Mer er ikke alltid bedre: Vårt felles ansvar for en bærekraftig medisin

Linn O. Getz, Institutt for samfunnsmedisin og sykepleie, Allmennmedisinsk forskningsenhet

DKNVS 24. april 2023

NTNU
Kunnskap for en bedre verden

NTNU

Kunnskap for en bedre verden

Noen premisser

Medisin [Medicine Definition & Meaning - Merriam-Webster]

- "the **science and art** dealing with the maintenance of health and the prevention, alleviation, or cure of disease"

- En **profesjon** med privilegier og plikter

Et samfunnsoppdrag

«Esoterisk» kunnskap: vanskelig å utfordre/kritisere

Definisjonsmakt betyr ansvar: Plikt til selvregulering; ivareta kunnskapens integritet og faglige standard

VIEWPOINT

Viewpoint

Professionalism: an ideal to be sustained

Richard L Cruess, Sylvia R Cruess, Sharon E Johnston

Introduction

A gulf has developed between the medical profession and the society it serves. As one observer noted, "A better informed community is asking for accountability, transparency, and sound professional standards", whereas medicine feels that "the professional's autonomy is severely restricted by budgets, bureaucracy, guidelines, and peer review".[1] The concept of professionalism bridges the interests of physicians and society[2–4] as society's need for the healer and its belief in the inherent virtue and morality of professionalism have served as the basis of modern medicine.[5,6] They are the source of the rights and privileges granted to the medical profession and of the values that physicians feel contribute to what is noble and good in their calling. expected of the professional and the role of medicine in society.

There is a social contract between society and medicine that hinges on professionalism.[8] This contract has been and remains largely unwritten, leading physicians to treat it as an implicit rather than an explicit concept. As societal expectations have changed and new demands made upon the medical profession, the social contract has changed and the profession must adapt. A definition that is agreed on and explicit must serve as the basis for the expectations of both society and medicine.

Nature of professionalism

The core elements of a profession are possession of a

Er samfunnsoppdraget gitt?
Medisin / etikk / politikk

Helse som menneskerettighet

2030-agendaen med bærekraftsmålene - regjeringen.no

Bærekraftig medisin / helsetjenester
- et sosialmedisinsk perspektiv på matrixen

Review

Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea

J P Mackenbach

Correspondence to:
Professor J P Mackenbach, Department of Public Health, Erasmus MC, University Medical Center Rotterdam, PO Box 2040, 3000 CA Rotterdam, The Netherlands; j.mackenbach@erasmusmc.nl

Accepted 27 October 2008
Published Online First
3 December 2008

ABSTRACT

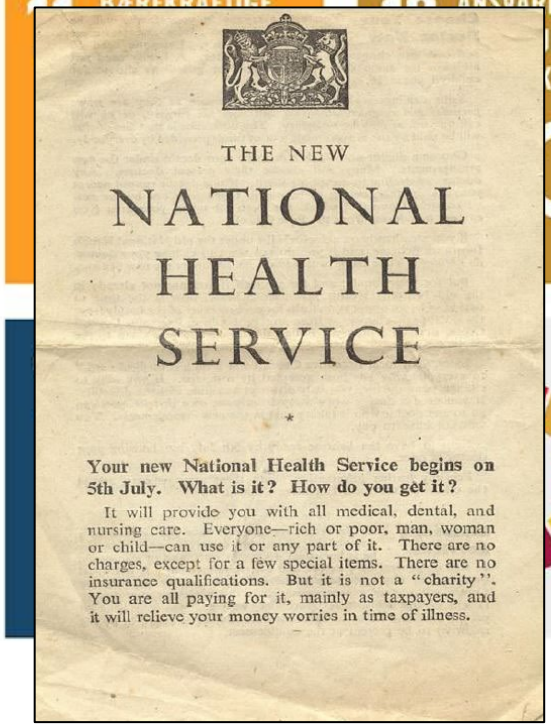
This article retraces the historical origins and contemporary resonances of Rudolf Virchow's famous statement "Medicine is a social science, and politics nothing but medicine at a larger scale". Virchow was convinced that social inequality was a root cause of ill-health, and that medicine therefore had to be a social science. Because of their intimate knowledge of the problems of society, doctors, according to Virchow, also were better statesmen. Although Virchow's analogies between biology and sociology are out of date, some of his core ideas still resonate in public health. This applies particularly to the notion that whole populations can be sick, and that political action may be needed to cure them. Aggregate population health may well be different from the sum (or average) of the health statuses of all individual members: populations sometimes operate as malfunctioning systems, and positive feedback loops will let population health diverge from the aggregate of individual health statuses. There is considerable controversy among epidemiologists and public health professionals about how

successes and failures of society as a whole, and the only way to improve health and reduce disease is by changing society by, therefore, political action.

The purpose of this article is to retrace the origins of this idea, which has recently become even more popular than it already was, as can be seen in the international movement towards "health in all policies".[3]

RUDOLF VIRCHOW AND THE REVOLUTION OF 1848

Rudolf Virchow, who was born in 1821, wrote extensive memoirs that were published on the occasion of his 80th birthday in 1901.[4] In his "Zur Erinnerung" Virchow describes the extraordinarily wide spectrum of his activities which not only extended from pathology to public health but also encompassed anthropology and prehistory. The key event which, in his own view, inspired him to all these activities was a trip that he made to Upper Silesia in early 1848 to conduct an official investigation into the causes of a typhus epidemic.[5]

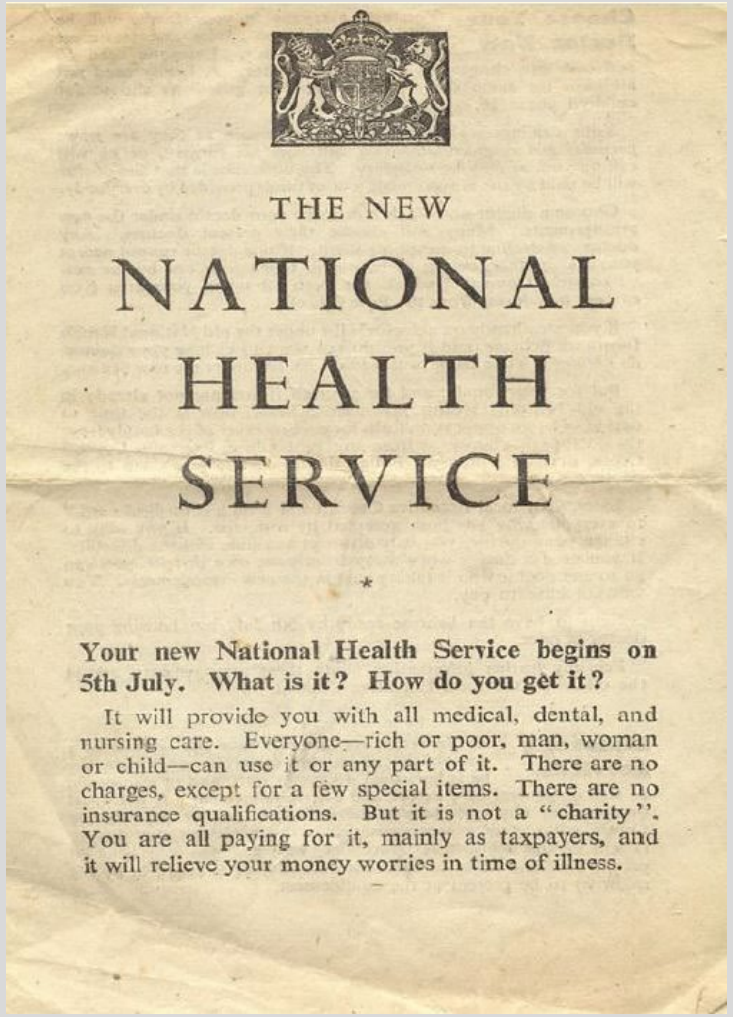


THE NEW
NATIONAL
HEALTH
SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Offentlig helsetjeneste for alle: den UK-Nordiske modellen



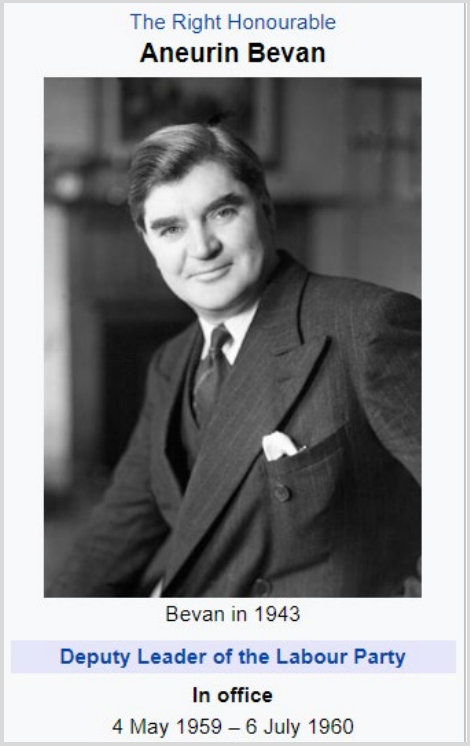
THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.



The Right Honourable

Aneurin Bevan

Bevan in 1943

Deputy Leader of the Labour Party

In office

4 May 1959 – 6 July 1960

"Healthy citizens are the greatest asset any country can have"

- Winston S. Churchill

"Universalise the best"

«Hælsevæsenet i Norge hold Champions League-nivå»

- Nils Arne Eggen

NRK Nyheter Sport Kultur Humor Distrikt Mer Logg in

Urix Urix forklarer Urix på NRK TV Urix i NRK Radio Korrespondentbrevet Nobels fredspris

2021

Norge topper kåring over verdens beste helsevesener

Norge klatrer fra en delt fjerdeplass til toppen på en stor
unders
bruker

EXHIBIT 1

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).
https://doi.org/10.26099/01DV-H208

Velferdsstaten er din helseforsikring

Vi trenger en sterk offentlig helsetjeneste som fortsatt sikrer at velferdsstaten er vår alles helseforsikring.

Ingvild Vatten Alsnes/Marte Kvittum Tangen

Publisert: 2022-12-06 — 15.38

Ingvild Vatten Alsnes

Marte Kvittum Tangen

Innlegg: ***Ingvild Vatten Alsnes****, fastlege, spesialist i allmennmedisin og styremedlem i Norsk forening for allmennmedisin*

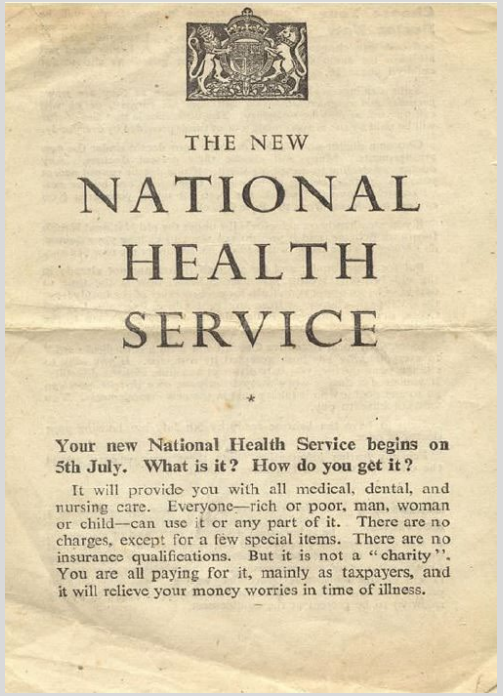
Marte Kvittum Tangen*, spesialist i allmennmedisin og leder av Norsk forening for allmennmedisin*

VELFERDSSTATEN SOM forsikringssystem er en god ide: Alle betaler inn, og de som har behov, henter ut. Når forsikringssystemet flyttes til private selskap, får vi et markedsstyrt fokus på profitt. I stedet for en kollektiv avtale blir avtalen individualisert. Helserisiko blir altså vurdert individuelt, fremfor gruppebasert.

Dette er diskriminerende og øker sosiale forskjeller. Pasienter som blir syke, opplever stigmatisering, og noen sykdommer oppleves mer belastende enn andre.

