

October 2026

What the media told New Zealand about health

Access, pressure and the contested measures



Lilly Herds
SOCIALHERDS

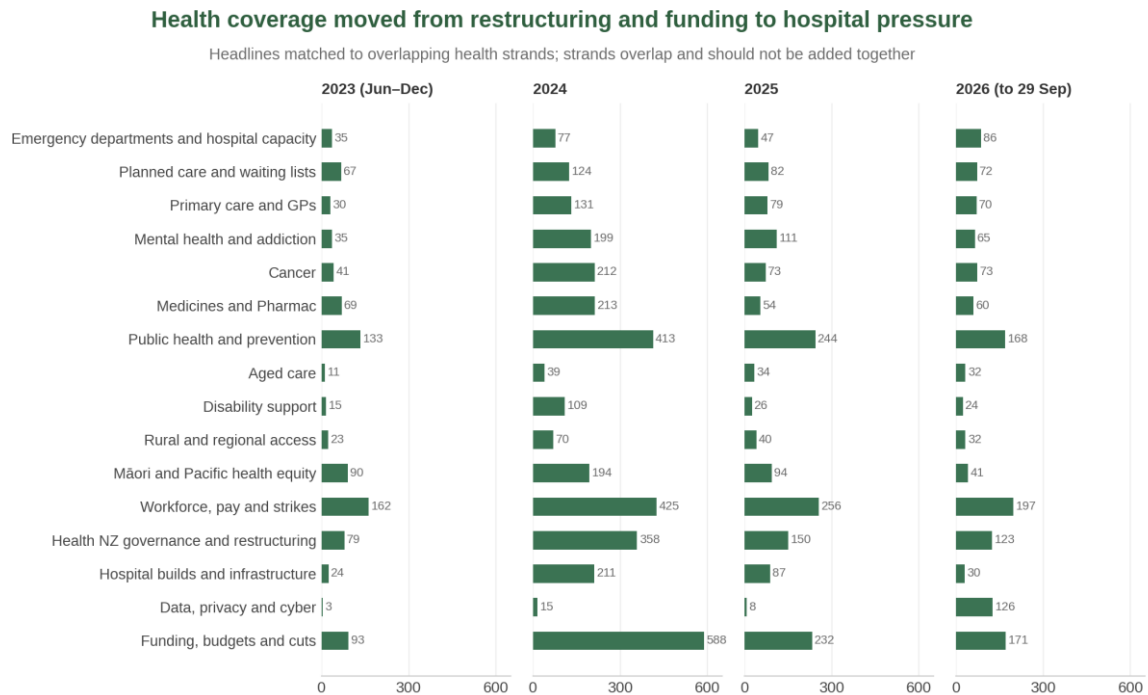
Contents

1	Executive summary	3
2	Background	6
2.1	Health is a persistent public issue	6
2.2	One topic contains several health systems	7
2.2.1	The measurement gap	8
2.3	What the Government inherited and what it set out to change	9
3	Hospitals: access under pressure	11
3.1	Emergency departments	11
3.2	Planned care and the contested targets	11
3.3	Hospital builds: Dunedin and the downsizing of ambition	12
4	Running the system: Health NZ, the workforce and data	14
4.1	Health NZ: from reform to commissioner and back	14
4.2	The workforce is the delivery mechanism	15
4.3	Patient data and cyber security	15
5	Care outside hospital	16
5.1	Primary care and GPs	16
5.2	Mental health and addiction	16
5.3	Disability support and aged care	17
5.4	Rural and regional access	17
6	Prevention, medicines and equity	18
6.1	Smokefree, vaping and public health	18
6.2	Medicines and the cancer drugs promise	19
6.3	Māori health and the end of Te Aka Whai Ora	19
7	Health as a political contest	21
8	What the headline frames reveal	23
9	Conclusion	25
10	What health policies need to cover	26
10.1	Define the problem, the patients affected and the stage of care	26
10.2	Measure everyone who needs care	26
10.3	Resource the workforce	26
10.4	Treat hospital pressure as a whole-system problem	26
10.5	Protect equity and regional access through change	26
10.6	Make delivery and outcomes accountable	26
11	Appendix: scope and method	27
11.1	Source data	27
11.2	Limits	27

1 Executive summary

This report examines what New Zealand’s media told—and enabled New Zealanders to understand—about health between June 2023 and 29 September 2026. It analyses **6,164 health headlines** published across 130 outlets. Health represented 7.3% of the 84,950 headlines in the Social Herds record and was the fourth most frequently reported topic over the period, behind the economy, local government and politics.

FIGURE 1



The coverage did not describe one health problem. It moved among emergency-department crowding, surgery and specialist waits, strikes and staff shortages, the finances and leadership of Health New Zealand, hospital builds, GP access and fees, mental health, disability and aged care, cancer medicines, the repeal of the smokefree legislation, the abolition of the Māori Health Authority and, in 2026, a major breach of patient data. Attention followed events: restructuring, funding and hospital builds dominated 2024; hospital pressure dominated the winter of 2026.

The reporting showed substantial government activity. The Government set five health targets and five mental health targets, replaced Health NZ’s board with a commissioner and later restored a board, cut administrative jobs, reviewed and downsized hospital projects, outsourced elective surgery, repealed the smokefree legislation, disestablished Te Aka Whai Ora, funded additional cancer medicines after a broken promise and, in 2026, replaced the leadership of health regulators. Clinicians, unions, patients and communities contested much of it in public.

Much of this activity responded to decisions taken before the period began. Health NZ had been created in 2022 to replace 20 district health boards, almost all of which had been in deficit; Pharmac had begun naming Māori and Pacific ethnicity in its funding criteria for new diabetes medicines; and the New Dunedin Hospital had been approved at a cost the incoming Government said it could not justify. The Government’s largest structural changes each came with a stated rationale: the smokefree legislation was repealed partly to fund tax cuts and, ministers argued, to avoid a cigarette black market; ethnicity-based prioritisation was removed in favour of allocating care by need; and Health NZ and the Dunedin project were brought under tighter budget

control. The media scrutinised the politics of each decision closely. It followed few of them through to their consequences for patients.

1.1 Health leads alarm coverage—both in volume and as a share of headlines

Across the dataset, alarm was most strongly represented in extreme events, welfare, health, extreme weather and environment when measured as a proportion of each topic’s headlines. Health had the largest number of alarm headlines overall and remained among the highest even after adjusting for the volume of coverage.

The coverage became markedly more alarmed. Alarm-framed headlines rose from under 9% of health coverage in 2023 and 2024 to 30.6% between July and September 2026, against less than 8% for all other topics in the record. Emergency departments carried the sharpest signal: 35.8% of ED and hospital-capacity headlines were framed as Alarm, and 21 headlines reported a death linked to an emergency department or waiting room—14 of them in 2026.

Topic	Alarm headlines / total	Alarm share
Extreme events	92 / 645	14.3%
Welfare	57 / 468	12.2%
Health	713 / 6,164	11.6%
Extreme weather	40 / 358	11.2%
Environment	160 / 1,448	11.0%

Media coverage did not establish whether patients were receiving more timely and effective care. Only 352 of the 6,164 health headlines—5.7%, or about one in eighteen—used outcome or measurement language of any kind. The Government’s own measures became contested: headlines reported official warnings that targets could be manipulated, claims that surgery referrals were being declined to meet them, and in 2026 a “hidden waiting list” of patients never accepted for specialist care. The measure was reported more often than the outcome it was meant to capture.

The **strongest finding is a lack of continuity along the patient pathway**. Headlines commonly reported one point of strain—a crowded ED, a strike, a deficit, a downsized hospital, a declined referral—without following the patient from prevention through primary care, referral, treatment and recovery. Responsibility was divided among ministers, Health NZ, Pharmac, primary-care providers, regulators and private contractors, and no single institution was visibly accountable for the complete result.

