Lightening **the Load**

The case for a fully-free public healthcare system

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GP

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Introduction

If ill-health is a burden, weighing heavily on individuals, their families and their communities, the prevention or treatment of that illness should be seen as a positive: a lightening of the load. Yet too often health spending is framed not as an investment but as a cost. This, ironically, obscures the *true* costs: the personal toll taken by ill-health, the charges that public under-investment pushes onto individuals, the collective hit from lost productivity and a diminished society. Just the economic cost of ill-health – the dollar costs of not investing, in other words – probably exceeds the government's annual outlay on the health service. Under-investment, not investment, is the greatest cost.

Having recognised this truth, other developed countries make much greater investments in their collective health and well-being than New Zealand does. They enjoy, as a result, better services and healthier lives. New Zealand urgently needs to start catching up. But it also needs to change the way it funds: it is not simply a matter of how much money is invested, but where.

Some current settings prevent money being spent efficiently. Despite the best efforts of doctors, dentists and other health workers, the health system contains too many barriers to people receiving preventative, holistic and joined up-care. Too often services are fragmented and reactive. Far too many New Zealanders, as a result, end up in hospital with life-threatening conditions that could have been addressed upstream. This in turn creates many needless costs.

One of the biggest barriers standing between people and the holistic healthcare they deserve is the system of user charges in primary care. This system is, to paraphrase Bill English's famous line on prisons, "a moral and fiscal failure". Preventing many people from seeing their GP, user charges are deeply unjust. If healthcare is a right, how can access be determined by the depth of one's pockets? The collective fiscal cost is also immense. GP fees encourage people to put off seeing a doctor until their condition has deteriorated so much that they turn up at A&E. Their well-being is diminished; the cost of treating them rises. And as their ability to sustain fulltime work is constrained, so is the economy.

This report argues for eliminating primary care charges altogether, as part of a shift towards what would be, in broad terms, a free public healthcare system. In this system, well-supported health workers would be freed up to provide patients with holistic and preventative care, acting as a fence at the top of the cliff rather than the ambulance at the bottom. In place of a fragmented, underfunded and reactive system, New Zealanders would enjoy public healthcare that was well-integrated and focused on patients, whānau, clinicians, and the relationships between all three. In this system, the government would spend more, but also better. And it would, above all, see that spending not as a cost but as an investment.

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Bottom-up change

The government's current health reforms will give the New Zealand system a new structure, but only that – a structure, waiting to be filled with content (beyond the content provided, of course, by existing healthcare principles and ideas). This opens up an opportunity to propose new visions.

The process of creating these visions would ideally be led by healthcare staff and patients. Far too much change, especially in New Zealand, is imposed from the top down, even though expertise in how the system works on the frontline – and therefore many of the best ideas for how it could function better – reside with those who use and work in that system. Prior experience has given this claim proof. The success of the Canterbury model of primary and secondary healthcare integration, admired worldwide, is largely attributable to the fact that it did not start with top-down edicts or extensive structural reorganisation. Instead, it was born from a slow and steady process that allowed staff from different parts of the health sector to come together, form new and powerful bonds, and use their collective expertise and wisdom to find different ways of working in an integrated manner.[1]

In another, less-heralded example, trials a decade ago in the Bay of Plenty showed that putting frontline staff in charge of finding efficiencies resulted in a reduction of the time taken for scheduling acute appointments from 5 hours to 1.5 hours. It also significantly reduced the need to rebook appointments at short notice and allowed patients to choose their appointment times, so that they were much more likely to turn up.[2] More generally, research has shown that giving doctors and nurses leadership opportunities can reduce acute admission rates and unwarranted variations in medical practice, and improves their organisations' financial and clinical performance.[1]

Meanwhile, some of the world's most exciting healthcare innovations involve deep public participation. In Thailand, for instance, an annual "national health assembly" has for over 10 years brought together roughly 2,000 doctors, campaigners and officials. Setting policy on issues such as addiction treatment and increasing healthcare coverage, it has been described by experts as an innovative and successful way to improve services.[3]

In short, healthcare staff and patients represent an immense and largely untapped source of innovation, whether it is a matter of locating efficiencies or reorganising services. This report proposes that a healthcare system that is free at the point of use – and which moreover uses preventative and other means to treat the 'whole person' – could be the basis of a new vision. But ultimately that is just one vision, one voice, to be added to a conversation that should be led by those with the most intimate experience of the system that we all seek to improve.

