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EDITORIAL OPEN ACCESS

Future of Healthcare

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Abstract

In the current editorial, I delineate the factors that must constitute a recipient rights-based health care system, at least a future health care system. As a reflection on what transpired in the two years of the pandemic, the considerations offered are to assist in rebuilding a realistic allied health care perspective that would not only meet the demands of the future but is able to cope should some other crisis-hit humanity. The conception here calls for more dominant roles for human services professionals involved in social care from various persuasions, such as social work, psychology and several other disciplines that are sector-specific to children and the frail aged.

Keywords: Future of Health Care; Pandemic 24 months; Recipient Rights in Healthcare

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Introduction

Across the world, the human populations seem to uphold the belief that the doctor is responsible for their health. This notion is widespread in all cultures across the world. Here, I outline the components that must exist in a future health care system that meets the recipient's needs, understood as rights. While amazing diversification and over-specialisation seem to be the way with disease diagnosis and treatment, there is not much communication with the recipient of health. We seem to be living in a world of super specialities. Recipients are made to run around from one shop front to the other and one specialist to the other. Upon reflection, I see that a General Practitioner (GP) in Australia is expected to know in a general way a lot about what seems to occur in specialities. Most recipients these days are concerned about reading a bit about their conditions - via the worldwide internet.

Additionally, through word of mouth and their friend's recommendations and previous experience, they too have a few names of specialists that they wish to possibly be considered. They visit the GP and ask if they could be referred to any of them. Most often, such requests are obliged too. It is here the world has changed. Take cardiologists at the basic level; they are termed according to what they do—invasive, non-invasive, and interventional cardiologists. Most recently, a friend of mine had to go through a nuclear cardiologist, an Echocardiograph-specialising in Cardiology Practice (I mean premises or facility), and he is now expected to go to another specialist known as Cardiac Electrophysiological Specialists (who fixes electricals and possibly recommends consideration of pacemakers). In a helpful way, we both began reading and quickly learned that there is ample knowledge on preventive cardiology. I wonder why we do not have more preventive cardiologists then? Is it because prevention is cheaper and non-lucrative? Even the most knowledgeable recipient is lost in this maze, and if he has no insurance, he is damned for good. Respect for life and trust became casualties in the pandemic. Let me now look at preventative health. GPs are becoming increasingly aware of the need to intervene early and assess risk, and they want to do so. However, they are struggling with the weight of dealing with established illnesses or established risk conditions, and they have limited ability to carry out the screening and prevention work that needs to go in this direction. The concept of prevention is securely established neither in the receptors' minds nor in the caregiving health system. Hence you could not go for a conversation on prevention. This is something that I seldom see. The elderly and the frail aged have come through the system and seem to be treated for the face of natural degeneration that life years set in. But with the younger age groups, there is no reason why we need to let them become patients. The entire public health system in many nations is crumbling. I am sure there have been improvements, but it appeared to me that social and structural obstacles prevent those improvements from being fully realised. There is also ample disregard for the natural and alternative forms of medical advice and treatment, such as natural medicine and Ayurveda.

Learning from the Pandemic

Two years after the anniversary of the Covid-19, I believe that all centralised approaches, from the state, alongside the failure of the World Health Organisation (WHO) as a world ombudsman in public health monitoring, are writ large. I am more convinced than ever that each country and its culture must look to its own resources as to what exists and what does not and stitch up its systems (Fullan, 2020). No fiction was written in the last two years; instead, it was our true story, our biography of the world where a virus was released, and then vaccine followed. Some of us were tested similar to the guinea pigs and the mice in the laboratories. Our brethren humans died by scores and thousands (see, World Health Organization, n.d.; Dodsworth, 2021). Pharmaceuticals and corporations released their sad research results

only after hordes of FOI (Freedom of Information) requests and court orders. What kind of a world are we living in? lack of equipment comparable to war situations in hospitals where compassionate people died to save others' lives (see, Ho et al., 2022). So much gagging by mainstream media, and the official corporation amidst the natural decay of the public systems, is what we can write as our biography. What a patient wanted to know was and is always the truth. And that is precisely what we did not tell in public health.

Need I reiterate that we actually killed a lot of our frail aged in the nursing homes by not visiting even on a Mother's or Father's Day.

Constituents of a Good Health System

I wish to delve into what would be the constituents of a good health system from a consumer perspective. I think ease of access, information to discern in a world full of competing information, and timely response are important, but I think the following are very primary to good and effective health care:

- Examining all citizens and non-citizens periodically for potential diseases, such as high blood pressure and diabetes.
- For example, investigate potential future health problems, such as high cholesterol and obesity.
- More often discussing the use of alcohol as well as safe drinking practices, with a view to offer advice on how to give up smoking etc. at workplaces, community settings and even in Trafalgar square in London or A railway Station in India. if you can have a preacher holding a bible going through a full stream of his voice to convert someone at every busy nook and corner, why not a raised platform or a pulpit for preventive public health?
- The system must encourage a healthy lifestyle by promoting healthy eating as well as physical activity.
- Last but not least, the pharmaceuticals and corporations must make and trade fundamental vaccinations, and only when absolutely necessary.

A reversal of "the doctor is responsible for my health" might not happen overnight. The governments too had orchestrated the same feeling when they were doing more of the health services as part of the public systems; now, with the dwindling size and capacity of the dollar, the whole philosophy requires radical change.

The patient/ consumer attitude is wired to believe that all we require are doctors, that doctors will heal us, and that hospitals and doctors will keep us alive. And that is shocking as many that had four jabs of covid vaccine too died, or several intermediate ones were maimed for life.

Conclusion

I have no idea where the world's best health care systems are, but what I have heard about them being in places like Korea and Denmark, etc. But this much, I am confident that future health care ought to refer to a whole range of opportunities for preventing illness, injury, disease, and mental health.

I do not expect the access to medical treatment to be uniform across nations, as demonstrated by vaccine nationalism during Covid-19 (see, Pulla, 2020) and the naked disregard for the demographics of countries within the continent of Africa.

Like most of us, I believe that having access to medical care should be a fundamental human right. But what rights are we talking about? When countries have been asked to bow down before pharmaceutical companies, and people have no access to stable, easily navigable, and cost-effective healthcare at all? We witnessed during the pandemic pig-headed pharmaceutical companies like Pfizer, and their attempts to mortgage many nations, with their culture, pride, and lifelines. No one can predict if such coercion will return in the near future as the state of world health continues to battle at the intersections of race, economics, and poverty.

The crucial element in all these is where we expect the future responsibility for public health to reside? The state? I doubt we will be states and nations anymore in future. What use is citizenship in countries with limited government

and limited welfare, and the countries are controlled by Mafiosi like corporations that are not necessarily about welfare?

I see a need for the care process (preventative care measures, safe care, coordinated care, and engagement and patient preferences), access (affordability and timeliness), administrative efficiency, equity, and healthcare outcomes, to be part of the universal health care— and this cannot be contributed unless we have a coordinated response of all integers including those who need health, that is, the citizens of any nation. Access and equity seem to be important elements, but at the moment, they are still empty words for many worldwide. Most futurologists know what is happening with corporations and pharmaceuticals. I envisage and see a diminishing role of the state in health; I will also be curious to see what use would global instruments like WHO be? The ugly proliferation and expansion of these organisations are counterproductive to the culture of self-regulation and compliance mechanisms that could build efficiencies in the corporate merchandising of health. Their mutual competition to gain more coverage will see some standards coming into place anyway.

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