How the New Zealand Health System Compares with Other Countries

ASMS 21st Annual Conference

Professor Don Matheson

Thank you for this opportunity to speak with you today. I last spoke to this ASMS annual meeting in the mid-1990s and now, over a decade later, I have been invited to talk with you again – a reflection of the similarity of the times in which we find ourselves.

I wish to discuss three points about the New Zealand health system:

1. Firstly, there is much that the rest of the world envies in the NZ health system and it is not the 'basket case' that some like to present us as in the effort to create a 'burning platform' for change.
2. Secondly, that despite our success, we do face a number of challenges in our quest for health – apart from reducing the estimated cost of health services in 2030.
3. Thirdly I will discuss the folly of those that think they alone control the health system, especially when they see 'structural change' as the answer – and discuss approaches that are more in keeping with the complexity of the problems that we face.

I have been working as an international consultant in health systems during the last 18 months, following an eight year stint with the Ministry. My work has taken me to Geneva, Manila, London, Cayman Islands, Papua New Guinea, Kazakhstan, Fiji, the Northern Territory of Australia and Italy. But there is no place like home.

So the perspective I bring to this meeting is one of an insider who is now an outsider. I have participated in a number of international forums and reviews on issues such as social determinants of health, primary health care and healthcare financing. At these international forums I reflect on what is good and different about our little country at the bottom of the world, but also which of the problems we face are common to health systems in all countries, and which are our home-grown little messes and successes.

Basket case?

Do we spend too much on health care? According to the Horn Report,[1]

New Zealand spends a high proportion of its national income on health. It is higher than the OECD average and, with the exception of the US, Switzerland, France and Germany, it is not materially different for the highest in the world.

And it goes on to say: *Sustainability of our public health and disability systems is under serious threat.*

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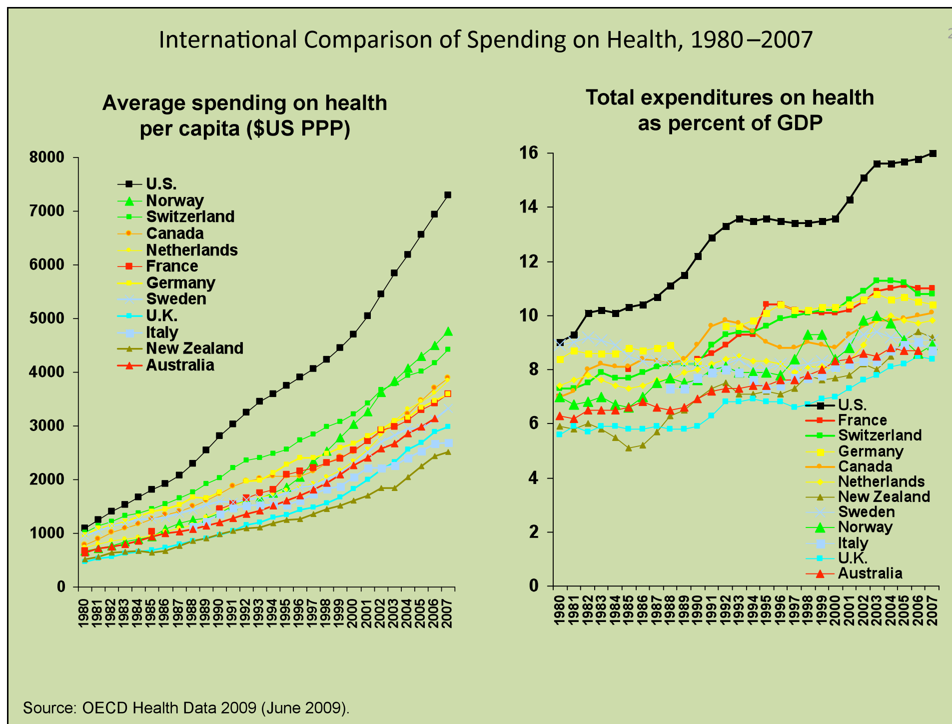
[1] Ministry of Health, July 2009, *Meeting the Challenge*: *Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*, Report of the Ministerial Review Group (This is also known as The Horn Report).



But In this graph we see that NZ has the lowest level of spending of comparable countries, and is materially different from the highest spenders in the world. In fact, increased expenditure from 2003 to 2007 only enabled us to keep in contact with the lowest of the comparable countries.[2]

I've heard of creative accounting, but the statements in the Horn Report break new ground in trying to turn good news into bad. You might like to use a similar approach to describing your own work, saying "With the exception of the patients that died, suffered injuries, or ended up with HDC complaints, all our patients did exceptionally well this year."

There is a bit of a tradition of economists and bankers reviewing health care systems. Usually this turns them into late entrants to the school of public health. For example, our own Gareth Morgan has this to say: *I accept that we need to treat obesity as we have dealt with smoking. This may mean being a bit of a nanny state, in order to avoid becoming a nursery state.*[3]

In the UK the banker Derek Wanless, in a UK Treasury-sponsored report,[4] asserted that the only effective way to tackle the ever-rising cost of healthcare is for the whole of society to 'fully engage' with prevention. By 'full engagement' Wanless meant action at all levels and in all sectors to do whatever can be done to reduce the risks of developing the chronic diseases burden.

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[2] In this discussion, note that the OECD has 30 countries. In this graph, nine countries are represented, as they are comparable with New Zealand in terms of economy and health expectations. A number of countries in OECD (such as Turkey, Mexico, Poland, Slovak republic) have very low expenditure, and also lower health outcomes, and are not included.

[3] Morgan, G and Simmons, G, 2009, *Health Cheque*, published by The Public Interest Publishing Co Ltd

[4] Wanless, Derek, 2004, *Securing Good Health for the Whole Population* HM Treasury

However, the Horn Report is unique amongst economists and bankers who have reviewed health systems, in its scepticism of the role of prevention. In fact, due to the narrowness of its economic lens, it is even cautious about past and future prevention efforts. It begrudgingly notes:

NZ's relatively strong commitment to prevention and public health has helped improve life expectancy, delayed the onset of disability associated chronic disease, and reduced inequalities.

But then goes on to say:

Opinion is divided however on the much narrower question of the extent to which further spending in this area at the expense of more immediate health needs might help reduce future health costs or improve the country's economic performance, thus making future health spending more affordable.

This breaks new ground in defining prevention and public health almost solely in terms of their impact on the economic. In fact improving life expectancy, delaying the onset of chronic disease, and reducing inequalities all improve economic performance[5 6 7]. However that is not the primary reason society chooses to do them. "*Prevention is better than cure*" is a widely accepted value in most societies, but obviously not in the future New Zealand that Horn envisions, where he is suggesting that the princely sum of 4% of health expenditure that we currently spend on Public Health should be spent on curative care.[8]

However it is not the misrepresentation of NZs position in relation to like countries in the OECD, or the blind spot regarding prevention that is most troubling about this report. Its main problem lies in its lack of appreciation of current New Zealand achievements.