MARKANT ØKNING. I dag har 700.000 nordmenn, eller én av fire i arbeidsstokken, privat helseforsikring, og de fleste får dette betalt av sin arbeidsgiver. Dette er en markant økning fra 2006, da tallet var 84.000. I tillegg til dette har 640.000 barn helseforsikring, noe som utgjør mer enn halvparten av alle under 18 år i Norge.

Dagens medisin 6.12.22



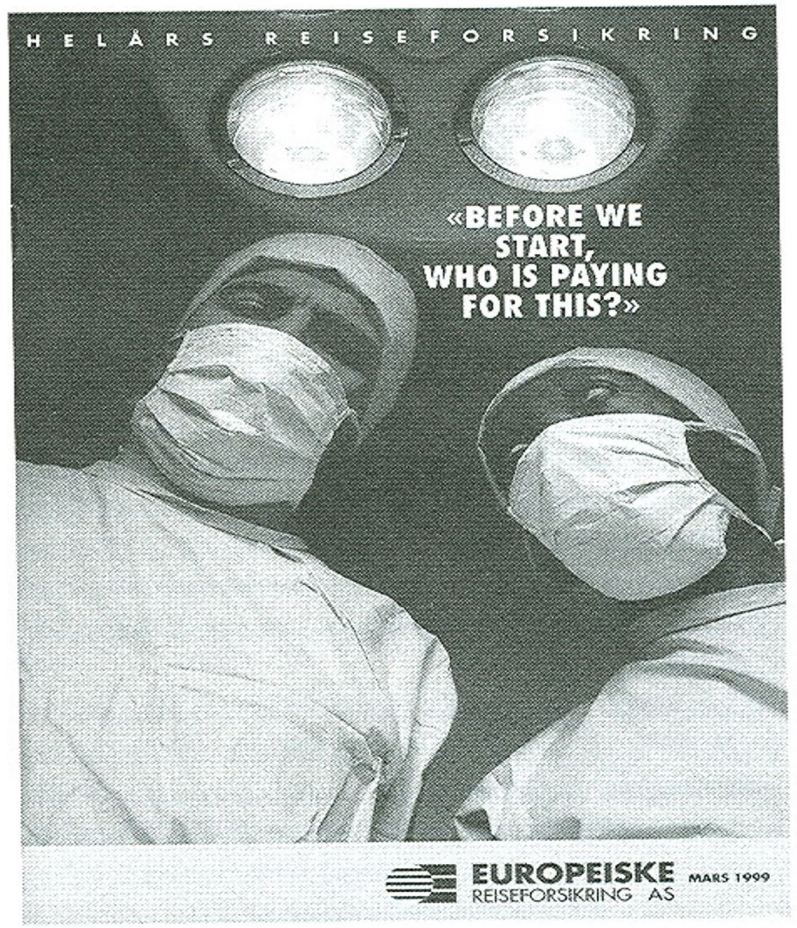
THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Velferdsstaten er din helseforsikring - Debatt og kronikk - Dagens Medisin



Figur 4 *Greit nok som argument for reiseforsikring, men hva om det skulle bli gjeldende for nordmenn i norske sykehus?*

Prof. i sosialmedisin Steinar Westin har advart mot en slik realitet i norsk helsetjeneste

Dagsavisen

Nyheter Debatt Kultur Pluss

DEBATT

«Har du helseforsikring?»

23/02/2023

Hvert eneste Dr. Dropin-kontor jeg går forbi, hver eneste annonse for Volvat og Aleris som dukker opp i feeden min, får det til å skumme i meg av raseri.

«Kanskje er det bare enn så lenge jeg kan ta meg råd til å være rasende», skriver Sandra Lillebø. (Foto: Helge Skodvin)

April 2023: 23 av 70 statseide selskap med private helseforsikringer!

Nær halvparten av statseide selskap har privat helseforsikring. LO frykter et klassedelt helsevesen, men regjeringen griper ikke inn.

VIL IKKE BRUKE EIERMAKTA

HELSE | Anna Krokene | 12. april

Private helseforsikringer i statseide selskaper

Vil ha politisk styring: – Staten skal ikke være med å todele helsetilbudet til folk

Nestleder i Fagforbundet, Odd-Haldgeir Larsen etterlyser politisk styring i statseide selskaper som kjøper private helseforsikringer.

Foto: Jan Ulleberg

Nestleder Odd-Haldgeir Larsen synes det er beklagelig at statlig eide selskaper kjøper private helseforsikringer til sine ansatte.

PER FLAKSTAD | per.flakstad@fagbladet.no

Publisert 13.04.2023 kl 11.40 Oppdatert 13.04.2023 kl 13.02

– Når statlige selskaper er med på å todele helsetilbudet til folk, så burde det være departementer og en regjering som tar fatt i det, sier Larsen til Klassekampen.

Avisen avslørte mandag at 32 av 70 selskaper der staten har direkte eierinteresser opplyser at de har private helseforsikringer.

Ifølge Odd-Haldgeir Larsen er det nettopp i slike spørsmål at det må være rom for politisk styring i selskapene. Han er uenig i at dette skal være opp til styrene og den daglige ledelsen i selskapene.

STREKKER IKKE TIL: Helseministerens virkelighetsfjerne ordre om å «gjøre mer med mindre» og «redusere vikarbruk» suger de siste kreftene ut av allerede slitne og desillusjonerte helsearbeidere. Illustrasjonsfoto: Getty Images

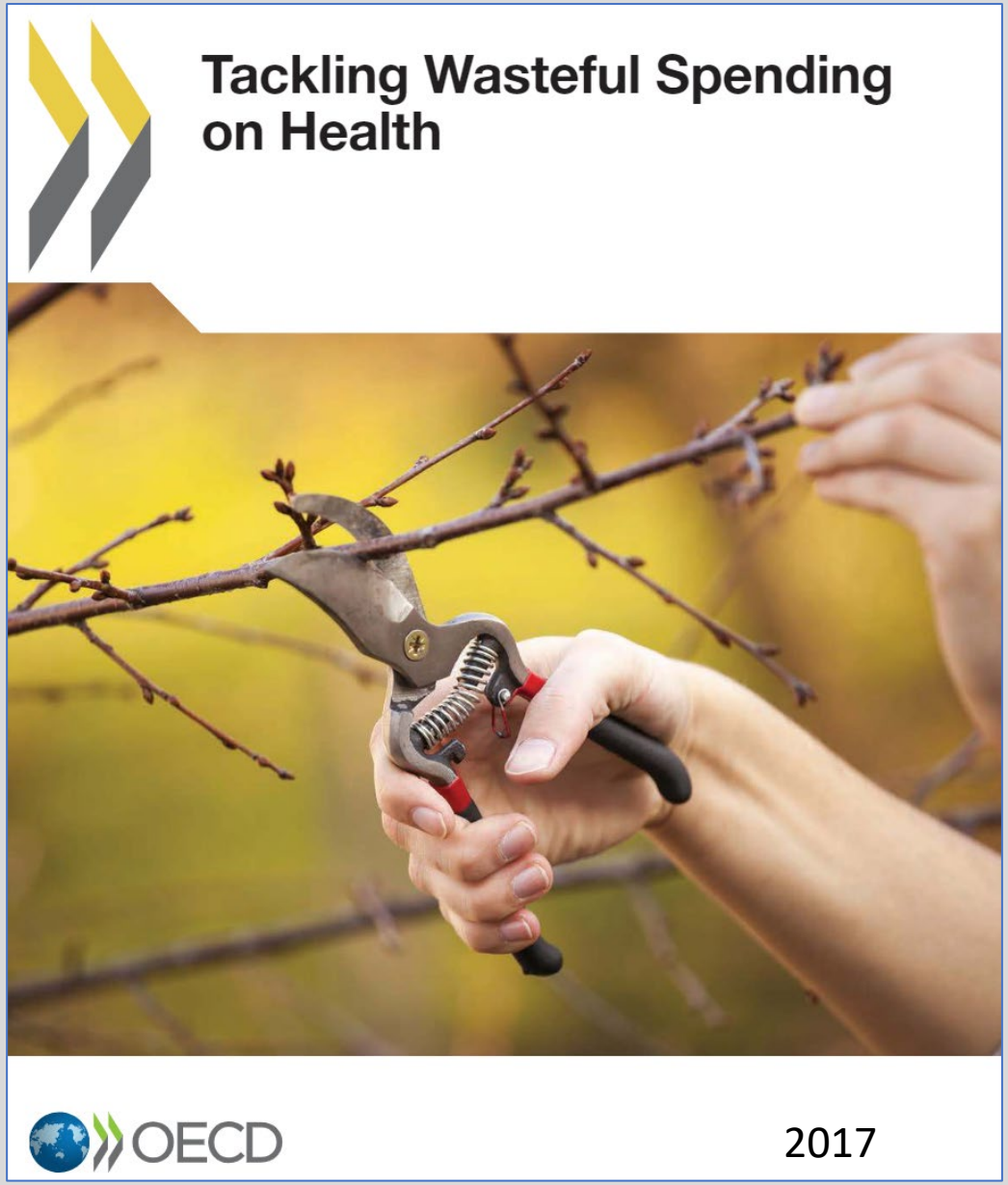
Starten på slutten – og et todelt helsevesen