Independent evidence also tells a different story from the tone of coverage. By 2026, almost a third of health headlines were framed as Alarm, describing a system in crisis. International comparisons place New Zealand’s average health outcomes among the better-performing high-income countries—third of ten in the Commonwealth Fund’s 2024 comparison, with life expectancy above the OECD average—but last of those ten on equity. Disparity, the system’s weakest result, received comparatively little and comparatively calm coverage: 305 health headlines (about one in twenty) concerned Māori and Pacific health equity, and 10.2% of them were framed as Alarm, against 35.8% for emergency departments. The removal of ethnicity-based health mechanisms was reported one decision at a time, largely as an argument about race and the Treaty, rather than as a question of whose health would change.

These gaps leave five challenges requiring continuing scrutiny:

- I. whether health targets measure access for everyone who needs care, including patients whose referrals are declined, rather than only those accepted onto a list;

- II. whether emergency-department pressure is being reduced at its sources—primary care, hospital beds and discharge into community and aged care—rather than managed through each winter;
- III. whether the health workforce is growing and staying long enough to deliver planned services, rather than being reported mainly through pay disputes;
- IV. whether the removal of the Māori Health Authority, the smokefree legislation and targeted funding narrows or widens health gaps; and
- V. whether downsized or delayed hospital projects and restructured services still meet regional need once media attention moves on.

The report shows that health-system strain, and the political contest over it, were made highly visible.

What the reporting did not resolve was whether more New Zealanders were getting timely care, and with what results.

2 Background

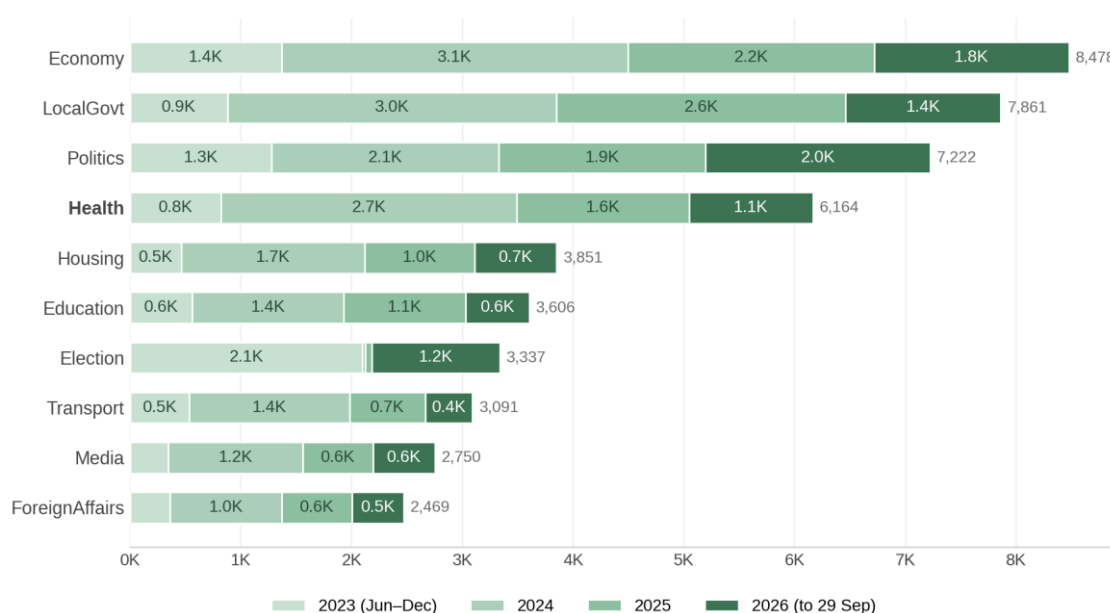
2.1 Health is a persistent public issue

Health was one of the most consistently reported topics in the Social Herds headline record. Between 1 June 2023 and 29 September 2026, 6,164 of the 84,950 recorded headlines—7.3%—were classified under Health. There were 819 in the partial 2023 period, 2,669 in 2024, 1,561 in 2025 and 1,115 in 2026 to 29 September. Health ranked fifth by headline volume in 2023, third in 2024, fourth in 2025 and fifth in the partial 2026 period.

FIGURE 2
The prominence given to health by New Zealand media

Ten most-covered political topics, June 2023 – 29 September 2026

Headline counts by topic and year; 2023 and 2026 are partial years



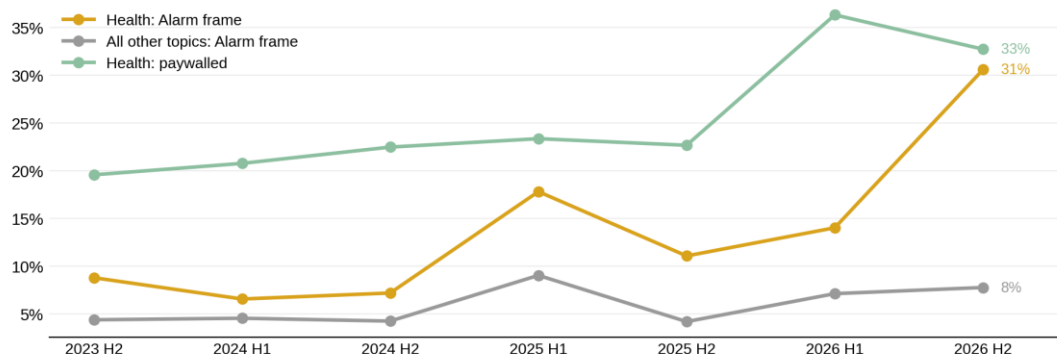
RNZ carried by far the largest share, with 1,984 health headlines, followed by the *New Zealand Herald* (689), *The Post* (620), Stuff (561), the *Otago Daily Times* (427) and Newsroom (269). Most coverage was conventional reporting: 4,426 headlines were classified as Reporting, 713 as Alarm, 565 as Analysis and 459 as Opinion. Only 116 headlines—1.9%—were coded as positive in direction.

The tone hardened over the period, and faster than for other topics. Alarm-framed headlines rose from 8.8% of health coverage in the second half of 2023 to 17.8% in the first half of 2025, then eased before reaching 30.6% between July and September 2026. Across all other topics, the Alarm share stayed between 4.2% and 9.0%. The paywalled share of health headlines rose from 16.8% in 2023 and 21.8% in 2024 to 34.5% in 2026.

FIGURE 3

Alarm framing in health rose well above the rest of the record

Share of headlines by half-year, July 2023 – 29 September 2026



The first half of 2023 (June only) is omitted. The negative-direction code is not shown: its use changed across the whole dataset from July 2026 (see Appendix).

Frequency and tone do not prove that health care worsened. They do show that **health remained a large and increasingly alarmed public issue, and that access to its coverage narrowed.**

2.2 One topic contains several health systems

Health is often discussed as though it were a single public service. In practice, prevention, general practice, hospital care, medicines, mental health, disability support and aged care have different providers, funders, measures and ministers. Patients need to be seen promptly, referred, treated and supported afterwards. Staff need workable conditions and pay. Health NZ needs to live within its budget. Government must weigh cost, evidence and public expectation.

These expectations can reinforce one another, but they can also conflict. Cutting administrative staff may save money while slowing clinical work. Outsourcing surgery may shorten waiting lists while drawing staff from public hospitals. A smaller hospital may be affordable while leaving fewer beds for a growing region. Declining a referral may keep a waiting-time target intact while leaving a patient without care.

For that reason, an improvement in a single measure says little on its own. What matters is who a policy is designed to help, where in the patient's care it acts, which institution delivers it, and how its effect on patients will be tracked.

FIGURE 4

New Zealand's patient pathway as presented through the headlines

Each stage was reported; the connections between stages, and the results for patients, were reported far less often

Identified need → prevention → timely primary care → referral accepted → treatment delivered → recovery and support → measured outcome



Health headlines by area of coverage, June 2023 – 29 September 2026. Areas overlap, so counts should not be added together.