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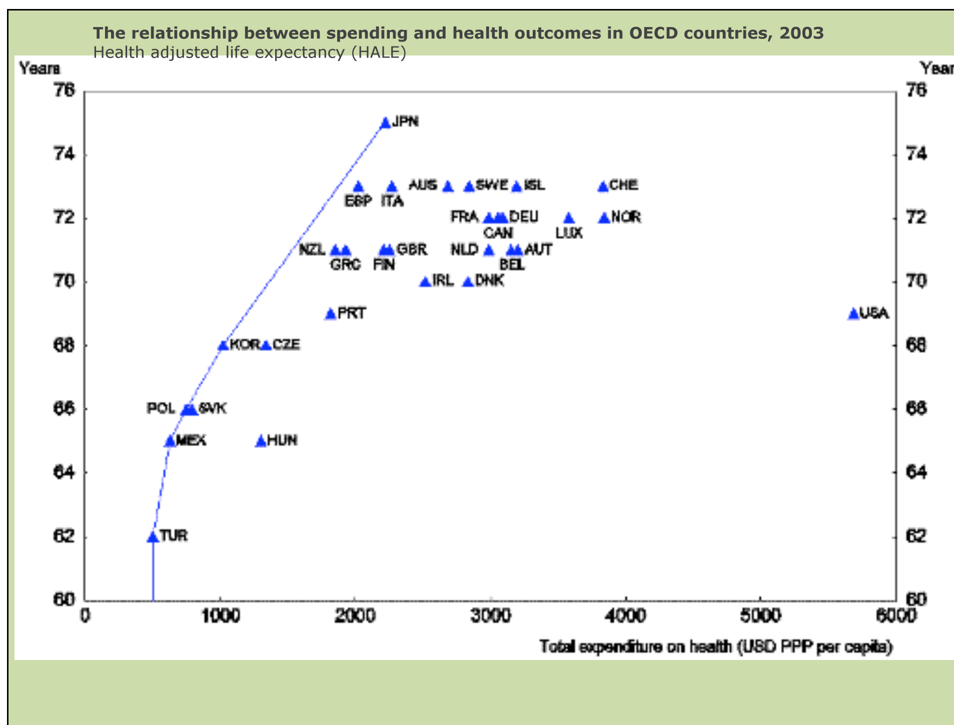
[5] Investing in Health for. Economic Development. Report of the Commission on Macroeconomics and Health. Chaired by Jeffrey D. Sachs .*whqlibdoc.who.int/publications/2001/924154550x.pdf*

[6] Chronic disease: an economic perspective', Marc Suhrcke, Rachel A. Nugent, David Stuckler and Lorenzo Rocco for Oxford health Alliance, 2009.*www.oxha.org › Initiatives › Economics*

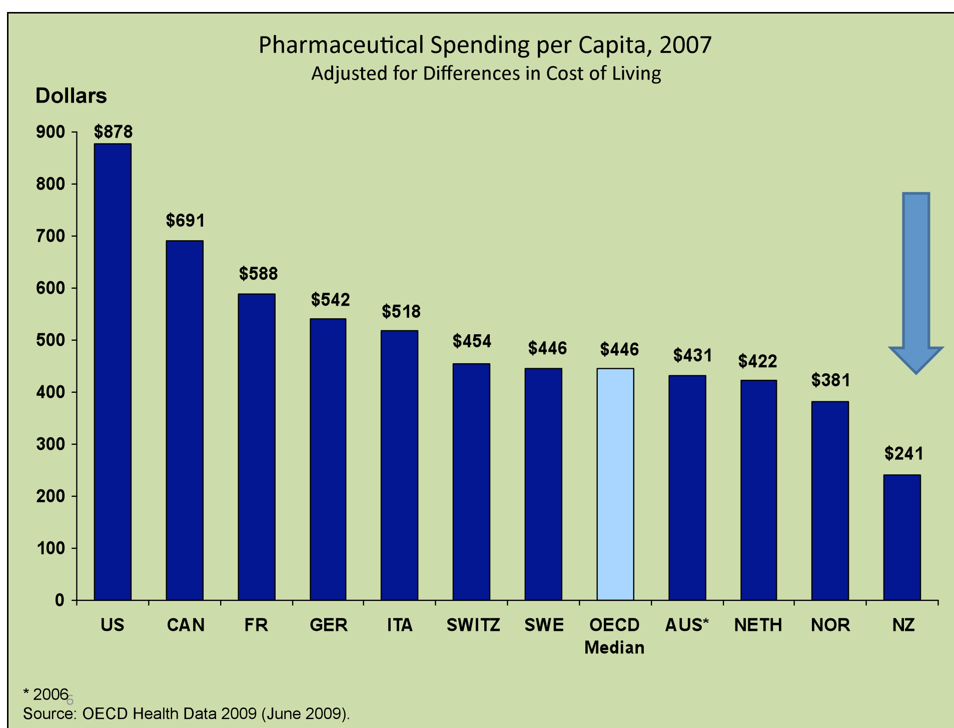
[7] Economic theory predicts, and econometric evidence finds, that inequality increases crime and political corruption and, in certain circumstances, constrains growth. Ref: Economic Costs of Inequality (November 2007). McAdams, Richard H., U of Chicago Law & Economics, Olin Working Paper No. 370; U of Chicago, Public Law Working Paper No. 189. Available at SSRN*: http://ssrn.com/abstract=1028874*

[8] Health Sector - Information Supporting the Estimates of Appropriations for the Government of New Zealand for the Year Ending 30 June 2010, NZ Treasury

The relationship with healthy life expectancy? We have a great result with low cost. The countries near the blue line are the most efficient. The most inefficient country is the USA with extremely high costs and moderate life expectancy gains.

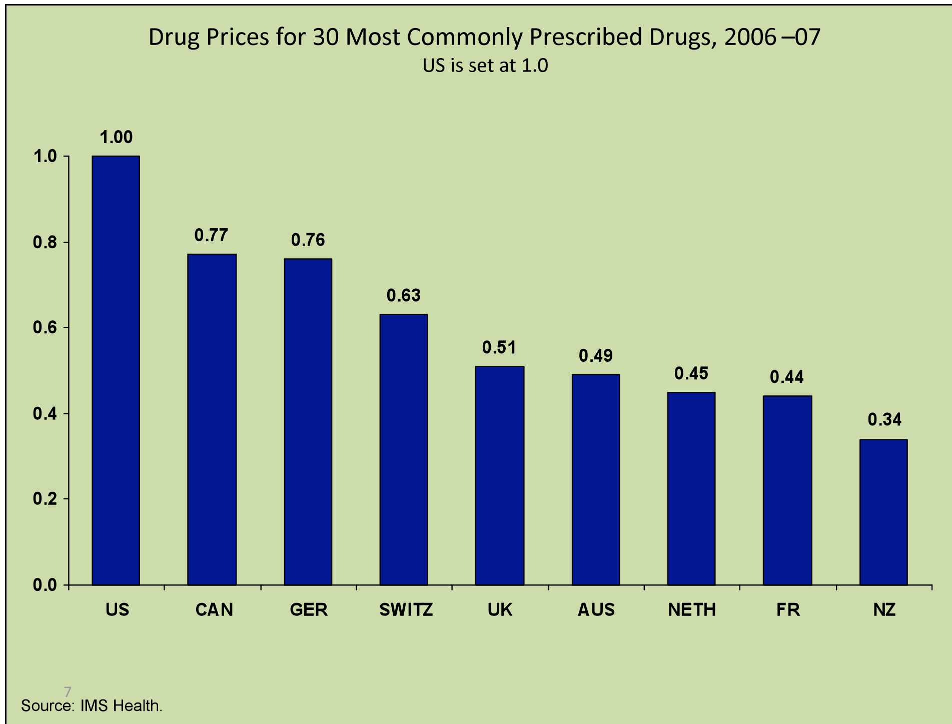


Drug purchasing? We have the best deal in the world.