Ole-Christian Kreyberg Normann, lege

Søndag 05. februar 2023 - 12:34

Bærekraftig medisin
– et produksjons-perspektiv på matrixen

OECD= Organisation for Economic Co-operation and Development

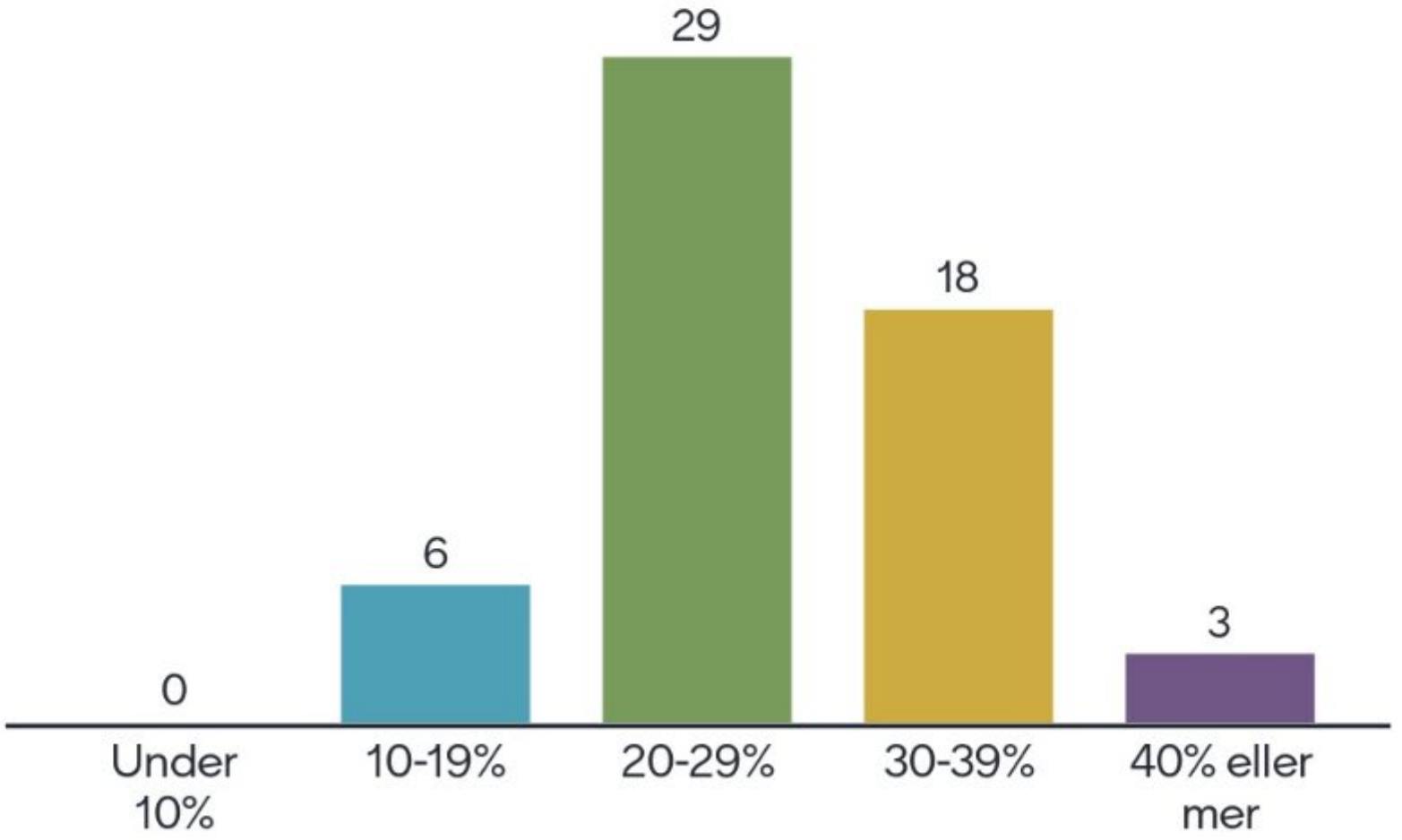


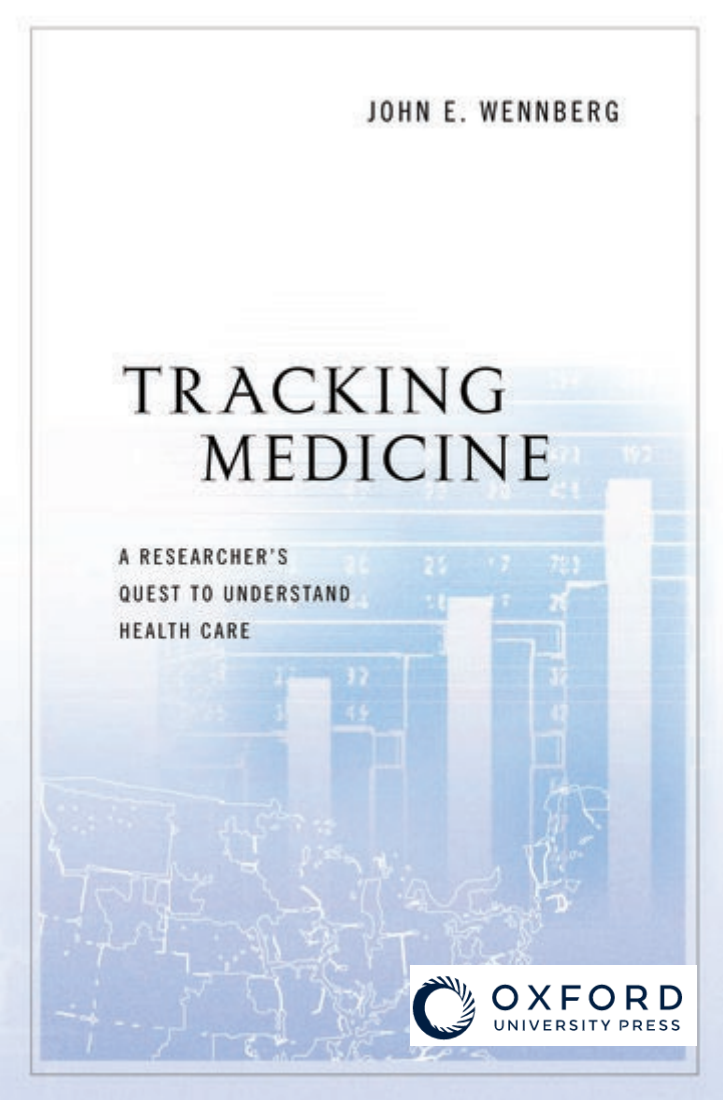
One fifth of health expenditure makes no or minimal contribution to good health outcomes

“Low value care”

Tackling Wasteful Spending on Health | en | OECD

Hvor stor andel av utredningene og behandlingen i det norske helsevesenet anslår du at er overutredning og overbehandling?

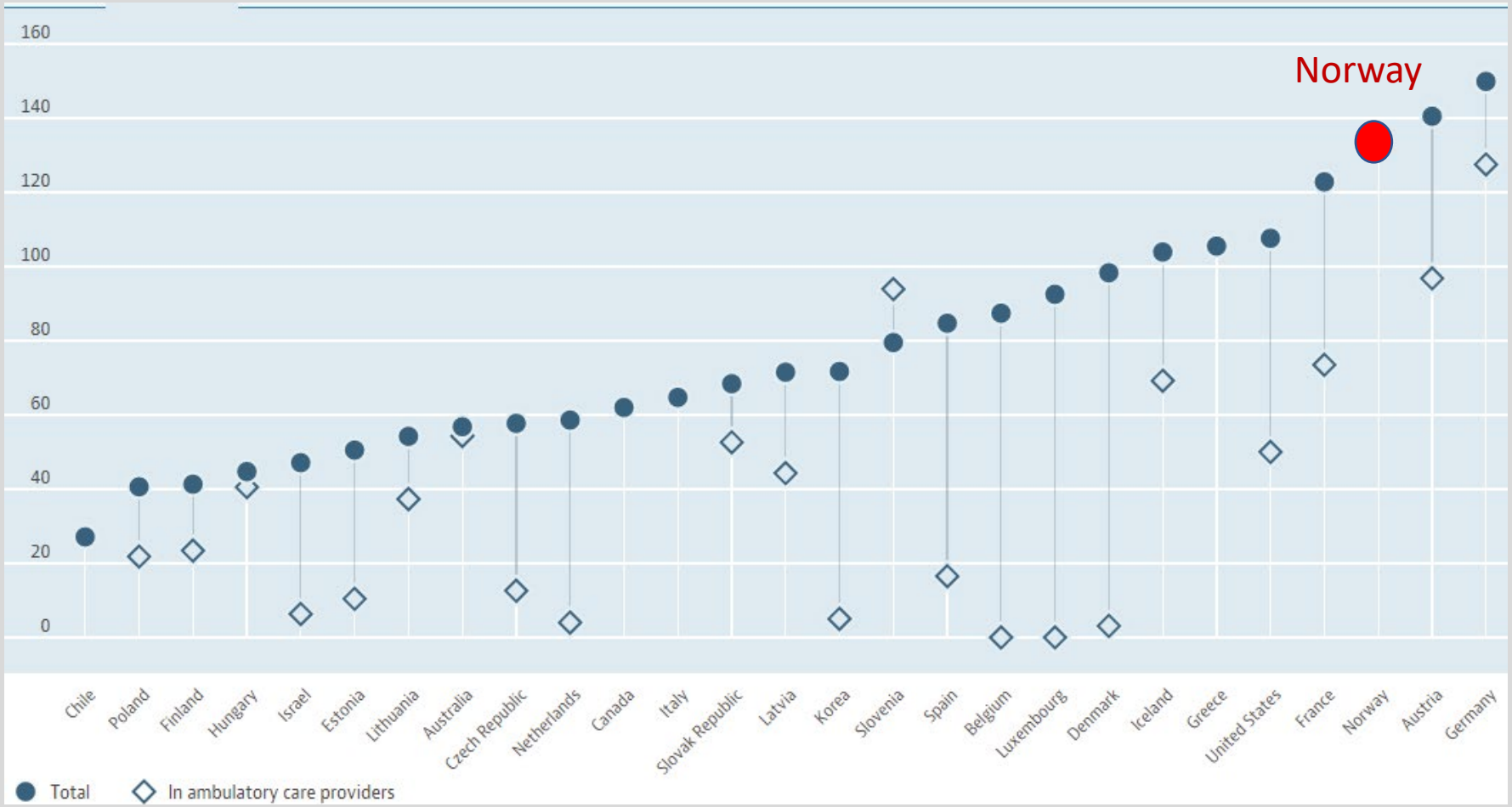




2010

Tre typer helsetjenester

- **Effektive**
- **Preferanse-sensitive**
- **Tilbudssensitive**



MRI scans performed in OECD-countries (2021). Norway ranks number 3 for total number and tops the list for outpatient MRI scans.

Health care use - Magnetic resonance imaging (MRI) exams - OECD Data

Helseministerens sykehustale 17. januar 2023

– «Jeg vil be sykehusene se på ***hva de kan gjøre mindre av***»,
sa helseminister Ingvild Kjerkol (Ap) i sykehustalen tirsdag.

https://www.dagensmedisin.no/eldre-ikke-bruk-folkehelse-helse-og-omsorgsdepartementet-kommunehelsetjeneste/ber-om-kritisk-gjennomgang-av-behovet-for-innleid-arbeidskraft/523025


1 UTRYDDE FATTIGDOM
2 UTRYDDE SULT
3 GOD HELSE OG LIVSKVALITET
4 GOD UTDANNING
5 LIKESTILLING MELLOM KJØNNENE
6 RENT VANN OG GODE SANITÆRFORHOLD
7 REN ENERGI TIL ALLE
8 ANSTENDIG ARB
9 INDUSTRI, INNOVASJON OG INFRASTRUKTUR
10 MINDRE ULIKHET
11 BÆREKRA BYER OG
12 ANSVARLIG FORBRUK OG PRODUKSJON
13 STOPPE KLIMAENDRINGENE
14 LIVET I HAVET
15 LIVET PÅ LAND
16 FRED, RETTFERDIGHET OG VELFUNGERENDE INSTITUSJONER
17 SAMARB FOR Å N

«Mer er ikke alltid bedre»

- kanoniske tekster og figurer i utvikling av innsikt

UA

Start Nyheter Ytring Meny

GJESTESKRIBENTEN

Kanonisk faglitteratur på pensumlista?

En slik tekst kan være så tankevekkende, opplysende eller forløsende at du senere husker hvor du befant deg da du leste den, skriver denne ukas gjesteskribent, som har begynt å interessere seg for den faglitterære kanon.

Linn Getz
Professor, MH-fakultetet

Publisert Fredag 18. november 2022

Medikalisering

-medisin utøves på nye domener*

Overdiagnostikk og overbehandling

-etablerte diagnoser/terapier ekspanderer, uten helsegevinster men med skadepotensiale

*latin dominium ‘herredømme’

Avoiding the Unintended Consequences of Growth in Medical Care

How Might More Be Worse?

1999

Elliott S. Fisher, MD, MPH
H. Gilbert Welch, MD, MPH

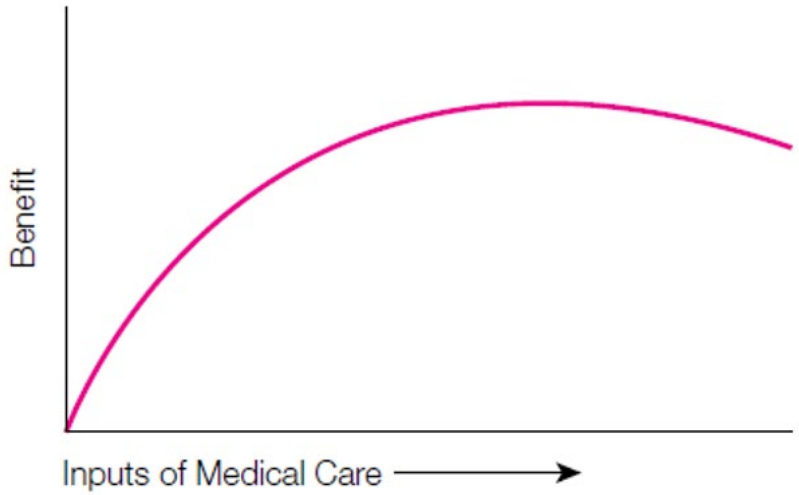
The United States has experienced dramatic growth in both the technical capabilities and share of resources devoted to medical care. While the benefits of more medical care are widely recognized, the possibility that harm may result from growth has received little attention. Because harm from more medical care is unexpected, findings of harm are discounted or ignored. We suggest that such findings may indicate a more general problem and deserve serious consideration. First, we delineate 2 levels of decision making where more medical care may be introduced: (1) decisions about whether or not to use a discrete diagnostic or therapeutic intervention and (2) decisions about whether to add system capacity, eg, the decision to purchase another scanner or employ another physician. Second, we explore how more medical care at either level may lead to harm. More diagnosis creates the potential for labeling and detection of pseudodisease—disease that would never become apparent to patients during their lifetime without testing. More treatment may lead to tampering, interventions to correct random rather than systematic variation, and lower treatment thresholds, where the risks outweigh the potential benefits. Because there are more diagnoses to treat and more treatments to provide, physicians may be more likely to make mistakes and to be distracted from the issues of greatest concern to their patients. Finally, we turn to the fundamental challenge—reducing the risk of harm from more medical care. We identify 4 ways in which inadequate information and improper reasoning may allow harmful practices to be adopted—a constrained model of disease, excessive extrapolation, a missing level of analysis, and the assumption that more is better.