Running beneath every stage

Workforce, pay and strikes (1,058) · Funding, budgets and cuts (1,028) · Health NZ governance (623) · Hospital builds (321) · Data and cyber (206)

Counts are health headlines by area of coverage, identified by keyword searches; areas overlap. The outcome figure is the share of all health headlines using outcome or measurement language.

2.2.1 The measurement gap

Unlike most policy areas, health had an explicit set of government targets. In March 2024, Newshub reported that the Government had set five health targets; headlines named targets for cancer treatment, emergency-department stays, specialist appointments and elective treatment. In July 2024, Newshub and the *Herald* reported five mental health targets.

Targets gave the media a common yardstick, and some coverage used it. RNZ reported in December 2024 where the system had and had not met the targets, and the *Herald* reported in September 2025 leaked data showing major hospitals failing emergency-department wait-time targets. But the measures themselves became contested. The *Herald* reported in September 2024 that officials had warned of manipulation; Labour claimed in November 2024 that surgeries were being rejected to game the waitlist targets; 1News reported in January 2026 a data gap in the true scale of declined specialist appointments; and *The Post* reported in May 2026 on a “hidden waiting list no-one reports” and in July 2026 on missing waiting-list data.

To test the measurement gap directly, headlines were searched for outcome or measurement language—results, data, figures, surveys, evidence, targets, rates, improvement or decline. Across all health headlines the share was 5.7% (352 headlines). It was lowest for aged care (2 of 112 headlines, 1.8%), disability support (3 of 156, 1.9%), medicines and Pharmac (10 of 466, 2.1%) and hospital builds (7 of 321, 2.2%).

What the official figures show

Health New Zealand's own results show how far the measures were from their targets. In the December quarter of 2025/26, 68.9% of emergency-department patients were admitted, discharged or transferred within six hours, and 65.9% of patients received elective treatment within four months, against targets of 95% for both. Five of 20 districts met the interim emergency-department milestone and eight met the elective milestone.

All five health targets measure time or coverage; none measures what happened to patients afterwards. The OECD reports no comparable New Zealand data on deaths that could have been prevented or treated.

Sources: Ministry of Health, All-of-Government health targets briefing, December quarter 2025/26; OECD, Health at a Glance 2025, New Zealand country note.

A target that counts only the patients accepted onto a list can improve while the patients turned away disappear. The contest over health measurement was itself one of the most important accountability stories of the period.

2.3 What the Government inherited and what it set out to change

The headline record begins in June 2023, partway through a health system already being rebuilt. Several earlier decisions shaped much of what followed, and the incoming Government's responses to them account for its largest structural changes.

On 1 July 2022, Health New Zealand–Te Whatu Ora replaced the country's 20 district health boards under the Pae Ora (Healthy Futures) Act 2022, alongside a new Māori Health Authority, Te Aka Whai Ora. The boards had been under sustained financial pressure: Newsroom reported a combined draft deficit of \$885 million for 2019/20, with all but one board in deficit. The reform was promoted as ending a "postcode lottery" in care. That promise recurred in the headlines—1News reported in July 2025 that the postcode lottery persisted three years after Health NZ's creation—and so did the dispute over who owned the new agency's deficit. Labour said in June 2024 that the blowout was the Government's responsibility (RNZ); the Health Minister said in October 2024 that the previous government "needs to own" the funding gap (Herald).

In December 2020, Pharmac decided to fund two new type 2 diabetes medicines, empagliflozin and dulaglutide, and for the first time named Māori and Pacific ethnicity in its funding criteria. It described this as an intentional move to promote equity of access for groups at high risk of complications. In June 2023, Newstalk ZB reported that Auckland surgeons must now consider ethnicity when prioritising patients for operations, through a waiting-list "equity adjuster" that drew immediate criticism. These measures were aimed at the gaps that independent data identifies as the system's weakest point.

The incoming Government's largest health changes each came with a stated rationale. The Finance Minister acknowledged that scrapping the smokefree legislation would help fund tax cuts, and the Prime Minister argued it would otherwise have driven a cigarette black market. ACT argued for allocating care by need rather than ethnicity—its leader said in May 2024 that he wanted to stop "lazily" categorising by race—and Health NZ dropped its ethnicity-based waiting-list tool in August 2024. Health NZ's board was replaced by a commissioner to bring spending under control, and the New Dunedin Hospital was ordered back within its budget.

Each decision received intense coverage of its politics—lobbying, race, protest and blame. Far less coverage followed any of them through to what happened to the patients they affected. Sections 3 to 7 trace that pattern.

What the official figures show

International comparisons place New Zealand's average outcomes among the better-performing high-income countries, and its distribution of care among the least equal. The Commonwealth Fund's 2024 comparison of ten countries ranked New Zealand third on health outcomes and fourth overall, but last, with the United States, on equity, because of large income-related differences in cost barriers to care.

Life expectancy was 82 years in 2023, 0.9 years above the OECD average, and survival 30 days after a heart attack or stroke was better than average. New Zealand had 2.5 hospital beds per 1,000 people, against an OECD average of 4.2. In the 2024/25 New Zealand Health Survey, 14.9% of adults had not visited a GP because of cost in the previous year, rising to 18.7% of Māori and 25.1% of Pacific adults.

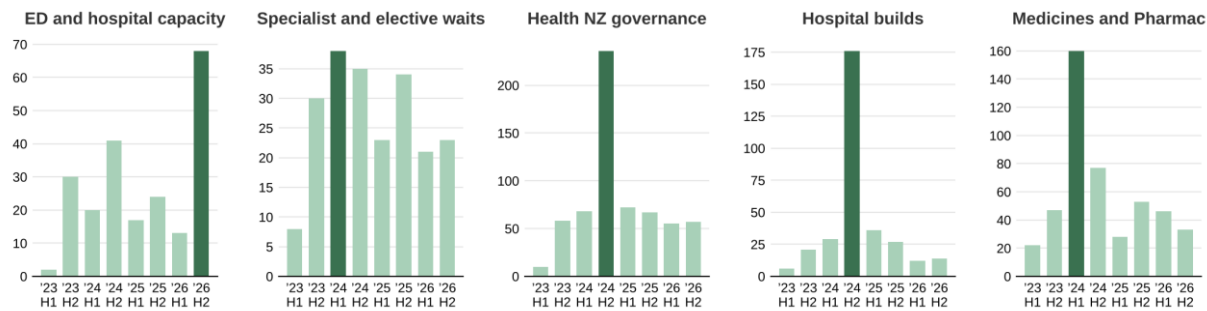
Sources: Commonwealth Fund, Mirror, Mirror 2024; OECD, Health at a Glance 2025, New Zealand country note; Ministry of Health, New Zealand Health Survey 2024/25.

3 Hospitals: access under pressure

Hospital coverage generated the sharpest signals in the record. Emergency departments, planned care and hospital builds each peaked at a different time, and each was reported through a different lens: crowding and death in the ED, targets and hidden lists in planned care, and cost and downsizing in hospital builds.

FIGURE 5
Health pressure points peaked at different times

Headlines per half-year; darker bar marks each area's peak. 2023 H1 is June only; 2026 H2 runs to 29 September



Areas overlap. Half-years are January–June (H1) and July–December (H2); 2026 H2 runs to 29 September.

3.1 Emergency departments

Emergency departments and hospital capacity produced 215 headlines: 32 in the partial 2023 period, 61 in 2024, 41 in 2025 and 81 in 2026. This was the most alarmed area of health coverage: 35.8% of its headlines were framed as Alarm, against 11.6% for health overall.

The story recurred each winter. RNZ reported in July 2023 that emergency departments were at breaking point, and Newshub in August 2023 recorded Waikato Hospital’s worst-ever day of ambulance ramping. In September 2024, RNZ reported that Health NZ had scrapped the “Code Black” alert used for EDs in crisis; in June 2025, *The Post* reported hundreds of “Code Red” critical overload incidents.

