

Our healthcare service must of course be evidence-based. But if it is not also confidence-based, we may lose a public health service with equal access for all

Confidence-based medicine

Some of my best friends and brightest colleagues are associated with the Center for Health Policy at Stanford University, which I visit each year. The milieu is a very varied one, in terms of both disciplines and age. There are talented young research assistants in their 20s, with impressively wide-ranging knowledge, and engaged emeritus professors who continue to challenge the established order, such as economists Kenneth Arrow (aged 90) and Victor Fuchs (86) and statistician Ingram Olkin (87). Arrow wrote the article *Uncertainty and the welfare economics of medical care* in 1963 (1). It is a classic in the field of health economics, which I wrote about in an editorial in 2010 (2). He was awarded the Nobel Prize in economics in 1972. Fuchs wrote the book *Who shall live?* in 1974 (3). In many ways, its publication sparked off the debate on prioritisation. Both Fuchs and Arrow are still intensely involved in the discussion on how to get the best possible healthcare service. They contribute analyses and proposals, individually and together, not least on how to reform the American health system (4).

Olkin has been particularly concerned with developing statistical methods that make it possible to analyse data from a number of studies simultaneously in order to estimate true effect size – i.e. meta-analyses. He is regarded as the father of multivariate meta-analysis (5). In his twilight years – after turning 70! – he has taken a particular interest in how the research results of clinical trials are reported, and has contributed to the development of standardised reporting tools such as CONSORT, QUORUM and STROBE. This is of course closely related to the quality of the meta-analyses. Only if results are reported in a comparable manner is it possible to synthesise them so that they provide a reasonably correct basis for decision-making for the individual patient, the doctor and the community.

I acquired new insights – this year as in previous years. But not only in the way I had expected to. My most important insights came during everyday conversations over coffee or around the dinner table. And from the Norwegian general practitioners' discussion forum, Eyr.

As usual, there have been many different discussions on Eyr in recent months, but a recurring theme has been frustration and concern in connection with the advent of the Coordination Reform – frustration over unnecessary tasks and meetings, over being steam-rollered by the health authorities and to some extent by the specialist health service, and concern that the services laboriously built up by the primary health service risk being lost through a failure to see the overall picture. The primary doctors are now really beginning to experience what the hospital doctors have been experiencing for a good while: the assaults on professional autonomy and the mutual distrust between those who are in practice and those who administrate and decide the framework conditions.

One of the discussion threads has been about an article published in *Tidsskriftet* earlier this autumn – to the effect that primary doctors have varying referral practice (6). The authors of the article are concerned that such varying practice may be an obstacle to the overarching health policy objectives of equal health services. It is an important discussion. Unfortunately, however, subsequent media

headlines and discussion have tended to suggest that some doctors refer «too much» and others «too little». And the totally meaningless term «unnecessary hospitalisations» has come up again.

It is understandable that there is debate on referral practice. It is the most important element in the demand for specialist health services – far more important than technological advances and new diagnostic and treatment options, which are often mentioned. Because the great majority of patient visits take place in the primary health service, a minute change in referral practice has major consequences. Will there be more «correct» referral practice if the primary health service has more knowledge and more standardised guidelines?

Most of my Stanford colleagues are also practising doctors. You don't have to talk to them for very long before discovering that treatment and referral traditions in the US and in Norway are very different. What I regard as a sensible wait-and-see attitude may be perceived as almost irresponsible practice. The fact that they use more drugs, do more tests and refer far more often to the specialist health service is not because they are lacking in knowledge. Nor is it because they are pressurised by lawyers or insurance companies, as we sometimes imagine. They do it because they believe it to be professionally correct – in their system. At the same time, they are concerned about the cost explosion in the American healthcare system, not least because higher costs lead to widening inequalities and the exclusion of more and more people.

Following the discussions on Eyr from the other side of the Atlantic has made me proud – and a little afraid. Proud – because it is so obvious when one compares Norway and the USA that a professionally aware and wide-reaching primary health service is what has contributed most to keeping healthcare service expenses at a reasonable level, and hence ensured almost equal accessibility for everyone in Norway. And afraid – because it is clearly evident just how easily this could disintegrate, for example as a result of ill-founded reforms. To play the part of gatekeeper, doctors need both confidence and self-confidence. If they lose these, expenses and inequalities will escalate. We can always improve, and the healthcare service must of course be evidence-based. But if it is not confidence-based as well, we have a lot to lose. We may lose a public health service with equal access for all.

Charlotte Haug
Editor

References

1. Arrow K. Uncertainty and the welfare economics of medical care. *Amer Econ Rev* 1963; 53: 941–73.
2. Haug C. Helsetjenesten er ikke som andre tjenester. *Tidsskr Nor Legeforen* 2010; 130: 1223.
3. Fuchs V. *Who shall live? Health, economics, and social choice*. New York: Basic Books, 1974.
4. Arrow K, Auerbach A, Bertko J et al. Toward a 21st-century health care system: recommendations for health care reform. *Ann Intern Med* 2009; 150: 493–5.
5. Becker BJ. Multivariate meta-analysis: contributions of Ingram Olkin. *Statistical Science* 2007; 22: 401–6.
6. Førde OH, Breidablik HJ, Øgar P. Truar skilnadene i tilvisingsrater målet om likeverdige helsetjenester? *Tidsskr Nor Legeforen* 2011; 131: 1878–81.