JAMA. 1999;281:446-453 www.jama.com

GROWTH IS A MAJOR FEATURE OF American medicine. Over the course of this century, the proportion of the economy devoted to medical care has more than quadrupled. TABLE 1 details this growth over the past 2 decades.[1] Price-adjusted spending on hospital and physician services has doubled, while spending on home health care has increased more than 10-fold. The number of physicians per capita has increased by 50%, while the number of cardiologists has doubled and the number of radiologists has increased 5-fold. Differences of a similar magnitude are found across US communities.[2]

Although medical care has obvious benefits, many assume that more medical care must lead to improved health and well-being. There are theoretical reasons, however, to believe that additional growth will be associated with pro-

Figure 1. The Law of Diminishing Returns



The first unit of input provides substantial benefits (imagine the first physician in a community), while additional units provide declining additional benefit (imagine the thousandth physician). Eventually, increasing inputs lead to no additional benefit (the "flat of the curve"). At some point, in theory, additional inputs lead to harm.

Strand R, Schei E.

Harmful knowledge?

Tidsskr Nor Lægeforen 2001; 121: 1502–6.

Figur 1 *Mulige mekanismer for hvordan ikke-intenderte skadelige effekter kan følge av kunnskapsutviklingen. Tilpasset etter Fisher & Welch (2)*

CLASSIC PAPER

The Ecology of Medical Care[*]

Reprinted from
The New England Journal of Medicine
265:885–892, 1961

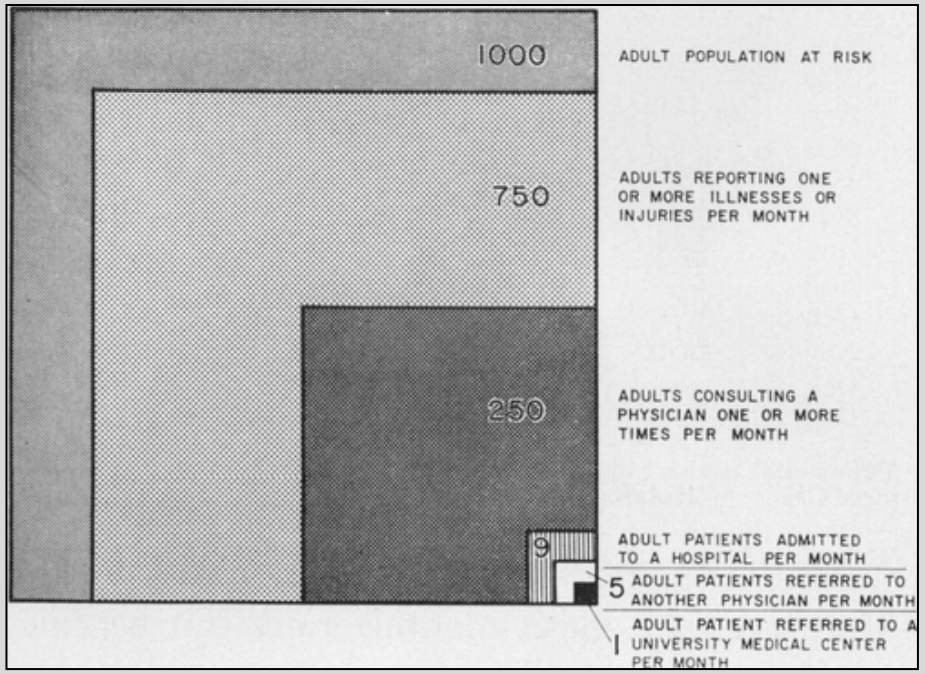
KERR L. WHITE, MD,† T. FRANKLIN WILLIAMS, MD,‡ AND
BERNARD G. GREENBERG, PHD*§

Chapel Hill, North Carolina

Current discussions about medical care appear largely concerned with two questions: Is the burgeoning harvest of new knowledge fostered by immense public investment in medical research being delivered effectively to the consumers? Is the available quantity, quality and distribution of contemporary medical care optimum in the opinion of the consumers? In addition, it may be asked: Whose responsibility is it to examine these questions and provide data upon which sound judgments and effective programs can be based?

The traditional indexes of the public's health, such as mortality and morbidity rates, are useful for defining patterns of ill-health and demographic characteristics of populations who experience specific diseases. They are of limited value in describing actions taken by individual patients and physicians about disease and other unclassified manifestations of ill-

* From the departments of Preventive Medicine and Medicine, School of Medicine, and the Department of Biostatistics, School of Public Health, University of North Carolina.
¶ Supported in part by a research grant (W-74) from the Division of Hospital Facilities, United States Public Health Service.
† Associate Professor of Preventive Medicine and Medicine, University of North Carolina School of Medicine.
‡ Associate Professor of Preventive Medicine and Medicine, University of North Carolina School of Medicine; Markle Scholar in The Medical Sciences.
§ Professor of Biostatistics, University of North Carolina School of Public Health.



Revised 2022 SHj & LG

1000 innbyggere

Man kjenner på sympromer…

…avventer, undersøker, beslutter

En del oppsøker helsetjensten (fastlegen)

-Åpen tilgang

-Fastlegen som portvakt

1/10 henvises 2. og 3. linjen

-Oppfølging hos fastlegen etterpå

1000 innbyggere

Man kjenner på sympromer…

…avventer, undersøker, beslutter

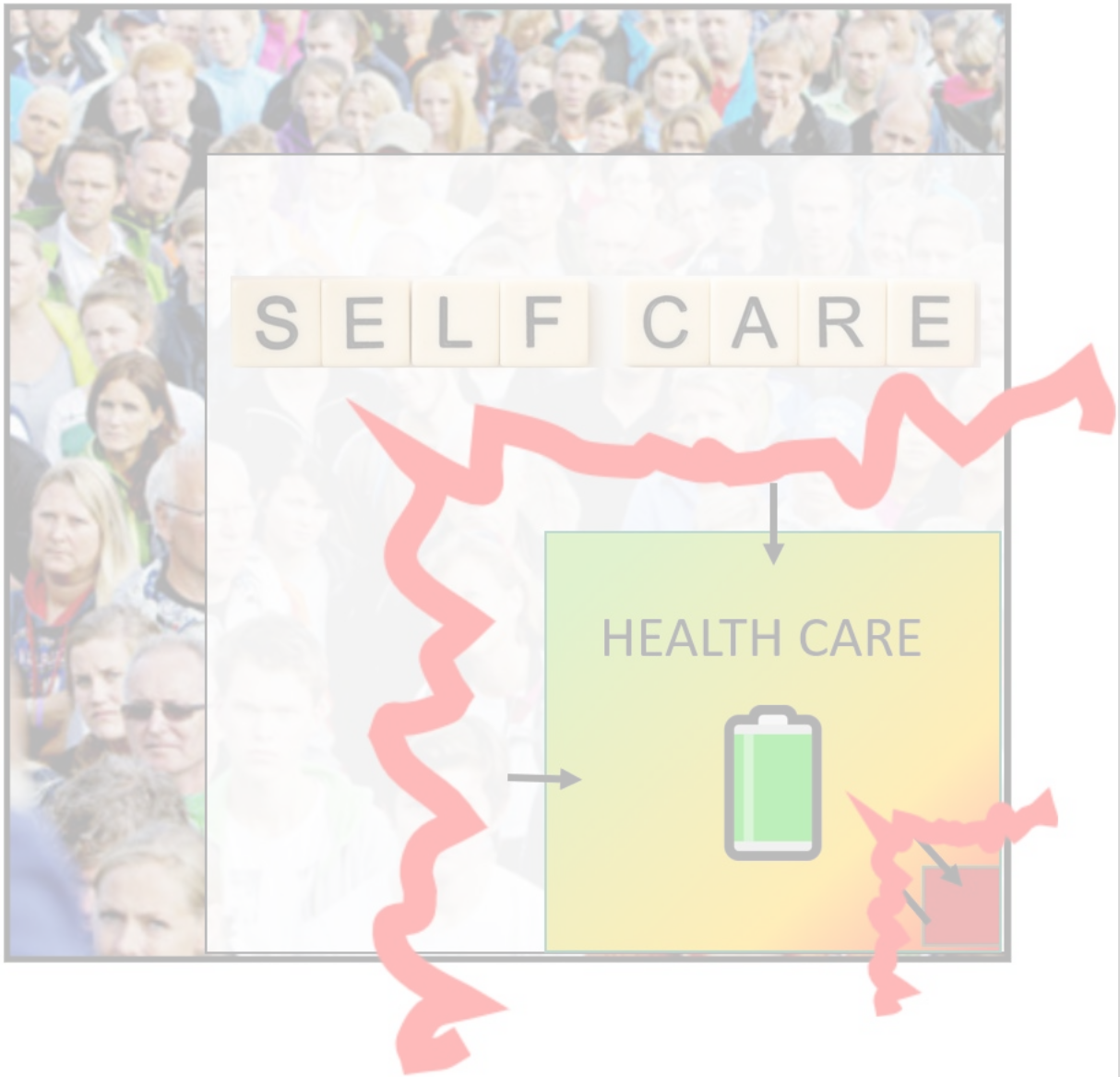
En del oppsøker helsetjensten (fastlegen)

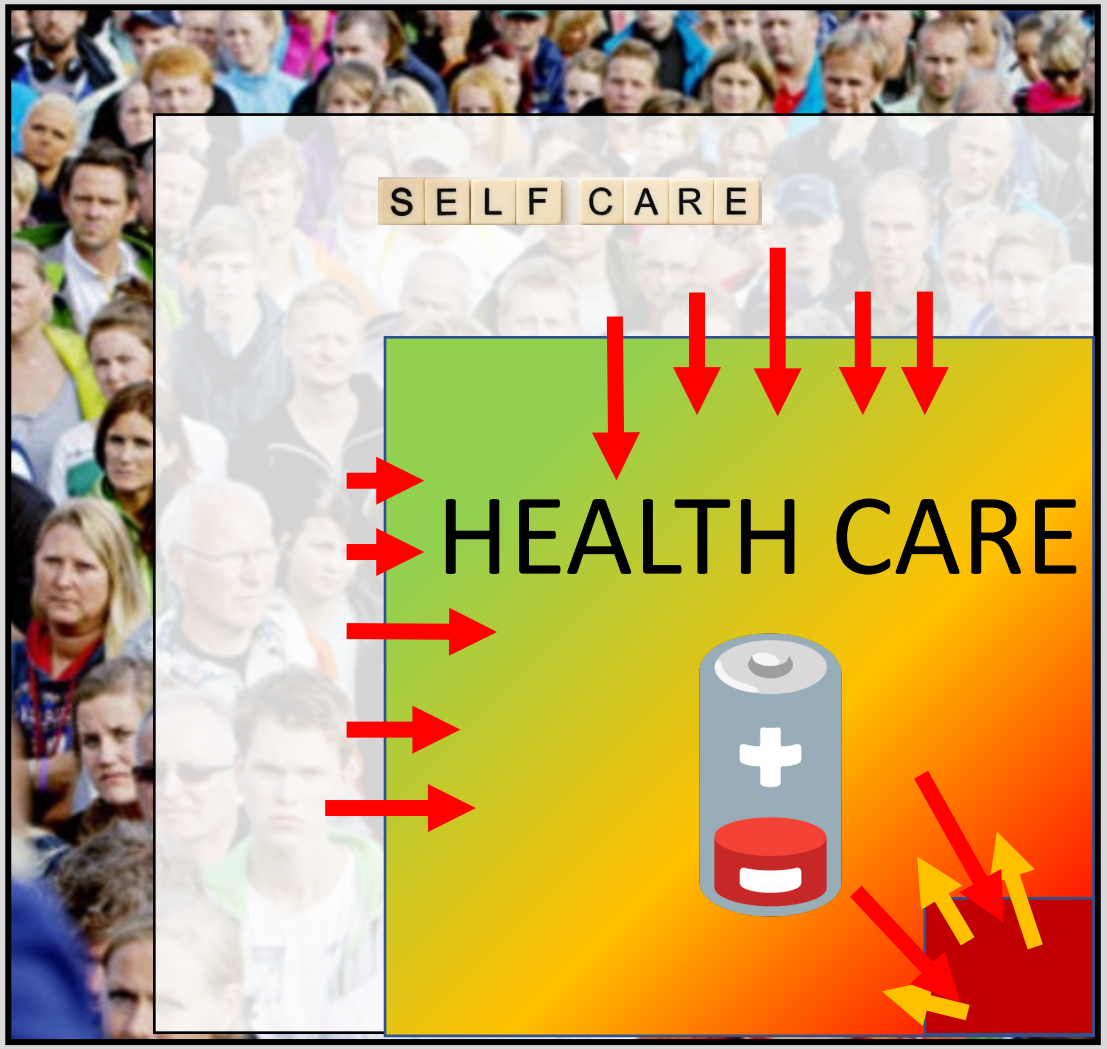
-Åpen tilgang

-Fastlegen som portvakt

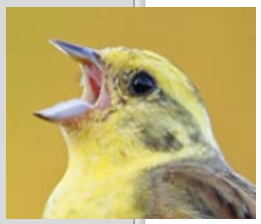
1/10 henvises 2. og 3. linjen

-Oppfølging hos fastlegen etterpå





«The new normal?»