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A system under strain

Too many New Zealanders experience persistent poor health. This cannot, of course, be blamed solely on the health system itself. Health, in the words of the Robert Wood Johnson Foundation, starts "in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink".[4] Poverty and discrimination play a large part in this story. Nonetheless, the healthcare system is central to our wider wellbeing. It is the principal means of treating illness and, if designed differently, could lead the way in preventing it.

Currently, however, that system is under immense strain. Healthcare workers, many of them already experiencing burnout, must contend with the uncertainty and stress created by the government's health-sector reforms. And these pressures will only worsen without immediate action. The healthcare training intake needs to be raised by at least 20 per cent to address gaping staff shortages, and a plan put in place to ensure retention of a healthcare workforce on the brink of quitting in droves. Staff need to be empowered to exercise genuine leadership in clinics and hospitals, so that they can enjoy more lasting job satisfaction and transform the way services run. New Zealand also needs to build on recent initiatives that, although of course imperfect, can help deliver healthcare more efficiently: the Canterbury model referenced above, for instance, or the 'healthcare home' system designed to allow staff to wrap services around patients.[5] [6] Innovative, equity-enhancing programmes delivered by Māori and Pacific providers, such as Ngāti Porou Hauora, should also be expanded.[7]

More must be done, crucially, to realise Māori rights to healthcare as guaranteed under Te Tiriti o Waitangi. Enduring discrimination in the healthcare system needs to be addressed, the disparity in access to services eliminated, and the whole system reoriented so that it can provide more collective and whānau-centred care where appropriate. Workforce training and institutional culture can do more to ensure culturally safe care, and welcome initiatives like the Māori Health Authority need to be brought to fruition.

Shortfalls in rural care also need urgent attention. This includes recruiting more medical trainees who come from rural areas and are thus more likely to return to serve in them, and finding innovative ways to deliver care in areas that struggle to attract GPs.

To make prevention a reality, New Zealand's appalling levels of poverty, discrimination and substandard housing must all be addressed. Even when healthcare is free or heavily discounted, families may find that – for instance – transport to a clinic, whether by car or bus, is simply unaffordable when every cent is already allocated.

Crucially, for the purposes of this paper, New Zealand needs to invest more in its health system, as a commitment to building the country's collective strength, resilience and well-being. Wider gains aside, such an investment would reap immense economic benefits by reducing the costs imposed by long-term ill-health. Respiratory disease is estimated to cost New Zealand $6.7 billion a year and diabetes $2.1bn (growing to $3.5bn in 20 years' time), to take just two instances.[8] [9] More broadly, government research has found that long-term conditions "are especially costly and are a source of significant economic burden on society … at a rough approximation, indirect costs (such as lost productivity) will equal the direct [health service] costs of a given condition."[10] Past Treasury research, adjusted for inflation, puts the economic cost of ill-health somewhere between $10bn and $27bn, depending on assumptions.[11] This may in fact exceed annual public spending on health services, which was roughly $21bn in 2020.

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And although that $21bn is not nothing, it is still inadequate. A comparison to 14 other major economies shows that, in 2020, New Zealand spent $6.7 billion a year less than the average; the gulf to the biggest investors was even greater.[12] These funding shortfalls, allied to the costs outlined above, show New Zealand's public finances in a new, and unflattering, light. The long-standing goal of 'balancing the books' has been achieved by keeping spending dangerously low: fiscal surpluses have been created by running social deficits. The government's books have been balanced on the backs of the poor. And in keeping public debt low, the government has, in a sad irony, passed on an immense debt of disease to future generations.[13]

The problems of primary care charges

The failure to invest sufficient public funds in primary care is especially marked. Currently user fees are charged for a wide range of services: GP visits, but also dentistry, prescriptions and some diagnostics. Costs also exist for many healthcare items like hearing aids, and in some secondary care areas – such as varicose veins, gallstones and cataracts – where public provision is so minimal, and waiting lists so long, that patients are virtually forced to pay for treatment privately.[14]

