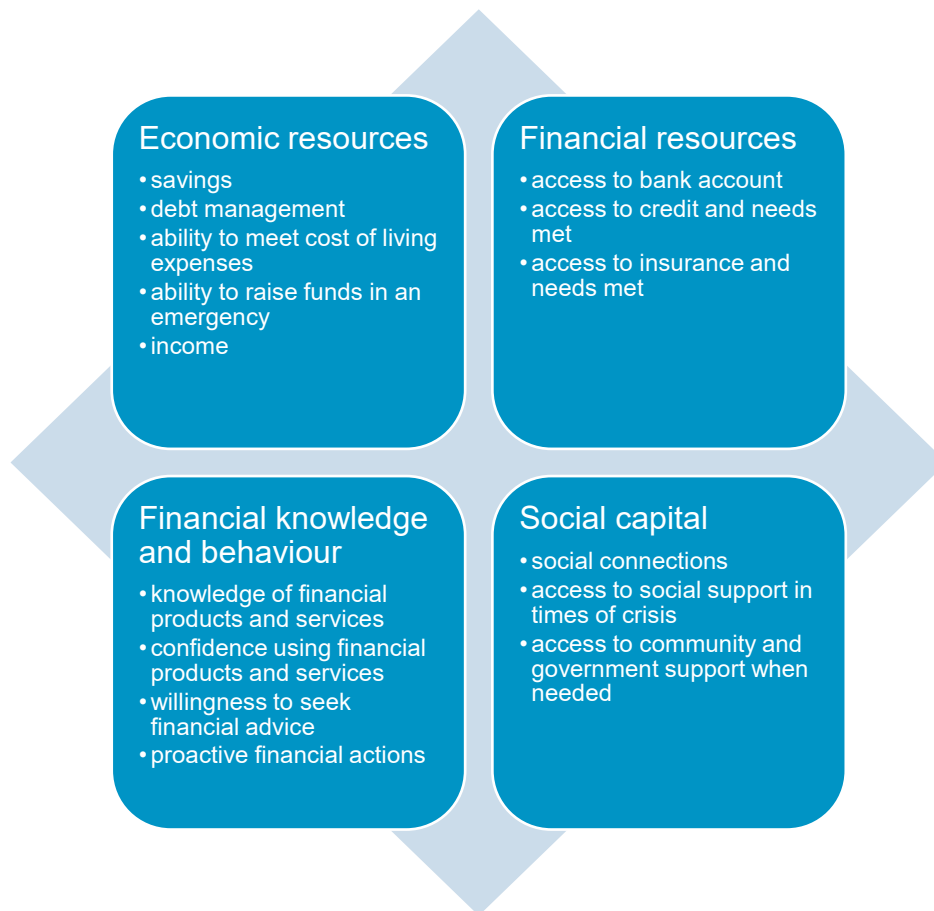
3 Building financial resilience

Resilience is the ability of individuals to “‘bounce back’ after adverse events and experiences, to adapt to changing circumstances and to deal with environmental stress” (Abbott-Chapman et al. 2008 quoted in Salignac et al. 2019)

The COVID pandemic highlighted the importance of financial resilience in determining how individuals and households managed the economic challenges while maintaining health and well-being. If individuals and households can manage health-related expenses, maintain treatment adherence and avoid medical impoverishment, while being supported by formal and informal networks, they are more likely to withstand financial shocks without sacrificing well-being (Jalili et al. 2025).

Financial resilience is multi-dimensional. The dimensions of financial resilience can be categorised into four components: economic resources; financial resources; financial knowledge and behaviour; and social capital (see Figure 1). These components are not exclusive – a lack of economic resources will limit access to financial resources. This framework highlights that financial resilience is based on the ability to plan and save, as well as being able to access credit and insurance to manage risk and recover from financial disruption more quickly.

Figure 1 Financial resilience framework components



Source: Salignac et al. (2019, Fig 1, 23)

The Financial Services Council survey of financial resilience indicates that about 48 percent of New Zealanders do not have savings or access to emergency funds, so that they can continue their current lifestyle for more than three months (Financial Services Council NZ 2026, 9). This is an improvement from 54 percent in 2025. But overall household savings decreased markedly from 2025 to 2026 (ibid, 13).

Increasing household savings across a range of dimensions, including access to group life and health insurance schemes, would enhance financial resilience and well-being outcomes.

3.1 Insurance and financial resilience

Insurance enables individuals, households and organisations to manage risk by spreading costs across time and, in some cases, sharing risk across a wider population. This increases individuals' and households' economic and financial resources, boosting financial resilience when they face a crisis or shock. It also provides access to an individual's savings or funds when needed and in a timely manner.

Group insurance schemes provide a range of benefits to employees and, potentially, their households. Although members of the household may not be direct beneficiaries of a group insurance scheme, they will be indirect beneficiaries. Life, trauma, and income protection insurance contribute to household financial resilience by providing income support for individuals, thereby supporting their households and enabling flexibility to manage care and recovery.



4 What is the problem?

Average household weekly expenditure on health rose by 70 percent from 2013 to 2023 (Stats NZ 2024). In the year ended 2025, 14.9 percent of New Zealand adults had an unmet need to see a GP due to cost (Ministry of Health 2025). New Zealand households face rising health, income and care risks (see section 6), yet many lack the financial resilience to manage these. Increasing the uptake of life and health insurance would help to build financial resilience.

In particular, employer-provided group insurance schemes could facilitate this increase in uptake. The application of FBT discourages employers from providing group insurance schemes, even when there are economic benefits for the employer from increased employee financial and physical wellbeing.

Private insurance penetration is lower in New Zealand than in other OECD countries, particularly for life insurance (see Table 1). One of the factors contributing to the low insurance penetration is that the government is a significant actor in the New Zealand insurance sector, through the Accident Compensation Corporation (ACC) and the Natural Hazards (EQC) Commission (Vucetich et al. 2014).

Table 1 Insurance penetration

As a percentage of GDP, 2021

	Total insurance penetration	Life insurance penetration
New Zealand	3.3	0.8
OECD average	6.3	3.7

Note: 2021 is the most recent year for which the OECD holds New Zealand data

Source: OECD (2025)

Increasing financial resilience is an important issue for all New Zealanders. Increasing the share of the population that has insurance will strengthen resilience. Employer-sponsored group insurance schemes are one way to increase access for employees because they usually have lower premiums for individuals and can be subsidised or paid for by the employer. Extending access to group insurance schemes for those in paid work delivers better outcomes for employers and employees by ensuring employees turn up to work ready and able. A healthy and fit workforce will improve productivity (NZIER 2024).

4.1 Making insurance accessible for all

Life and health insurance products provide targeted savings vehicles for individuals and their families, increasing their financial resilience by spreading costs and risks and avoiding the need to tap into savings or other assets.

Individuals and households are effectively self-insuring to manage OOP payments for health and social services. The lower their financial resilience, the greater the household's risk associated with OOP payments, reducing their capacity to bounce back. However, voluntary insurance is often not offered at an affordable price for households and for people with underlying health conditions. It therefore risks exacerbating inequities (OECD 2024, 24).



Employer-sponsored group schemes can reduce the cost for the employee and their household, in part because the insurer's risk is spread across the group scheme. Increasing access to employer-sponsored group life and health insurance products can deliver benefits for employees, employers and the government. These include giving employees greater choice and flexibility to manage their own and their households' health and wellbeing, improving workforce productivity, and reducing pressure on public resources.

The application of FBT to employer-sponsored group insurance schemes substantially raises the cost of these schemes for the employer. This makes it unattractive for employers to offer insurance schemes to their employees and is another factor likely to suppress insurance uptake and scale in New Zealand.

Removing FBT from employer-sponsored group insurance schemes would reduce the cost to employers. By making such schemes more cost-effective, these schemes are more likely to be offered to employees, increasing uptake of insurance by employees and their households and enhancing financial resilience in New Zealand. In turn, this can increase the funding base of the wider health and social services system and reduce pressure on public resources. Figure 2 sets out the intervention logic for removing FBT on group insurance schemes.

The use of insurance to access private services is often regarded as privileging those who can afford it, implying that those without the financial means are deprived of access or relegated to lesser services. Increasing access to insurance via group schemes goes some way to addressing the issue of affordability.¹ New Zealanders with insurance can only use it to access services in the private sector or when making co-payments, such as for GP visits. It is not possible to use private funds or insurance to pay for services in the public system in New Zealand (except if you are not a New Zealand citizen, resident or work visa holder).