Linn Getz

Sustainable and responsible preventive medicine

Conceptualising ethical dilemmas arising from clinical implementation of advancing medical technology

Doctoral thesis
for the degree of philosophiae doctor

Trondheim, June 2006

Norwegian University of Science and Technology
Faculty of Medicine
Department of Public Health and General Practice

NTNU
Innovation and Creativity

LANDSPÍTALI
UNIVERSITY HOSPITAL

2006

Samtidens og biomedisinens «grand narratives»

«Aksiomer»

-Framskrittet er uomtvistelig («Ikke ennå, men snart…»)

-Teknologien gir løsningene

-Testing eliminerer usikkerhet

-Krigsmetaforer

- *«The power of goodness»…*

Bredere internasjonal oppmerksomhet rundt medisinsk overaktivitet og skade fra ca. 2010-12

Editor's Ch

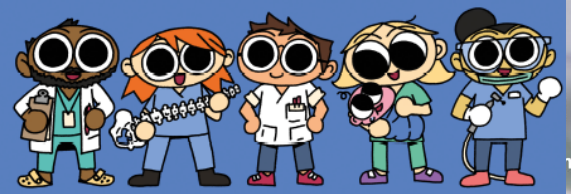
Less mec

BMJ 2009 ;

Cite this as:

MER ER IKKE ALLTID BEDRE

En nasjonal kampanje mot overdiagnostikk og overbehandling



#mererikkealltidbedre

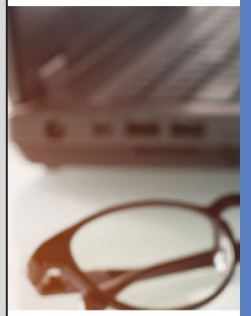
www.klokevalg.org

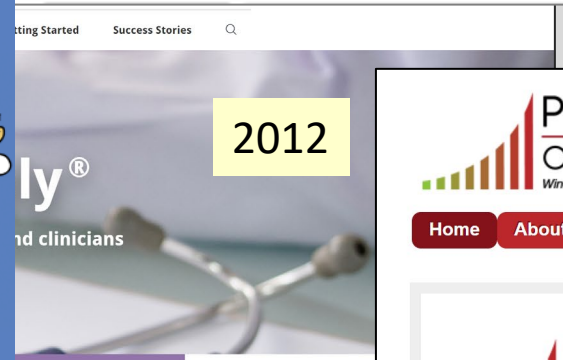
Gjør kloke valg

Preventing overdiagnosis: how to stop harming the healthy

BMJ 2012 ; 344 doi: https://doi.org/10.1136/bmj.e3502 (Published 29 May 2012)

Cite this as: *BMJ* 2012;344:e3502





2012

PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine

thebmj

Home | About | Resources | Definition Reform | Associate Partne

PREVENTING OVERDIAGNOSIS

2023

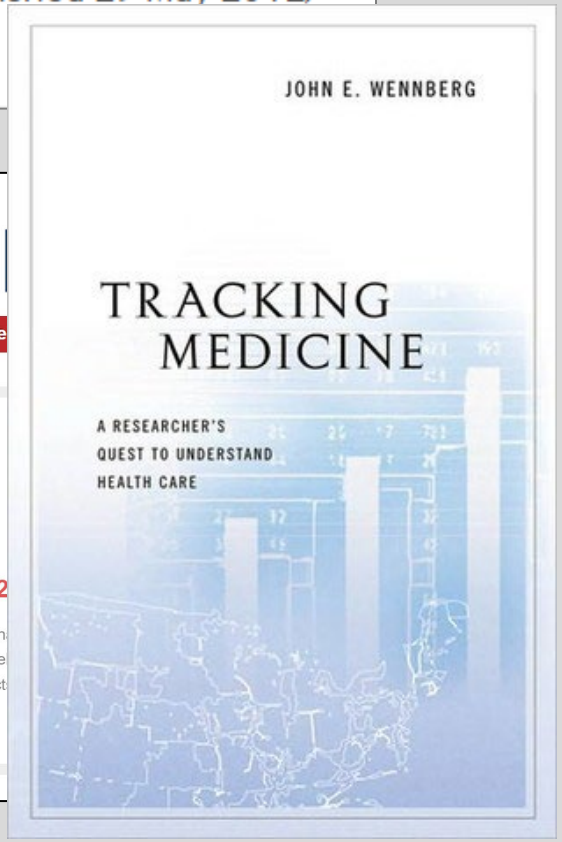
AUG 14-16, COPENHAGEN

PODC 202

The 2023 Intern

held at the Hote

Call for Abstract



Helseangst på markedstorget

Aftenposten Nyheter Meninger Podkast A-magasinet Vink Søk Meny

13 vanlige symptomer som kan være kreft

Oppslag av typen «tegn du må ta på alvor» bidrar antagelig til unødig helseangst og overforbruk av helsetjenester, skriver Atle Fretheim. *Fo vg.no og Atle Fretheim*

Atle Fretheim

19.08.2019 21:00 | Oppdatert 20.08.2019 20:12

Aleris Executive Health

Alle undersøkelser på en dag!

Aleris Executive Health baserer seg på prinsippet om forebygging; potensielle helserisikoer oppdages tidlig og håndteres før de blir større og mer omfattende problemer som påvirker både arbeids- og livssituasjon negativt.

Gjennom en årlig heldagsundersøkelse kartlegges helsetilstanden bredt og grundig. Denne undersøkelsen danner grunnlaget for en individuell og helhetlig plan for oppfølging.

Ønsker du mer informasjon?

Ring oss eller send en e-post: executive@aleris.no

Helsetopp slår alarm: Slik lokker bemanningsbyråer offentlig ansatte med millionlønn og bonuser

Fagbladet 21.11.22 Helsetopp slår alarm: Slik lokker bemanningsbyråer offentlig ansatte med millionlønn og bonuser - Fagbladet.no

Anno 2023: En kulturkrise?

«Det er som en stor konspirasjon av ulike trender:
Frykt og angst, individualisme, rettighetstankegang og forbrukermentalitet i samspill med en vanvittig kommersialisering av helse (…) og et medisinfag som blir stadig mer spesialisert og nærsynt»

- Anna Stavdal, leder WONCA

Doktor Dropout: Hva skjer med legerollen når helsevesenet presses fra alle kanter? – Morgenbladet 2023

1999

Avoiding the Unintended Consequences of Growth in Medical Care

How Might More Be Worse?

Elliott S. Fisher, MD, MPH
H. Gilbert Welch, MD, MPH

The United States has experienced dramatic growth in both the technical capabilities and share of resources devoted to medical care. While the benefits of more medical care are widely recognized, the possibility that harm may result from growth has received little attention. Because harm from more medical care is unexpected, findings of harm are discounted or ignored. We suggest that such findings may indicate a more general problem and deserve serious consideration. First, we delineate 2 levels of decision making where more medical care may be introduced: (1) decisions about whether or not to use a discrete diagnostic or therapeutic intervention and (2) decisions about whether to add system capacity, eg, the decision to purchase another scanner or employ another physician. Second, we explore how more medical care at either level may lead to harm. More diagnosis creates the potential for labeling and detection of pseudodisease—disease that would never become apparent to patients during their lifetime without testing. More treatment may lead to tampering, interventions to correct random rather than systematic variation, and lower treatment thresholds, where the risks outweigh the potential benefits. Because there are more diagnoses to treat and more treatments to provide, physicians may be more likely to make mistakes and to be distracted from the issues of greatest concern to their patients. Finally, we turn to the fundamental challenge—reducing the risk of harm from more medical care. We identify 4 ways in which inadequate information and improper reasoning may allow harmful practices to be adopted—a constrained model of disease, excessive extrapolation, a missing level of analysis, and the assumption that more is better.

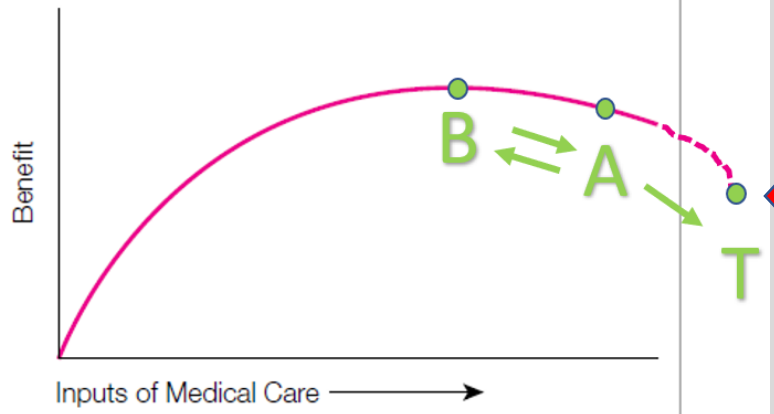
JAMA. 1999;281:446-453 www.jama.com

GROWTH IS A MAJOR FEATURE OF American medicine. Over the course of this century, the proportion of the economy devoted to medical care has more than quadrupled. TABLE 1 details this growth over the past 2 decades.[1] Price-adjusted spending on hospital and physician services has doubled, while spending on home health care has increased more than 10-fold. The number of physicians per capita has increased by 50%, while the number of cardiologists has doubled and the number of radiologists has increased 5-fold. Differences of a similar magnitude are found across US communities.[2]

Although medical care has obvious benefits, many assume that more medical care must lead to improved health and well-being. There are theoretical reasons, however, to believe that additional growth will be associated with pro-

Revised 2022 SHj & LG

Figure The Law of Diminishing Returns



Vippe-punkt?

The first unit of input provides substantial benefits (imagine the first physician in a community), while additional units provide declining additional benefit (imagine the thousandth physician). Eventually, increasing inputs lead to no additional benefit (the "flat of the curve"). At some point, in theory, additional inputs lead to harm.

A resourceful, sustainable healthcare system should function at top benefit level (B) without overuse (A). Ultimately, overuse can lead to irreversible breakdown of healthcare services if allowed to increase beyond a hypthetical tipping-point (T). Green elements added to original figure by Getz & Hjörleifsson.

En eskalerende klimakrise

FRA REDAKTØREN

Helseskadelige helseutslipp

BÆREKRAFT

Are Brean Om forfatteren

Det britiske National Health Service har vedtatt verdens første nasjonale plan for et klimanøytralt helsevesen. Hvem kan ta et lignende forpliktende initiativ i Norge?