These costs are like a barrier erected between people and the healthcare they need. This is most evident in the number of New Zealanders unable to access primary care for cost reasons – roughly one in seven people. Nearly one in five report cost barriers to accessing care more generally, and well over 1.5 million adults have a cost-related unmet need for dental care.[15] These figures are even worse for people on low incomes, Māori, Pacific peoples and people with disabilities.[16] (On top of that, it is estimated that well over half a million people, or 9 per cent of the population, have an unmet need for hospital care, for multiple reasons. This is in addition to the Covid-related backlog of more than 100,000 cancelled procedures and specialist appointments in 2021.[17]) In the best-performing health systems internationally, as few as one in 20 face cost barriers to receiving treatment.[3]

Primary care charges thus contribute to the terrible toll that ill-health takes on New Zealanders. The impact of fees is especially felt by those living in poverty, creating a clear injustice. And eliminating fees would generate ripples of change. Although it might not cut hospital inpatient admissions, research suggests it would reduce the rate of complications and the length of hospital stays, improving health outcomes overall.[18] [19] [20] [21] [22] Preserving primary care charges, in other words, increases the costs imposed on secondary care. Primary care charges are, moreover, not 'planned' elements of the system but an accident of history, stemming from GPs' refusal to be part of the fully public health system created by the first Labour government.[23]

Not only do these charges create barriers for patients, they also make the whole system more fragmented, widening divisions between primary and secondary care, and public and private. This impedes what should be a continuum or smooth flow of care across the health service. It is especially problematic in an era where people often have multiple conditions, greater care is delivered in the community, and patients interact with many different health workers in many different parts of the system.[24] New Zealand GP Steven Main has noted the "absurdity" of charges in hospitals where GPs provide out-of-hours services from the same building that houses a hospital emergency department. "See a doctor (possibly the same one in some places) at one end of a corridor and you get treated without charge. A few metres down the corridor in the same building, see a doctor and you get a bill – which could run to well over a hundred dollars if it's the middle of the night."[25]

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International research has long shown that primary care fees are especially damaging to treatment for low-income and less healthy individuals.[26] Global organisations such as the World Health Organisation, and even the fiscally conservative World Bank, have warned that such charges do more harm than good, and create clear inequities in healthcare access.[27] [28] US research, Main notes, has shown that even small co-payments, in the order of a few dollars, have "measurable effects in reducing uptake of medical services, both essential as well as less essential, with consequent potential for adversely affecting the already poorer health of the least well off".[25]

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These charges are also unusual in the developed world, where the most widely admired healthcare systems are free at the point of use – whether based on general taxation, as in Britain's NHS, or compulsory insurance, as in continental Europe. They significantly outperform those that are *not* free at the point of use, including the notoriously ineffective American private-insurance-based model, but also our own system.[29]

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Public healthcare is part of the public good, the set of shared interests we all have as citizens, regardless of what our private interests may be. Leaving individuals to pay for so much of their own healthcare represents a collective failure to adequately invest in that public good.

Free at the point of use

Even if primary care charges are a problem, it could be argued that they should be removed only for those struggling to pay them (generally the poorest patients), and not for well-off people perfectly able to pay to see their GP. In a world of constrained resources, the removal of fees for all patients could be seen as diverting extra spending from where it is most needed – in GP practices serving low-income communities.

However, the evidence suggests that fully-free healthcare systems do a good job by their poorest members: in Britain's fully tax-funded NHS, for instance, just 5 per cent of citizens in 2014 reported cost-related barriers to healthcare. No doubt this is in part because the philosophy that undergirds free systems – the idea that healthcare is a right rather than something to be 'bought' in the marketplace – is also highly conducive to tackling healthcare inequities. The Commonwealth Fund, a US-based NGO that analyses global health systems, has argued: "When a country fails to meet the needs of the most vulnerable, it also fails to meet needs for the average citizen."[3] The counterpart is equally true: a country that fails to meet health needs for the average citizen will also fail to meet the needs of the most vulnerable.

Fully public healthcare systems often work on the basis of the 'proportionate universalism' championed by the British health academic Michael Marmot, in which a basic set of public services is offered universally (and generally free of charge) but extra services are layered over the top for those most in need.[30] This combines elements of universal and targeted services, mirroring the way that, for instance, the world's best-performing welfare systems pay out both universal and targeted benefits.

