Pitfalls for the health services

The health services in Norway of today, with their generally high quality, relatively low patient charges and hospitalisations that are free of charge, have not come about by themselves. No law of nature would indicate such a development. This edifice rests on two pillars: humanism and natural science. Where do we go from here?

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Against all «laws of nature», or more precisely, against the «inverse care law» (1), in this country we have succeeded in developing public, solidarity-based and fair health services for the entire population (2). In former times, health services were, as a rule, reserved for those who could pay. In other parts of the world, this remains the grim reality. Even in the USA, one of the richest countries in the world, the struggle for decent, solidarity-based health services has not yet been won (3). In our country, the quality of patient treatment is generally high, as demonstrated by, for example, cancer survival statistics (4). The basis of medicine in the natural sciences has helped bring about continuous improvement through research, self-critical analyses, development of new hypotheses and testing of the results.

Nevertheless, our health services are facing challenges and threats. Some of these pertain to the governance ideology to be applied (5). There are several pitfalls that need to be avoided if we are to succeed in maintaining and developing the key values of today's services. We need to avoid unfair distribution, dilution of the value base, failure of trust, erroneous priorities, overconsumption and insufficient patient co-determination.

Unfair distribution

The public health services that we have developed in Norway are often regarded as the most civilised and modern way to organise such services (6). Historians tend to agree that a main impetus for the development of public welfare has come from an influential labour movement that succeeded in achieving real power and putting its visions for a more equitable society on the agenda (7). It is easy to take today's organisation for granted. The superiority of the welfare model is internationally renowned, but there are development trends indicating that it might be at risk.

The UK has also enjoyed high-quality, tax-financed health services (the National Health Service) (8). But a crisis is looming. The health services are in a process of disintegration, despite widespread opposition from professionals (9). The events in the UK are a prime example of how even well-established public health systems can run up against the power of the market and the temptations of privatisation (10).

The only guarantee for decent health services for all is that everybody is treated equally (11). In Norway, there is considerable pressure for the establishment of more private services, with related private health insurance policies. Since health services always are and always will remain a scarce commodity (12), private health services will drain resources from the public ones through several mechanisms. The public sector is drained of resources in the form of health personnel, funding from the Norwegian Labour and Welfare Administration, the healthiest patients with the best prognosis and educational resources (fewer persons must educate more candidates), as well as confidence among the population. Confidence in public services is reduced, because the organisation and operation of private health services are simplified when the healthiest patients are selected, and resources can be devoted to marketing. Collective solutions must be sufficiently attractive to persuade people that they are best served by them. The moment that a majority feels the need to look around for private options, the willingness to pay taxes is reduced – and the schemes collapse (13). Very soon, we will end up with an unfair, two-tiered healthcare system.