Foto: Einar Nilsen

Menneskeskapte klimaendringer er vår tids største trussel mot folkehelsen (1). For å begrense global oppvarming og minske helsekonsekvensene haster det å nå målet om nullutslipp. Stadig flere samfunnsaktører tar konsekvensen av dette. Alt fra kommuner til klesprodusenter har i flere år siktet mot klimanøytralitet (2, 3), og selv den norske rederinæringen har nå som erklært mål å bli klimanøytral (4).

Paradoksalt nok henger helsevesenet langt etter, både når det gjelder å innse sitt eget helseskadelige klimautslipp – og å gjøre noe med det. Det er beregnet at dersom den globale helsesektoren var et land, ville det ha vært verdens femte største produsent av klimautslipp (5). Problemet angår hele helsesektorens verdikjede. Den farmasøytiske industrien er eksempelvis beregnet til å være mer utslippsintensiv enn bilindustrien (6).

«Verdens 5. største land»

> Shipping+ luftfart

UA

Start Nyheter Ytring Meny

GJESTESKRIBENTEN

Akademisk utkall: Mayday for vår felles helsetjeneste!

Mens vi i Akademia funderer på innovasjon, bærekraft og store fremtidige søknader, kan vår offentlige, likeverdige og dyrebare helsetjeneste gå under.

Norsk helsetjeneste er et organisatorisk flaggskip, men nå er skuta tunglastet og skroget krenger. Hva gjør kapteinen (aka statsministeren)? Han søker seg til privat helsetjeneste når han får en strekk i låret, kommenterer denne ukas gjesteskribent, som benytter anledningen til å sende ut et SOS-signal. Tor H. Monsen

Linn Getz
Professor, NTNU

Publisert Fredag 06. januar 2023 - 13:39 Sist oppdatert Lørdag 07. januar 2023 - 13:34

TORSDAG 23. FEBRUAR 2023

Tidsskriftet
DEN NORSKE LEGEFORENING

ARTIKLER FAGOMRÅDER UTGAVER PODKAST FORFATTERVEILEDNING LEGEJOBBER SØK

LEDER

Besinnelse for bærekraft

BÆREKRAFT

ENGLISH

ARTIKKEL
LITTERATUR
KOMMENTARER (0)

Stefán Hjörleifsson, Linn Okkenhaug Getz Om forfatterne

Publisert: 20. februar 2023
Utgave 3, 21. februar 2023

Tidsskr Nor Legeforen 2023
doi: 10.4045/tidsskr.23.0025

PDF
SKRIV UT
KOMMENTER ARTIKKEL

Slik ressursene nå brukes, står vår solidariske, offentlige helsetjeneste for fall. Vi omtaler tre store trusler og maner til besinnelse og samhold.

Norge har hatt bred politisk enighet og lite debatt om verdien av en felles offentlig helsetjeneste basert på kvalitet, likeverd og solidaritet. I 70 år har dette velferdsgodet vært en hjørnestein i et samfunn preget av fellesskap og tillit. Men nå rakner det. Den offentlige helsetjenesten trues fra flere hold, og vi må sikre systemets bærekraft.

Begrepet bærekraft egner seg til å belyse situasjoner der egen framferd og ressursbruk kan lede til alvorlig eller uopprettelig skade. Slik ble det lansert i FN-rapporten «Vår felles framtid» fra 1987 (1). Her omtalte Gro Harlem Brundtland risikoen for at jorden kan bli ubeboelig for kommende generasjoner på grunn av uvettig forvaltning av ressurser.

Akademiker eller aktivist?
Her er hva JEG ønsker meg

Solidaritet og bærekraft – bærende etiske prinsipper?

Concise argument

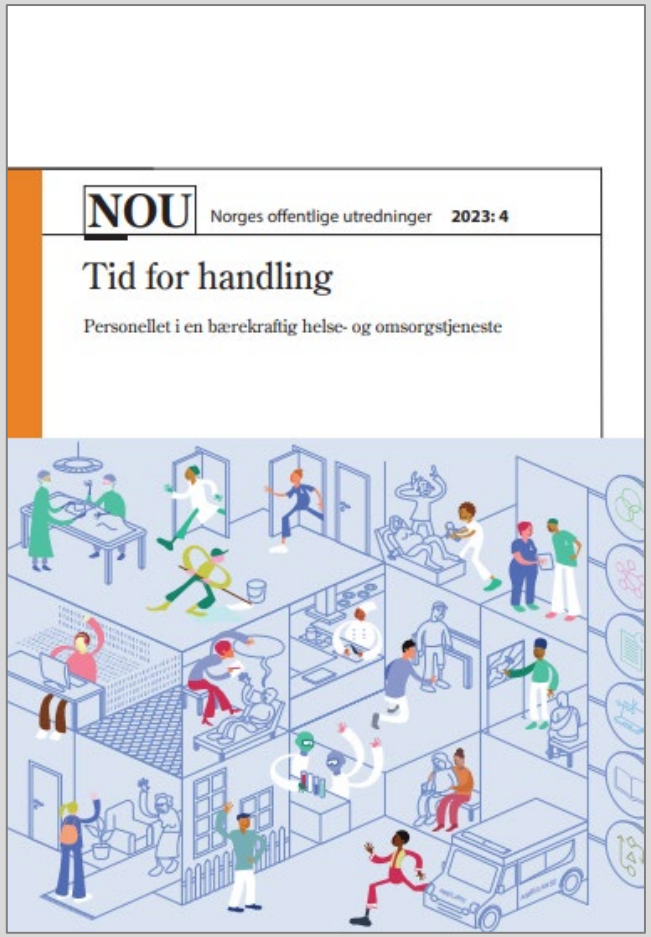
Solidarity, sustainability and medical ethics

Zoë Fritz

With the roll out of vaccinations for COVID-19 across the globe, Julian Savulescu proposes an algorithm for when mandatory vaccination might be ethically justified.[2] Drawing and expanding upon the 2007 Nuffield Council of Bioethics report he suggests that four criteria are required: 1. There is a grave threat to public health 2. The vaccine is safe and effective 3. Mandatory vaccination has a superior cost/benefit profile compared with other alternatives 4. The level of coercion is proportionate. Discussing the value judgement associated with each criterion, he concludes that, at least initially (where uncertainty around safety is greater), mandatory vaccina-

beneficence etc) but has a *freestanding* role, which should be independently assessed.[3] He acknowledges that solidarity per se is not valuable: there is solidarity, he notes, among a firing squad and within a terrorist cell. He develops Prainsack and Buyx metaphor of solidarity as the putty of justice[4] and suggests five individually necessary and sufficient conditions of morally valuable solidarity: it must be (1) norm grounded (2) acknowledged (3) political (4) action and (5) on others' behalf. He suggests that solidarity (with X) is morally required 'when it constitutes equitable treatment of X such as to countermand or resist inequitable treatment of X'. He notes that moral dilemmas

Solidarity, sustainability and medical ethics (bmj.com)



KOMMISJONSMEDLEM: Magne Wang Fredriksen har vært en representert for pasienter og brukere i Helsepersonellkommisjonen. Tone Herregården

– Pasientene vil ikke ha mest mulig behandling, de vil ha riktig behandling

Generalsekretær i MS-forbundet Magne Wang Fredriksen, som har vært «folkestemmen» i Helsepersonellkommisjonen, tror ikke pasienter og brukere frykter prioriteringsdebatten. – Det er helt avgjørende at vi klarer å prioritere og begrense oss til det som er mest nødvendig.

Leni Aurora Brækhus
JOURNALIST

PUBLISERT Fredag 03. februar 2023 - 12:59

Torsdag overleverte Helsepersonellkommisjonen sin utredning til helse- og omsorgsminister Ingvild Kjerkol (Ap). Da hadde det gått drøyt ett år siden kommisjonen med 16 medlemmer startet arbeidet sitt.

Kommisjonsmedlem Magne Wang Fredriksen, som er generalsekretær i MS-forbundet, beskriver prosessen som krevende, men også veldig spennende.

THE LANCET

Comment

Addressing overuse and underuse around the world

The benefits of modern medical care have advanced the health of populations around the world, but with better health has come rising health-care spending. Not surprisingly, there is global interest in optimising the delivery of health services, exemplified by the universal health coverage (UHC) and waste in research campaigns.[1,2] Comparatively neglected is a paradox that afflicts high-income countries (H low-income and middle-income countries alike: the failure to deliver needed services alon continuing delivery of unnecessary services. T Series on right care[3-6] aims to bring these two

by the continuing burden of poverty, malnutrition, and infectious disease, rapidly rising rates of chronic diseases,[13] and the adoption of expensive yet unproven medical technologies.

Defining the right care and understanding the forces that work against it constitute a crucial pathway to real

Published Online
January 8, 2017
http://dx.doi.org/10.1016/S0140-6736(16)32573-9

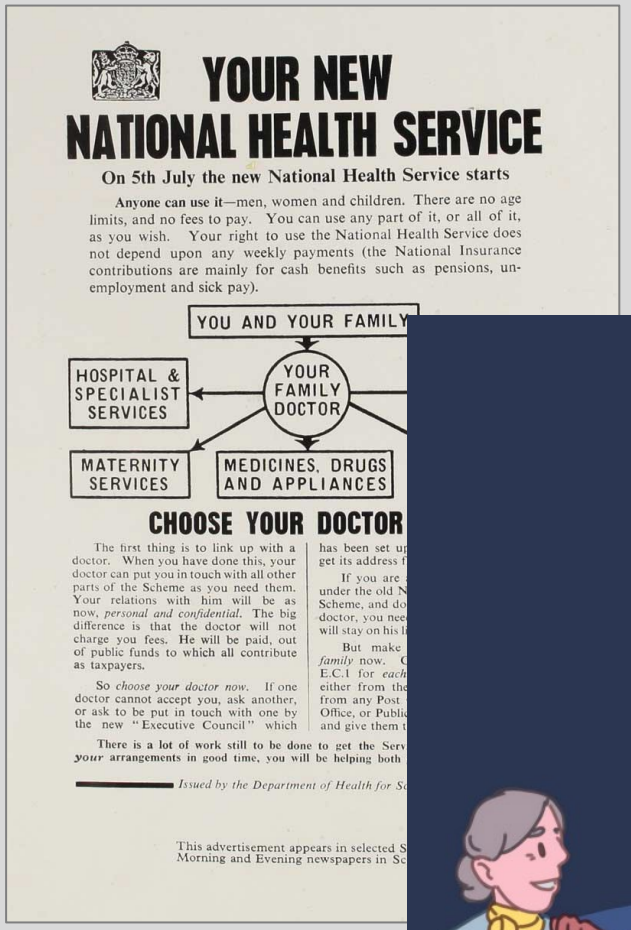
See Online/Series
http://dx.doi.org/10.1016/S0140-6736(16)32585-5,
http://dx.doi.org/10.1016/S0140-6736(16)30946-1,

Underuse of proven medical care and overuse of unproven services causes suffering to millions of people around the world. The costs are serious: physical, psychological, and social harms for patients and wasteful misallocation of resources for society.

Addressing overuse and underuse around the world - The Lancet

Ikke for mye og ikke for lite
- hvem er meningsberettiget?

Fastlegeordning – det beste svaret?



YOUR NEW
NATIONAL HEALTH SERVICE

On 5th July the new National Health Service starts

Anyone can use it—men, women and children. There are no age limits, and no fees to pay. You can use any part of it, or all of it, as you wish. Your right to use the National Health Service does not depend upon any weekly payments (the National Insurance contributions are mainly for cash benefits such as pensions, unemployment and sick pay).

YOU AND YOUR FAMILY

HOSPITAL & SPECIALIST SERVICES

YOUR FAMILY DOCTOR

MATERNITY SERVICES

MEDICINES, DRUGS AND APPLIANCES

CHOOSE YOUR DOCTOR

The first thing is to link up with a doctor. When you have done this, your doctor can put you in touch with all other parts of the Scheme as you need them. Your relations with him will be as now, *personal and confidential*. The big difference is that the doctor will not charge you fees. He will be paid, out of public funds to which all contribute as taxpayers.