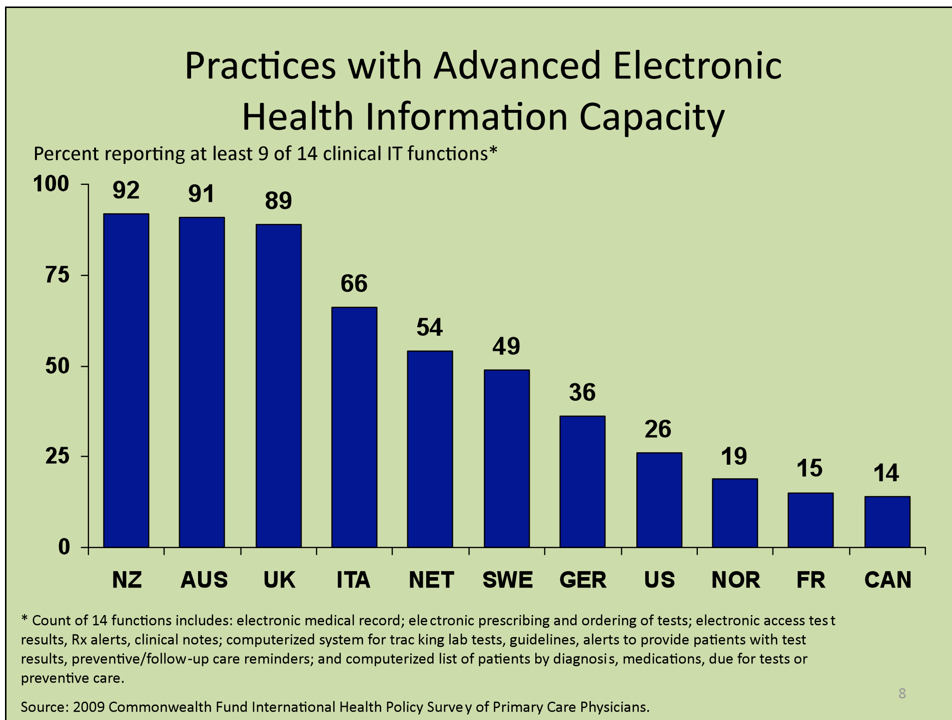


* 2006

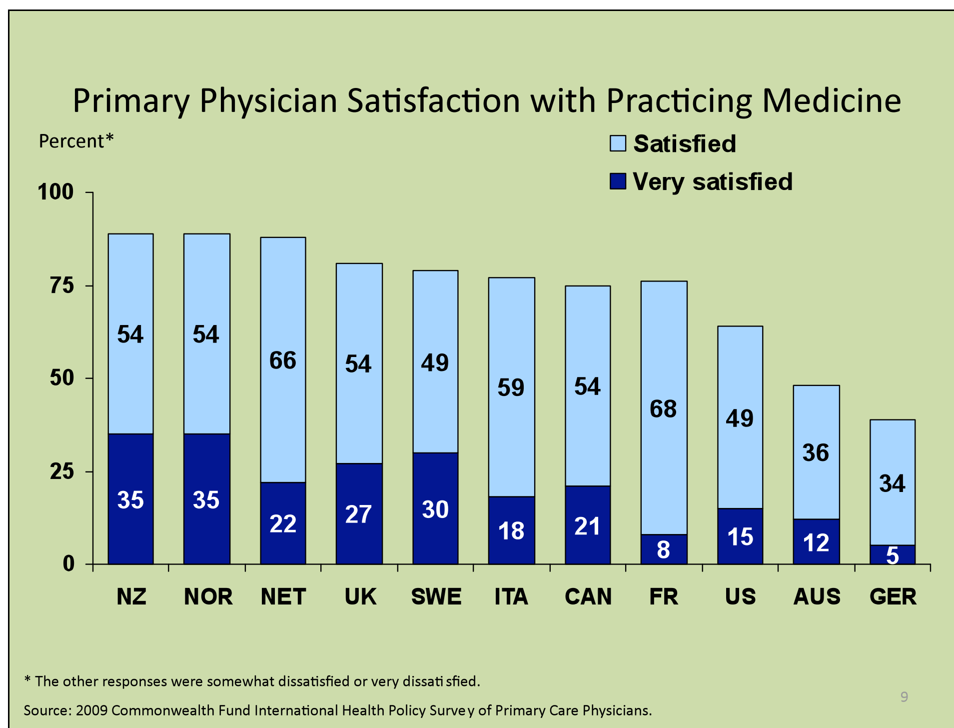
Source: OECD Health Data 2009 (June 2009).



Our use of technology? The geeks rule down under.



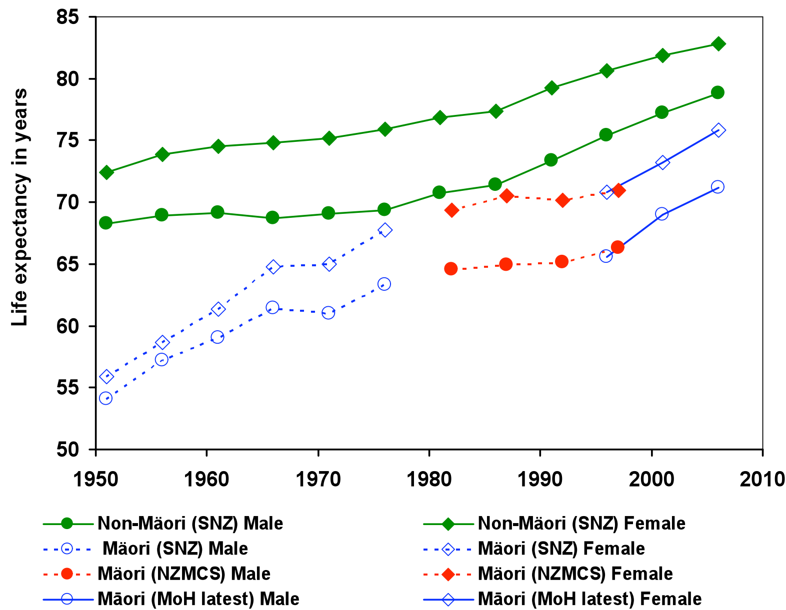
Outbreaks of satisfaction amongst primary care doctors? Our rate is higher than the rest.



