The answer is more investment in health and welfare—not more rationing of healthcare!

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We wish to respond to the editorial by Dr Connor published in the NZMJ on 25 February last. His arguments are based on one premise: “The attempt to meet all the healthcare needs would overwhelm any country’s resources, including the need for other social goods, etc…” This is a central mantra of neoliberal philosophy, with its policies for free market economies and the private provision of public service, with which we strongly disagree.

High levels of unmet need and a creaking healthcare system should suggest a need to examine the underlying reasons for both and should not rely on a managerialist technical solution.

It is obvious that a major contribution to the high level of unmet need lies in predeterminants of health such as: poverty, access to primary healthcare, inadequate housing, and poor diet. The other main reason for the creaking health and welfare services is the thirty years of underinvestment. Objective data from many democratic countries shows that neither healthcare needs nor the required level of adequate funding are overwhelming, as follows:

1. Multi-national European studies have shown that investment policies in healthcare and other welfare services pay large positive fiscal dividends and promote economic growth (i.e., for every dollar put into health services governments get more dollars back, often referred to as fiscal multipliers). Even the International Monetary Fund, a bastion of neoliberalism, which initially disagreed with the results of these studies, has since conceded that such positive fiscal multipliers do result from investments in health and welfare.

2. Finland is an exemplar of a country that has shown what can be achieved by a policy of welfare investment. By comparison (See Figure 1) our own level of social expenditure per capita is much lower, and we can afford to do much better.

![Public Social Expenditure in 15 comparable countries](source: OECD Social Spending Indicator 2021)
The assault on the healthcare system of Aotearoa New Zealand started in earnest with Rogernomics in the early 1990s, and continued through the Core Services Committee and the National Waiting Time Project. These steps were needed to prepare the public for the progressive rationing of secondary elective healthcare. There was some isolated and sporadic opposition to these moves from the medical profession. However, we neither mounted a coordinated opposition to them through our representative bodies, nor did we effectively highlight the fundamental underlying problems by addressing either the predeterminant of health or the chronic underfunding of primary and secondary healthcare.

Undoubtedly, the situation has continued to deteriorate because not only has residual neoliberalism continued to eat away at healthcare funding, but it has also fuelled a widening of the gap between the “haves” and the “have nots”. As a consequence, people in the lowest decile groups have suffered the double jeopardy of the worst predeterminants of health and the poorest access to healthcare services.

So, coming to Dr Connor’s proposal that, as the secondary healthcare system is under massive stress and about to collapse, a potential solution is to extend rationing into acute secondary healthcare. Why again should this be contemplated, rather than a move to an investment model for health and welfare spending that has been shown to be successful overseas? Is it likely that yet again we, the medical profession, will not advocate en masse on behalf of the public?

If serious rationing of acute secondary services takes off rapidly here, as happened before with elective healthcare, we are likely to end up with a USA-type healthcare system, that is heavily privatised and inefficient, and where: the wealthiest 20% have some of the best healthcare in the world; middle-class Americans live in dread of having a major acute or chronic illness and thereby needing to declare bankruptcy; and a poor, uninsured 27.5 million people have almost no access to healthcare. It is easy to see how such a dystopian scenario is unlikely to motivate doctors like ourselves, who can afford to pay for private healthcare, but would be a persistent nightmare for many other people.

The real question is not “whether it is time to ration acute secondary care?” It is instead: “when will the medical profession wake from its slumbers and begin advocating for the changes in policies for adequate health and welfare funding to achieve the goal of equity of health outcomes for all the people we serve?”.
COMPETING INTERESTS
Nil.

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REFERENCES