The winter of 2026 was the most intense period in the record. Between 1 August and 29 September, 40 ED and hospital-capacity headlines appeared, 27 of them framed as Alarm. RNZ reported patient beds angled in ED corridors and plans for tents, patients left in soiled beds at North Shore, and Tauranga ED staff declaring a “state of emergency”. The *Herald* reported that Whangārei Hospital had been at critical capacity seven times longer that winter, and a nurses’ union claim that Whanganui’s ED reached 680% capacity—a figure Health NZ disputed. Deaths became part of the story: 21 headlines linked a death to an emergency department or waiting room, 14 of them in 2026—most of them concerning a single patient who died in the Waikato Hospital ED waiting room in July.

The Minister’s account and the headlines diverged. On 17 September 2026, RNZ reported the Minister saying the health system was improving despite a “very challenging” winter. The same month, the *Herald* reported a Waikato patient collapsing in the waiting room and the daughter of a man who died after a nine-hour ED wait speaking out. The headline record showed winter pressure clearly. It rarely connected that pressure to its sources—GP access, hospital bed numbers and discharge into aged and community care.

3.2 Planned care and the contested targets

Planned care and waiting lists produced 212 headlines. Individual cases dominated: a man who lost sight in one eye waiting for a specialist (*Herald*, June 2023), a patient who waited four years for a specialist appointment (Stuff, March 2024), and breast-cancer patients waiting years for reconstruction (RNZ, August 2024). The

Government's response was partly to buy capacity: RNZ reported in June 2025 that almost 10,000 extra elective surgeries had been delivered by outsourcing to private providers.

What distinguished health from other topics was the argument about the list itself. Twenty-nine headlines referred explicitly to the health targets, and a further ten to declined referrals, hidden waiting lists or missing waiting-list data—six of those in 2026. *The Post* reported in March 2026 that the majority of cardiology referrals were being declined. The *Herald* reported in February 2026 that some patients had waited up to 14 times longer than the target for a cancer diagnosis.

The headlines established that a measured waiting list and the real demand for care can diverge. They did not establish by how much, or who was left outside the count.

3.3 Hospital builds: Dunedin and the downsizing of ambition

Hospital builds and infrastructure produced 321 headlines, 205 of them in 2024. The new Dunedin Hospital dominated: 151 health headlines named Dunedin, 102 of them in 2024. RNZ reported on 27 September 2024 that the Government had signalled a downgrade; within days, Stuff and RNZ reported up to 35,000 people protesting—the “biggest protest in Dunedin in decades”. Thirty-six Dunedin headlines appeared between 27 September and 6 October 2024.

The Government had set out its case the day before the downgrade headlines. In a statement on 26 September 2024, ministers said the project had been approved at \$1.59 billion under the previous government, against a 2017 estimate of \$1.2–1.4 billion; that the appropriation had since risen to \$1.88 billion; and that costs could approach \$3 billion, which they said would make it “one of the most expensive hospitals ever built in the southern hemisphere”. An independent review by Robert Rust, a former chief executive of Health Infrastructure New South Wales, found the project “probably not achievable within the approved budget”. Ministers also warned that upgrades at Whangārei, Nelson, Hawke's Bay, Palmerston North and Tauranga hospitals could be put at risk. Headlines had reported the cost blowout—“costs now over \$2 billion” (*Otago Daily Times*, May 2024) and forecasts “near \$3b” (*BusinessDesk*, September 2024)—but none carried the ministers' comparison, and the trade-off with other regions was rarely pursued.

The story then followed the project with unusual continuity. The Spinoff reported in February 2025 the Minister confirming that the south would get a new hospital; the *Otago Daily Times* reported bed cuts in May 2025; the *Herald* reported construction resuming in July 2025; RNZ reported in March 2026 that the approved budget was higher than the Government had claimed, and in August 2026 the opening of the outpatient building. Elsewhere, *The Post* reported in September 2024 that more than \$3.2 billion of hospital projects were under review, and 1News that Health NZ planned smaller buildings and reuse of existing ones.

Build coverage used almost no outcome language—7 of 321 headlines (2.2%). The recurring questions were cost, size and delay. Whether a smaller hospital would meet regional demand was argued mainly through bed numbers, not through projected waits or patient outcomes.

What was done	Health and mental health targets were set; elective surgery was outsourced; ED alert systems were changed; hospital projects were reviewed, downsized and restarted.
What received scrutiny	ED crowding and deaths, individual waits, target performance, declined referrals, the Dunedin Hospital downgrade and project costs.
What remained under the radar	The true scale of unmet demand outside official lists; the sources of ED pressure in primary and community care; and whether downsized builds, and the regional upgrades said to depend on them, will meet regional need.
The accountability test	For each target: who is counted, who is excluded, and whether patient outcomes improve alongside the measure.

4 Running the system: Health NZ, the workforce and data

Much of the health coverage concerned not patients but the machinery that serves them: Health NZ’s finances and leadership, the staff it employs, the regulators who oversee them and, in 2026, the security of patient data.

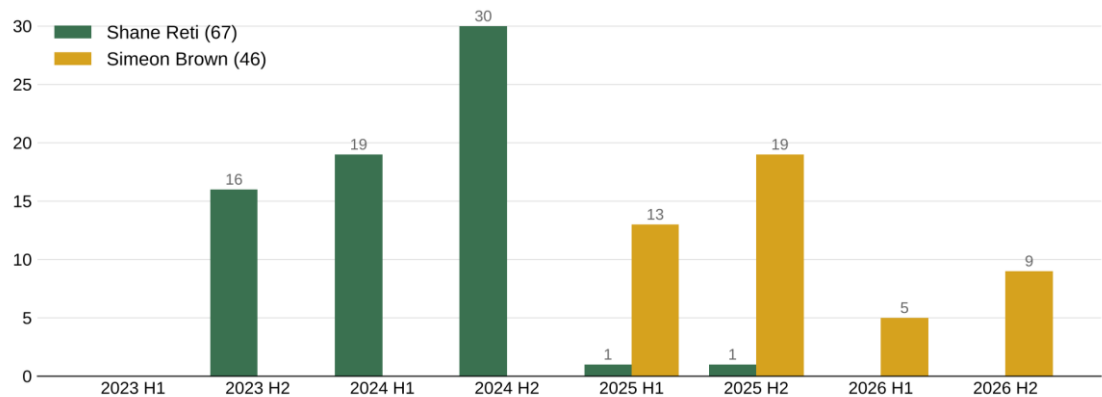
4.1 Health NZ: from reform to commissioner and back

Health NZ governance and restructuring produced 623 headlines, 304 of them in 2024. The coverage fell into three phases. In 2023, the new national agency was judged on its first year: RNZ reported in June 2023 that doctors had given Te Whatu Ora a “fail mark”, and in August 2023 a restructure of more than 400 jobs.

The second phase began in mid-2024. Interest.co.nz reported in June that Health NZ could not stay within its budget; the board was replaced by commissioner Lester Levy in July. Commissioner coverage was intense: 42 headlines named Levy or the Health NZ commissioner between late July 2024 and February 2025. Headlines reported a deficit approaching \$1 billion (*Herald*, October 2024), spending on catering as the financial crisis loomed (RNZ, October 2024), union claims of 1,500 proposed job losses (Stuff, November 2024) and a contest over the account itself: *The Post* reported the Prime Minister repeating an incorrect Health NZ claim, Politik that the Government’s claims had started to unravel, and Labour’s leader accused the commissioner of “cooking the books”.

The third phase followed Simeon Brown’s appointment as Minister in early 2025. Newsroom reported in February 2025 that he declined to express confidence in the commissioner; RNZ reported in July 2025 that a board had been re-established; and in December 2025 that the Minister had set \$500 million of “efficiency targets”. In July 2026, the *Herald* reported that Health NZ would be allowed to run deficits for longer. A Newsroom analysis in April 2026 explained “how the Levy finally broke”. What these changes meant for patients was reported far less than who was in charge.