Health Equity? We are showing improvement, and the only country in the world able to measure it in a timely way.[9]

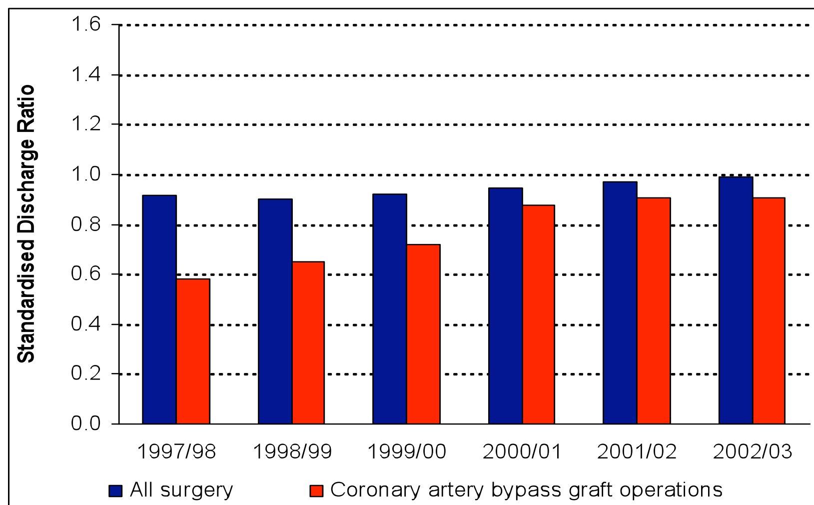
[9] Slide courtesy of Tony Blakely, University of Otago. 2009.

Life expectancy trends by ethnicity



Since the late 1990's there has been a return to improved life expectancy for Māori, parallel with the improvement for non-Māori. (Note data missing for a period for Māori due to change in definition of ethnicity). We are once again back on a track, which if it continues could see Aotearoa again addressing the unfair differences in health outcomes between Māori and non-Māori. A similar pattern of reducing inequality is seen with between low income and other citizens.

Addressing Inequalities in Surgery for Māori:non-Māori Standardised Discharge Ratios (NZHIS data)



The achievement in addressing equity has been due to work both inside and outside of the health sector. Addressing health equity has relevance – inside a surgical unit, as the above illustrates where the equity gap is progressively being addressed. This graph shows that surgical intervention rates (all types combined) and CABG rates were lower for Maori than

European ethnic groups (adjusting for age) until recently. Māori rates are still much too low when adjusted for need (e.g. CHD mortality rates are double those of Europeans, yet CABG rates are similar). This highlights the importance in seeing the pursuit of 'equity' as being across the health sector, including the work of cardiac surgeons as in this case.

The most comprehensive analysis of the NZ Health system performance in relation to other countries comes from the Commonwealth Fund. How does quality, access, efficiency and life expectancy in New Zealand compare with other countries? In the table below note that New Zealand has the lowest expenditure, yet the Fund concludes:

New Zealand, Australia, and the U.K. continue to demonstrate superior performance, with Germany joining their ranks of top performers.[10]

Overall Ranking

Country Rankings
1.0-2.66
2.67-4.33
4.34-6.0

	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
OVERALL RANKING (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy, and Productive Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data
Source: Calculated by Commonwealth Fund based on the Commonwealt h Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health P olicy Survey of Primary Care Physicians, and the Commonwealth Fu nd Commission on a High Performance Health System National Scorecard.

The conclusion one draws from this is that New Zealand has one of the highest performing health systems with the lowest expenditure amongst comparable countries. From an international perspective, we have a health system that contains much to make as proud, and in fact is the envy of the rest of the world in many respects.

Rather than as the Horn Report requested, *a public health and disability system of the same standard as other OECD countries*[11] we should actually strive for one that maintains our health well above the OECD standard and remains value for money comparatively speaking.

For some reason, these inconvenient truths did not find their way into the Horn Report. Instead, efforts were made to catastrophise the NZ health system, to try and ignite a very damp platform to usher in radical change. Why? In whose interests is it to deny our nations successes, trumpet our shortcomings, create fictitious pictures of the future, and attempt to

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[10] Karen Davis, Cathy Schoen,et al. Mirror, Mirror on the Wall: *An International Update on the Comparative Performance of American Health Care* The Commonwealth Fund, May 15, 2007, Vol 59 accessed 7 December 2009

[11] The Horn Report, op cit, p 3

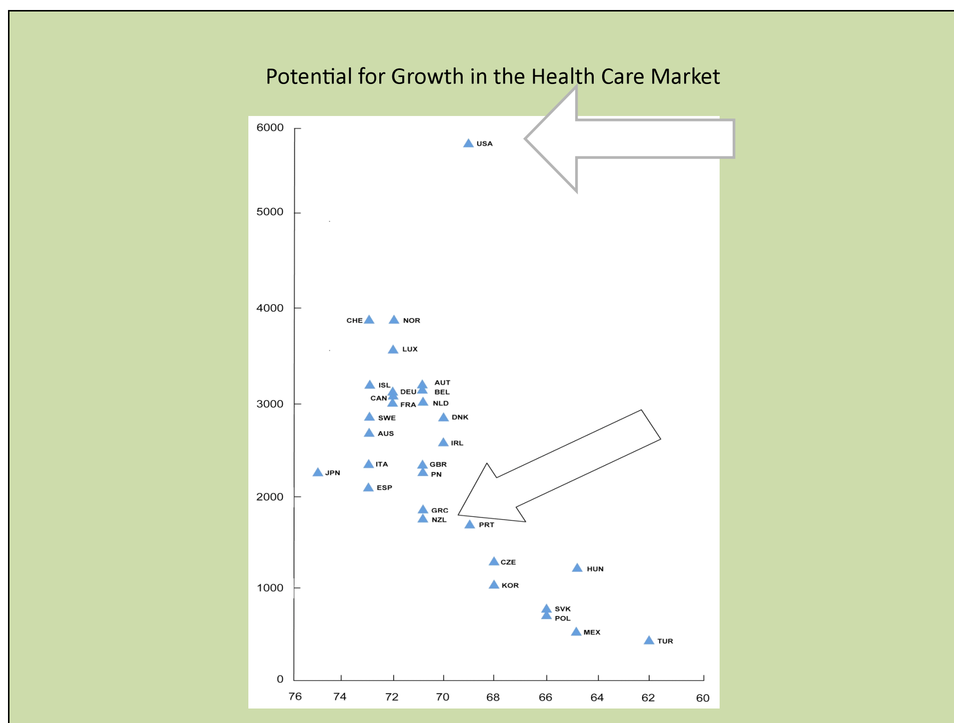
create a climate of concern that justifies a panicked response such as: *the sheer size and immediacy of this challenge* [the low cost of health care compared to other countries?] *suggests we need to move quickly on a number of fronts at once.*[12]

Many a general would be proud of such a clear and succinct instruction to his army! The enemy is everywhere, move quickly on all fronts!

In my view, the international comparisons are a cause for celebration not panic, and considered and appropriate action that explores the evidence for our successes and failures is required rather than “moving quickly on a number of fronts at once” in response to a non-existent crisis.