So *choose your doctor now*. If one doctor cannot accept you, ask another, or ask to be put in touch with one by the new "Executive Council" which

There is a lot of work still to be done to get the Serv*your* arrangements in good time, you will be helping both

Issued by the Department of Health for S

This advertisement appears in selected S
Morning and Evening newspapers in Sc

Bolteløkka legesenter

11. 59 FORSLAG FOR EN BÆREKRAFTIG ALLMENNLEGETJENESTE.....339


Det er dokumentert at en fastlegeordning er effektiv – spørsmålet er bare hvordan den kan gjøres ennå mer velfungerende
DR KATE SIDAWAY-LEE
DR REBECCA ROSEN
PROFESSOR STEINAR HUNSKAR
Prof Steinar Hunskår, ekspertvitne i det britiske Parlamentet
15:47:36
15:56:35

Research

Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg and Steinar Hunskaar

Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care:

a registry-based observational study in Norway

Abstract

Background
Continuity, usually considered a quality aspect of primary care, is under pressure in Norway, and elsewhere.

Aim
To analyse the association between longitudinal continuity with a named regular general practitioner (RGP) and use of out-of-hours (OOH) services, acute hospital admission, and mortality.

Design and setting
Registry-based observational study in Norway covering 4 552 978 Norwegians listed with their RGPs.

Method
Duration of RGP–patient relationship was used as explanatory variable for the use of OOH services, acute hospital admission, and mortality in 2018. Several patient-related and RGP-related covariates were included in the analyses by individual linking to high-quality national registries. Duration of RGP–patient relationship was categorised as 1, 2–3, 4–5, 6–10, 11–15, or >15 years. Results are given as adjusted odds ratio (OR) with 95% confidence intervals (CI) resulting from multilevel logistic regression analyses.

Results
Compared with a 1-year RGP–patient relationship, the OR for use of OOH services decreased gradually from 0.87 (95% CI = 0.86 to 0.88) after 2–3 years' duration to 0.70 (95% CI = 0.69 to 0.71) after >15 years. OR for acute hospital admission decreased gradually from 0.88 (95% CI = 0.86 to 0.90) after 2–3 years' duration to 0.72 (95% CI = 0.70 to 0.73) after >15 years. OR for dying decreased gradually from 0.92 (95% CI = 0.86 to 0.98) after 2–3 years' duration, to 0.75 (95% CI = 0.70 to 0.80) after an RGP–patient relationship of >15 years.

Conclusion
Length of RGP–patient relationship is significantly associated with lower use of OOH services, fewer acute hospital admissions, and lower mortality. The presence of a dose–response relationship between continuity and these outcomes indicates that the associations are causal.

INTRODUCTION

Continuity is a core value of primary care. McWhinney described continuity as an implicit contract between a patient and a GP, who then takes personal responsibility for the patient's medical needs.[1,2] Continuity is not limited by the type of disease and bridges episodes of various illnesses. Greater continuity with a primary care physician has been shown to be associated with lower mortality rates,[3] fewer hospital admissions,[4,5] less use of emergency departments,[6] and fewer referrals for specialist health care.[7,8] Nevertheless, continuity has been declining in recent years.[9]

There is no uniform agreement about how continuity should be defined, but three aspects are usually described: informational, longitudinal, and interpersonal.[10] Informational continuity means that the doctor has adequate access to all relevant information about the patient. Longitudinal continuity means that it transcends multiple episodes of illness, and interpersonal refers to a trustful relationship between patient and physician. Various methods have been used for measuring continuity. Most of them are based on visit patterns with different providers over time.[10,11] An example is the Usual Provider of Care (UPC) index, which calculates the percentage of all contacts that is with the most frequent provider.[12] Most of these studies have been conducted with limited patient samples and rather short observation periods. There is scarce literature on studies with large- or full-scale populations, long follow-up, and hard endpoints.

In a limited number of countries, such as the UK, the Netherlands, Denmark, or Norway, most inhabitants are listed with a general practice or a named regular general practitioner (RGP) who is responsible for taking care of their medical needs. Such RGP schemes are usually established not only to increase continuity of care as an assumed aspect of quality, but also to prevent unnecessary spending by introducing the RGP as a gatekeeper. It should be noted, however, that patients also value such personal relationships with their RGP.[13]

The aim of the present study, based on Norwegian registry data, was to analyse, on a national level, the effects of longitudinal RGP continuity associated with use of out-of-hours (OOH) services, acute hospital admissions, and mortality.

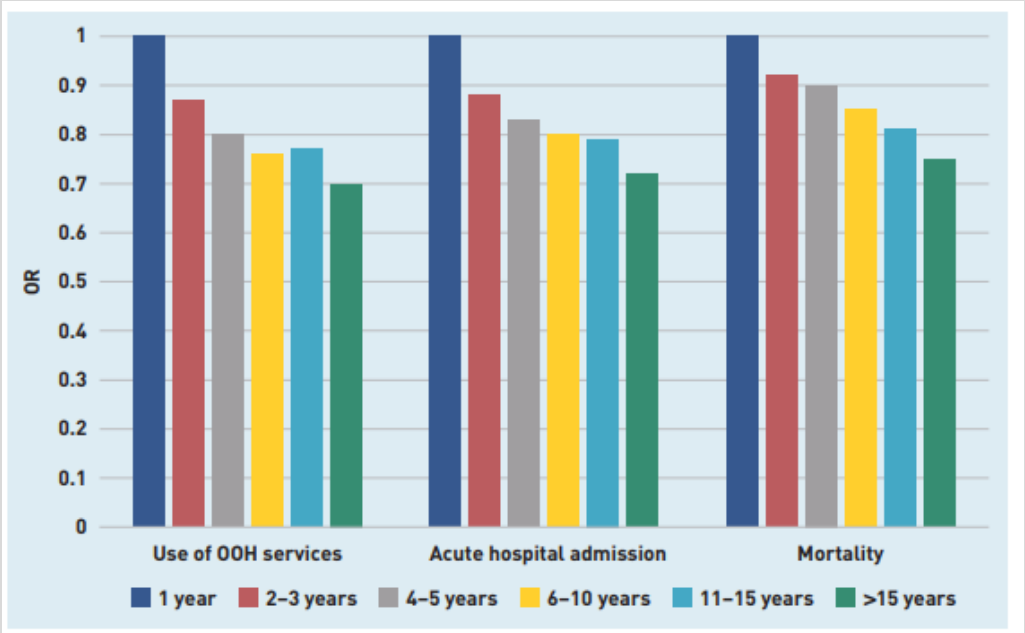
METHOD

The Norwegian RGP Scheme

In Norway, the state is responsible for hospitals, while the primary healthcare system is the responsibility of the

H Sandvik, PhD, senior researcher, National Centre for Emergency Primary Health Care, NORCE Norwegian Research Centre, Bergen. **Ø Hetlevik**, PhD, professor, Department of Global Public Health and Primary Care, University of Bergen, Bergen. **J Blinkenberg**, MD, researcher, National Centre for Emergency Primary Health Care, NORCE Norwegian Research Centre, Bergen; Department of Global Public Health and Primary Care, University of Bergen, Bergen. **S Hunskaar**, National Centre for Emergency Primary Health Care, NORCE Norwegian

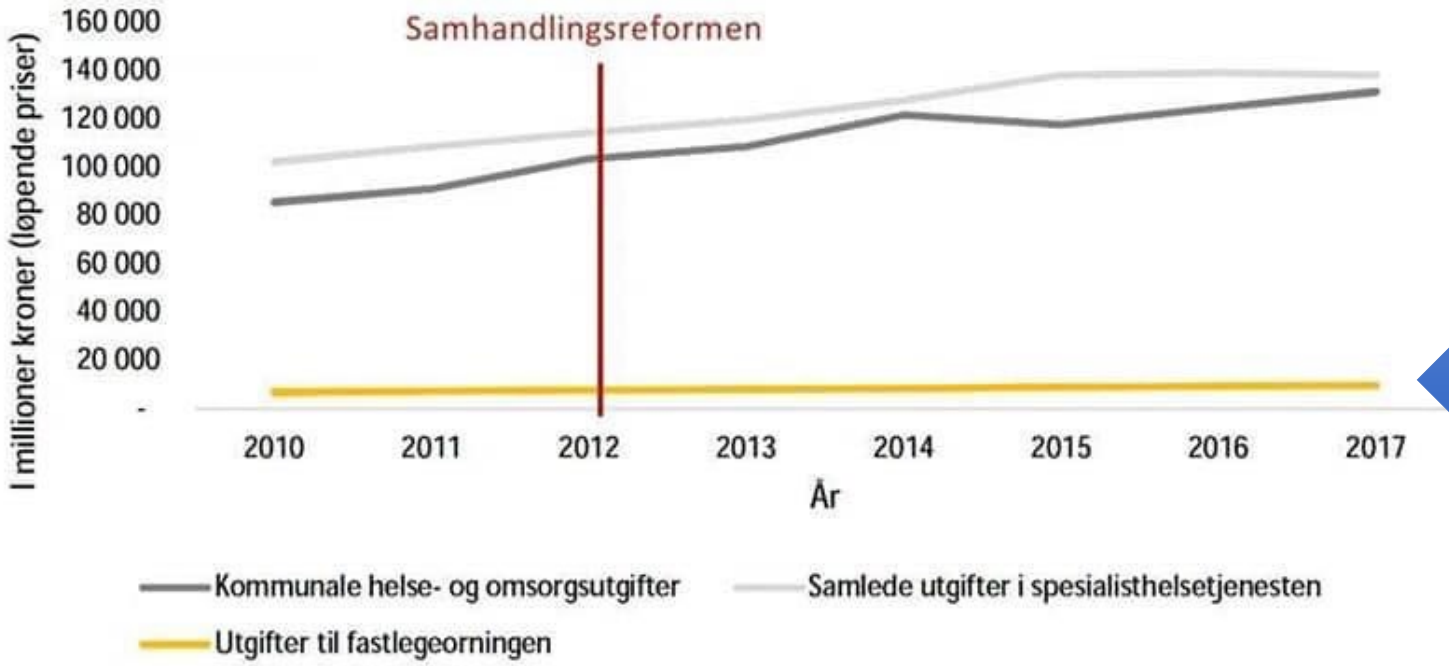
Address for correspondence
Hogne Sandvik, National Centre for Emergency Primary Health Care, NORCE Norwegian Research Centre, Årstadveien 17, 5009 Bergen, Norway.
Email: Hogne.Sandvik@uib.no
Submitted: 3 June 2021; **Editor's response:** 5 August 2021; **final acceptance:** 20 August 2021.



British Journal of General Practice, Feb 2022

Stagnerte investeringer i «førstelinjen». Hvem tar sørge-for ansvar for påkrevd forskning og fagutvikling?

I faktiske utgifter har fastlegeordningen økt med ca. 3 milliarder siden 2010, mens spesialisthelsetjenester og andre kommunale helse- og omsorgsutgifter har økt med ca. 35 og 45 milliarder i samme tidsperiode.



Fastlegeordningen

FIGUR 2.2: ÅRLIG VEKST I KOMMUNALE HELSE- OG OMSORGSUTGIFTER, SAMLEDE UTGIFTER I SPESIALISTHELSETJENESTEN, SAMT UTGIFTER TIL FASTLEGEORDNINGEN – LØPENDE PRISER

evaluering-av-fastlegeordningen---sluttrapport-fra-ey-og-vista-analyse.pdf

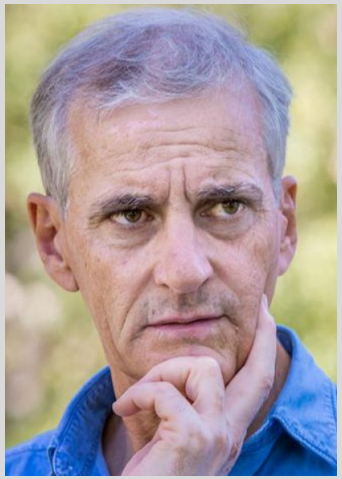
OUR COMMON FUTURE

THE WORLD COMMISSION ON ENVIRONMENT AND DEVELOPMENT

«Brundtland-rapporten», 1987

Bærekraftig utvikling: "Utvikling som imøtekommer dagens behov uten å ødelegge mulighetene for at kommende generasjoner skal få dekket sine behov".

En haltende AP-statsminister i 2022



Fastlege/legevakt?