Dilution of values and decreasing trust

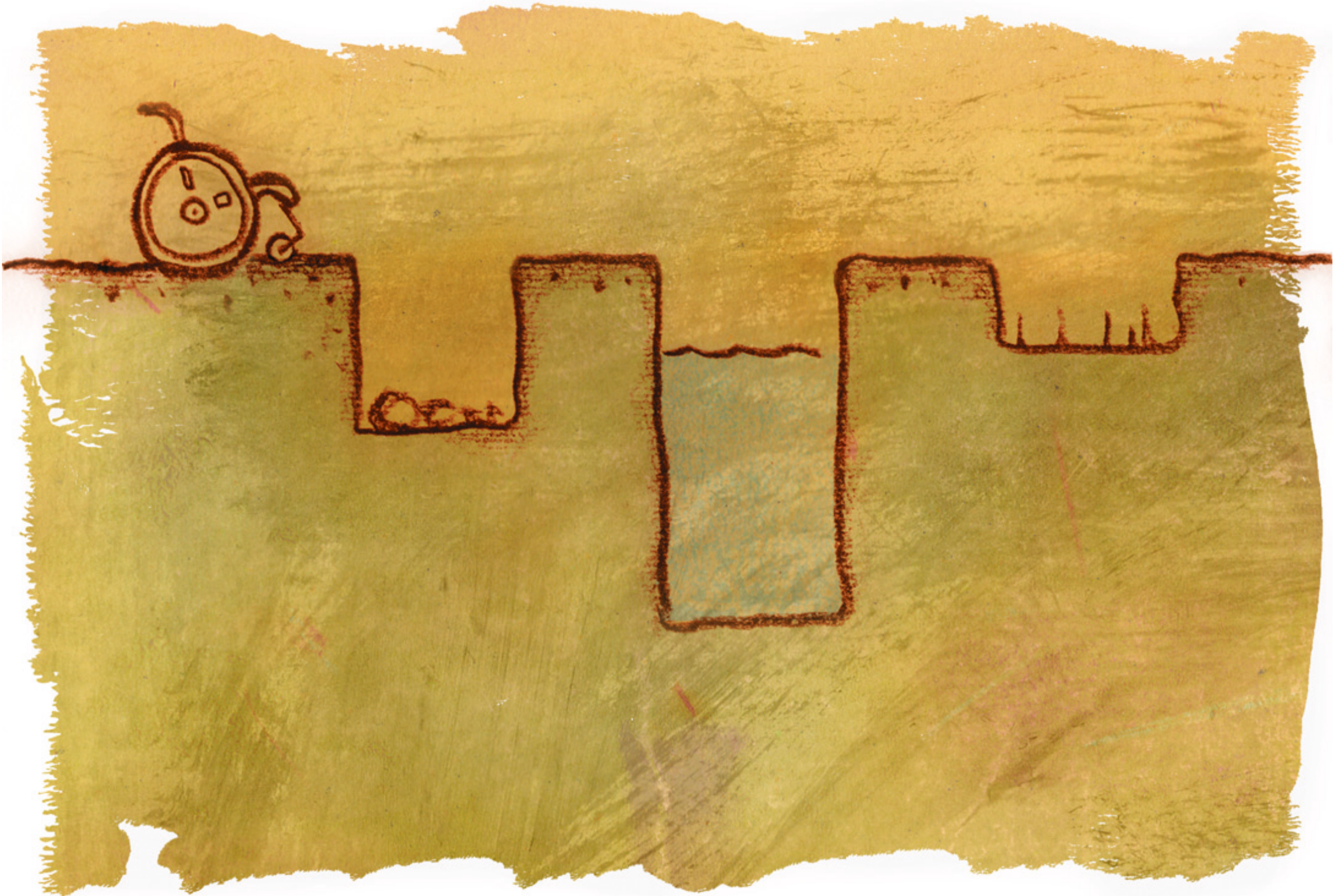
In trade and industry, market solutions function well in many ways. However, insufficient regulation sometimes gives rise to an uncomfortably high degree of social, financial and health inequality (14). Many cherish the idea that market solutions will have positive effects on the health services as well. Some of these ideas lay at the root of the Norwegian hospital reform in 2002 (15), and are currently at the root of the present reforms in the UK (10).

Market mechanisms function poorly in the health services for several reasons. One of them is that the market and the health services have completely different rules of the game and very different value systems. If a health service changes from being an act based on the desire to provide help into an act based on a desire to earn more money, the value base erodes (2, 11). A shift will take place from an arena where one can expect empathy and care, to an arena where doctors increasingly turn into salesmen who compete for «customers». Trust erodes, because the patient feels uncertain about the motivation behind the supply of services. The relationship between the doctor and the patient deteriorates. The treatment effect is weakened, because placebo is replaced by nocebo. Costs increase, because all this leads to increasing supply, increasing demand and an increasing need for quality control by public authorities (12, 16, 17).

Erroneous priorities and overconsumption

When seen in light of objective measures of health, John E. Wennberg's analyses of regional inequalities in health services demonstrate where there is room for cost reductions and priorities in the health services (17). Wennberg categorises health services in three groups.

The first category is referred to as *efficient and necessary health services*. These are health services the benefits of which nobody questions, not in the medical community, nor among politicians or the population in general. Examples of such services include emergency medicine for traumas, antibiotic treatment of serious infections and vaccination programmes. The main challenge facing such treatments consists in avoiding unfair social and geographical distribution of the provision of services (18, 19). In the public debate on health services, there appears to be a widespread misconception that all medical treatment constitutes necessary health services. In reality, this category may account for only one-fifth of all health services in Norway. I base this assumption on Wennberg's studies in the USA, which showed that this



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category accounted for only 15 % of the total consumption of health services (17).