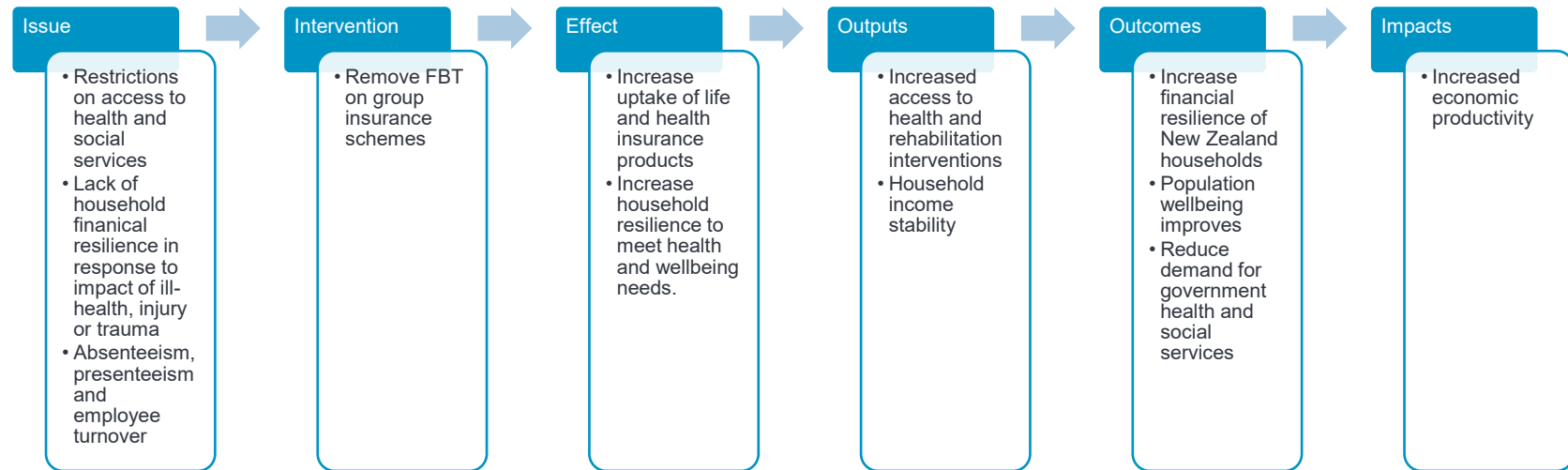
In summary, the case for change:

- Employer-based insurance enables faster access to treatment and disease management for working people, reducing time away from work, maintaining productivity and lessening the caregiving burden on families.
- The social service and health system performance is usually assessed based on equity and efficiency.
 - There are *equity* benefits. Productive workers should have rapid access to rehabilitation that prioritises return to work. Both ACC and private insurance costs are borne by the insurer and the insured, not the general taxpayer. Hence, the benefits go to those who pay, with some positive externalities for the economy. This does not reduce equity for the taxpayer or the rest of the population.
 - On *efficiency* grounds, the New Zealand health insurance market in particular is regarded as highly efficient.²

¹ We recognise that this applies to employees and excludes the self-employed.

² Health insurance organisations claims paid out are equivalent to between 76 and 94 percent of premium income (Southern Cross Medical Society Group 2025)

Figure 2 Intervention logic – removing FBT on group insurance schemes



Source: NZIER

5 Role of insurance

Combined with health insurance or as a substitute, other insurance, including trauma and income protection schemes, provides individuals with support for health and mental health treatment, recovery from ill-health or injury, rehabilitation support, and long-term support in the case of disability. Some provide specific income support during treatment and rehabilitation, or the funds can be applied for that purpose. Life insurance products that pay out on terminal illness or death support the individual's beneficiaries, including their household.

These insurance products have three possible functions for the individual or household, which can duplicate, complement or supplement public services. Insurance policies may provide for one, all or a combination of these functions. Insurance can:

- 1 facilitate access to private providers, who offer a private alternative to public provision of healthcare, recovery services and rehabilitation support (duplicates public services)
- 2 reimburse co-payments, such as for GP visits (complements public services)
- 3 cover services that are not covered by the public system, such as dental visits (supplementing public services).

(Colombo and Tapay 2004)

Health insurance provides access to private healthcare, particularly elective care. Life, trauma, total and permanent disability and income protection insurance provide the financial resources to access services that duplicate, complement or supplement publicly funded social services. These include, for example, rehabilitation services provided under ACC, income support from the Ministry for Social Development (MSD-WINZ) and services funded by HealthNZ under the Needs Assessment and Service Coordination (NASC) service. These social services have private-sector substitutes that can provide more flexible and/or comprehensive services. Public services are often subject to time limits, which may mean that people cannot access them or that their care is cut short.

Payouts from life, trauma and income protection insurance that provide temporary or ongoing income to individuals or households could be categorised as supplementing public services. With this type of income support, these people will not be applying for government income support. More importantly, these insurance products support financial resilience by providing income support that better meets the income replacement needs of the household than a WINZ payment. ACC income support is set at 80 percent of the individual's earnings, but this support is not available for all injuries.

All insurance attributes contribute to an individual's or household's financial resilience by providing funds to meet and overcome unforeseen emergencies and by maintaining income for households. Individuals and households can choose how to manage their well-being needs.

5.1 Life insurance

Life insurance provides a lump-sum payment or monthly payments following the death of the individual insured. Some policies also provide terminal illness cover, which pays if the individual is expected to live less than 12 months.

Life insurance directly supports household financial resilience by providing benefits that help the family cover the costs of a terminal illness, meet funeral costs, and provide economic resources to better manage finances following the death of the individual insured. Generally, this gives beneficiaries time to adjust and manage their well-being. This can reduce the household's need to seek government support.

Insurance products also help protect household income and savings by providing benefits to the insured and also their wider family, in the event of death.

5.2 Trauma insurance

Trauma or critical illness insurance pays a benefit if the insured suffers a (covered) critical illness or injury. It can fund treatment and recovery, including mental-health-related needs in some circumstances. It can also provide income support.

The payout can help:

- pay for private medical and surgical costs, non-Pharmac-funded drugs, and other significant health expenses not covered by ACC
- manage recovery and home care costs
- replace lost income if the individual cannot work, and a family member stops working to care for them.

Recovering from a critical illness or injury is a long-term process that can affect the whole household. Trauma insurance supports financial resilience by providing access to financial resources and reducing the need to drain savings, sell assets or get into debt.

5.3 Income protection insurance

Income protection insurance helps maintain income during incapacity and supports return to work.

Income protection insurance usually pays a monthly benefit of up to 75 percent of the individual's income if they cannot work due to a long-term injury or illness. Income protection insurance can provide support after sick leave entitlements run out. The individual chooses the stand-down period and the duration of the benefit period.

5.4 Private health insurance

Life, trauma and income protection insurance products are complemented by private health insurance. Access to health insurance delivers benefits for individuals and households by giving them greater choice about how and when they access health services. It has been found to help individuals better manage their health over time by getting early intervention, which reduces the likelihood that a health problem will become acute, in turn reducing pressure on the public health system (NZIER 2024).

Table 2 summarises the coverage and benefits of life and health insurance products.



Table 2 Life and health insurance products and benefits

	Coverage	Benefit
Life insurance	Debt coverage Terminal illness coverage	Household financial resilience
Trauma	Funds treatment and recovery	Facilitates rehabilitation and supports the individual
Total and permanent disability	Funds treatment, rehabilitation and ongoing care support	Facilitates rehabilitation and supports the individual
Income Protection	Maintains income during incapacity and supports return to work	Facilitates rehabilitation in appropriate timeframe
Health	Specific health treatments	Timely treatment prevents development of acute conditions

Source: NZIER



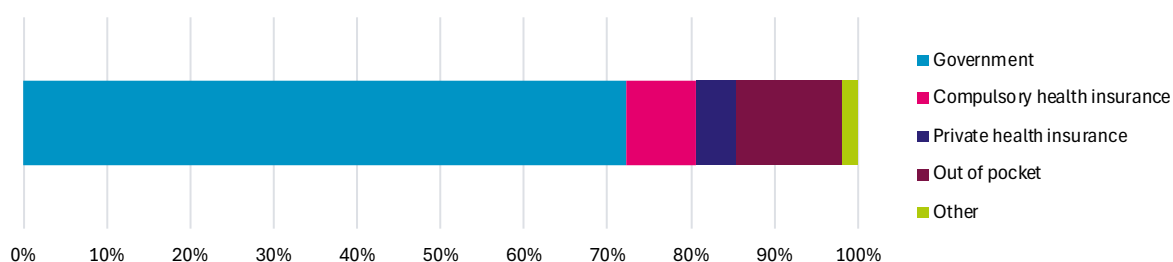
6 Health and social services and New Zealanders' well-being

New Zealand has a hybrid health and social service system, in that private delivery and funding already sit alongside the public system. Rising demand and constrained supply are pushing the public system toward greater use of private capacity and partnerships (Clark 2026).