FIGURE 6
Two health ministers, two phases of the system
Health headlines naming each Health Minister, by half-year



Ministers were named in relatively few health headlines—Shane Reti in 67 and Simeon Brown in 46—compared with the 623 headlines on Health NZ governance. In 2026, a new governance story emerged around the regulators: 18 headlines concerned the Medical Council, Nursing Council and other practitioner bodies, including RNZ’s report of concerns about the Minister’s replacement of Medical Council leadership, Newsroom’s report of the Nursing Council head’s sudden resignation and *The Post*’s report that ministers had bypassed usual processes to hand-pick council members.

4.2 The workforce is the delivery mechanism

Workforce, pay and strikes produced 1,058 headlines—the largest area of health coverage. A narrower search found 111 headlines about strikes and 209 about shortages, recruitment, locums or overseas staff.

Industrial action ran across the whole period. *The Post* reported in September 2023 senior doctors striking for the first time; junior doctors struck in May 2024; RNZ reported nationwide nurses’ strikes in December 2024 and July 2025. In October 2025 RNZ reported the Minister accusing doctors of crossing an “ethical line” with a mega-strike, and in November that the strike had grown to 16,700 workers. Shortage stories were more local and more continuous: Newshub reported in June 2024 that Health NZ had frozen hiring of graduate nurses; *The Conversation* argued in November 2024 that reliance on overseas-trained staff was unsustainable; and RNZ reported in September 2026 that two thirds of overseas-trained specialists left again within five years.

Pay disputes and service pressure were often reported side by side, and occasionally together—nurses’ 2025 strikes were explicitly about safe staffing as well as pay. What was harder to find was a sustained account of workforce supply: how many clinicians the system needs, how many it is training and keeping, and where the gaps fall.

4.3 Patient data and cyber security

Data, privacy and cyber security was a minor area until 2026, which accounted for 137 of its 206 headlines. The Manage My Health breach generated 87 headlines, 80 of them in January 2026. Coverage followed the breach closely—the hack and ransom demand, a High Court injunction, GPs’ pushback against blame, and the MediMap breach in February. RNZ reported in May 2026 that the Privacy Commissioner would monitor security upgrades; Stuff reported in September that two agencies had been ordered to fix security after nearly 100,000 patients’ data was exposed.

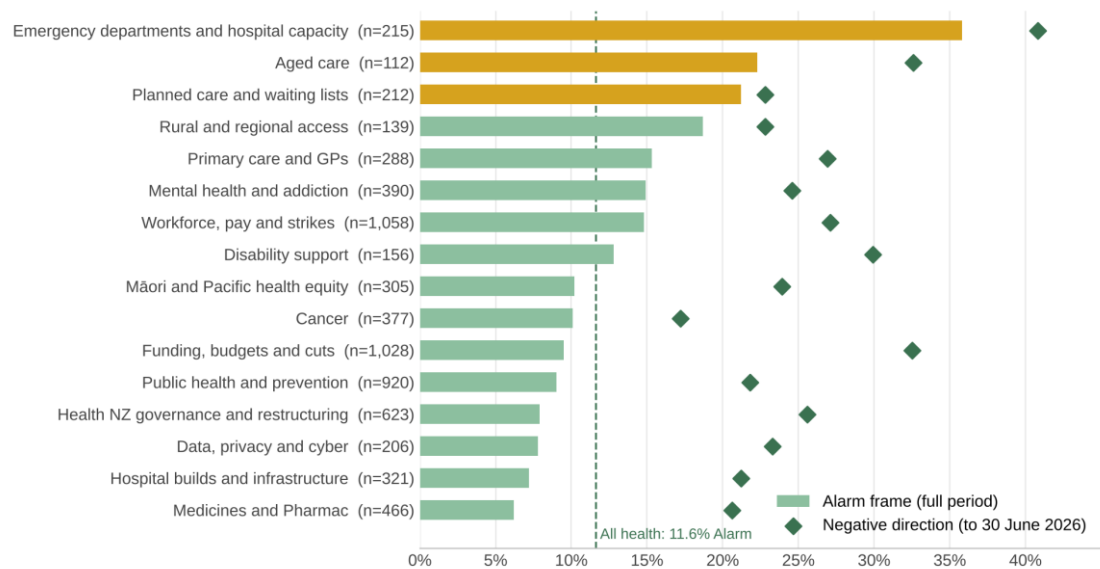
This was one of the few health stories with visible follow-through. It also showed where responsibility sat uneasily: a private portal provider, general practices, Health NZ and the Privacy Commissioner all held part of it.

What was done	Health NZ’s board was replaced by a commissioner and later restored; administrative jobs were cut; efficiency targets set; pay rounds negotiated amid strikes; regulator leadership replaced.
What received scrutiny	The deficit and its explanation, commissioner decisions, job cuts, strikes, graduate-nurse hiring, regulator appointments and the Manage My Health breach.
What remained under the radar	The effect of restructuring and cuts on patient services; a sustained account of workforce supply and retention; and clear accountability for patient data held by private providers.
The accountability test	Report staffing, service volumes and patient outcomes alongside each restructuring and savings decision.

5 Care outside hospital

Many of the pressures reported in hospitals begin, or could be relieved, outside them. Primary care, mental health, disability support, aged care and rural services were reported less often than hospitals, but several carried stronger signals.

FIGURE 7
Emergency care and aged care carried the sharpest signals
Share of each area's headlines coded Alarm (bars) and Negative (diamonds)



Negative direction is measured to 30 June 2026 because the code's use changed across the dataset from July 2026.

5.1 Primary care and GPs

Primary care and GPs produced 288 headlines. Coverage moved from warnings of collapse—Stuff reported in February 2024 that primary care was “perilously close to collapse”—to access and cost. The *Herald* reported in November 2024 that Auckland practices would raise fees amid a funding crisis; *The Post* reported in November 2025 that a patient’s address affected what they paid; and RNZ reported in May 2026 a GP telling medical students to consider another career. Government responses included an online GP service and, in June 2026, the *Herald’s* report that pharmacies could treat common conditions without a GP visit.

Primary-care headlines were more often paywalled (31.2%) than health coverage overall (23.7%). The connection between primary-care access and ED demand was made by clinicians—RNZ reported in August 2024 a woman who waited 16 hours in ED only to be referred back to her GP—but seldom as a systemic account.

5.2 Mental health and addiction

Mental health and addiction produced 390 headlines, 188 of them in 2024. Coverage was shaped by two events: the mental health targets announced in July 2024, and the funding of Mike King’s Gumboot Friday, which produced 41 headlines naming King, 32 of them in 2024. RNZ reported in February 2025 that frontline mental health money had been used for a controversial fund.

The targets did produce some follow-up. The *Herald* reported in June 2026 that the Government was hitting most national mental health targets, but that some regions lagged. The same month 1News reported the

mental health watchdog warning that the system was “losing ground” for the most vulnerable, and in August RNZ reported fears that young people were slipping through gaps in mental health data.

What the official figures show

In the New Zealand Health Survey, high or very high psychological distress among adults rose from 7.4% in 2019/20 to 14.3% in 2024/25, and unmet need for mental health support rose from 8.8% in 2021/22 to 10.5%. The targets and the survey measure different things over different periods, but the contrast shows how far a target can sit from an outcome.

Source: Ministry of Health, New Zealand Health Survey 2024/25.

5.3 Disability support and aged care

Disability support produced 156 headlines, concentrated in March 2024, when the *Herald* reported sudden restrictions on disability support funding and that the Finance Minister had been “blindsided” by the controversy. A review followed. Later coverage was intermittent: Newsroom reported in October 2024 disabled people “shut out of care” after a funding freeze, and RNZ reported in June 2026 advocates’ doubts that a report on disability healthcare access would lead to change.