For although targeted systems appeal to the supposedly commonsense notion that those most in need should be the first beneficiaries of limited public funds, universal systems also have strong selling points. They face a lower administrative burden of trying to determine who is and is not eligible, and are thus more efficient (in some senses); they impose fewer hoops for recipients to jump through and fewer of the (often demeaning) bureaucratic interrogations characteristic of targeted systems; they create fewer incentives for citizens to 'game' the system, for instance by artificially lowering their income in order to gain access; their services, being universal, attract little or no stigma; and they are less vulnerable to political changes, and less likely to be wound back, than services aimed only at the poorest.

For all these reasons and more, New Zealand should shift over time to a fully-free public healthcare system. Even if no political party is likely to immediately implement such a policy, this should still be the vision, a metaphorical marker post towards which more incremental reforms can aim.

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Scope

For reasons of tractability and practicality, this paper focuses on eliminating certain primary healthcare user fees: those charged for GP visits, principally, but also for dentistry, prescriptions and diagnostics (scans, laboratory tests, and so on). Despite its limited scope, this is already a moderately ambitious list: even in the NHS, for instance, dentistry is not free, although it is heavily subsidised. Nonetheless, the above list leaves various forms of treatment out of scope, including optometry, social and community care, and the secondary care areas discussed above. (All of these issues would merit further investigation.)

Estimating the upfront cost

Shifting to a fully public healthcare system should be seen most fundamentally as an investment in our collective health and wellbeing. Nonetheless, some estimate of the upfront costs is required, to establish the feasibility of the plan and the demands it would place on alternative funding arrangements.

The cost of removing GP fees alone can be estimated in various ways. In 2003, Tom Robinson calculated the likely cost at $435m-592m (based on 1998-99 data), which updated for inflation would give a range of $744m-$1bn.[31] In 2014, Toni Ashton estimated the cost of extending free GP visits to 13-16-year-olds at $23.4m, or roughly $4m per age cohort per year, including induced demand for consultations and pharmaceuticals (though not after-hours care, where data is lacking).[32] Adjusting this figure for inflation, and for the average number of GP visits for older age cohorts, gives a minimum cost of $1bn. The true figure, however, would be substantially higher, given that the fees now charged for adult consultations (on average upwards of $40) are much higher than the $23 average fee for youth consultations that Ashton used.[33] Similarly, an estimate assuming New Zealand's roughly 5,000-strong GP workforce was placed on a $200,000 salary (the midpoint of the hospital medical specialist scale) would be around $1bn.[34] Attempts to estimate costs by assembling information on the quantum of existing GP fees, prescription fees, diagnostic charges and so on have not proved fruitful.

Further estimates can be derived from the expenditure section of the 2019 Household Economic Survey (HES), in which a sample of several thousand households was asked to compile a regular diary of expenses. In that survey, the weekly household spending figure for "medical services" was $15.20. Multiplied by 52 and 1,864,000 households, this gives an annual total of $1.5bn.[35] "Medical services" covers not just GP fees but also charges levied by optometrists, physiotherapists, psychologists and podiatrists, among others. This might therefore be an overestimate of the likely costs, assuming not all such fees would be covered even in a notionally "free" system. However, the HES also lists, in a separate category, spending on "therapeutic products" such as hearing aids, artificial limbs, surgical supports, wheelchairs and crutches, which conversely might be covered under a free system. This spending totalled $380m a year. Hospital fees and related services were another $97m, and paramedical services $19m. If these various inclusions and exclusions balanced out in the $1.5bn figure above, it might be a broadly correct estimate.

For dentistry, the New Zealand Dental Association estimates that providing basic services to 380,000 low-income adults would cost $187m-450m (while delivering economic benefits of $4.50 for every dollar invested).[36] A 2018 Ministry of Health report put the cost of fully-free dentistry at $658m.[37] However, it is not clear exactly how it obtained this figure, and unmet dental need is generally considered to be very high. Estimates of dental costs can also be derived from the HES, where the weekly household spending figure for "dentistry services" was $11.60, which works out to a total annual cost of $1.1bn.[35]

Combined, the HES data suggest spending on the primary healthcare areas of interest for this paper was $2.6bn ($1.5bn for medical services and $1.1bn for dentistry). As this is similar to, or slightly higher than, the other estimates above, it could be regarded as the public funding that would be needed to make core elements of primary healthcare free at the point of use.

