

Health Policy

A Comprehensive Health System as a Public Good, Not a Commodity

Our Vision

The primary care crisis is a problem of misalignment. Primary care has been structurally placed outside the centre of the health system and funded to produce appointments rather than better health outcomes.

This is not a failure of general practice teams; it is the predictable result of a broken funding model. Clinicians are pushed into volume-driven business models, then blamed when care becomes fragmented and transactional.

Health is a public good, not a commodity. The Alliance believes the state must provide one integrated pathway for community wellbeing. We reject artificial divisions between physical and mental health, and between medical, dental, and other essential care.

The Community Health Service (CHS) is more than a rescue package for general practice. It is the community-based operating model for the whole health system, and the mechanism that makes prevention worth funding rather than something the system absorbs the cost of failing at.

1. The Community Health Service

The Alliance will transition primary care from a fragmented network of struggling private businesses into a cohesive Community Health Service (CHS).

The CHS will:

- provide an integrated pathway into community healthcare;
- bring dental, optical, audiology, mental health, and allied health services into public provision;
- fund care teams rather than individual appointments;
- employ community health workers on the same terms as their hospital counterparts;
- devolve operational decisions to local Community Health Boards

2. The Clinical Team: The Right Team, Not Just a Doctor

We will replace the “doctor-does-everything” bottleneck with locally aligned, multidisciplinary community health teams. Each profession will work to its full scope, and people will be matched with the right clinical or non-clinical support from the first meeting in a flexible and responsive way.

Practice Nurses as the Backbone

Practice nurses are the continuity and coordination workforce of the CHS. Their role covers:

- proactive long-term condition programmes;
- prevention and screening;
- immunisations;
- whānau follow-up and care planning;
- escalation using agreed clinical pathways;
- rapid clinical response within scope, including standing orders and nurse prescribing where credentialled.

A GP is available on site to support escalation and provide clinical backup as needed.

Nurse Practitioners as First-Contact Clinicians

Nurse practitioners provide first-contact care for a defined enrolled population. Their role covers:

- first-contact assessment and diagnosis;
- prescribing;
- ongoing management and continuity across a wide range of presentations;
- care delivered at community and satellite clinics under a hub-and-spoke model.

A GP is available at the hub for escalation, clinical backup, and circuit visits to review high-complexity patients in person. This creates faster access while preserving safe escalation routes for diagnostic uncertainty and high-risk complexity.

Workforce expansion will be managed carefully so that training quality keeps pace with numbers.

GPs as Specialist Generalists

GPs in the CHS operate as specialist generalists, a role analogous to that of hospital-based consultants. Their role covers:

- complexity, diagnostic ambiguity, multi-morbidity, frailty, and clinical risk;

- senior clinical decision-making;
- mentorship and supervision of the wider team;
- clinical governance across the service;
- safe escalation pathways to secondary care.

Rather than being trapped in short, high-churn appointments, GPs are freed up to do the work only they are trained for.

Workforce Pipeline

We will

- uncap funded training spots for nurse practitioners;
- fund a national framework for Practice Nurses to gain Designated Prescribing Rights;
- remove the financial barriers that currently stop staff from upskilling.

3. Mental Health: No Wrong Door

Mental health is health, yet it is currently treated as a separate, hard-to-access crisis service.

Integrated Support

Every CHS Hub will include on-site, appropriately trained mental health clinicians. We will invest in growing the counselling workforce, funding training for counsellors. In rural and smaller clinics, virtual backup will supplement on-site capacity where needed.

Immediate Access

We move from a “referral and wait” model to a “warm hand-over” model. If a nurse identifies a mental health need, they can walk the patient down the hall to a clinician immediately.

We also recognise that many people present with mental health difficulties that are rooted in social and economic circumstances. CHS Hubs will maintain active links with social services, housing support, and community organisations, ensuring people can be connected to the right support and are not limited to just the nearest clinical pathway.

4. Full Integration: Teeth, Eyes, Ears, and Allied Health

A healthy body requires more than just a GP. We will bring essential services out of the private sector and into the public CHS Hubs.

Dental, Optical, and Audiology

These will no longer be private luxuries. Dental care, optical care, and audiology will be integrated directly into CHS Hubs and fully funded.

The case for this goes beyond preventing hospital emergencies. People without front teeth struggle to find employment; people who cannot see struggle to participate fully in daily life; people with untreated hearing loss become isolated. A health system that treats these as optional extras is treating participation in ordinary life as an optional extra.

Clinical Pharmacists

Clinical pharmacists are core members of the CHS team. We will embed pharmacists directly into CHS Hubs to improve medication safety, reduce harmful drug interactions, and improve quality of life for patients managing multiple conditions.

Community pharmacy has been consolidating into national chains, and the clinical advice pharmacists once gave across the counter without charging for it is not something a discount model can carry indefinitely. The CHS model funds that expertise as part of the care team, rather than leaving it to be cross-subsidised by retail margin.