6.1 Health sector

Healthcare is predominantly publicly funded in New Zealand. The health sector provides universal health coverage through a mostly publicly funded and partly publicly provided delivery system, including inpatient and outpatient care, mental health care, long-term care, and prescription drugs. Access to public hospital care is free for the resident population, while primary care is subsidised. Patients make co-payments for some services and products.

Figure 3 Health expenditure by type of funding, 2023



Source: OECD (2025b); NZIER

As a result, the government is the major funder of health care in New Zealand, providing 72 percent of funding (see Figure 3), which represents about 14.2 percent of total government expenditure. About 8 percent of health expenditure is funded by the ACC, 5 percent by private health insurance (PHI) and 13 percent are OOP payments by patients.³ About 35 percent of the New Zealand population had some form of private health insurance in 2024/25 (Ministry of Health 2025).

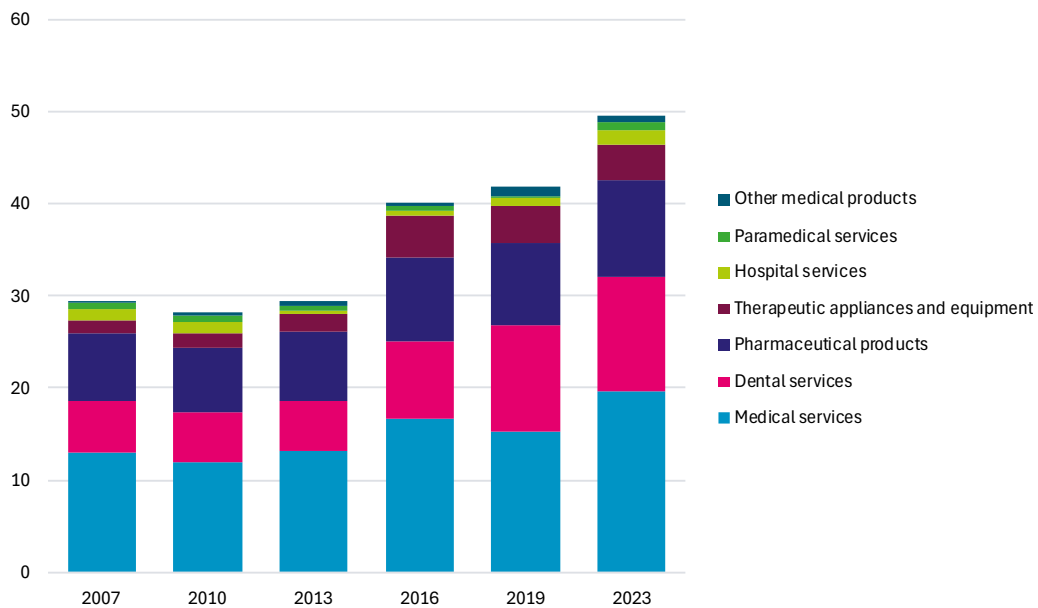
Household expenditure on health has been rising. The average weekly expenditure rose by 70 percent between 2013 and 2023, while total household expenditure rose by 34 percent. Figure 4 shows the increase in expenditure and the mix of services.

³ These include co-payments to GPs, prescription costs and dental care. It also includes payments for medical services in the private health sector that are not covered by health insurance.



Figure 4 Household weekly expenditure on health

NZ dollars



Source: Stats NZ and NZIER

The private health sector operates in parallel, providing a limited range of diagnostic and surgical services, including services provided by private hospitals. The public health system commissions some of these services. There are also private providers of mental health and long-term care services, which are mostly fully or partly subsidised by the public health system. Aged care service providers are predominantly non-government entities (corporate or not-for-profit), although the government is a significant funder for these services.

The New Zealand health system faces growing challenges, including reported staff shortages across primary and secondary health care, long waiting lists, and rising care costs. Long waiting lists affect the New Zealand workforce and its productivity, as people with chronic conditions experience absenteeism and presenteeism at work, reduce their working hours, or leave the workforce altogether. Long wait times for treatment of chronic conditions also negatively affect the mental health of individuals and their families.

6.2 Accident Compensation Corporation

ACC is a form of compulsory health insurance. It provides comprehensive, no-fault personal injury cover for all New Zealanders and visitors to New Zealand. Its role is to help prevent injuries and get injured people back to everyday life after an accident. It funds tailored support, which might include treatment, rehabilitation and weekly compensation of up to 80 percent of pre-injury income.

The largest ACC account is the Earners' Account with \$2.695 billion in levy revenue annually. This account exists as a workers' insurance scheme for workplace accidents. It is the original account replacing workers' compensation schemes with a social insurance scheme. Employer-based group insurance schemes have a similar rationale, in particular to increase access to services that support a return to work.



ACC provides many benefits to New Zealanders through no-fault personal injury cover, but it is struggling to keep up with the increasing complexity of cases and the lengthening rehabilitation time. The claims management process is also acting as a roadblock to access to treatment.

In its 2025 review of ACC for the Ministry of Business, Innovation and Employment (MBIE), Finity Consulting found inefficiencies in the claims management process and noted that rehabilitation performance had clearly declined (Finity Consulting Pty Ltd 2025, 2).

Recent reporting from ACC indicates that it has improved its case management and that an increasing number of people have returned to work. However, there does not appear to have been any improvements in rehabilitation outcomes, with increasing delays for individuals accessing rehabilitation services and increased use of staged funding for rehabilitation services (Hartwich 2026). Although some of the reduction in case numbers may reflect an overdue review of cases, it also appears that some people (and employers) are finding it more difficult to access rehabilitation services.

6.3 Social support and financial resilience

Health conditions and other trauma can have a wider impact on individuals and their families as they go through recovery and rehabilitation, often over an extended period of time. Support for immediate care and rehabilitation is available through the public health system, and there is some income support through ACC and MSD (ACC cover at 80 percent of income is generous, but MSD-WINZ cover does not meet replacement value). These include services funded by HealthNZ under the NASC service, rehabilitation services provided by ACC, and income support from ACC or MSD-WINZ.

Public or government-funded services are often subject to some form of 'means testing' and/or time limits, which may mean that people cannot access the services or their care is cut short. These social services have private-sector substitutes, which can be purchased 'out of pocket'.

6.4 Unmet need

The New Zealand population is growing, but it is ageing faster. Population growth increases the demand for healthcare services, including access to primary care, hospital care, mental health and rehabilitation services. An ageing population increases demand for primary and hospital care, as well as chronic disease management.

Over the four years to 2024, unmet need for primary health care has increased, as set out in Table 3. Wait times and cost are the most significant reasons. Unmet need for mental health care has also increased. The cost of dental healthcare has been an issue for around 40 percent of the population since 2013 (Ministry of Health 2025).



Table 3 Unmet need for health care in New Zealand

Percent of total population

	2021/22	2022/23	2023/24	2024/25
Unmet need for dental health care due to cost	37.9	44.1	45.0	43.0
Unmet need for GP due to cost	11.1	12.8	15.1	14.9
Unmet need for GP due to wait time	11.6	21.3	24.8	25.5
Unmet need for mental health care and addiction services	8.8	7.5	10.9	10.5

Source: Ministry of Health, NZIER

Avoidable hospital admissions are linked to conditions for which well-established, effective treatments are available and can be delivered within the primary healthcare system. These include asthma, chronic obstructive pulmonary disease and congestive heart failure. Hospital admissions for these conditions should be avoidable and are, therefore, a marker of access to primary care. New Zealand data on avoidable hospital admissions are available for the age groups 0–4 years and 45–64 years. Avoidable hospital admissions are relatively high in the 0–4 age group, which puts pressure on caregivers and family members (see Table 4).

