"Courage, pray for courage." There are many days I hear her say those words and they keep me going when I am afraid of what's ahead. No one has any guarantees, but when I awaken during the night with my fears, I think of all the things I am thankful for. My blessings keep me going. I sometimes also think about all the families that are touched by serious illness and how they have been faced with bankruptcy and choices of buying a prescription or food. Americans are hard working and resilient and they deserve better. Health care for everyone can be solved and looking positively towards the future will carry us to that goal so we can focus on being well.

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Public Versus Private Health Care

Norman Simms—University of Waikato (NZ)

When I listen on satellite television to the acrimonious debates about reforms of American health care, it is difficult to recognize in either the *pro* (Democrat) or *contra* (Republican) positions anything resembling the experience my family has known over the past half century. My wife, our two children, and I have been living out of the United States since the mid-1960s, first in Canada, then in New Zealand, and for substantial periods of time in Israel and France. Each of these four nations has some form of public, state-run, government-supported, or national health system. Thus as an outsider who was once an insider, both sides seem to be more

engaged in what psychohistorians call group fantasies than rational discourse. Health care, in this sense, becomes, like disease itself, a projected waking group dream about the "body politic."

All four "socialist" systems of health care I have lived in have changed in the course of 50 years, not always for the better. There are three points that stand out which I wish to indicate before delving into why the American "town-meetings," television exposés, and grandiose speeches seem to go off the rails. Let me focus on the system we are most familiar with in the place where we have lived longest. This is not because New Zealand's system is the best in the world (which it isn't) or better than most (which it used to be) but simply because having lived in it for 40 years it is a living reality and not a rhetorical construct or a fantasy image.

Since 1970 in New Zealand, we have always chosen our own family doctors and when required, have been recommended to specialists. Where there are more than one, we have usually been able to make choices. No one appoints a doctor for us, and we consistently see the same doctor. On the whole, the notion here is that everyone's health depends on everyone else's, rather than something belonging within the envelope of the skin to an individual or within the walls of the house of one family.

The quality of care has been excellent or at least as good as we could expect when circumstances have not been optimum, such as when for political and economic reasons there have been staff shortages at the best of hospitals, and when individual doctors or nurses, and not the "system," have been deficient in provision of care. In our experience, the more these state medical plans have leaned toward the North American system, the more they have fallen down in provision of efficient and extensive care. The atomizing of health care creates the monstrous and chaotic paradigm of Hobbes' pre-state ("a war of all against all") society: not only

is disease the enemy who invades the private body, but each of one's neighbors is a rival whose health and well-being deprives the isolated ego of its strength and longevity.

When desired or necessary, the state insurance and care have been open to private supplementation. In New Zealand it is possible to opt for private doctors and nurses even inside the state hospitals, since for the most part it is the public institutions rather than smaller private hospitals run by insurance companies that have the most range and the most modern facilities available. The doctors we know see themselves as offering a service and sometimes when right-leaning governments have cut back on state subsidies, they have created their own lower rates or charged nothing for children under six, pensioners, and families on benefits.

Thus the arguments against a national health care system in the U.S. seem to rest on a series of assertions that sound bizarre outside of that particular and peculiar country. One, big governments are bad because bureaucracies are inefficient, top-heavy with administrators, and weighted down with paperwork. Two, private health, like private business in a free enterprise system, works best because competition improves quality, sharpens the need to please customers, and is attentive to individual needs. Three, taxes are a form of legalized robbery. Four, individuals always know best what to do for themselves and their families. Five, the only way to measure a doctor's worth is by the amount of money he or she can earn. Six, people who can't afford good health care don't deserve it because they are lazy, stupid, welfare-dependent or on illegal hallucinogenic drugs.

These arguments raise the question as to what is meant by *big government*? Outside the U.S.A., the terms *government* and *state* are not interchangeable, the first referring to the centralized mechanisms of power run by elected parties with the most seats in a parliament; the second referring to the organs of management and implementation of

government policies. My nearly 70 years of experience suggests that individual companies seek to maximize profits by cutting corners and by putting their own development above that of the general public, while civil servants and professionals working for public enterprises focus on their tasks in relation to patients and clients without concern for their own financial status. At worst it seems to me that any large systems, whether private or public, tend to bog down in paperwork so that the best thing to do is to opt for smaller, regionally-based hospitals and clinics rather than overly-centralized and impersonally-run facilities.