Allied Health

We will expand free public access:

- Physiotherapy;
- Podiatry;
- Occupational Therapy.

Access to these services currently depends more on the cause of a problem than on the need. Injury is covered through ACC. The same treatment for illness, age-related decline, or falls prevention is largely left to private payment or to a limited and uneven pool of publicly funded services. We will fund them on the same basis regardless of cause.

5. Integrated Funding: The Lever for Change

Fragmented funding drives fragmented care. We cannot fix the system while funding Primary Care via capitation, per person, and Hospitals via activity, per treatment.

Blended Team Funding

Funding must follow the team, not the visit. We will introduce specific funding lines for Team Functions like chronic care clinics and pharmacy reviews, so that a practice

doing proactive work is paid for it, rather than penalised for the appointments it did not need to book.

System Alignment

We will treat community and hospital services as one economic system.

Redeployment

This is primarily about redeploying and aligning existing funding. By investing in the CHS to prevent illness, we stop paying for the expensive consequences of missed prevention via hospital admissions.

The Virtuous Cycle

Where hospital funding follows activity, an admission that never happens reads as revenue forgone. Under our model a prevented admission is a gain to the system rather than a loss to a budget line. The savings stays in the system and is reinvested in prevention.

6. Public Stewardship & The "GP Rescue"

We must remove the commercial burden that distracts health professionals from care.

The Mechanism

The CHS will be established as the funding vehicle for all public primary care. Practices are invited to join voluntarily and those that opt in receive full CHS support, with the CHS assuming responsibility for the business functions:

- rent and premises;
- administration;
- payroll;
- IT and systems.

Practices that choose not to join are not compelled, but public funding flows through the CHS model. In practice, the economics of primary care in most communities make full private operation unviable, so the transition is expected to be largely voluntary and organic. Nothing in the model requires compulsion in order to function. We do not need to own every building, but we must own the responsibility for the infrastructure.

The Result

Staff become salaried public employees with guaranteed hours and pay. Doctors are freed to focus entirely on patients, not running a business.

Operational Autonomy

While we centralise the support, we decentralise the operations. The local practice retains the agency to make decisions about their own rosters, workflow, and clinical priorities, ensuring the system remains agile and responsive to local needs. We devolve the management as far as possible, to ensure a broken printer does not need approval from Wellington.

7. Workforce Parity

We will end the drift of staff from clinics to hospitals.

All community health workers, including GPs, Nurses, Pharmacists, Allied Health, and Admin, will be employed on the same collective agreements as their hospital counterparts, including the ASMS SECA for doctors.

Placing primary care workers under the same union coverage as hospital workers shifts healthcare unions from being primarily advocates for secondary care to advocates for the whole system, the majority of which is in the community.

8. Subsidiarity & Local Agency

A national service does not mean "one size fits all". We are committed to the principle of subsidiarity. Decisions should be made by the lowest level capable of making them.

Local Governance

We guarantee continued central government funding to ensure every community gets their fair share. Operational decision-making will be devolved to local Community Health Boards. We fund nationally to ensure equity, and we govern locally to ensure relevance.

Māori Health Providers

We uphold tino rangatiratanga. Māori Health Providers will have the option to integrate or remain independent. In either case, they will receive full 100 percent funding parity for delivery of care and guaranteed pay equity for their staff. We support by-Māori, for-Māori care, not assimilation.

9. The Health System We Are Building

Treating issues in the community before they become emergencies takes pressure off hospitals that are currently absorbing the cost of everything primary care was not funded to catch.

Take dementia. The 2024 Lancet Commission identified fourteen modifiable risk factors, estimating that addressing all of them could prevent or delay around 45 percent of cases. Hearing loss, untreated vision loss, and social isolation are three of the fourteen. They are also three of the things a person in our country currently pays for privately or goes without.

We can fund hearing aids, glasses, and the community services that keep people connected now, or we can fund a secure unit later. That same choice repeats across the whole system, and we have spent forty years making the expensive version of it.

The health service the Alliance is building is:

- **One system.** Not a primary sector, a secondary sector, a dental market, and a mental health crisis line. One service, with the parts funded to work together rather than to protect their own budgets;
- **Public.** Funded from taxation and delivered by public services, with nobody's profit riding on the decision to treat;
- **Free where it counts.** No fee standing between a person and the care they need, whether that care is a GP, a filling, a pair of glasses, or a counsellor;
- **Built around prevention.** Funded to keep people well rather than paid to process them once they are not;
- **No wrong door.** Whatever door a person comes in, they reach the right clinician without being sent away to start again somewhere else;
- **From cradle to grave.** A service that knows you across a life, not one that meets you in fragments.

None of this is a new idea here. The 1938 Social Security Act set out to build a universal health service for this country, and it was the most ambitious attempt in the world at the time. Opposition from the medical profession forced a compromise on the family doctor, and the co-payment we still pay today is what remains of that retreat.

Aotearoa New Zealand wrote the first draft and settled for less than it intended. Finishing it is the work in front of us.