Table 4 Avoidable hospital admissions

Year ended June

Prioritised ethnicity	2020	2021	2022	2023	2024	% change 2020-2024
Māori 0-4 yrs	5,618	5,400	5,734	7,064	7,022	25.0
Pacific 0-4 yrs	2,876	2,847	2,936	4,174	4,006	39.3
Other 0-4 yrs	8,397	9,470	8,734	12,227	11,215	33.6
Total 0-4 yrs	16,891	17,717	17,404	23,465	22,243	31.7
Māori 45-64 yrs	11,481	11,426	11,338	12,084	12,729	10.9
Pacific 45-64 yrs	4,990	5,118	4,798	5,562	5,937	19.0
Other 45-64 yrs	29,891	30,394	29,919	30,931	31,200	4.4
Total 45-64 yrs	46,362	46,938	46,055	48,577	49,866	7.6

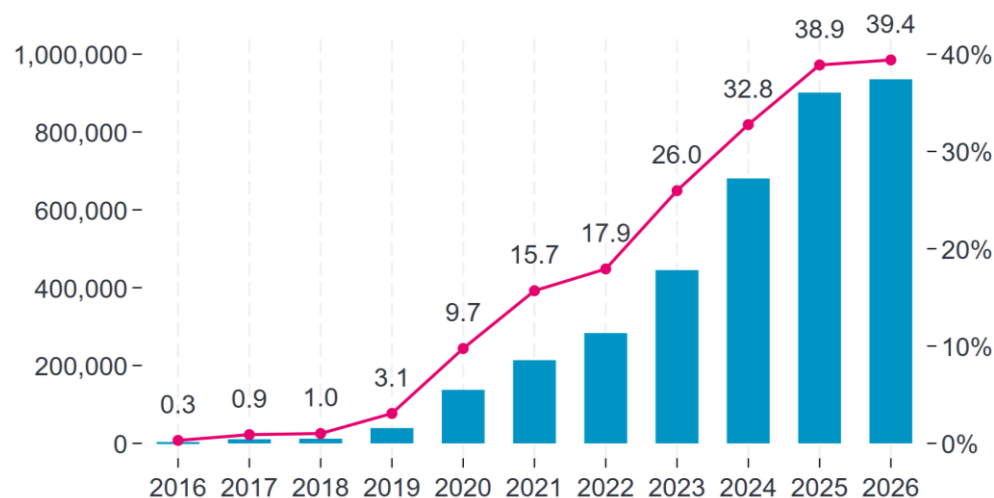
Source: Ministry of Health 2025

New Zealanders are experiencing longer wait times when they are referred to a specialist and then for elective surgery, with a long wait defined as waiting 120 days or more. Elective surgery is often delayed because acute cases take precedence, but there is increasing demand across a number of conditions (NZIER 2024). As a result, the public health sector is diverting cases to the private health providers, and individuals are choosing to go directly to the private health system. Figure 5 shows the increase in the number of people who have long wait times for a first specialist appointment in the public health system.



Figure 5 Long wait time for first specialist appointment

Number of patients and % of total patients, year ended June

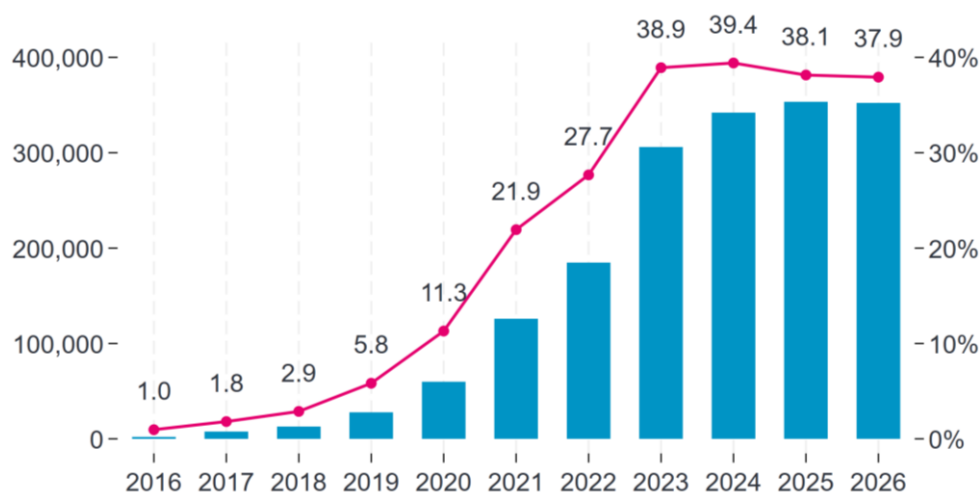


Source: Health NZ

Following a specialist appointment, people are also experiencing long wait times for elective surgery, as illustrated in Figure 6.

Figure 6 Long wait time for elective treatment

Number of patients and % of total patients, year ended June



Source: Health NZ

Health NZ's mental health and addiction target results for the December quarter 2025 indicate that 81.9 percent of those seeking access to specialist mental health and addiction services were able to do so within three weeks, and 83 percent of those seeking access to primary mental health and addiction services were able to do so within a week. There is some variation across the four regions of New Zealand. However, in 2024–25, 10 percent of the population reported an unmet need for mental health services (see Table 3).



BusinessNZ has reported on the impact of reduced employees' access to rehabilitation services through ACC. They estimated that the aggregate loss of productive capacity in the economy in 2023/24 was \$12.2 billion (BusinessNZ 2025).

The slower the process of rehabilitation, the less likely the individual is to recover fully, contributing to long-term dependency. Early, targeted intervention is critical. When support is provided within the first 20 days, about 70 percent of injured workers return to their jobs. By 45 days, the rate falls to 50 percent, and after 70 days, it drops to 35 percent (The Royal Australasian College of Physicians and The Australian Faculty of Occupational and Environmental Medicine, 2010, quoted in Finity Consulting Pty Ltd 2025, 22).

Early return to work and allowing injured persons to return to pre-injury activities, boosts physical and mental recovery. It also cuts long-term disability risk, keeps workers connected to their workplace and prevents further deconditioning. Better return to work outcomes protects worker's income, limits wage-replacement payments and lowers overall claim costs, which ultimately reduces the costs to the ACC as well as benefiting the individual claimant (Finity Consulting Pty Ltd 2025, 22).

ACC sources rehabilitation services from private providers, such as physiotherapists. Individuals can access these same services without ACC approval, funded by out-of-pocket payments.



7 Costs versus benefits

There are costs and benefits to investing in better health, well-being and social support outcomes for individuals, organisations and the government. For individuals, the direct cost of injury, ill health or other trauma includes the costs, if any, of medical treatment and reduced work hours, that is, reduced pay. There are also indirect costs, such as the impact on family members who provide care or must work increased hours to compensate for a reduction in income.

The benefit of timely intervention and full rehabilitation is the ability to continue working at full capacity and capability, which contributes to the individual's wellbeing and financial resilience.

Delays in employees' access to government-funded services increase employer costs by raising operating expenses and reducing productivity. An employer whose workforce is not in good health will incur indirect costs, including absenteeism, presenteeism and higher staff turnover, as workers with ill health reduce their work hours or leave the workforce. These costs contribute to lost production, reduced productivity, and reduced revenue for the business or organisation due to individuals' ill health.

The business or organisation may also incur higher staff costs if it retains more staff to compensate for absenteeism and presenteeism. Staff turnover costs include recruitment and onboarding, as well as training. Depending on the extent of training required, the new employee may take several months to reach full productivity.

The direct cost of intervention for the organisation is the cost of health and wellbeing programmes, including employee assistance programmes (EAPs), workplace vaccination programmes, and group insurance premiums or subsidies. These costs may be shared between the employee and the employer. The benefits for the organisation come from reduced costs due to a lower incidence and/or impact of ill health amongst its staff. The organisation accrues indirect benefits from reduced absenteeism, presenteeism, and staff turnover. The reduction in absenteeism, presenteeism and turnover directly contributes to increased production and productivity.

Providing access to group insurance schemes provides direct benefits to employees by ensuring timely access to healthcare, supporting recovery and rehabilitation, improving overall health outcomes, and enhancing income resilience. These benefits may also increase their engagement at work.

Improved health and wellbeing in the population should reduce the costs of health care and other social support, such as income and disability support and caregiving. A healthier population is likely to have better educational outcomes and employment options, as well as higher lifetime income, benefiting the government and the economy. More specifically, there are costs for individuals and their employers of enduring ill-health or health-related disability.

Table 5 sets out our estimate of the costs of absenteeism, presenteeism, and staff turnover, with three options for the number of hours worked at low productivity per week. Appendix A provides more detail and an explanation of the assumptions behind these estimates.



Table 5 Estimated cost of absenteeism, presenteeism and staff turnover

Per employee, at the average full-time wage (September 2025)

	1% of hours worked at low productivity ⁵	5.4% of hours worked at low productivity	10.9% of hours worked at low productivity
Average annual gross salary ¹	\$90,688.00	\$90,688.00	\$90,688.00
Absenteeism – 6.7 days ²	\$2,336.96	\$2,336.96	\$2,336.96
Presenteeism – 50% reduction in productivity ³	\$143.01	\$2,448.58	\$4,942.50
Staff turnover ⁴	\$6,801.60	\$6,801.60	\$6,801.60
Total cost per employee	\$9,281.57	\$11,587.14	\$14,081.06

Sources: 1: Stats NZ (2025), 2: Southern Cross Health Insurance and BusinessNZ (2025), 3: Southern Cross Health Society (2009); Holt 2010), 4: Baxter et al. (2015), 5: Holt (2010); NZIER

Considering the indirect costs of ill health in the active workforce, from absenteeism and presenteeism, there is a significant cost to the economy of not accessing health care and other services within shorter timeframes (Holt 2010; Bryan, Bryce, and Roberts 2020).