Wennberg refers to the second category as *preference-sensitive health services*. These are health services where there are two or more options for the interventions that can be carried out (17). Examples include prosthetic surgery for arthrosis, treatment of mild hypertension, check-ups by a specialist, numerous examinations and screening programmes. The main challenge involved in these types of services is that their use is excessively dependent on the doctors' own experience, to a varying extent on a knowledge basis and to an insufficient extent on the patient's preferences (17).

The problems are associated with major variations in practice and an absence of evaluation of treatment results (20). The patients are too little involved in making real choices, even though methods for patient co-determination have been developed (17). Studies indicate that if patients are able to make an informed choice, many will decline an offer of costly treatment and choose simpler solutions (17). Herein, there is most likely a potential for cost savings in Norwegian health service provision (20). Wennberg showed that this category accounted for 25 % of the total consumption of health services in the USA (17).

Wennberg refers to his third category as *supply-sensitive health services*. This does not refer to specific forms of treatment or services like those above, but describes services that vary in extent due to variations in availability. Examples of such services include numerous consultations with specialists (21), hospitalisations (22), treatments by physiotherapists and chiropractors, and the alternative-medicine business. The main challenge for such services is that their extent varies considerably according to available supply, without having an appreciable effect in terms of better health or lower mortality in the population (17). This often entails higher costs, more unnecessary adverse effects (20, 23), less transparent health services and less patient satisfaction (17).

We need more knowledge on what would constitute a sensible extent of health service provision, and a far higher awareness among professionals and health policy makers about the relationship between supply and demand. What we do not need is an increasing range of health service options in an open health market. This will mean higher costs and more treatment-related injuries (20). Supply-sensitive health services may account for more than half of all Norwegian health services. Herein lies a likely potential for cost reductions and thus more latitude for reconsideration of priorities.

In other words, the challenge of erroneous priorities and overconsumption in the health services consists in prioritising and distributing necessary health services in an equitable manner, raising the quality of, and reducing the scope of, preference-sensitive services and regulating supply-sensitive health services to a level which can be documented as sensible. This is a major challenge for the medical profession. If we fail to meet it ourselves, others will attempt to do so using less scientific methods (5).

Empathy and patient co-determination

The key skills of health personnel, their capacity for empathy and for giving priority to the needs of patients, must be protected and nurtured. This empathy can be threatened by several factors: finances, technology, narcissism and insufficient training. The first of these threats is associated with the development of market solutions in the health services and the dilution of core values.

It is a challenging job to continuously encounter people who suffer from serious health disorders or who are afraid that they may have a serious or terminal disease. If the doctors have failed to develop appropriate attitudes or skills to handle this challenge, numerous psychological mechanisms to avoid the most important tasks may set in. In today's health services, the use of technology and ordering more advanced examinations is one such mechanism.

Narcissism is a concept of behaviour associated with the self-image of an individual in relation to the environment. Differences in power and knowledge between the doctor and the patient may give rise to ideas in the doctors that they are best capable of making choices on the patient's behalf. Treatment may be offered without any consultation with the patient. Many patients feel obligated to accept whatever is offered, even though they would have preferred a simpler solution if given an informed choice. A paradox that underscores this point is that doctors often choose simpler solutions for themselves than what they offer in terms of treatment to their patients (24).

A fourth reason for a lack of empathy among health personnel could be that this topic receives insufficient attention during recruitment, training and supervision. Several features of modern health service provision may thus threaten the capacity for empathy among health workers.

Knowledge basis

There is ample documentation in favour of perpetuating the main features of Norwegian health service provision: A shared, solidarity-based, tax-financed health system based on humanism and natural science. Avoiding the pitfalls will be a main task for all those who are responsible for our health services.

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The author has completed the ICMJE form and declares no conflicts of interest.

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Received 30 April 2013, first revision submitted 13 May 2013, approved 21 May 2013. Medical editor: Hanne Støre Valeur.