Larger figures can, of course, be obtained. For instance, all "health" spending in the HES comes to $4.1bn.[35] But this includes spending on items such as over-the-counter medicines, bandages and plasters, and contact lenses, none of which would presumably be covered even in a "free" system. A World Bank estimate of $896 p.a. of "out-of-pocket" spending per capita gives a total cost of $3.7bn – but again, this will be covering a wider range of costs than those targeted here.[38]

The baseline figure of $2.6bn, however, would need to be adjusted upwards for induced demand – the phenomenon of more treatment being sought once it is free. Most estimates put the likely increase in demand at between 6 and 28 per cent.[25] Robinson, for instance, assumed a 14 per cent increase in demand, based on historical experience both in New Zealand and overseas and the assumption that healthcare workers would take steps to manage demand if it increased to a greater extent.[31] This would raise the cost to approximately $3bn.

In terms of other adjustments, no immediate savings to secondary healthcare would be assumed, given the evidence that free primary healthcare may not in the short-term reliably reduce hospital inpatient admissions. While it removes the financial incentive to present at emergency departments, and thus eases the pressure on the latter, it also creates more opportunities within primary care for conditions to be diagnosed and referred to the secondary sector for treatment.[18]

Indeed the ripple effect of extra costs entering the hospital system could be significant. It is entirely possible that, in addition to an extra c.$3bn in primary healthcare, the same level of investment might be needed to manage the flow-on effects on hospital service provision in the short to medium term.[39] Detailing these costs, however, is beyond the scope of this report.

Over time, of course, a free healthcare system would realise savings by reducing the health burden discussed above and delivering more efficient, joined-up care. In the short term, however, decision-makers would have to fund the extra costs. This is one element of a long-standing obstacle to reform, known as double-running, in which a preventative system has to be built (and paid for) alongside the existing reactive system, which cannot be dispensed with until many years later when the impacts of the preventative services are felt.

That leaves roughly $3bn a year to be raised. However, if most of that total is already being spent privately (bar a relatively small amount of induced demand), the question is simply how that cost might be redistributed, and whether a different payment mechanism (such as direct taxation or compulsory insurance) might lead to better outcomes. Moreover, a sum of c.$3bn would have to be seen in the context of annual health spending of $21bn and government revenue of over $110bn.[40]

This $3bn would not, of course, meet all the health system's funding needs. In the next year alone, inflation could drive costs up $1bn-1.5bn, pay equity for nurses might cost $1bn, and adjustments for ageing and other demographic changes could require another $500m. Significant investment is needed to address long-standing hospital staff shortages. Existing GP services also need a funding boost, especially in low-income practices. Informal estimates suggest the latter might need another $100m a year simply to deliver a level of care equivalent to that enjoyed by wealthier practices. Moreover, dire shortages of practices in areas such as South Auckland need to be addressed.[41] The capacity to deliver more healthcare in high-needs areas must be strengthened, lest the removal of fees worsen equity issues by doing more to improve access in already well-served areas than it does in under-served ones. No wonder, then, that the international comparisons discussed above suggest New Zealand needs to spend another $6.7bn a year just to match the average spending in a sample of developed countries.

The upfront cost of removing primary care charges could, of course, be reduced by doing it gradually – for instance by extending free GP visits to 14-18-year-olds, or the over-65s – or by targeting it at the most in-need groups. However, although this might make the tax rises more politically acceptable, it might also render the whole proposal *less* palatable, because many middle-income taxpayers might not see themselves as "getting" anything in exchange for what would still be increased taxes. It is also a less inspiring vision, and might suffer from the targetting issues described above.

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GPs' views

Aside from the cost, one obstacle to achieving a free primary healthcare system could be GPs themselves, given their historical objections to becoming "salaried employees of the state", in the words of the healthcare academic Robin Gauld. As Gauld notes in his history of the health system, GPs in 1938 were nervous that, if fee-charging were banned, state payments would not keep up with the true cost of delivering healthcare (or the income they wished to enjoy). To some extent that fear has been borne out, as the proportion of a visit cost covered by the public subsidy has diminished over time.[23]

Interviews conducted for this report revealed mixed views on this question among current GPs. Undoubtedly many would remain resistant to being brought more fully into the public healthcare system, seeing themselves as independent businesspeople who value the freedom to charge as they see fit. However, it is important to note that the proposal is to change only the charging structure of healthcare, not GPs' choices as to how to treat patients. GPs receive a significant public subsidy per patient, and thus already have a funding relationship with the state. And although GPs are free to opt out of the scheme of free visits for the under-13s, in practice virtually all have joined it. This suggests that, firstly, abolishing fees is not incompatible with good GP practice, and, secondly, there cannot be a strong philosophical argument for rejecting the proposition for the whole population if it is already acceptable for some of it.