Other costs

We have not included an estimate of the cost of employing additional staff to cover for those experiencing presenteeism or absenteeism. Some roles, such as teachers or nurses, may need relief cover. In some cases, a business or organisation has additional staff to ensure it meets its production requirements at all times, despite presenteeism or absenteeism.

These estimates do not capture the impact of reduced income for individuals or households, or the increased costs associated with care support, rehabilitation treatment or long-term disability.



8 The impact of removing FBT on group insurance schemes

Ill health imposes costs on New Zealand society and the economy (NZIER 2024). These costs come in the form of direct costs and indirect costs. Increasing PHI uptake and improving access to healthcare services will reduce or eliminate these costs, thereby benefiting New Zealand employers and the economy.

We have updated our estimates of the costs of ill health for those on the waitlist in the public health sector for elective procedures (see Appendix B), using the model developed by Holt for the New Zealand economy (Holt 2010).

We estimate the direct cost of the procedures being performed in the public health system to be \$57.9 million, as shown in Table 17. Hence, an increased use of PHI would shift this cost out of public health expenditure.

The indirect costs of ill health to New Zealand society include absenteeism, presenteeism, and reduced hours worked, all of which we have calculated based on Holt's (ibid) findings. We use the average full-time hourly wage of \$43.99 (Stats NZ 2026), assume a workweek of 8 hours per day, 5 days a week and use the average number of weeks on the waitlist of 12.3 to help calculate the indirect costs.

We estimate absenteeism affected 16 percent of workers and accounted for a loss of 0.3 percent of the total hours worked. Presenteeism was found to affect 50 percent of workers and accounted for a loss of 5.4 percent of the total hours worked. And working fewer hours was found to affect 23 percent of workers and accounted for a loss of 1.9 percent of the total hours worked.

From Table 6 the overall direct cost to the health system of the procedures affected is \$57.9 million, and the indirect cost is \$357.1 million, with absenteeism, presenteeism and working fewer hours having indirect costs of \$5.4 million, \$302.7 million and \$49.0 million, respectively. The total cost to New Zealand society is \$415.0 million. Given that increased uptake of PHI could lead to improved health outcomes, the benefits reflect the reduction in these costs.



Table 6 Direct and indirect costs for identified elective health procedure groups⁴

		Number of people affected	Work hours lost		Cost
			Hours lost	Proportion of total hours worked	Evaluated at full-time hourly wage (\$m)
Direct cost		9,469	-	-	\$57.9
Indirect costs	Absenteeism	1,673	122,324	0.3%	\$5.4
	Presenteeism	5,230	6,880,707	5.4%	\$302.7
	Working fewer hours	2,406	1,113,655	1.9%	\$49.0
	Total	10,459	8,116,686	7.6%	\$357.1
Total costs		10,459	8,116,686	7.6%	\$415.0

Source: NZIER

The economic benefits to New Zealand society have been calculated in the same way as the costs above. They are smaller than the current costs to society, as while there is a large reduction in the amount of time spent on a waiting list for a procedure, 51 days on average, patients will still spend 31 days waiting in the private health system, during which some people are likely to experience absenteeism, presenteeism, and reduced work hours. This means the number of weeks on the waitlist for the indirect benefits is 7.3 rather than 11.7, as used for the costs.

From Table 7, the overall direct benefit of increased PHI uptake to the public health system is \$57.9 million, and the indirect benefit to the public health system is \$222.1 million, with absenteeism, presenteeism and working fewer hours having indirect benefits of \$3.3 million, \$188.3 million and \$30.5 million, respectively. We estimate the total benefit to New Zealand society of increased access to PHI is \$280.0 million.

This estimate does not include projected savings if employees' health conditions do not escalate to acute treatment needs and they maintain better health outcomes.

⁴ See Table 17 for full list of identified elective health procedure groups covered in our analysis.



Table 7 Benefits of identified elective health procedure groups moving to the private health system

		Number of people affected	Work hours		Benefit
			Hours lost	Proportion of total hours worked	Evaluated at full-time hourly wage (\$m)
Direct benefit		6,469	-	-	\$57.9
Indirect benefits	Absenteeism	1,673	70,079	0.3%	\$3.3
	Presenteeism	5,230	4,279,464	5.4%	\$188.3
	Working fewer hours	2,406	692,639	1.9%	\$30.5
	Total	10,459	5,048,183	7.6%	\$222.1
Total benefits		10,459	5,048,183	7.6%	\$280.0

Source: NZIER

We estimate that the impact of removing FBT from group private health insurance will be \$130.9 million. This assumes that private health insurance accounts for 20 percent of the annual FBT total. The data on premiums collected for private health insurance includes both employer subsidised and unsubsidised schemes. Hence, we have estimated the total share of employer subsidised in PHI to be between 31 and 41 percent, dependent on the average FBT rate for those schemes.

Table 8 Costs of removing FBT on group private health insurance

	FBT rate of 49.25%	FBT rate of 63.93%
Total premiums	\$1,042,304,163	\$1,042,304,163
Potential FBT ¹	\$446,378,087	\$579,430,480
2024/25 FBT total	\$909,000,000	\$909,000,000
FBT at 20% of total FBT take	\$181,800,000	\$181,800,000
Estimated share of calculated group private health insurance that is employer-subsidised	40.73%	31.38%
After including an income tax deduction of 28%	\$130,896,000	\$130,896,000

Notes

1 Assumes all premiums are employer-subsidised and thus have FBT paid on them

Source: Financial Services Council, NZIER

We estimate the total benefit to New Zealand society of removing FBT on other group insurance products is \$128.7 million. This is from the amount paid out in accepted claims from group insurance products that is currently paid out and is forecast to be paid out based on the assumptions of increased uptake of policies if FBT on them were removed, and that these claim amounts would otherwise be picked up by other mechanisms in New Zealand like ACC or benefits through MSD. Of the \$128.7 million, \$111.6 million comes from



claims by existing policyholders, with \$17.1 million from additional policyholders forecast due to the FBT removal.

Table 9 Additional claims from further uptake of other group insurance products

Group insurance product	Accepted claims	Accepted claims amount paid out	Average accepted claim amount	Additional claims	Additional claims amount paid out	Accepted and additional claims amount paid out
Income protection	271	\$38,862,746	\$143,405	41	\$5,950,983	\$44,813,729
Life	453	\$51,398,235	\$113,462	69	\$7,870,520	\$59,268,755
Total and permanent disability	29	\$8,350,812	\$287,959	4	\$1,278,745	\$9,629,557
Trauma	365	\$8,996,649	\$24,648	56	\$1,377,641	\$10,374,290
Total	1,118	\$111,641,274	\$99,858	171	\$17,095,428	\$128,736,702

Source: Financial Services Council, NZIER

As the average FBT rate will fall somewhere between a minimum of 49.25 percent and a maximum of 63.93 percent depending on the employee's income, we have used these two rates to give a range between the minimum and maximum FBT that could be paid.

Table 10 shows the minimum cost of removing FBT (an FBT rate of 49.25 percent) on other group insurance products is \$79.8 million, while Table 11 shows the maximum cost of removing FBT (an FBT rate of 63.93 percent) on other group insurance products is \$103.6 million.

Table 10 FBT forgone on other group insurance products at 49.25 percent FBT rate

Group insurance product	Ongoing premiums paid	Cost with FBT added	FBT forgone	After income tax deduction of 28%
Income protection	\$74,509,987	\$111,206,156	\$36,696,169	\$26,421,241
Life	\$107,359,144	\$160,233,522	\$52,874,378	\$38,069,552
Total and permanent disability	\$23,772,777	\$35,480,870	\$11,708,093	\$8,429,827
Trauma	\$15,022,211	\$22,420,650	\$7,398,439	\$5,326,876
Total	\$225,001,464	\$335,814,685	\$110,813,221	\$79,785,519

Source: Financial Services Council, NZIER



Table 11 FBT forgone on other group insurance products at 63.93 percent FBT rate

Group insurance product	Ongoing premiums paid	Cost with FBT added	FBT forgone	After income tax deduction of 28%
Income protection	\$74,509,987	\$122,144,222	\$47,634,235	\$34,296,649
Life	\$107,359,144	\$175,993,845	\$68,634,701	\$49,416,985
Total and permanent disability	\$23,772,777	\$38,970,713	\$15,197,936	\$10,942,514
Trauma	\$15,022,211	\$24,625,910	\$9,603,699	\$6,914,664
Total	\$225,001,464	\$368,844,900	\$143,843,436	\$103,567,274

Source: Financial Services Council, NZIER

We estimate that the total cost of removing FBT across all group insurance products is between \$210.7 million and \$234.5 million, and the benefit realised from direct health benefits, reduced absenteeism, presenteeism and working more hours, as well as covering costs that might otherwise have to be covered through government functions like ACC or MSD, to be \$408.7 million. This gives an estimated net benefit between \$174.3 million and \$198.1 million from removing FBT on group insurance products.