Unless of course you were viewing the problem from a different angle. Concerned about the gaping hole in the NZ health care market – a hole that you hoped with a bit less interference from the government some the private provider could fill. I refer to the untapped potential of the private healthcare market to sell medical goods, services and health insurance to the NZ consumer and government. The untapped potential to extend the private health sector, as has been so successfully done in the USA.

There are a number of parties with vested interests in the growth of the NZ healthcare market. One needs to look only at the efforts leading up to the last election to destabilise PHARMAC (over the Herceptin Issue) as evidence that constituency. Being an “efficient” buyer in the market is not favoured by monopolistic sellers such as the pharmaceutical industry.



[12] Ibid, p 12

The private sector plays an important and irreplaceable role in the New Zealand healthcare system – however it needs to operate within the government's stewardship otherwise it will works against societal goals of a fair health system for all New Zealanders. I am opposed to seeing the NZ healthcare sector taken down a track where you end up with very expensive care and very poor health outcomes – a position the USA now finds itself in and is struggling to reverse.

Given that NZ is not a basket case, what are the challenges?

There are major challenges that we face in the New Zealand health sector. These are the continuing challenge of health equity, and the challenge of caring for our young.

Health equity relates to differences in the health of different populations that are unfair and unjust. In the late 90s and early part of the 00s we focused, quite successfully on health inequalities. In retrospect, I think health equity would have been a better word to use as it brings attention to the fact that it is not the differences in the populations that is the issue, but the unfair and unjust nature of those differences.[13]

We did make good progress on these issues in the last ten years – beginning in the late 90s, Wyatt Creech as Minister of Health championed the approach of a common strategy to improve the performance of the health system for all New Zealanders to

- *build certainty and confidence in the security and stability of the New Zealand health and disability system*
- *give equity of health status to all New Zealanders*
- *maximise the benefits of early intervention, proper integration of services, health promotion, and involvement of communities in developing their own solutions to their health issues.*[14]

The approach to addressing health equity was internalised across the health system, with stunning results at the clinical as well as the population level.

New Zealand's leading role was recognised in the work of the Commission on the Social Determinants of Health[15] in its report to WHO that was approved by the world's health Ministers in May this year.

How do we find ourselves in 2009 with a review "Meeting the Challenge" that fails to emphasise that addressing health equity is a core purpose of our health system, unlike the

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[13] Martin Tobias; Tony Blakely; Don Matheson; Kumanan Rasanathan; June Atkinson, 2009 Changing trends in indigenous inequalities in mortality: lessons from New Zealand, International Journal of Epidemiology; doi: 10.1093/ije/dyp156

[14] Ministry of Health, 1999, The Government's Medium-Term Strategy for Health and Disability Support Services

[15] World Health Organization, 2008,Closing the gap in a generation: health equity through action on the social determinants of health, Final Report of the Commission on Social Determinants of Health, Geneva.

view taken a decade previously? Have we had enough "Equity" for now? This would repeat the mistake of the 90s where we elevated efficiency to a goal in the health system, instead of seeing efficiency as an ingredient to achieving real health sector goals such as equity and quality.

"Better, sooner, more convenient primary health care 'for all New Zealanders'" is an admirable goal, but if it really is about primary health care then we must place the emphasis on these questions:

- Better for whom?
- Sooner for whom?
- More convenient for whom?

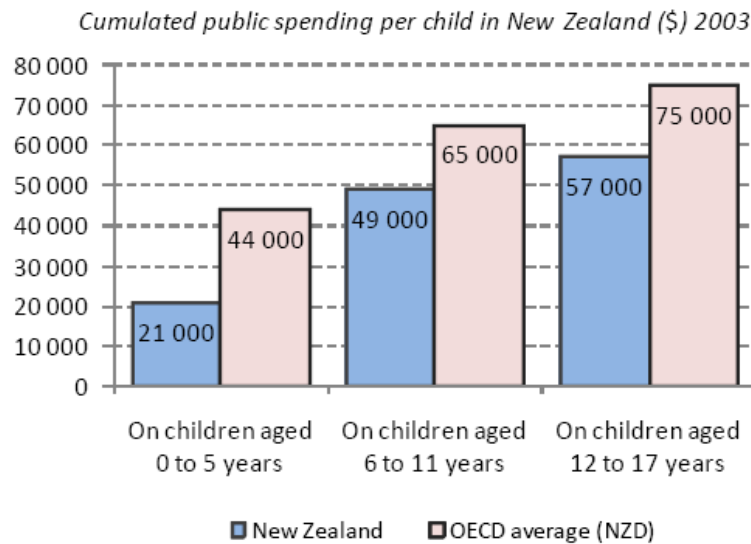
We already know that 6% of New Zealanders are unable to access PHC when they need it due to the level of fees charged alongside other access issues.[16] Is it going to be better, sooner, and more convenient for them?

One area that is a complete embarrassment in international terms is our support for children and young people. Our material support for children and young people is very low compared to OECD average, and although there has been some improvement, indicators such as teenage suicide remain unacceptably high.

www.oecd.org/els/social/childwellbeing 2009

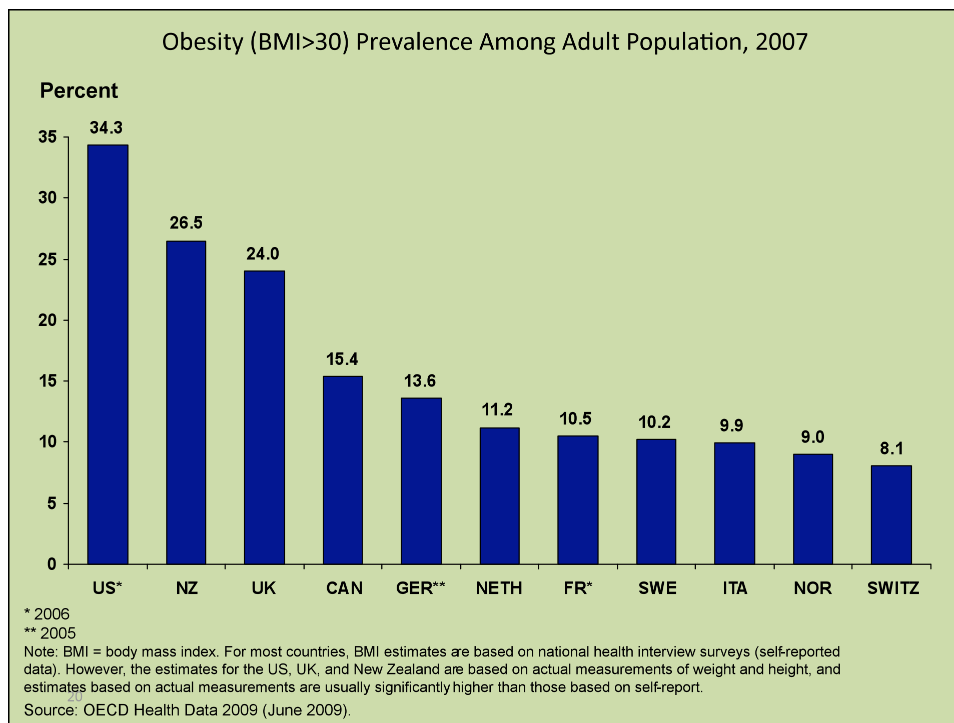
[16] Ministry of Health, 2008, A Portrait of Health – The 2006/07 New Zealand Health Survey