Volvat
INNGÅR I CAPIO EUROPA


Dagbladet eksklusivt - Skadet Støre gikk til privatlege

Skadet Støre gikk til privatlege

Jonas Gahr Støre bommet på straffe og strakk låret. Behandling fikk han hos privatlege der startprisen er 1700 kroner timen. - Disse aktørene driver lovlig, men kan ikke forvente at regjeringen står og heier på dem, sa helseministeren til Dagbladet i vår.

Støre faller sammen

FALLER: Statsminister Jonas Gahr Støre får smake på gresset når han skal ta sin straffe i kjendiskampen under Norway Cup. Resultatet ble en skade som privatlege behandlet. Video: Dagbladet TV

Steinar Solås Suvatne, Kjetil Kjær Andersland

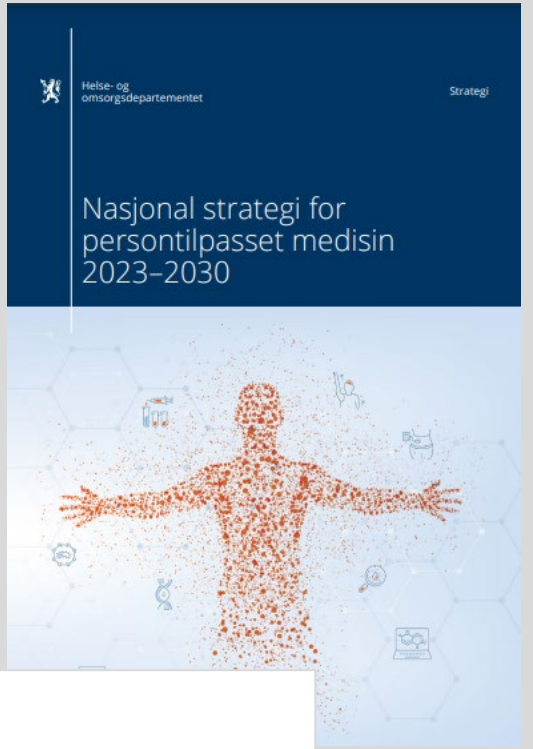
Publisert torsdag 18. august 2022 - 20:58

Dagbladet eksklusivt - Skadet Støre gikk til privatlege


1 UTRYDDE FATTIGDOM
2 UTRYDDE SULT
3 GOD HELSE OG LIVSKVALITET
4 GOD UTDANNING
5 LIKESTILLING MELLOM KJØNNENE
6 RENT VANN OG GODE SANITÆRFORHOLD
7 REN ENERGI TIL ALLE
8 ANSTENDIG ARBEID OG ØKONOMISK VEKST
9 INDUSTRI, INNOVASJON OG INFRASTRUKTUR
10 MINDRE ULIKHET
12 ANSVARLIG FORBRUK OG PRODUKSJON
13 STOPPE KLIMAENDRINGENE
14 LIVET I HAVET
16 FRED, RETTFERDIGHET OG VELFUNGERENDE INSTITUSJONER
17 SAMARBEID FOR Å NÅ MÅLENE

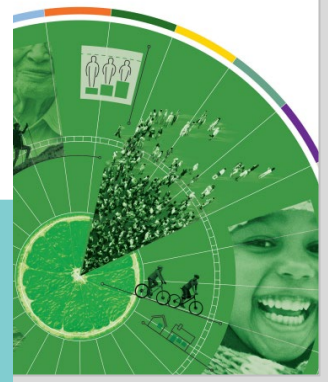

DET KONGELIGE KOMMUNAL- OG MODERNISERINGSDEPARTEMENT
Meld. St. 40
(2020–2021)
Melding til Stortinget
Mål med mening
Norges handlingsplan for å nå bærekraftsmålene innen 2030
2030

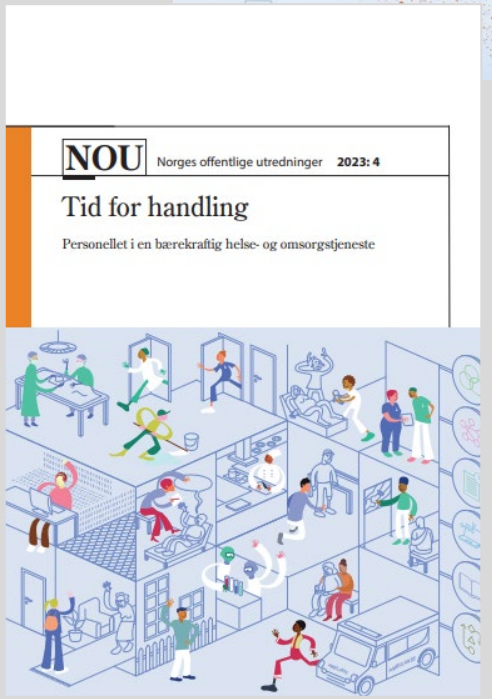

NOU Norges offentlige utredninger 2023: 5
Den store forskjellen
Om kvinners helse og betydningen av kjønn for helse


Helse- og omsorgsdepartementet
Strategi
Nasjonal strategi for persontilpasset medisin 2023–2030


DET KONGELIGE HELSE- OG OMSORGSDEPARTEMENT
Meld. St. 15
(2022–2023)
Melding til Stortinget
Folkehelsemeldinga
Nasjonal strategi for utjamning av sosiale helseforskjellar


NOU Norges offentlige utredninger 2023: 8
Fellesskapets sykehus
Styring, finansiering, samhandling og ledelse




NOU Norges offentlige utredninger 2023: 4
Tid for handling
Personellet i en bærekraftig helse- og omsorgstjeneste

UA

Start Nyheter Ytring Meny

YTRING

Bærekraftig medisin – framover i alle retninger

Det er ikke så enkelt å være bærekraftvennlig NTNU-medisiner for tiden. Ukas gjesteskribent er rammet av tvisyn idet hun betrakter både retten og vrangen, det tragiske og det komiske, det alvorlige og det latterlige i våre bestrebelser etter å bygge og bevare verdens beste helsetjeneste på en livskraftig klode.

Linn Okkenhaug Getz
Professor i Almennmedisin

Publisert Fredag 31. mars 2023 - 11:56

DET KONGELIGE KOMMUNAL- OG MODERNISERINGSDEPARTEMENT

Meld. St. 40
(2020–2021)
Melding til Stortinget

Mål med mening

Norges handlingsplan for å nå bærekraftsmålene innen 2030

NOU Norges offentlige utredninger 2023: 5

Den store forskjellen

Om kvinners helse og betydningen av kjønn for helse

Helse- og omsorgsdepartementet Strategi

Nasjonal strategi for persontilpasset medisin 2023–2030

DET KONGELIGE HELSE- OG OMSORGSDEPARTEMENT

Meld. St. 15
(2022–2023)
Melding til Stortinget

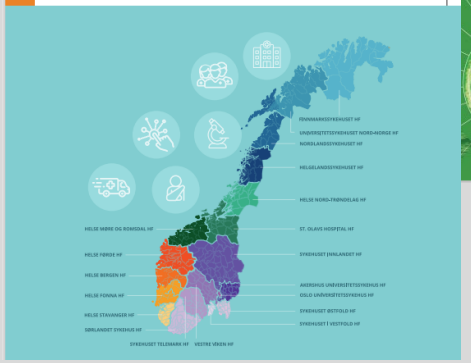
Folkehelsemeldinga

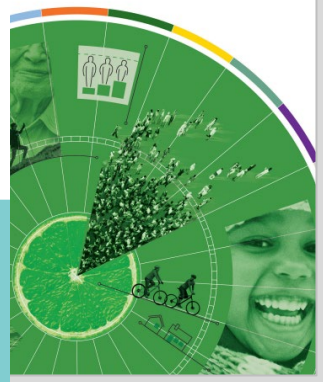
Nasjonal strategi for utjamning av sosiale helseforskjellar

NOU Norges offentlige utredninger 2023: 8

Fellesskapets sykehus

Styring, finansiering, samhandling og ledelse

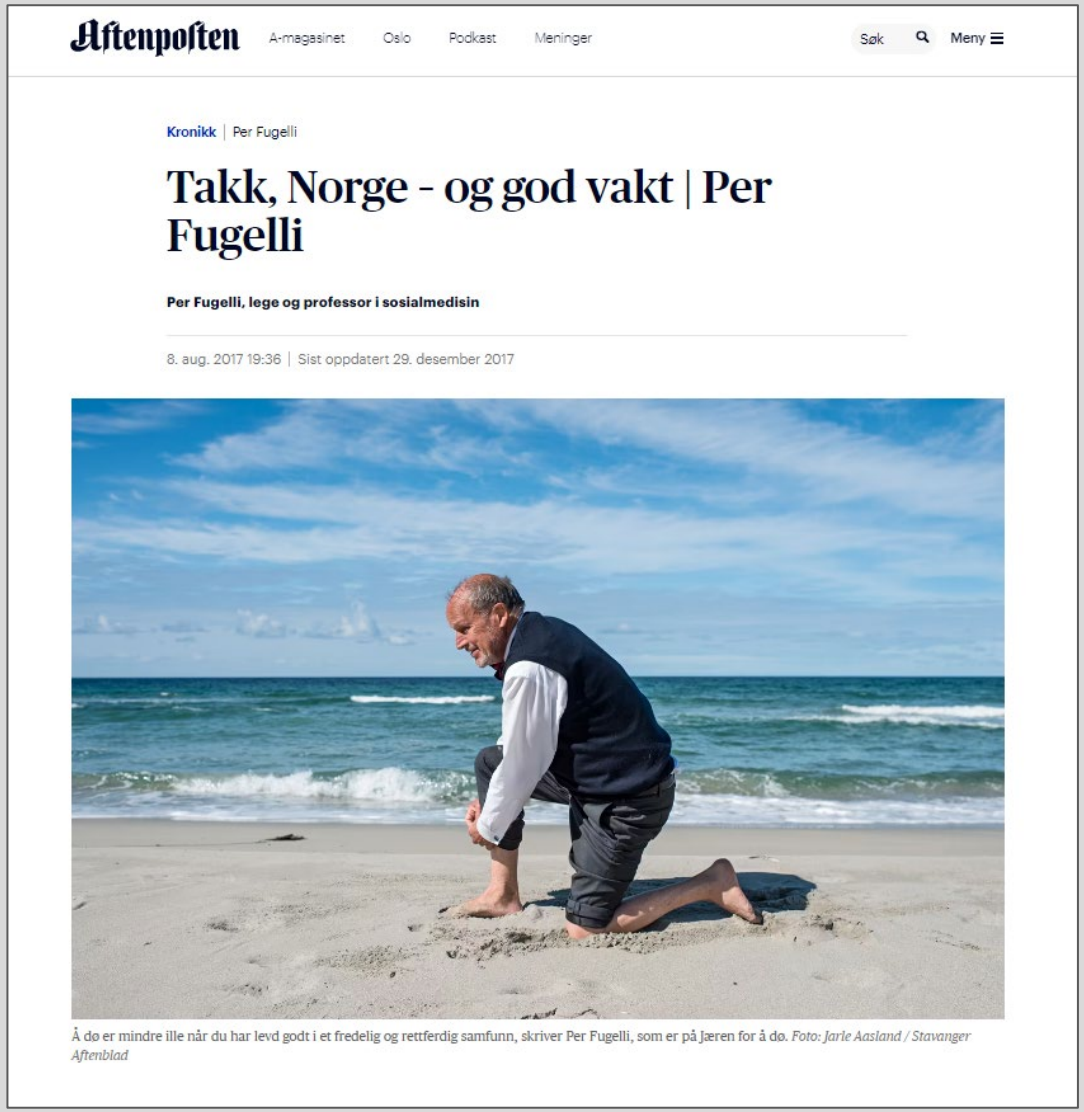




NOU Norges offentlige utredninger 2023: 4

Tid for handling

Personellet i en bærekraftig helse- og omsorgstjeneste



Det er lettere å dø når du vet at kjæresten din, ungene dine og barnebarna skal leve videre i Velferdsstaten Norge.

- Per Fugelli

Nå er det vår vakt!

Takk, Norge – og god vakt | Per Fugelli (aftenposten.no)