Table 12 Total costs and benefits of removing FBT from group health and other insurance products

	49.25 percent FBT rate	63.93 percent FBT rate
Group health insurance cost		\$130,896,000
Other group insurance costs	\$79,785,519	\$103,567,274
Total group insurance costs	\$210,681,519	\$234,463,274
Group health insurance benefit		\$280,003,623
Other group insurance benefit		\$128,736,702
Total group insurance benefit		\$408,740,325
Total group insurance benefits (costs)	\$198,058,806	\$174,277,051

Source: Financial Services Council, NZIER



9 Implementation and risks

Insurance has not been a core part of many households' approach to financial resilience in New Zealand (see section 4), in part because there has been a strong expectation that the government will fund and deliver social services. Increasing access for employees to group life and health insurance schemes can increase household financial resilience by increasing their ability to manage the impact of ill-health, injury or other trauma, including the death of a primary income earner. Increasing access to life, trauma and health insurance has material benefits for individuals and employers, while potentially reducing some demand in the public social service system.

An individual seeking life, trauma or health insurance generally faces higher costs than those who join group schemes sponsored by their employers. Making group schemes more attractive to employers by removing FBT would likely make them more accessible to those in employment.

We have used data on elective health services to model the potential impact of increased use of group health and life insurance products. Life and trauma insurance products allow beneficiaries to fund time off work for recovery and rehabilitation and to access these services more quickly, facilitating a return to work. Insurance products can also support the individual's household with income support in the event of severe disability or terminal illness. Evaluating these benefits is more difficult because we do not have a comparable baseline measure to that for elective surgery.

There are also some wider benefits to giving New Zealanders greater choice and flexibility in managing their health and social service support. This could also reduce the pressure on government services if people get early interventions. Table 13 summarises the wider costs and benefits of removing FBT on group insurance schemes.

Table 13 Summary of costs and benefits

	Costs	Benefits
Employee	Salary Sacrifice Premium Costs	Financial resilience Improved well-being
Employer	Increased cost of managing payroll	Reduced cost of absenteeism, presenteeism and staff turnover Increased productivity
Government	Health expenditure Mental health expenditure ACC Foregone tax revenue	Reduced demand Reallocation of some expenditure Medium to long-term benefits

Source: NZIER



9.1 Trade-offs

There is a strong ethos that the government should be the primary provider of health and social services in New Zealand. This does not recognise that New Zealand has retained a hybrid system where delivery outside the hospital-based health and social service system is by private entities and that at least 20 percent of expenditure is funded by individuals or other private sources, including insurance. The fiscal trade-offs are getting sharper, and the government is increasingly having to reallocate (i.e. prioritise) funding. In this context, there has to be greater openness to nudging the public-private boundary for the funding and delivery of services, while ensuring that it does not reduce equity in access to services.

There will be a reduction in the government's FBT income, which will only be partially offset against reduced government expenditure elsewhere. The direct benefits will be shared by employees and their employers. In the medium term, increasing workforce productivity will deliver wider economic benefits, including potentially increasing tax revenue.

The other trade-off is that this benefit will not be extended to the self-employed or those not in the workforce, unless they are members of the households who will benefit from employer schemes.

There is also the consideration that many in employment contribute to KiwiSaver. As contribution rates to KiwiSaver increase, there is a risk that insurance will be seen as unaffordable. Life, trauma and health insurance are complementary to KiwiSaver, by ensuring that households do not need to make hardship applications in the event of illness or trauma.

Risks

The proposal to remove FBT from group health and life insurance schemes aims to increase financial resilience for individuals and households by reducing the impact of unexpected health, injury, or trauma events. Insurance payouts can be used to get faster access to medical care and rehabilitation, as well as to smooth the impact on household income.

This proposal does not address the needs of all individuals and households across New Zealand. In particular, those who are self-employed or out of the workforce will not have access to group schemes and will continue to pay premiums based on their personal profiles.

Affordability will likely remain an issue for many employees, who need to balance their daily financial needs with saving for retirement through KiwiSaver and ensuring that they have financial resources to meet shocks.

There are concerns that greater use of private health and social services will reduce the capacity and capability of the public system. Where public and private services are direct substitutes, as in elective medical procedures, it will be important to ensure that public and private providers work together to develop staff capability. As many procedures seem to be increasingly outsourced, this may not be a significant issue.

Maintaining a strong public health system that delivers acute care and supports the wider health and social service sector can help focus the health sector.

Beyond the health sector, an increase in the use of insurance-based funding could strengthen the sector by reducing the dependence on public funding.



10 Conclusion: Speedy access has positive ripple effects

It is timely for New Zealanders and the government to reconsider the public-private funding mix for health and social services in the context of household financial resilience and households' increasing use of OOP to obtain these services. Expanding employees' access to group life and health insurance schemes can increase household financial resilience by improving their ability to manage the impact of ill-health, injury or other trauma, including the death of a primary income earner. In turn, this means that individuals can remain in the workforce as fully productive employees. Making group schemes more attractive to employers by removing FBT would help to make them more accessible for employees.

Calculating the impact of increased group insurance scheme uptake on government income and expenditure is based on several assumptions. We expect that increased access to group insurance products would increase their use by individuals and households to manage health, injury, and trauma events. This would likely increase the use of private health and social service providers. It is also expected that those with insurance will be able to access rehabilitation services and return to work more quickly. It would also provide the means to manage disruption to household income.

Employers will benefit as their employees are better able to manage their health and rehabilitation from injury and trauma, reducing the costs of absenteeism, presenteeism, and staff turnover. A healthy and fit workforce is more productive, which delivers economic benefits.

These benefits may not fully offset the government's lost tax revenue in monetary terms, although the benefits of increased wellbeing and productivity across the workforce may provide a better outcome for the economy in the medium term. There may be some benefit for the health and social service system itself if there is reduced demand for long-term and acute care.

The counterfactual is for the government to continue as the main funder and provider of health and social services. Constraints on government finance mean that services will also be constrained. In turn, individuals have limited choices and face wait times that reduce the likelihood of a full recovery and return to work. Individuals and households will continue to bear the direct costs of this and will increasingly turn to OOP funds to cover their health and social support needs, reducing their financial resilience.



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Appendix A Why employee health and income resilience matter to the economy

Health and wellbeing have an impact on productivity, for the individual, their employer and the wider economy (NZIER 2024). Labour productivity is generally measured as a function of output and hours worked. The simplest approach to monetising individual worker productivity is to calculate the average value of an hour worked. The cost of lost productivity is then a function of hours or days multiplied by earnings per hour or per day.

This does not capture all aspects of lost productivity because it does not account for the degree of interdependence among job functions. Factors such as the replaceability of an employee, the extent to which an employee works as part of a team, and the time sensitivity of an employee's work will increase the cost of lost productivity where other individuals' work is compromised by the absence or presenteeism of the individual with ill health (Nicholson et al., quoted in Mattke et al. 2007, 215). These factors will determine how an organisation manages an individual's absence or presenteeism, with consequent implications for any productivity losses.

Absenteeism

Absenteeism is most closely related to ill health. Absenteeism is time taken off work for sick leave or to care for others who are ill. Absenteeism also can be a function of an employee's poor engagement at work.

Recent estimates of absenteeism in New Zealand show it is rising (Southern Cross Health Insurance and BusinessNZ 2025). The 2025 Workplace Wellness Report reports the average rate of absenteeism was 6.7 days for the year, up from 5.5 days in 2022 (ibid, page 5). This could be the result of a number of factors, including increased awareness that individuals should not come to work when they are sick, and the legislated increase in sick leave entitlements to 10 days per year.

The length of an absence from work affects productivity. A worker who is absent for a day on an intermittent basis may contribute more to reduced productivity because it is difficult to plan for such absences. An employee who is absent for a longer period, such as a week or more, can be substituted for in the work process.

Approximately 20 percent of the New Zealand workforce takes no sick leave over a year. In 2008, about 46 percent had more than a week off work (Holt 2010, 23–24). If a similar distribution still holds, then 46 percent of employees took more than 6.7 days off work in 2024.