Aged care produced only 112 headlines, but 22.3% were framed as Alarm, the second-highest share of any area of health coverage. Only two used outcome language. RNZ reported in August 2026 a \$650 million funding gap in the sector; *The Post* reported the same month a report setting out a way forward “after years of inaction”, and that 1,200 home-support jobs were at risk. Aged care matters to hospital pressure because it is where many older patients go next.

5.4 Rural and regional access

Rural and regional access produced 139 headlines. Headlines reported Health NZ telling Northlanders that Dargaville Hospital was safe without on-site doctors, senior doctors at Gisborne Hospital striking because the hospital was “on the brink of collapse” (RNZ, May 2025), gynaecological cancer patients being sent from Wellington to Christchurch and Health NZ preparing to send some to Australia, and staff shortages leaving rural hospital beds empty (RNZ, May 2026). Regional stories were often told as local crises rather than as a pattern of access across the country.

What was done	Online GP and pharmacy-first services were introduced; mental health targets and funds set up; disability funding restricted and reviewed; aged-care funding reviewed.
What received scrutiny	GP fees and access, the Gumboot Friday contract, disability funding restrictions, aged-care funding and regional hospital crises.
What remained under the radar	How primary, community and aged care affect hospital demand; whether mental health targets improved outcomes; and access for disabled and rural patients over time.
The accountability test	Measure access and waiting across the whole pathway, including care outside hospital.

6 Prevention, medicines and equity

Three of the most politically charged health decisions of the period—the smokefree repeal, the cancer medicines promise and the abolition of the Māori Health Authority—sat outside hospital operations. Each produced a concentrated burst of coverage, and each carried consequences that would take years to measure.

6.1 Smokefree, vaping and public health

Public health and prevention produced 920 headlines. Smoking and tobacco accounted for 179 headlines, 102 of them in 2024. Newshub reported in November 2023 the Finance Minister admitting that scrapping the smokefree laws would help fund tax cuts. The heated-tobacco excise cut produced 21 headlines, 20 of them in 2024, including RNZ’s report that \$216 million had been set aside to pay for it and continuing questions about NZ First’s industry links.

Much of the smokefree story sits outside the health topic. Of 576 headlines in the record that mention smoking, tobacco, vaping or the Associate Health Minister, Casey Costello, 246 were classified under other topics, such as the repeal itself, crime, integrity and politics. Read together, they show sustained scrutiny of the decision’s politics. Labour’s leader called the change “morally reprehensible” and its health spokesperson said the Government was putting “tobacco, smoking lobby interests” over New Zealanders’ health (Newshub and Herald, November 2023). Labour twice called for Ms Costello to be sacked; the Chief Ombudsman criticised her for withholding tobacco documents (RNZ, September 2024); and Labour asked the Auditor-General to investigate the heated-tobacco tax cut, a request declined as out of scope. National was also held to account: the Prime Minister admitted a claim about Northland tobacco outlets was wrong (December 2023), and RNZ reported in March 2024 that his tobacco “talking points” contradicted official advice. RNZ reported officials telling Ms Costello that the “most benefit” of the heated-tobacco tax cut would go to Philip Morris, and in September 2025 that she had breached rules by giving health officials a tobacco industry-friendly document.

The black-market argument followed an unusual arc. The Prime Minister cited it as a reason for repeal in November 2023, and experts disputed it. By 2026 the illicit trade had become a story in its own right, with 17 headlines that year, including a proposed taskforce and Ms Costello’s appointment as Minister for Organised Crime. The effect of the repeal on smoking and vaping received less attention, although some reporting did return to outcomes.

Unusually, the smokefree story did return to outcomes. *The Post* reported in November 2025 that the Smokefree 2025 goal had been missed as smoking rates stalled; RNZ reported that New Zealand had plummeted in a global tobacco-control ranking, and in December 2025 that Māori smoking rates had stalled for the first time in over a decade. Other public-health stories were event-driven: 37 headlines on measles, 27 of them in 2025, and 58 on influenza, 31 of them in 2026.

What the official figures show

Daily smoking among adults fell from 11.9% in 2019/20 to 6.8% in 2024/25, but remained 15.0% among Māori and 10.3% among Pacific adults. Over the same period, daily vaping rose from 3.5% to 11.7% of adults, and to 27.5% among Māori adults. New Zealand’s daily smoking rate was well below the OECD average of 14.8%.

Sources: Ministry of Health, *New Zealand Health Survey 2024/25*; OECD, *Health at a Glance 2025*, New Zealand country note.

6.2 Medicines and the cancer drugs promise

Medicines and Pharmac produced 466 headlines. Pharmac and cancer medicines were named in 216 headlines, and cancer drugs specifically in 84—75 of them in 2024, and 59 between March and July 2024 alone. National's election promise to fund cancer drugs was not met in the May 2024 Budget. *The Post* published an "anatomy of a failure to deliver", the Health Minister said the proposal had not been ready in time, and within weeks the Government announced a \$600 million boost to fund 26 cancer treatments (*The Post*, June 2024).

The promise produced sustained scrutiny while it was broken, and much less once it was repaired. RNZ reported in November 2024 a patient saying promised drugs were still unfunded; by 2026, *The Post* was reporting a plea for more medicine funding after the Government approved only a "sliver" of Pharmac's bid. Medicines had one of the lowest shares of outcome language: 10 of 466 headlines (2.1%).

6.3 Māori health and the end of Te Aka Whai Ora

Māori and Pacific health equity produced 305 headlines. The Māori Health Authority, Te Aka Whai Ora, was named in 68 headlines, 46 of them in 2024; 33 appeared between 20 February and 6 March 2024, when RNZ reported the disestablishment bill passing under urgency and hundreds of doctors "devastated" by its scrapping. The Waitangi Tribunal ordered a priority inquiry (*Herald*, May 2024), and the challenge reached the courts in August 2025.

Coverage then turned to the practical effects of the change: the Health Minister intervening to scrap a Hawke's Bay policy targeting Māori and Pasifika (*Herald*, September 2024), and Māori and public health teams facing cuts (Stuff, November 2024). Outcome-focused headlines were few: 24 of 305 (7.9%), slightly above the health average. In September 2026, RNZ reported that the Government had no plans to revisit a stand-alone Māori health authority.

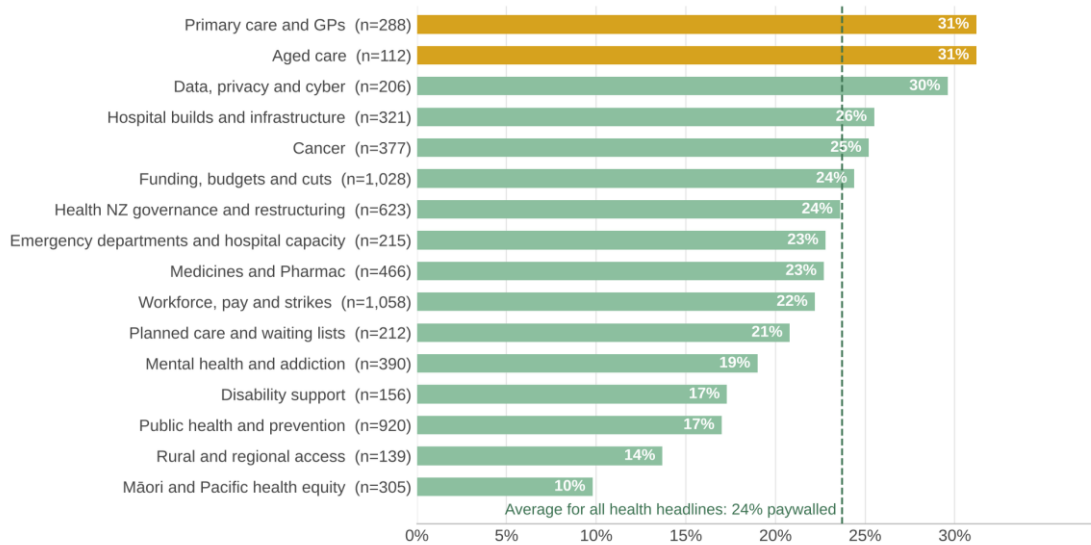
Te Aka Whai Ora was the most visible of several equity mechanisms removed during the period, but the others were reported as separate events, in about 20 health headlines across three years. Health NZ dropped the waiting-list tool that factored in ethnicity in August 2024, despite review findings (RNZ); a *Herald* headline called it "a fair outcome for all". In 2026, Pharmac proposed removing Māori and Pacific special access to diabetes medicines. Te Ao Māori News reported Māori health leaders' warning that the changes "could deepen inequities and cost lives", *The Post* reported that ethnicity was "a vital factor in determining the effectiveness of funded medicines", and a *Post* headline described the proposal as "colonisation in action".