Early childhood spending in New Zealand is half of that spent in later stages, 2003

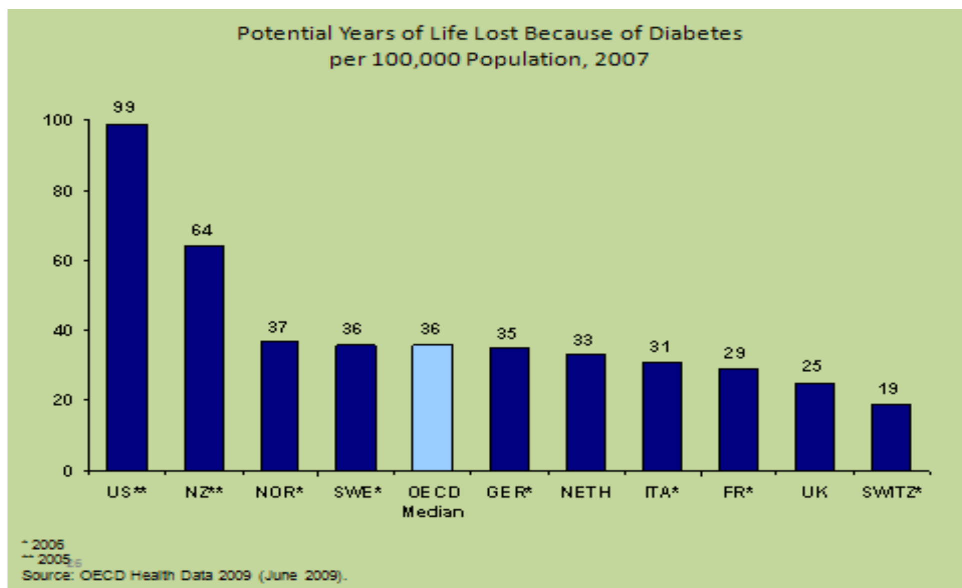


[www.oecd.org/els/social/childwellbeing 2009](http://www.oecd.org/els/social/childwellbeing)

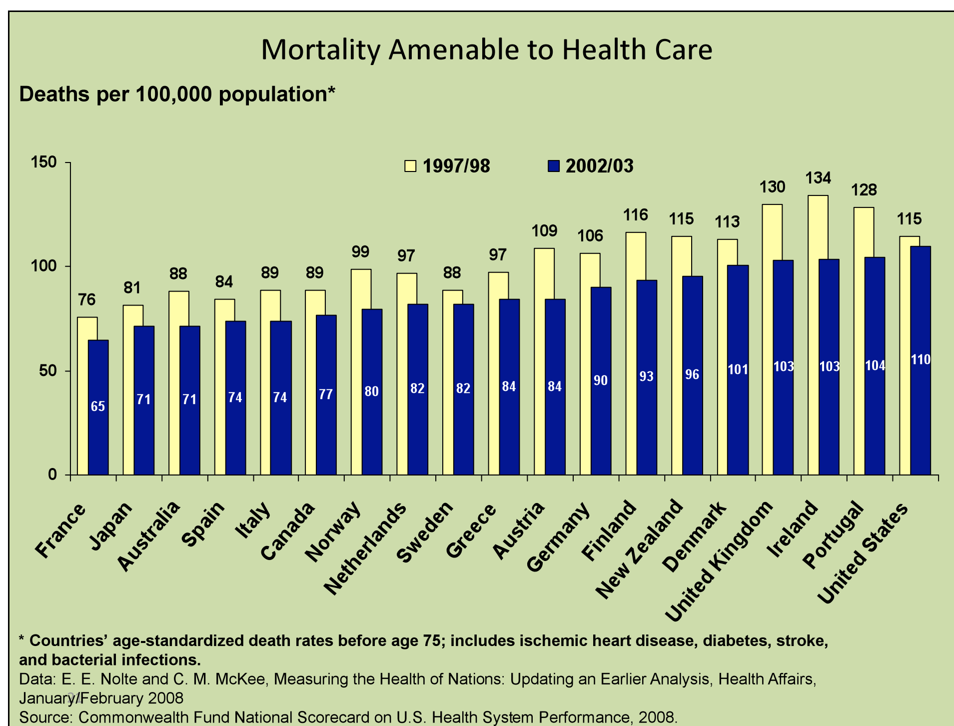
Then there are the issues of overweight and obesity. Clearly this is an issue that needs focused attention, and something a little more sophisticated than the current "nanny" vs "non nanny" debate. Our prevalence is second only to the USA:



And this contributes to a loss of human potential:



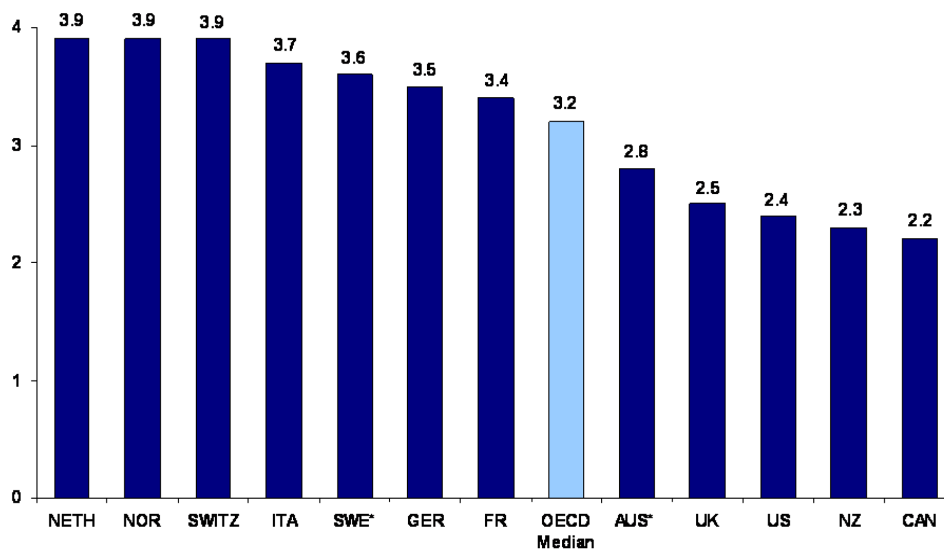
Much remains to be done by the NZ Healthcare system.



The graph above shows both the recent improvement (97 -03) in mortality of people aged less than 75 that is amenable to health care. It shows good progress, but also considerable potential (compared to France, Australia, Japan) to make further improvements through the healthcare system.

