Comprehensive healthcare system needed

Gil Barbezat

The editorial by Saxon Connor published in your *Journal*[1] raises many debatable points. His suggested answers to the challenges posed by increasing demands of healthcare will be of great concern to many. Particularly disturbing is that his solutions lie in some form of further restriction and rationing, rather than any possibility of expanding the provision of resources for services. He reflects the view of the privileged who can afford an alternative source of healthcare, something elusive to the majority of our population.

Abiding by the principles of the Treaty of Waitangi could be life-saving. Care of the community is far more important than the rights of individuals. Thoughts of any further restrictions amongst those who already have the poorest provision of services and outcomes are abhorrent. The rise in average lifespan has come at a price; some of us are more privileged than others, and bear a societal obligation to contribute towards benefitting our community's health and paying for it.

Connor glibly uses phrases such as: match "available resources", "healthcare is a right", "reasonably achieved within funding provided", "DHBs to provide a good and safe working environment for staff". He also notes that secondary care is "in crisis", with its big deficits, shortfall in staff training and availability, emergencies displacing elective requirements, "wide variety of acceptance" of rationing. All these factors are important but have an immense range of interpretations which need to be debated; it cannot be assumed, as he seems to do, that his interpretations encapsulate all the answers. His stock answer, illustrated in every section of the table, is to reduce demand, equating health values and life itself with commodities, such as dairy products and wool. That is not the type of health system most of us could tolerate. While perfection is not practically possible, we can surely do far better than his range of limitations.

Secondary care funding problems are particularly prone to occur when not based on sound public health and primary care foundations. Usurping those functions introduces practices which are often misguided, misinterpreted and result in costly and unnecessary interventions. This applies particularly to end of life care.

In a democratic society, we elect our politicians to develop and enact policies compatible with our prioritisation of values. Surely health, housing and education must be priorities if we are to maintain a civilised collaborative community who value their future. When the population is presented with the alternative of spending discretionary income on unnecessary luxuries or basic community necessities required of a satisfactorily functioning public health system, we do not have to look far to see what vast differences such choices produce on populations.

The result of favouring the individual above the community results in a situation currently bedevilling the USA. Despite the highest per capita expenditure on health (19.7% of GDP), close to 30 million have no access to funded healthcare; preventive medicine is only available to those who can afford it, life expectancy is decreasing, and the commonest cause of bankruptcy is healthcare debt.[2] In contrast, a medium income country, Costa Rica, has revolutionised its healthcare provision over the last 50 years with a more community-based public health approach; it has reversed its declining life expectancy, and now has a better record and longevity rate than the USA at less than half the cost (7% of GDP).[3,4]

There is a ray of hope in that Connor calls for legitimate institutions to make transparent decisions from information-led data with public engagement. We can only wish that were possible, but that would require firm support from the community and the political will of those in power. There is certainly much room for improvement in current DHB health provision. We wait with bated breath for the small print of the "new health system" soon to be enacted. Greater efficiency is required to meet resource issues. Changes should be focussed around the needs of patients as members of a community, with medical education, staff and facilities tailored to meet those requirements. The shoe needs to be designed to fit the foot, not the foot squeezed into whatever footwear is cobbled together by ad hoc assembly of readily available historic components.

COMPETING INTERESTS
Nil.

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REFERENCES
1. Saxon Connor. Is it time to ration access to acute secondary care health services to save the Aotearoa health system? NZMJ 2022 Feb 25; 135(1550): 7-12.
2. Wager W, Ortaliza J, Cox C. How does health spending in the U.S. compare to other countries? Peterson-KFF Health System Tracker 2022 Jan21. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries-2/
3. VanderZanden, Pesec M, Abrams MK, et al. What does community oriented primary health care look like? Lessons from Costa Rica. The Commonwealth Fund. Case Study 2021 March 16. https://www.commonwealthfund.org/publications/case-study/2021/mar/community-oriented-primary-care-lessons-costa-rica
4. Gawande A. Costa Ricans live longer than we do. What's the secret? The New Yorker, 2001; Aug 30: pp30-41.