Presenteeism

Presenteeism refers to employees being physically present at work but unable to perform their job duties to 100 percent of their capability or capacity. A number of factors contribute to presenteeism, including individual attributes and organisational attributes. Presenteeism is also associated with health issues, where an individual comes to work despite being unwell or because they are living with a long-term condition (Kişi 2025, 8648). Presenteeism due to ill health can be defined in at least two ways: *going to work despite feeling unhealthy*; or *reduced productivity at work due to health problems* (Bryan et al. 2022, 410–11).



A number of health conditions are associated with presenteeism due to ill health: allergies; arthritis or joint pain/stiffness; asthma; back or neck disorder; breathing disorder-bronchitis or emphysema; depression, anxiety or emotional disorder; diabetes; heart or circulatory problems-artery disease, high blood pressure, angina; migraines/chronic headaches; and stomach or bowel disorder (Collins et al. 2005). Many of these conditions are found in combination or as comorbidities. The presence of a chronic medical condition is a stronger predictor of presenteeism.

In their assessment of the impact of presenteeism across the Dow US workforce, Collins et al. found that 65 percent of respondents reported one or more chronic health conditions. The highest presenteeism costs were associated with those who reported depression, anxiety or emotional disorder as their primary condition, but the conclusion was that, *For all chronic conditions studied, the cost associated with performance based work loss or "presenteeism" greatly exceeded the combined costs of absenteeism and medical treatment combined* (Collins et al. 2005, 547).

In the United Kingdom, about 9 percent of the workforce exhibits presenteeism that reduces their productivity in any given month, and ill health is the most important driver of presenteeism (Bryan et al. 2022). Developing a physical condition doubles the probability of reduced productivity at work, while moving from good to poor mental health is likely to increase the probability of presenteeism by threefold (ibid., 13).

In assessing the cost of ill health in New Zealand, Holt found that almost half of the active workforce experienced some degree of presenteeism (Holt 2010, 30). Although presenteeism is highly associated with self-rated health status, 33 percent of those who rated their health status as excellent experienced some presenteeism (ibid, 33). Holt suggested that presenteeism could affect between 1 and 10.9 percent of the total hours worked across the economy (ibid, 31).

The cost of presenteeism is reduced worker productivity. Workers are present at work but not completing their full daily workload. Estimates of the reduction in productivity are based on survey data and vary widely. An individual's assessment of the impact of a health condition on their productivity is largely subjective. It will also vary depending on the type of role and the nature of an individual's health condition. Estimates of the reduction in productivity range from 15 to 50 percent (Southern Cross Health Society 2009; Holt 2010; Bryan et al. 2020).

These estimates relate to the average across the total working population. An individual's personal experience of presenteeism due to ill health may differ substantially.

Staff turnover

All organisations experience staff turnover, where employees choose to leave the organisation or are dismissed by the employer. The rate of staff turnover varies with changes in economic conditions – high unemployment rates tend to reduce staff turnover. Employees leaving the workforce due to ill-health also contribute to staff turnover.

Employees who report greater wellbeing at work also report greater engagement at work. Increased staff engagement is associated with lower staff turnover and may help reduce absenteeism and presenteeism.

Staff turnover is a cost to the business, especially if the employer has invested in training and the employee has developed skills specific to the organisation. The employer has to spend on recruitment and training the new employee. National staff turnover in New



Zealand was estimated at 21.4 percent in 2023, of which 17.4 percent was voluntary (LawsonWilliams 2024). The cost of employee turnover can range from 75 to 300 percent of the wage or base salary cost. Based on a limited number of case studies, it is estimated that workplace health measures can reduce staff turnover by 10 to 25 percent (Table 2, Baxter et al. 2015, 5).

The costs of absenteeism, presenteeism and staff turnover – methodology

We have estimated the average costs of absenteeism, presenteeism and staff turnover due to ill health, based on international and New Zealand analysis and data.⁵ These estimates are from an employee-level perspective. It is not possible to capture the variations associated with business size and other specific conditions to provide organisation-specific estimates.

There is a range of values for the calculations' inputs, reflecting the range of how people experience ill health in the workplace. We have chosen to make conservative assumptions to ensure that we do not overestimate the costs of ill health.

The following assumptions were made:

- The average hourly wage as at December 2025 has been used as the benchmark (Stats NZ 2026). The employee is assumed to be employed to work a 40-hour week.
- Absenteeism is estimated using the average rate of absenteeism of 6.7 days for the year, from the 2025 Workplace Wellness Report.
- Presenteeism is estimated to have a 50 percent impact on productivity. This is the value that was used in the Southern Cross assessment of presenteeism in 2008. It is the maximum of the range for this input. It is similar to international estimates of the impact of ill-health-based presenteeism on productivity. We believe this is partially offset by using the average number of hours worked at low productivity.
- We have used the range of average hours worked at low productivity, as estimated by Holt (2010).
- Our estimates of the cost of staff turnover due to health-related factors draw on the model developed in Australia by Baxter et al. (2015). We use their lower value for the cost of turnover of 75 percent of the employee's wage, and we have applied LawsonWilliams (ibid, 2024) national rate of turnover of 17.4 percent to calculate a per employee estimate.

Table 5 summarises the costs of absenteeism, presenteeism and staff turnover, with three options for the number of hours worked at low productivity in a week.

⁵ Holt's population based analysis has not been updated to our knowledge, and some of the data sets are no longer available.



Appendix B Impact of increased use of private health insurance

B.1 Methods and scope

For the removal of FBT on group private health insurance, we have based our methodology and assumptions on the 2024 report for Southern Cross Medical Care Society and on data for private health service utilisation.

We base our analysis on the projection that there would be 201,408 additional group private health insurance policyholders if FBT is removed from private health insurance schemes in the workplace. This is based on Southern Cross' projection that there would be 143,000 additional Southern Cross health insurance policyholders if FBT were removed and its 71 percent market share of the private health insurance market.

We also utilise the assumption that private health insurance accounts for 20 percent of the annual FBT total, rising from \$106.8 million in 2023 to \$130.9 million in 2024/25, after the assumption that employers claim an income tax deduction using the 28 percent corporate income tax rate.

Waitlist data for Southern Cross Medical Care Society members and Health NZ were obtained for procedures identified by Southern Cross as the most likely and easiest to transfer from the public to the private health system. Procedures without waitlist data for both Southern Cross and Health NZ have been excluded from the analysis. The list of procedures and their groupings can be found in Appendix B.2. It should be noted that Southern Cross and Health NZ use different classifications for procedures, so they have been selected and grouped based on Southern Cross's advice. Hence, our analysis only captures a subset of procedures that could be provided under the private health system.

The waitlist data for the identified procedures was then combined with the population of existing Southern Cross health insurance policyholders to obtain utilisation rates for each procedure.

The number of expected events that could be moved was then compared with inpatient hospital events in the public health system to estimate the bed days and costs that could be saved by moving them to the private health system. The inpatient events compared were elective events that did not involve time spent in an intensive care unit or on non-invasive ventilation in the 2024/25 June financial year for each procedure group.

The waitlist events were restricted to those within 365 days to ensure comparability between Southern Cross and Health NZ data, and to people who exited the waitlist in the 2024/25 June financial year. The financial years from 2019/20 to 2023/24 were also investigated to determine whether 2024/25 was an appropriate financial year for analysis, and no significant differences were found between the years.

We have assumed that both the utilisation rate and the types of procedures previously identified by Southern Cross Medical Care Society are representative of those of private health insurers, given their large market share.

For the removal of FBT on other group insurance products, including income protection, life, total and permanent disability, and trauma, we have used the premiums paid to calculate a range of FBT paid between the top FBT rate of 63.93 percent and the bottom FBT rate of 49.25 percent. We have then compared this to the amount paid out in accepted claims for those group insurance products, with the addition of new claims that could be



accepted if there are additional policyholders based on the same percentage increase seen by Southern Cross when FBT was added to private health insurance of 15.31 percent.

B.2 Data and evidence

Table 14 shows the difference in the number of people on the waitlist, the number of days on the waitlist and the average days on the waitlist for the identified procedure groups. This shows key differences in waitlist time between the public and private health systems for the identified procedure groups.