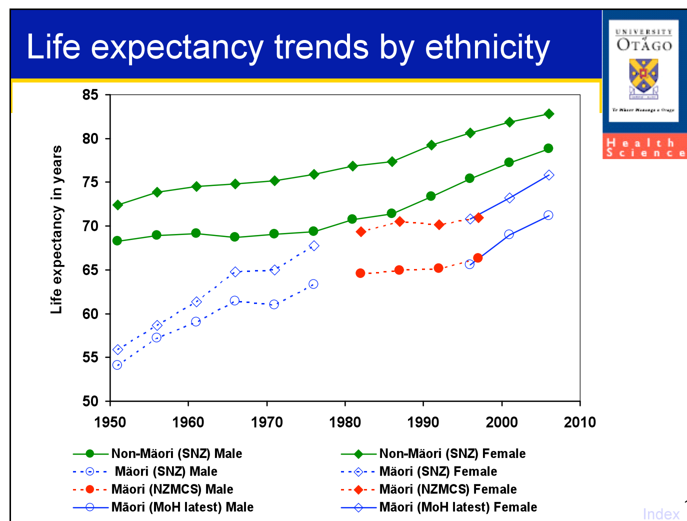
To tackle this task we need a workforce. And comparatively speaking, it is lean:

Number of Practicing Physicians per 1,000 Population, 2007:



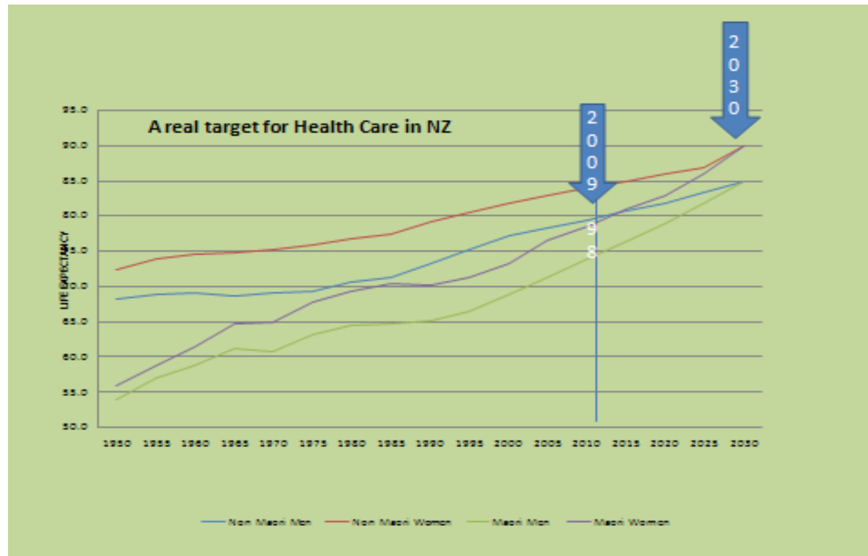
We have considerable potential to improve further, and already have a leaner workforce than others to do the job.

This graph shows the positive impact of the health system since 1950s in regard to ethnic inequalities, where we made great progress except from the late 80s to the late 90s.



So the NZ health system certainly does have its challenges – I suggest the focus on the human ones such as health equity and the welfare of our children and young people and chronic diseases such as diabetes would be a better focus for our activities rather than a focus only on the theoretical health expenditure in 2030. Then we can look at how we can

achieve these more efficiently. Health equity for all New Zealanders is an achievable goal by 2030 –and a lot more achievable than GDP equity with Australia.



After all what is our “brand” as a nation? What makes us attractive? Clean Green? Internationally, a nation that values equity is attractive – most don’t. Healthier young people boost productivity. Less chronic disease has a protective effect on social spending and increases productivity. In fact all these features have been shown to positively impact on economic growth.

The folly of health system structural change

The Cabinet response to the Horn Report has been reassuring. They have avoided the key recommendation for major structural change, and noted that structural change takes some years to be effective (which makes even more remarkable the achievements of the New Zealand health sector given re-structuring paralysis for most of that time).

Expanding the role of Pharmac, consolidation and focusing on health professional workforce and quality activities are sensible actions to take, provided (and this is the major concern) that health equity is a major goal and quality is not seen as divorced from equity.

Restructuring is a classic folly that health systems engage in. Follies are those useless but intriguing monuments that people build without reason. Structural change and restructuring health systems has a class of follies all to itself. Its evidence base for effectiveness is increasingly thin, and it is now so common that there is even helpful advice to clinicians about how to “restructure proof” their work[17] – by doing such novel things as using evidence, involving patients, and listening to junior colleagues.

[17] Braithwaite J How to restructure-proof your health service. BMJ 2007;335:99 (14 July), doi:10.1136/bmj.39272.443137.59

Having been spared from creating a new HFA, we need to be mindful of the downside of other structural moves such as mergers, (which put UK PHCTs back 18 months). As noted in the UK this has shown that

The gains in efficiency sought through restructuring are elusive at best, and reorganising twice in a six year period created the opposite, with inefficiencies resulting. ... Continuously rearranging things exacerbates this, creating bewilderment and even incredulity.[18]

In other words, one of the best ways to send our workforce to Australia is to restructure the sector

So how should we approach change in a modern, complex health system? I suggest that the Cabinet approach, resisting the temptation to see the answers in structures, is a good one.

The New Zealand approach, popularised from the 90s, is to put out an EOI[19] and develop a business case. Although this may generate some good ideas, it is an inadequate process for developing system wide thinking and change. Responders go into a solitary huddle, desperately searching to regurgitate the 'in words' so that their application has resonance with some unseen committee. As Jeff said in his talk this morning, "We lack the spaces and places where people can renew hope and develop solutions."

The current move to support 'super PHOs' for instance, presents a number of serious risks as well as opportunities to the sector that should be openly discussed and debated. These mainly stem from the not-so-hidden agenda for these super PHOs to move over time to be budget holders.

- Budget holding by large PHOs may undermine the viability of rural and provincial DHBs. Particularly if there is "no extra money" – then the money will come from somewhere.

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[18] Fulop N, Protopsaltis G, Hutchings A, King A, Allen P, Normand C, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. BMJ 2002; 325:246-9. Other articles of interest relating to restructuring in the above reference:

Braithwaite J, Westbrook M, Hindle D, Iedema R, Black D. 2006 Does restructuring hospitals result in greater efficiency? An empirical test using diachronic data. *Health Serv Manage Res* 19:1-12.

Fulop N, Protopsaltis G, King A, Allen P, Hutchings A, Normand C., 2005, Changing organisations: a study of the context and processes of mergers of health care providers in England. *Soc Sci Med* 60:119-30.

Harvey D. Hospital games. *BMJ* 2000;321:713. McKinley W, Scherer A., 2000, Some unanticipated consequences of organizational restructuring. *Acad Manage Rev* 25:735-52.

Devlin N, Maynard A, Mays N., 2001, New Zealand's health sector reforms: back to the future? *BMJ* 322:1171-4.

Gaynor M, Vogt W. Competition among hospitals. *RAND J Econ* 2003;34:764-85.