The record contains rare outcome evidence on this question. In June 2023, MāoriPlus reported a study showing positive outcomes from prioritising Māori and Pasifika patients for diabetes treatment. The Government's case was one of principle: that care should be allocated by need, not ethnicity. Coverage reported the decisions and the argument about principle. It rarely asked whether the groups affected would be better or worse off—the question the independent data suggests matters most.

FIGURE 8

Community-care stories were more often paywalled

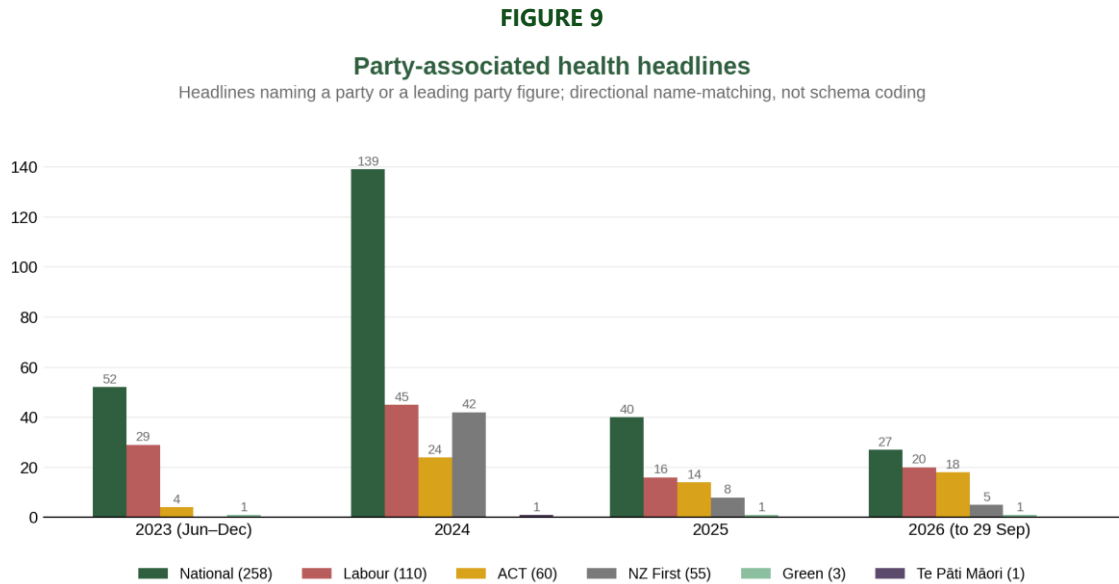
Share of each area's headlines that were paywalled (the rest were free); areas at 30% or more highlighted



What was done	The smokefree legislation was repealed and heated-tobacco excise cut; extra cancer medicines funded after the Budget; Te Aka Whai Ora disestablished.
What received scrutiny	The tax-cut link to smokefree repeal, tobacco-industry links, ministerial conduct, the broken cancer drugs promise and the process for abolishing the Māori Health Authority.
What remained under the radar	Longer-term effects on smoking, vaping, medicine access and Māori and Pacific health outcomes, and the combined effect of removing several equity mechanisms, beyond a few late reports of stalled progress.
The accountability test	Track smoking, medicine access and equity gaps against the promises and decisions that changed them.

7 Health as a political contest

Health coverage was dominated by the governing parties. National and its ministers were associated with 258 headlines, compared with 110 for Labour, 60 for ACT, 55 for New Zealand First, three for the Greens and one for Te Pāti Māori.



Directional name-matching of party names and leading party figures; headlines can name more than one party.

National’s visibility peaked at 139 headlines in 2024, the year of the commissioner, the Dunedin downgrade and the cancer drugs promise. New Zealand First’s peaked at 42 in 2024, almost entirely through Casey Costello and tobacco. Labour’s fell from 45 in 2024 to 16 in 2025 before recovering to 20 in 2026 as it released campaign policies: free cervical screening (November 2025), free maternity scans and the return of free prescriptions (June 2026), reinstating the smokefree legislation (August 2026) and a job guarantee for graduate nurses (September 2026).

The 2026 campaign produced a wider range of alternatives than earlier coverage. ACT campaigned on closing the medicine funding gap with Australia, expanding pharmacists’ powers and \$2 billion for two cancer centres, which an Otago oncology professor called “magical thinking”. New Zealand First proposed a 15-point “Make NZ Healthy” plan, which Newsroom described as “more vibes and vitamins than actual evidence”. National celebrated the start of a hospital inpatient build and, the *Herald* reported, kept Labour’s multi-year health funding system.

The contest therefore moved from government decisions to competing offers:

- ◆ health targets, and whether they were being met or gamed;
- ◆ Health NZ’s deficit and who was responsible for it;
- ◆ the smokefree repeal, which Labour pledged to reverse;
- ◆ cancer medicines and Pharmac funding;
- ◆ primary-care cost, through free prescriptions, GP fees and pharmacist powers; and
- ◆ the workforce, through strikes, graduate nurse jobs and overseas recruitment.

Peaks in the graph measure visibility, not the quality of proposals. Headlines reported announcements and disagreement, but rarely compared parties against a common test: which patients would benefit, how quickly, at what cost and how progress would be measured.

What was done	The governing parties set targets, restructured Health NZ and changed prevention, medicines and Māori health settings. Opposition parties released alternatives late in the period.
What received scrutiny	Ministerial decisions, broken promises and the deficit dominated. Opposition policy became visible mainly in the 2026 campaign.
What remained under the radar	The costing, workforce requirements and evidence behind competing campaign offers.
The appropriate comparison	Whether each party offers a funded, staffed and measurable pathway from identified need to better care.

8 What the headline frames reveal

Reporting dominated, accounting for 4,426 of the 6,164 headlines. Analysis (565) and Opinion (459) together made up 16.6%. The accountability tags identified 555 capability signals, 356 pressure signals, 118 integrity signals and 117 governance signals; because coding is less complete in earlier years, these are minimum counts and not a clean trend.

The profile by area of coverage shows where coverage tested results and where it did not.