There are, moreover, reasons to think that attitudes may be changing. Surveys of GPs indicate they are increasingly seeking to work part-time. There is a sense, at least anecdotally, that many younger GPs desire a better work-life balance and have correspondingly less desire to work the long hours needed to buy or build up a practice. This generation may be more open to a less stressful, less entrepreneurial and more state-led approach to primary care.[42]

In addition, the world of primary care is changing. GPs are increasingly expected to co-locate and work with other primary care practitioners. A partial shift has already been effected from fee-for-service arrangements (per-visit funding) to 'capitation' (funding provided per patient, irrespective of how many visits that patient makes). A growing number of GPs work in larger ownership structures – whether corporate or not-for-profit – where they operate more like salary-earners than independent business owners. And GPs are increasingly being asked to treat more complex cases as part of the move towards care in the community, deepening their workload and making the per-visit charging model ever-more difficult to operate.

For all these reasons, even the section of the GP workforce traditionally attached to fee-charging might accept a shift to a fully public system. This would, however, have to work for them financially. This is a practical reality, given GPs' standing in the community and, consequently, their political power and ability to resist unwanted change.

GPs' financial requirements could be met in different ways. One would be to complete the shift to capitation funding. This funding would, of course, have to cover the true cost of delivering care; there is a strong perception, particularly among practices in low-income communities, that currently it does not. Capitation funding also creates a financial incentive for GPs to not offer enrolled patients appointments, since they receive the funding regardless of how many consultations they provide. However, such issues could presumably be managed with appropriate performance measures and monitoring.

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In this model, GPs would continue to own their practices with relatively little change to their existing business structure. Under a more radical option, recently floated by healthcare academics, the government would salary all GPs and gradually purchase clinics.[15] The salary paid might, as above, be the midpoint of the hospital medical specialist scale, roughly $200,000. This is at or above the income typically enjoyed by GPs, suggesting that this model might prove attractive.[42] Under this system, the government would also take responsibility for maintaining and building said clinics. One can see a tentative prefiguring of this system in some rural areas, where GP services are provided by doctors employed within the hospital sector and paid according to the hospital specialists collective contract.

This hints at other potential attractions of this model for GPs. As noted above, the GP workload has become ever-more complex. It requires increased availability to patients via telephone and email; closer working with other primary care specialists and therefore more meetings and other administrative tasks; and the processing of a much larger volume of scans, tests and other diagnostics. Such burdens are not formally (or not sufficiently) recognised in the current funding arrangements for GPs. If GPs were, in contrast, placed on a collective contract akin to that negotiated by hospital specialists, they would receive the benefits enjoyed by the latter, including dedicated non-contact (administrative) hours and professional development funding. This could increase the costs of running the health system and reduce its observed productivity, on a crude dollar-per-patient-seen basis. However, the long-term trade-off, in terms of a better supported workforce and ultimately better care, would be worth it.

Structural options

In developed countries, there are broadly four ways in which healthcare is delivered. Leaving aside the widely discredited American system, which relies on citizens taking out private health insurance, the three remaining options are the national health service or Beveridge model, the social insurance or Bismarck model, and the single-payer national health insurance model.[43]

The national health service model is the basis, most famously, for Britain's NHS, the blueprint for which was written by the social reformer William Beveridge. (This system is also used in much of Scandinavia, with variations.) In the NHS, health care is funded out of general taxation and most services are delivered in publicly owned and operated hospitals.

The social insurance model, by contrast, derives from the nineteenth-century German statesman Otto von Bismarck. In this system, citizens are required to sign up to one of a wide range of not-for-profit health insurers. Those insurers are usually funded by contributions from employers and employees, and services can be delivered by either public or private institutions (often the latter). Subsidies are usually available for people who would otherwise struggle to afford insurance. This system is widespread in continental Europe.

The national health insurance model, finally, combines elements of the Beveridge and Bismarck systems. It is sometimes called single-payer because healthcare is funded from a single, government-run insurance fund into which every citizen pays, hence its affinities with the national health service model. However, as with the social-insurance model, health services are provided by a wide range of institutions, many of them private. The classic version of this system operates in Canada.