Vaughan V., 2007, Primary care chiefs: a reorganisation too far. Health Serv J March 8. Oxman A, Sackett D, Chalmers I, Prescott T., 2005, A surrealistic meta-analysis of redisorganization theories. *J R Soc Med* 98:563-8. Smith J, Walshe K, Hunter D. J. 2001, The "redisorganisation" of the NHS. *BMJ* 323:1262-3.

[19] Ministry of Health, September 2009, Request for Expression of Interest (EOI) for the delivery of Better, Sooner, More Convenient Primary Health Care

- The move to budget holding will move control from a public institution (a DHB) to a private institution (a super PHO) and thus effectively removing the social barrier to user fees for secondary care, and potentially increasing the more inefficient forms of health care financing, out of pocket expenditure. In other words, more direct costs are pushed onto the consumer.

- Consolidation of funding streams (such as care plus, low cost access) appears amnesic about why these funding streams were introduced in the first place – i.e. that these activities were not occurring consistently and required greater incentives.

- Equity: the experience of budget holding in the late 90s demonstrated the highest rewards went to IPAs who covered the most expensive and erratic providers. This excludes providers of services to high need areas, who did not engage in budget holding, because they were thrifty to begin with, and hence missed out on the huge financial windfalls that it yielded.

WHO[20] in its recent report on systems thinking for health system strengthening gives advice on a simple schema for approaching health interventions:

- Convene stakeholders

- Collectively brainstorm

- Conceptualize effects

- Adapt and redesign

To that I would add, the need to be clear about the fundamental values to which the country aspires, such as health equity, prevention of illness and universal access to care. In addition, the need to critically assemble the real research evidence, and not 'spin' it to try and create a burning platform.

As noted by Gauld, New Zealand's political system is not geared towards gradual and careful consideration of policy and intervention. Instead each incoming government is compelled to launch itself into poorly scoped implementation. This system abusive cycle is repeating itself again, with the 'rationale' for the reforms being based on a highly erroneous OECD report[21], and an over-reliance on the latest developments in the National Health Service championed by visiting English academics.[22] [23] Their advice is fine, but the context of the NHS is very different from that of NZ, and we need solutions that reflect our context.

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[20] Systems thinking for health systems strengthening by Don de Savigny and Taghreed Adam

Alliance for Health Policy and Systems Research. IV.World Health Organization. ISBN 978 92 4 156389 5 (NLM)

[21] Matheson D. Our Minister has been mis-informed. (available from the author)

[22] Judith Smith and Jacqueline Cummings, 2009, Taking the Temperature of Primary Health Organisations: A Briefing Paper, Victoria University of Wellington, www.victoria.ac.nz/hsrc/reports/Taking the Temperature.pdf Accessed 7 December 2009

[23] Nicholas Mays and Gary Blick, 2008, How Can Primary Health Care Contribute Better to Health System Sustainability?: A Treasury Perspective

In the current process, we are failing again (as we did in the early 90s and the early 00s[24]) to effectively engage with the full intellectual and emotional capital that we can apply to improving health care. The 'thinking' and innovation is about to be largely confined to a small group of PHO managers, largely remnants of the IPAs of the 90s, and the chance to involve clinicians, patients, and researchers in the wider creative process about the future direction of the system may be lost. This is further complicated by the frame of reference for this thinking being extremely narrow, the timeframe short, and the goal reduced to their impact on some far-flung economic marker.

However it is this third step of the WHO framework, to "conceptualise effects" where we most often fail – we do not collectively discuss the likely effects of system change, preferring to infer the impact on preconceived ideological positions rather than examine the real evidence of the performance of the system across disciplines as diverse as clinical medicine, economics and public health.

So taking the above discussion, our approach should be that of a top global performer, looking to see how we can keep ahead of the field at the next Olympics. Mindful of the fact that our current ranking has been due to the way all the parts of the system have cooperated, rather than the simplistic logic of what is politically hot or cold at this political micro moment, such as:

Big or small is good or bad, Ministry of Health is bad, back room function consolidation is good, DHBs are bad, big PHOs are good, too much PHC and PH is bad, more spending on hospitals is good, bureaucracy is bad, front line is good (except when it has to be bureaucratic then it is bad.)

The role of the health professionals is crucial in this. As Julian Le Grand[25] notes, we have the potential to act as both knaves and knights. As government employees, as knights, honourably committed to the public good, or as knaves, interested only in personal gain? Our voice and views, both knaves and knights, have largely brought us to where we are today. It is important that issues are fully explored from a systems perspective and consideration of the impacts on all parts of the system, without falling into the simplistic slogans mentioned above. You are inside the system – you know it intimately. The power is partially in your hands to take it forward – but not alone, not as a knave.

Dynamic networks are required that cross stakeholder groups and inspire new knowledge and innovation. Progress must be informed and supported by more system-wide planning, evaluation and research, and its credibility continuously checked with the real experience of our patients.

On the global scene, speaking broader than health, the last three decades have seen the abandonment of that search for a holistic balance, and imagination has been replaced with a

[24] R Gould, 2008, The Unintended Consequences of New Zealand's Primary Health Care Reforms Journal of Health Politics, Policy and Law 33(1):93-115; DOI:10.1215/03616878-2007-048

25 Julian Le Grand, 2003, Motivation, Agency and Public Policy: Of Knights and Knaves,Pawns and Queens Oxford University Press, New York, ISBN: 0-19-926699-9

sort of delusional certainty based on the belief surrounding an economic theory.[26] As John Ralston Saul says in his book *The Collapse of Globalism*:

Globalists have often stated that their ideology is not an ideology at all, but an expression of the inevitable and unstoppable forces of technology and international market forces. Any attempt to claim inevitability for an economic theory is just a pseudo scientific version of the old 'God is on my side' argument.

Even the movement's supreme leader has been at a loss to explain why self-interested bankers collapsed the global system: "I still don't fully understand why it happened," said Alan Greenspan, former chair of US Federal Reserve Board, as the USA's financial bedrock collapsed.[27] Maybe the answer is not to be found only through the lens of an economist.

We should take advantage of this period in human history where the market "emperor" can now be seen without even a jockstrap, and as we are a leader in global health systems see if we cannot forge a new direction for health, one built on the understanding of the complexity of the system, the complexity of the lives of the people we treat, the importance of our shared cultural values, the intimate relationship with the planet on which we live...and not fall again into the trap of following failed narrow neoliberal economic logic.

The pursuit of equity is core of this new direction, to quote Nelson Mandela:

Massive poverty and obscene inequality are such terrible scourges of our times – they have to rank alongside slavery and apartheid as social evils. ... Overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life."[28]

Clinicians can and must play a fundamental role in taking forward the health system of this country. I leave you with the words of Virchow:

Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them.[29]

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[26] John Ralston Saul,2009, *The Collapse of Globalism*, Atlantic Books, Great Britain

[27] Alan Greenspan, 23 October 2008, reported in ttp://www.docudharma.com/diary/9901/ accessed 7December 2009

[28] Nelson Mandela, 3 February 2005, public address in Trafalgar Square during the G7 finance ministers' meeting, London, England

[29] Laszlo, E, Jong You You, Pauling, L, (eds) 1986, The World Encyclopedia of Peace, Volume III, p.362