Tidsskriftet Tidsskrift for Den norske legeforening

Why are there waiting lists in the health service, and must we accept them?

PERSPECTIVES

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Given the emphasis placed on quality and cost control in the public specialist health service, waiting lists are inevitable and can even be beneficial. However, growing waiting lists can also undermine public trust in public services, creating a willingness to pay for private alternatives, which in turn carries the risk of increased costs and greater inequalities.

The waiting-time pledge from Norway's Minister of Health and Care Services, Jan Christian Vestre, has raised the question of why there are waiting lists in the health service, and whether they are unavoidable. It has been argued that making health care more affordable increases demand, and that opting for private care can help reduce waiting times in the public health service. Waiting lists can thus be viewed as a form of rationing in the specialist health service, with the private sector helping to relieve the pressure on overstretched public services.

Most agree that unnecessary waiting times for the investigation and treatment of serious diseases, where the benefits of treatment are well documented, are not acceptable. Most also agree that other services can wait. Meanwhile, a growing private sector, coupled with longer waiting times and inefficiencies in the public health service, may reduce patients' tolerance for waiting times and lead to them seeking private care.

In light of this, it is worth revisiting the key objectives of the specialist health service in Norway. We believe that two strategic measures could help reduce waiting lists without changing the Norwegian model. These measures involve controlling supply-driven and low-value care while strengthening generalist competence and clinical networks within the specialist health service.

Conflicting objectives lead to different solutions

Healthcare services delivered in a free market result in market failure. Without regulation, the market becomes inefficient because of factors such as supplier-induced demand, asymmetric information and external effects that are not reflected in market prices (1). To provide universal, equitable and accessible health care to the population, state regulation of the healthcare market is needed (regardless of whether health care is regarded as a commodity or a right) (2). The main challenge for the Government is balancing costs, quality and access (1, 3, 4).

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The United States operates a market-based model in which rapid access and quality appear to be prioritised over cost. In contrast, several Western European countries have adopted insurance-based models that regulate the provision and quality of health care. At the population level, all of these models result in shorter waiting times for those who can afford to pay or are covered by payment schemes, but they create unequal access to care. They also enable only limited cost control (5–7).

Waiting lists – the Achilles' heel of the Scandinavian

model

In the Scandinavian public health care model, state regulation balances the quality and cost of the service provision. This approach, however, can lead to waiting lists. Such lists serve as a natural rationing mechanism in systems where cost control and quality are prioritised over rapid access. It is therefore the state's responsibility to minimise the need for rationing to ensure that waiting times do not compromise patient care or public health.

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Strong public regulation is underpinned by a robust social contract between the state and taxpayers (8), which is based on the expectation that public welfare services are accessible whenever and wherever they are needed. In Scandinavia, activity-based funding forms part of a broader approach to managing waiting lists more effectively. However, this has not solved the problem: waiting times continue to grow despite incentives to increase service production. Simply increasing resources does not address the challenge of managing waiting lists (9, 10).

Waiting lists spiralling out of control

Allowing those who can afford to do so to pay privately for 'shortcuts' to health care risks undermining public trust and the social contract between the state and its citizens. It may also lead to a shift towards an insurance- or market-based model, which is known to drive up costs. Evidence suggests a rising demand for private health care in Norway, as reflected in the growth of private health insurance (11). This in turn is increasing the risk of greater inequalities in access to care. Competition between public and private providers for the same healthcare staff is also considered problematic.

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The growing demand for private services may be a result of disillusionment with the social contract, not due to lower quality but to increasing waiting times and unequal access to services. When universal access is no longer seen as a state priority, patients turn to private options that are considered more likely to deliver care when it is needed (8). Given the risk of higher costs and greater inequalities under a market-driven approach, we argue that the waiting list problem requires structural reform rather than privatisation or short-term boosts in resources with unproven impact, such as overtime in outpatient clinics (10).

Horizontal and vertical management can reduce waiting times

The negative effects of waiting lists as a rationing mechanism can still be mitigated by improving internal resource use within the health service. Waiting lists can be managed in two ways: horizontally and vertically, and these approaches are closely linked.

