



Tidsskriftet
DEN NORSKE LEGEFORENING

Equality in treatment of mental disorders

LEDER

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Good registry data are required to ensure that the treatment you receive will not be dependent on where you live.

Modern psychiatric treatment should be based on solid scientific evidence and laid down in national and international guidelines (1). Equality in service provision is incompatible with large variations in treatment depending on the patient's place of residence. While there is a great deal of documentation regarding variation in treatment practices in somatic medicine (2–4), we have less knowledge of this in mental health care (5, 6). It is therefore commendable that Schou and colleagues now present a study of regional variations in prescribing practices for the antipsychotic drug clozapine (7).

Clozapine is recommended for patients with treatment-resistant schizophrenia, defined as non-response to trials of at least two other antipsychotic drugs (8). There is international consensus about the guidelines, and the evidence base for the use of clozapine is considered to be very good. Schou and colleagues find, however, large geographical variations in its use. The prescribing rate per 100 000 inhabitants was twice as high for patients resident in Troms county as in Akershus county, and this variation did not correlate with the proportion of the population being treated for schizophrenia in the respective counties (7). It is difficult to determine exactly what an appropriate level of prescribing should be, but the degree of variation indicates that patients with severe illness are not receiving optimal treatment.

In 2015, Northern Norway and Western Norway Health Authorities were charged by the Ministry of Health and Care Services with developing a national health atlas in collaboration with the Directorate of Health. A health atlas is a tool to ensure that the population is provided with appropriate health services. The health enterprises' responsibility to ensure service availability lies at the root of the analyses in the health atlases, and unwarranted variation in treatment practices may mean that this responsibility

is being insufficiently attended to (4).

Pending more effective access to data, immediate establishment of a registry for psychiatry and addiction disorders is required

The health atlases have helped identify considerable geographical variations that cannot be explained by variations in the severity of the disease or patient preferences, but rather by local variations in clinical practices (9). This phenomenon is referred to as unwarranted variation and has been recognised for many years, internationally as well as in Norway (2, 3). It has nevertheless proven difficult to understand or explain the underlying causes of such large variations in practices. Therefore, it is also difficult to implement effective measures to reduce these unwanted variations (3).

Good-quality registry data in Norway permit us to follow patients over time and across treatment institutions. By analysing such data we can better understand and explain how practices vary around the country and elucidate possible associations between clinical practices and the patients' health. We can also link to data outside the health sector to see how patient characteristics affect the treatment. Such knowledge is necessary for the design of interventions to ensure more equality in service provision.

Privacy concerns are not the main reason why such analyses of individual data are rarely undertaken in Norway. The reason tends rather to be of a practical nature. The casework is time-consuming, and all the small differences between the regulations for each registry are difficult to navigate. Fortunately, processes have been initiated to improve the situation. A new health registry act containing many good proposals for change is now the subject of a consultation round, and there are high expectations for the health analysis platform, once it has been put in place.

Pending more effective access to data, immediate establishment of a registry for psychiatry and addiction disorders is required, as proposed by the government in 2016 (10). It will contain information from the primary and specialist health services, the Prescription Database, the Causes of Death Registry and the Population Register, and will be able to provide sufficient data for production of statistics and health analyses, as well as for research relevant for quality improvement of the health services and contingency planning. The registry will also be important to stimulate clinical debate within Norwegian psychiatry and provide it with a more empirically based foundation. In this regard, the article by Schou and colleagues represents a key contribution to the debate on how we can ensure equality in service provision to patients, irrespective of where in Norway they live.

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Published: 23 September 2019. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.19.0545

Received 27.8.2019, accepted 2.9.2019.

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