In the "good old days" of the 1970s and early 1980s, there were many advantages to the national health service that made it perhaps the best in the world. For one, each health board was composed of doctors, nurses, and elected members of the public. For another, rather than competing, each hospital cooperated with and complemented the others in matters such as sharing specialist services, taking overflow from crowded facilities, and so forth. Third, centralized purchasing of equipment, medicines, food, cleaners, etc. kept costs down as much as possible. Things changed here during the right wing revolution of the 1990s. Managerial models were imposed at the expense of service ethics and collegiality, to the point where for a while there were no longer hospitals, but instead Crown Health Enterprises, whose mission it was to make profits.

Today, in a modified version of the original system, many of the bad aspects of an attempt to privatize and nationalize health remain. While nowhere as horrendous as in America, these reminders still indicate the essential flaws in imposing the business model on a medical service: competition for care between individual doctors and hospitals leads to a focus on flashy instant treatments often inappropriate in terms of patient needs, while reduction in resources leads to delays, errors, and death. For example, in the past few

months a new medical lab testing service from Australia outbid the long-standing local group. Within weeks it proved inefficient and virtually impossible to coordinate. The overseas managers sought to maximize profits, made cuts to save resources and keep staff numbers down, and now, having failed to such an extent that the City Council has had to act, the old group has been asked back to try to salvage pathological testing in the nation's largest city. This is not a matter of socialism versus capitalism, but of greed and stupidity versus competence.

The question is whether competition or cooperation stimulates the best results and the most cost-efficient outcomes. Because it is motivated by profit, I do not believe that the business model provides the best structure for a health care system. Private enterprise allows for most business ventures to fail and for entrepreneurs to begin again; this is unacceptable in terms of the care and treatment of sick people. The outcomes that should be held steadily in view are cure of illness, mending of injuries, and care of those who require it. Outrageously high salaries and bonuses, especially for top administrators and bureaucrats, exploit the fears and pains of people who are sick and hurt. Since a considerable proportion of the hundreds of billions of dollars spent in the health care system goes to exorbitant salaries and excessive non-professional activities, one of the key factors that ought to be considered is encouraging, through scholarships and vigorous recruitment drives, larger numbers of men and women to train as doctors and nurses and to develop a wide range of intermediary preventative careers, general practitioners, social medicine experts, and other specialists. In this way, the closed-shop aspect of medicine will be given some fresh air and salaries would subside from the astronomical levels now achieved. The culture of litigation would also need to be addressed, so that physicians and hospital directors did not feel compelled to prepare for catastrophic costs

from malpractice suits and other claims.

Once we clear away this matter of definitions and of ideologies, something remains that is much deeper and profoundly shaped by group fantasies rather than by logical reasoning or historical experience. While it would be invidious to ascribe malicious intent to either side in the debate, I cannot help but hear in the cheers or jeers and see in the slogans and banners indications of psychohistorical forces. From the other side of the world, the current debate in America seems to miss the point. The imagery put forth by each side reflects different paradigms of care-giving, each side side-stepping the real issues and seeking to project on the other the neurotic fears about their own selfish dreams.

Norman Simms, PhD, *was born in Brooklyn, New York and educated in the U.S.A. prior to moving to New Zealand where he teaches literature at the University of Waikato. He is a prolific author and the editor of* Mentalities/ Menalites. *Dr. Simms can be contacted at nsimms@waikato.ac.nz.* ❑

Life's Final Moments in European Health Care

Peter Petschauer—Appalachian State University

Four people are involved in the description of my wife Joni's and my experiences with health care in Europe, the heartland of the supposed socialist or National Socialist expressions of health care. They are my father, Dr. Erich Petschauer; my mother, Hildegard Petschauer; my stepmother, Micky (Emmie Anders) Petschauer; and Agnes (Neas) Obwexer.

In each case, I am dealing with the last years of their lives and how they were treated in various parts of Germany