With a *horizontal approach*, beneficial care is prioritised over low-value care, and diagnostic procedures or treatments without a documented effect are eliminated. More is not always better, and considerable efficiency gains can be achieved by reducing overdiagnosis and overtreatment. But how do we determine what is well documented and beneficial? The renowned American healthcare researcher John E. Wennberg (12) categorised health care into three groups: *effective care*, such as treatments with well-documented efficacy and broad professional consensus; *preference-sensitive care*, where multiple treatment options exist and patient preferences should carry significant weight; and *supply-sensitive care*, where the intervention has a low cost–benefit value and consumption is driven by availability.

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Wennberg estimated that in the United States, 15 % of healthcare resources are spent on effective care, 25 % on preference-sensitive care and 60 % on supply-sensitive care with uncertain benefit or debatable efficacy (6). Although the United States spends roughly twice as much per capita on health care as Norway and the American figures are not exactly transferable, this framework can nonetheless help inform solutions to the waiting list problem (7). Broadly speaking, the problem is underuse of beneficial effective care and overuse of low-value preference- and supply-sensitive care. Controlling the volume of care and the supply per patient has a greater impact on waiting lists than controlling the price of services. Thus, it is the volume that must be managed. Wennberg notes that deprioritising low-value care is best achieved within clinical networks, but if this is not feasible, it must be centrally managed.

Jeffrey Braithwaite, another international expert in the field, suggests viewing health care in a 60–30–10 perspective (13). According to him, around 60 % of care is supported by sufficient evidence, including cost–benefit considerations; 30 % lacks such evidence and therefore represents a misallocation of societal resources; and 10 % of care is directly harmful to patients.

> ***«Broadly speaking, the problem is underuse of beneficial effective care and overuse of low-value preference- and supply-sensitive care»***

What does this mean for waiting times at Norwegian hospitals? For effective care, waiting times should be minimal in order to avoid loss of life or health. For preference- and supply-sensitive care, waiting times can have a positive, rationing effect. Patients are given time to try conservative treatments and lifestyle changes before undergoing any surgical interventions, for example in cases of hip or knee osteoarthritis. Studies show that systematic exercise can reduce pain and improve function, leading some patients to forgo surgery (14). However, Wennberg demonstrates that supply-sensitive care drives unnecessary utilisation, thereby contributing to unnecessarily long waiting lists. One such example is preference- and supply-sensitive outpatient follow-up.

A *vertical approach* involves scaling down the specialisation level of diagnostic and therapeutic services (15). The Norwegian health service is primarily based on the principle of lowest effective care level, supported by a well-developed primary care service. However, the specialist health service does not follow this approach (15), and more patients are being assessed and treated at a higher care level by specialists with less broad expertise. This results in parallel appointments with multiple clinicians within the specialist health service.

An intermediate level in the healthcare pyramid, staffed by specialists with broad expertise and the mandate and capacity to address multiple problems in a single consultation, would reduce the number of referrals, which could potentially shorten waiting times.

Wennberg also shows that referring multi-morbid, chronically ill patients to highly specialised, high-intensity care leads to overuse at the expense of both quality and cost-efficiency. He further demonstrates the self-reinforcing negative effect that occurs when unnecessary supply-sensitive interventions trigger additional consultations with different specialists, which leads to a demand for more specialist staff to manage the waiting lists that the healthcare providers themselves have unnecessarily created (12, 16, 17). Increasing resource use in low-value services risks legitimising them, diverting resources from beneficial care and prolonging waiting times.

It is possible to uphold the social contract

A successful horizontal and vertical approach to priority-setting – and, by extension, to managing waiting lists – has the potential to help redistribute resources to those who need them most, who stand to gain the greatest benefit and who require immediate access to stable services in order to carry on with their daily life, regardless of geographic location.

Focusing solely on reducing waiting times for all planned interventions and examinations in the specialist health service will neither improve public health nor eliminate waiting times. Instead, attention should be given to adjusting which services are provided, where follow-up will be carried out and who is responsible for it. Stronger governance of beneficial and effective care (18), delivered at a lower specialist service level with an enhanced mandate for

broad-based expertise and networked collaboration, can substantially reduce waiting lists, free up resources, improve quality and strengthen public trust in the health service (15).

Greater insight is needed into how waiting lists are prioritised and organised according to these principles. Understanding the implications of health policy and economic decisions also requires increased investment in healthcare research in Norway.

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Publisert: 23 February 2026. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.25.0787
Received 15.12.2025, first revision submitted 19.1.2026, accepted 22.1.2026.