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A steady course in health policy

ARE BREAN

Are Brean (born 1965), Editor-in-Chief of the Journal of the Norwegian Medical Association. He is an MD, PhD and specialist in neurology.

The direction of Norwegian health policy will change little, irrespective of the outcome of the general elections. It is only then that the main health-policy job will start.

Photo: Einar Nilsen

The 2017 general elections seem set to remain a cliff-hanger to the end. In many areas, the outcome will make a difference for practical policy. When it comes to health, however, the differences between the political parties appear to be constantly shrinking. In a close reading of the party programmes you almost need a surgical microscope to detect any nuances in their health policies.

Since the Conservatives changed their mind about the future of the health trusts, the health-policy unanimity with Labour seems almost conspicuous. Their views on the scheme for free choice of treatment seems to account for the greatest difference between the health policies of the two parties. Until today, close to 4 000 patients have made use of this scheme (1). In light of nearly seven million patient contacts in the somatic specialist health services alone (2), this scheme has virtually only symbolic value.

The Health Party, which is the boldest – and strangest – element in the health-policy arena, constitutes an exception to this unanimity. Although well-intentioned, the demands they have included in their political platform are occasionally rather bizarre, such as 'all those who want it shall receive treatment', and that specific, controversial and poorly documented therapies should receive full public funding (3). In a situation where antimicrobial resistance causes 25 000 deaths each year in Europe alone (4), it is also hard to take seriously a 'health party' with top parliamentary candidates who have lost their authorisation because of irresponsible practices involving extensive prescribing of antibiotics (5).

Irrespective of the colour of the new government, the next parliamentary period will not usher in any fundamental changes to Norwegian health policy. This will make it even more interesting to hear what today's health services look like from some of those who wear the white coats. We in the Journal of the Norwegian Medical Association have therefore asked doctors to provide their different perspectives and diagnoses of the state of the health services at election campaign time. In total, these 15 articles paint a sombre picture of the trends in the health services and of the lack of willingness to find political solutions. Many of the contributions make it look as though an elite of non-elected bureaucrats have usurped the position of the politicians as well as the experts, as described also by Rune Slagstad in a previous article in the Journal of the Norwegian Medical Association (6). This postulates that the health bureaucrats are the real decision-makers – with no democratic accountability.

The regular GP scheme and the health enterprise reform can be seen as a giant privatisation drive, as pointed out by Elisabeth Swensen (7). When the patient comes with a price tag and efficiency is measured in the number of patients, the road lies open to commercial, private provision of services. Swensen's point can be taken even further than she does herself: the cyclopic counting of patient contacts rewards hospitals and GPs who have the largest number of their local inhabitants as patients. Moreover, the more frequently they appear as patients, the higher the reward. The maximum amount of poor health is rewarded, while the health services aim for the opposite – the best possible health. Proper debate about such issues, about goals and means in the health services, has been virtually absent in the election campaign.

Nor has global health been on the agenda. However, Norway's health is also global health (8). Universal health coverage – the principle that everybody should have the same access to health services – is one of the great global health challenges: 'Leaving no one behind', as stated in one of the United Nations' 17 sustainability goals (8). We are used to thinking that such challenges belong to poor countries. However, in Norway as well as in many other wealthy, democratic countries we can see a trend that may distance us from this principle. Impoverishment of public health services is a trend in many Western countries (9). This paves the way for more inequality – and for health services where your wallet decides your opportunities for effective health assistance.

In Norway, a recent debate has focused on private purchases of cancer drugs. The use of private health insurance is also increasing sharply (10). In a recent Gallup survey, altogether 61 % were of the opinion that we already have a two-tiered health service, and only 34 % felt confident that they would receive the best cancer drugs should they need cancer therapy in a public Norwegian hospital (11). The figures reveal an incipient loss of confidence in public health services. This should be a cause of concern for all of us.

There is much to indicate that funding systems and forms of organisation both help set the health services on a steady course towards a two-tiered system and more inequality. The 2017 general election campaign revealed no political willingness for a change of direction. The main health-policy job will therefore start only after the elections. Then we will have another four years to persuade the politicians to take health inequality seriously.

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