All the models have their strengths and weaknesses. The NHS, for instance, is immensely efficient, reducing administrative and transaction costs by largely eliminating third parties (health insurers) from the system. It has historically scored highly on efficiency but also on quality of care in the regular Commonwealth Fund comparisons of major health systems.[44] To the extent that the NHS underperforms other models on some measures, this is likely due to its relatively lean funding. In 2017, for instance, it cost US$3,405 per capita, as against $4,495 for the German social-insurance model and $4,522 for the Canadian single-payer system.[44] This has been exacerbated by a decade of further underfunding by Conservative-led governments, sparking a series of horror stories that do not, however, reflect any intrinsic weaknesses in the model. Another advantage is that it would be structurally easy to deliver in New Zealand, which already has a large amount of healthcare funded out of general taxation.

Conversely, some commentators point to advantages in the social-insurance or single-payer models, including their ability to harness the resources of both public and private sectors in the delivery of care. While New Zealand does not have a strong tradition of social-insurance arrangements, it does have ACC, a much-admired if only partly realised version of the original Woodhouse vision. Its insurance-like nature can be seen in the way it charges different organisations and workers different levies according to risk calculations, then pays for treatment out of that collective pot. The current government is also proposing to introduce social unemployment insurance, in which $3.6bn would be levied annually from employers and employees to fund time-limited, ACC-style unemployment benefits paid at 80 per cent of previous salary. Disability advocates have also recently proposed a major reform of health and social care that would see ACC's cover extended to those affected by long-term illness and disability.[45]

Revenue options

If an NHS-style model were chosen, some $3bn in taxes would have to be raised from general taxation. This could be generated through a new tax on upper-end wealth or the income generated from that wealth (a glaring absence from New Zealand's tax system).[46] This could take the form of a net wealth tax, a capital gains tax, an inheritance tax, a property tax, or some combination of the above. All such taxes could be designed to generate upwards of $3bn in revenue and to fall largely on the wealthy. The 2017-19 capital gains tax debate, though, is a reminder that it is never easy to introduce new taxes in New Zealand, and it is not clear how popular would be a pitch to increase taxes on high earners to fund free healthcare.

If a social-insurance model were chosen, the revenue-raising option would likely be closer to a social security flat-rate levy on all salary earners. The average developed country generates one-quarter of its tax revenue from such levies; currently, the OECD estimates that New Zealand has no such taxes, although arguably an ACC levy is one and the proposed social insurance scheme would create another.[47] The advantages of such levies is that, without being strictly hypothecated (reserved for a particular purpose), they give taxpayers a clear story about "something for something": a flat-rate salary tax in exchange for healthcare delivered free when they need to use it. A 1 per cent levy paid by both employers and employees would, on salary income of $176bn (as declared to Inland Revenue in 2019), raise roughly $3.6bn, similar to the proposed social insurance scheme.[48] However, by dint of being levied at a flat rate, such taxes are not progressive, and could be seen to fall too heavily on the middle classes.

Either way, the upfront costs would be significant. However, this would substantially be a redistribution of costs already incurred by individuals, potentially in a fairer and more efficient manner, rather than a totally 'new' imposition of government spending. And the greater efficiencies from more joined-up care would reduce that upfront cost at the years went by.

Concluding thoughts

Anyone who has wasted hundreds of dollars on an unused gym membership knows how hard it can be to make an upfront commitment when the payoff is some way distant. Yet that is the kind of foresight we require from our governments now. They need to recognise that current fiscal surpluses come at the expense of yawning social deficits, and that an extra collective commitment of taxes now will have an immense future benefit: in lives lived free of the burden of disease, in more resilient and happier communities, but also in a more vibrant economy.

A recent major study of 25 European countries found that health spending's fiscal multiplier – the extra income generated across the economy for each dollar invested – was 4.3.[49] [50] As the WHO has noted, "There is now an urgent need to move away from the notion of health and health workers as purely an expenditure to be contained. To the extent that resources are wisely spent, investing in health is a productive investment."[51] Making healthcare free at the point of use would, in this view, not be just – or not even principally – a cost; rather, it would be an investment in our collective well-being.

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‘Lightening the Load – the case for a fully-free public healthcare system’ was originally a paper and keynote presentation by Max Rashbrooke at the ASMS National Conference in November 2022.

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