Table 14 Waitlist data for Southern Cross and Health NZ in 2024/25 by procedure

Procedure group	People on waitlist		Total days on waitlist		Average days on waitlist	
	Southern Cross	Health NZ	Southern Cross	Health NZ	Southern Cross	Health NZ
Carpal Tunnel Release	961	3,036	52,549	321,294	54.7	105.8
Cataract extraction and insert IOL	4,588	3,850	203,701	240,927	44.4	62.6
Cholecystectomy	996	3,316	38,667	336,050	38.8	101.3
Colonoscopy (+/- Biopsy / Polyp)	5,382	288	307,662	9,637	57.2	33.5
Colposcopy with Biopsy	816	1,402	22,497	67,199	27.6	47.9
Coronary Angiography	1,303	4,112	31,984	230,998	24.5	56.2
Endometriosis Surgery	1,406	199	62,613	26,490	44.5	133.1
Excision of Skin Lesion	13,181	5,693	361,498	391,818	27.4	68.8
Gastroscopy (+/- Biopsy / Polyp)	3,058	679	142,548	34,299	46.6	50.5
Gastroscopy and Colonoscopy	2,827	7,519	106,450	351,446	37.7	46.7
Hernia - Inguinal Repair	1,514	3,381	65,302	383,279	43.1	113.4
Hysterectomy	1,617	2,751	81,879	290,274	50.6	105.5
Hysteroscopy D&C +/- other proc	2,720	5,368	91,196	337,215	33.5	62.8
Intravitreal injection	7,317	20	115,914	660	15.8	33.0
Moh's Surgery	1,982	102	97,296	9,014	49.1	88.4
Prostatectomy	448	2,870	22,045	305,577	49.2	106.5
Removal of Haemorrhoids	822	936	37,091	127,302	45.1	136.0
Removal of Teeth	4,909	2,675	255,025	356,904	52.0	133.4
Sigmoidoscopy	1,525	958	24,960	49,689	16.4	51.9
Tonsillectomy	1,733	1,548	98,469	217,461	56.8	140.5
Total Hip Replacement	1,934	3,265	120,678	410,507	62.4	125.7
Total Knee Replacement	1,839	2,606	128,870	377,279	70.1	144.8
Transrectal Ultrasound and Biopsy	4	330	840	20,674	210.0	62.6
Varicose Veins, Resection	180	323	14,436	49,528	80.2	153.3
Total	63,062	57,227	2,484,170	4,945,521	39.4	86.4

Source: Southern Cross, Health NZ



To obtain the utilisation rates for each procedure group for Southern Cross health insurance policyholders, the number of events for each procedure group was compared to the existing Southern Cross policyholder population in 2024/25. This utilisation rate was then applied to the projected increase of 201,408 group private health insurance members to determine the expected number of events that could be transferred from the public to the private health system.

The number of new waitlist events could not exceed the total for the year for Health NZ, as this would imply additional events rather than events moving from the public to the private health system. We estimate this would result in up to 10,459 waitlist events moving from the public health system to the private health system for Southern Cross health insurance policyholders and a saving of 471,630 days on the waitlist, or 52.6 percent of the expected days on the public health waitlist for those patients. The waitlist events that are estimated as potentially moving to the private system represent 14 percent of the existing Health NZ waitlist. This proportion is realistically achievable, considering likely health insurance coverage and patient complexity.

Table 15 Measures for expected waitlist events moved to the private health system by procedure group

Procedure group	Southern Cross waitlist events per 1,000 policyholders	Expected new waitlist events	Total waitlist savings (days)	Waitlist days reduced by percentage
Carpal Tunnel Release	1.03	208	10,638	48.3%
Cataract extraction and insert IOL	4.91	990	17,997	29.0%
Cholecystectomy	1.07	215	13,441	61.7%
Colonoscopy (+/- Biopsy / Polyp)	5.76	-	0	0.0%
Colposcopy with Biopsy	0.87	176	3,583	42.5%
Coronary Angiography	1.40	282	8,919	56.3%
Endometriosis Surgery	1.51	199	17,627	66.5%
Excision of Skin Lesion	14.11	2,843	117,696	60.2%
Gastroscopy (+/- Biopsy / Polyp)	3.27	660	2,573	7.7%
Gastroscopy and Colonoscopy	3.03	610	5,542	19.4%
Hernia - Inguinal Repair	1.62	327	22,965	62.0%
Hysterectomy	1.73	349	19,152	52.0%
Hysteroscopy D&C +/- other proc	2.91	587	17,194	46.6%
Intravitreal injection	7.84	20	343	52.0%
Moh's Surgery	2.12	102	4,006	44.4%
Prostatectomy	0.48	97	5,554	53.8%
Removal of Haemorrhoids	0.88	178	16,177	66.8%
Removal of Teeth	5.26	1,059	86,278	61.1%
Sigmoidoscopy	1.63	329	11,679	68.4%
Tonsillectomy	1.86	374	31,288	59.6%



Procedure group	Southern Cross waitlist events per 1,000 policyholders	Expected new waitlist events	Total waitlist savings (days)	Waitlist days reduced by percentage
Total Hip Replacement	2.07	418	26,472	50.4%
Total Knee Replacement	1.97	397	29,654	51.6%
Transrectal Ultrasound and Biopsy	0.00	-	0	0.0%
Varicose Veins, Resection	0.19	39	2,852	47.7%
Total	1.03	10,459	471,630	52.6%

Source: Southern Cross, Health NZ, NZIER

Table 16 shows that the total ongoing premiums paid for other group insurance products in 2025 were \$225 million, with 1,118 claims accepted associated with these premiums. These 1,118 claims had \$111 million paid out, with an average claim amount across all other group insurance products of \$99,858.

Table 16 Measures for other group insurance products in 2025

Group insurance product	Ongoing premiums paid	Accepted claims	Accepted claims amount paid out	Average claim amount
Income protection	\$74,509,987	271	\$38,862,746	\$143,405
Life	\$107,359,144	453	\$51,398,235	\$113,462
Total and permanent disability	\$23,772,777	29	\$8,350,812	\$287,959
Trauma	\$15,022,211	365	\$8,996,649	\$24,648
Total	\$225,001,464	1,118	\$111,641,274	\$99,858

Source: Financial Services Council, NZIER

B.3 Health system and fiscal implications

We estimate the total number of bed days that could be moved to the private health system is 5,752, with an associated value of \$57,934,062. Our estimates assume that patients are of an appropriate complexity to be treated in the private health system and that private hospitals have the capacity to accommodate the increased volume of procedures.

In Table 17 no inpatient events were recorded for the cataract extraction and insert IOL procedure group, as it is delivered in an outpatient setting, which means that there are no bed days or cost weight information. Health NZ does not have the same level of information, particularly about the specific procedure and its complexity, as well as about outpatient events compared to inpatient events. Thus, the full impact of moving the cataract extraction and insert IOL procedure group from the public health system to the private health system is not shown, and the total number of events has decreased from 10,459 in Table 15 to 9,469 in Table 17.



Table 17 Measures for expected waitlist events moved to the private health system by procedure group

Procedure group	Expected inpatient events	Average length of stay	Average cost weight	Bed days moved to private	Cost weight value moved to private
Carpal Tunnel Release	208	0.07	0.42	14	\$619,233
Cataract extraction and insert IOL	990	-	-	-	-
Cholecystectomy	215	1.13	1.33	243	\$2,019,953
Colonoscopy (+/- Biopsy / Polyp)	-	0.06	0.42	-	-
Colposcopy with Biopsy	176	0.10	0.54	18	\$669,842
Coronary Angiography	282	0.36	0.78	101	\$1,551,283
Endometriosis Surgery	199	0.70	1.05	140	\$1,480,111
Excision of Skin Lesion	2,843	0.24	0.45	693	\$9,094,277
Gastroscopy (+/- Biopsy / Polyp)	660	0.09	0.45	59	\$2,115,734
Gastroscopy and Colonoscopy	610	0.18	0.47	110	\$2,032,474
Hernia - Inguinal Repair	327	0.52	0.96	169	\$2,215,724
Hysterectomy	349	2.29	2.19	799	\$5,392,326
Hysteroscopy D&C +/- other proc	587	0.18	0.59	107	\$2,445,096
Intravitreal injection	20	0.14	0.72	3	\$101,962
Moh's Surgery	102	-	0.40	0	\$286,530
Prostatectomy	97	1.74	1.56	168	\$1,064,515
Removal of Haemorrhoids	178	0.18	0.49	31	\$616,065
Removal of Teeth	1,059	0.09	0.67	100	\$5,005,049
Sigmoidoscopy	329	0.60	0.64	198	\$1,485,941
Tonsillectomy	374	0.48	0.69	178	\$1,815,989
Total Hip Replacement	418	3.10	3.12	1298	\$9,207,364
Total Knee Replacement	397	3.31	3.07	1314	\$8,584,223
Transrectal Ultrasound and Biopsy	-	0.06	0.56	-	-
Varicose Veins, Resection	39	0.24	0.47	9	\$130,370
Total	9,469	0.56	0.85	5,752	\$57,934,062

Source: Southern Cross, Health NZ, NZIER