Area of coverage	Headlines	Alarm	Negative*	Paywalled	Outcome language
Planned care and waiting lists	212	21.2%	22.8%	20.8%	10.4%
Rural and regional access	139	18.7%	22.8%	13.7%	9.4%
Māori and Pacific health equity	305	10.2%	23.9%	9.8%	7.9%
Public health and prevention	920	9.0%	21.8%	17.0%	7.7%
Mental health and addiction	390	14.9%	24.6%	19.0%	6.9%
Health NZ governance and restructuring	623	7.9%	25.6%	23.6%	6.9%
Emergency departments and hospital capacity	215	35.8%	40.8%	22.8%	5.6%
Primary care and GPs	288	15.3%	26.9%	31.2%	5.2%
Cancer	377	10.1%	17.2%	25.2%	4.8%
Workforce, pay and strikes	1,058	14.8%	27.1%	22.2%	3.8%
Funding, budgets and cuts	1,028	9.5%	32.5%	24.4%	2.9%
Hospital builds and infrastructure	321	7.2%	21.2%	25.5%	2.2%
Medicines and Pharmac	466	6.2%	20.6%	22.7%	2.1%
Disability support	156	12.8%	29.9%	17.3%	1.9%
Aged care	112	22.3%	32.6%	31.2%	1.8%
All health	6,164	11.6%	23.4%	23.7%	5.7%

**Negative direction measured to 30 June 2026. Areas overlap. "Outcome language" is a directional keyword search for results, data, figures, surveys, evidence, targets, rates, improvement or decline. The data and cyber security area (53.4%) is excluded because the word "data" inflates it.*

The distribution suggests the same gap found in other topics. Health generated sustained and increasingly alarmed reporting, but a small share explicitly tested whether a decision had produced the result it promised. Where targets and regular statistics exist—planned care, public health, Māori health—coverage measured slightly more, though never more than one headline in ten. Where change was structural, financial or concerned long-term care—aged care, disability support, medicines, hospital builds, funding and the workforce—it measured least, at under 4%.

Following responsibility over time would require the media to return to five sequences:

- ◆ **Emergency care:** demand → primary-care access → ED stay → bed availability → discharge to community or aged care.
- ◆ **Planned care:** referral → accepted or declined → specialist appointment → treatment → outcome.
- ◆ **Hospital builds:** regional need → approved design → cost and timetable → capacity delivered → waits reduced.

- ◆ **Workforce:** training places → graduates employed → retention → safe staffing on wards.
- ◆ **Prevention and equity:** policy decision → smoking, vaccination and access rates → outcomes by group.

9 Conclusion

The headline record explains why health remained one of New Zealand's most prominent public issues. It showed a system under visible strain—crowded emergency departments, long waits, strikes, deficits and downsized hospitals—and a government acting on many fronts at once. It also exposed disagreement about what success should mean: meeting targets, living within budget, shorter waits, more staff or fairer outcomes.

The central weakness was not an absence of reporting or of alarm. It was the difficulty of connecting system decisions to patient outcomes. Health NZ's finances, leadership and structure received far more attention than what those changes meant for care. The targets that were meant to provide accountability became contested, and the patients outside the measured lists were only beginning to be counted by the end of the period.

Set against independent evidence, the emphasis of coverage was uneven. Headlines described a system in crisis, and the strain they reported was real. But international comparisons rate New Zealand's average outcomes well and its equity poorly, and coverage gave the least sustained attention to that weakness. The Government's largest structural changes—repealing the smokefree legislation, removing ethnicity-based prioritisation and taking budget control of Health NZ—each had a stated rationale, and each was scrutinised closely as politics. Whether they improved or worsened health for the people they affected was rarely asked.

Future scrutiny should concentrate on a small number of connected measures:

- ◆ performance against health targets, alongside the number of declined referrals and patients not accepted onto lists;
- ◆ time in emergency departments, with bed occupancy and discharge delays;
- ◆ GP access and cost, as a driver of hospital demand;
- ◆ workforce numbers trained, employed and retained;
- ◆ hospital-build capacity delivered against regional need;
- ◆ smoking, vaccination and medicine access by population group; and
- ◆ outcomes for Māori, Pacific, rural, disabled and older patients.

Media organisations have an important continuing role. Individual headlines exposed ED deaths, hidden waiting lists, broken promises and a major data breach. Stronger accountability will require following those stories over time: returning to commitments, distinguishing a measure from an outcome, and testing claims of improvement against the patients they concern.

Political parties should be assessed against the same standard. The relevant question is not which party generates the most health headlines or offers the most free services. It is which proposals form a credible, funded and staffed pathway from identified need to better care—and make clear who is responsible if that pathway fails.

New Zealand does not lack health news or health promises. What it still needs is continuity: between prevention and primary care, between referral and treatment, and between hospital care and the support patients need afterwards.

10 What health policies need to cover

The findings in this report provide a common test for assessing health policies across parties. A credible policy need not solve every problem through one programme, but it should identify the problem it addresses, connect its intervention to a deliverable outcome and make its costs and risks visible.

10.1 Define the problem, the patients affected and the stage of care

State whether the policy addresses prevention, primary care, referral and diagnosis, emergency or planned hospital care, medicines, mental health, disability or aged care. Quantify the starting position and identify the patients and places affected.

10.2 Measure everyone who needs care

Report performance against targets together with the patients not counted: declined referrals, people unable to enrol with a GP, and those waiting to get onto a list. Publish the data regularly and consistently.

10.3 Resource the workforce

Identify the doctors, nurses, midwives, allied health staff and support workers needed to deliver the policy, where they will be trained or recruited, and how they will be retained.

10.4 Treat hospital pressure as a whole-system problem

Show how primary care, hospital beds, and discharge into community, disability and aged care will be adjusted together, rather than managing emergency-department pressure one winter at a time.

10.5 Protect equity and regional access through change

Where services, hospitals or agencies are restructured, show how Māori, Pacific, rural, disabled and older patients will be protected, and how regional access will be maintained during transition.

10.6 Make delivery and outcomes accountable

Name the organisation responsible for each stage, publish milestones and funding, and report against comparable measures over time. The accountability chain should run from identified need to policy, funded service, capable workforce, timely access, treatment and the patient's outcome.

Applied consistently, this test allows different political approaches to be compared without assuming that one model of funding, provision or organisation is inherently correct. It asks whether each proposal is matched to an evidenced need and offers a credible, funded and accountable route to better care.

11 Appendix: scope and method

11.1 Source data

The source is the Social Herds headline workbook (tbl_data_raw_AllData_2026.xlsx), built from the Democracy Project's daily news briefings and classified under the SocialHerd schema. The version analysed contains 84,950 headlines from 1 June 2023 to 29 September 2026. The health subset comprises the 6,164 headlines with Health as the parent topic. Health-related headlines filed under other topics, such as Politics or Employment, are not included, except in section 6.1, which draws on smokefree headlines classified under other topics. Context on events before June 2023 is drawn from the sources named in the text.

11.2 Limits

- ◆ **Unit of analysis:** the headline, not the full article. Counts measure visibility and repetition, not readership, persuasion or the quality of the underlying reporting.
- ◆ **Partial years:** 2023 runs from June and 2026 to 29 September. January and March 2025 are only partly covered in the source data.
- ◆ **Direction coding:** the share of headlines coded Negative rose sharply across the whole dataset from July 2026 (from about 16–20% of all headlines to 42–51%), which indicates a change in classification rather than in coverage alone. This report therefore measures negative direction to 30 June 2026 and uses the Alarm frame, which did not change in the same way, as its main measure of tone.
- ◆ **Areas of coverage:** health headlines were grouped by keyword searches of the headline text and the Child and Subcategory fields. The word lists are recorded and can be rerun. Headlines can fall into several areas, so counts should not be added together.
- ◆ **Outcome language:** a directional keyword search for results, data, figures, surveys, evidence, targets, rates, improvement or decline. It identifies headlines that signal measurement; it does not assess whether the underlying article measured outcomes well.
- ◆ **Party and minister visibility:** based on name-matching of party names and leading party figures in headline text, not on schema coding. Treat as directional.
- ◆ **Accountability tags:** the Flag field is less completely coded in earlier years, so tag counts are minimums.
- ◆ **External data:** a small number of official figures (Health New Zealand target results, the New Zealand Health Survey 2024/25, OECD Health at a Glance 2025 and the Commonwealth Fund's Mirror, Mirror 2024) and one ministerial statement are shown for context, mostly in separate boxes. They are not part of the headline analysis, and their reporting periods differ from it.
- ◆ **Topic boundaries:** some health-related headlines are classified under other topics. Smokefree and tobacco coverage is the clearest case: 246 of 576 relevant headlines sit outside Health.