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Priority setting – and other strategies for improving resource use

PERSPECTIVES

MORTEN MAGELSSEN

mortemag@uio.no
Morten Magelssen, professor and head of the Centre for Medical Ethics, University of Oslo
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MATHIAS BARRA

Mathias Barra, research professor at Health Services Research, Akershus University Hospital, and professor at the Division of Health Services Research and Psychiatry, University of Oslo
The author has completed the ICMJE form and declares no conflicts of interest.

ELI FEIRING

Eli Feiring, political scientist, professor of health policy and medical ethics at the Department of Health Management and Health Economics, University of Oslo, and Vice-Dean at the Faculty of Medicine, University of Oslo
The author has completed the ICMJE form and declares no conflicts of interest.

HENRIETTE SINDING AASEN

Henriette Sinding Aasen, professor of law at the Faculty of Law, University of Bergen
The author has completed the ICMJE form and declares no conflicts of interest.

When resources are scarce, the health service must use them wisely. Priority setting, choosing wisely (as part of the Choosing Wisely Norway campaign), withholding treatment and efficiency measures are four strategies that can help improve resource use.

There is often no clear distinction made between the four approaches, and all are sometimes referred to as 'priority setting'. We believe it is important to understand their definitions and how they overlap and differ from one another.

Scarce resources

The health service has never had, and will never have, sufficient resources to provide *all* beneficial and/or desirable health care. As diagnostic and treatment options expand, the gap between desirable and sustainable resource use increases further. All of the key resources in the health service are scarce: staff and their expertise, time and attention (1), equipment capacity, hospital beds and money.

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Not all resource use in the health service improves health outcomes; some healthcare interventions have little or no benefit and sometimes more resources are used than necessary. It has been estimated that 20 % of resource use in hospitals could be eliminated without adversely affecting patients' health (2). Overdiagnosis and overtreatment are a significant challenge.

Regardless of the size of health budgets, it is essential to use resources wisely. In addition to improving efficiency, many consider clearer *priority setting* to be a necessary part of the solution. However, the actual concept of priority setting is often applied incorrectly. Politicians and managers frequently refer to priority setting as placing greater focus on something and allocating more resources to it (up-prioritisation) – they are less likely to discuss what should be deprioritised (3). The term is often used broadly to cover all decisions about how resources should be allocated in the health service. However, at its core, *priority setting* involves saying *no* to one thing in order to be able to say *yes* to another. We consider it important to clarify the understanding and application of priority setting and to distinguish it from related concepts such as choosing wisely (as part of the *Gjør kloke valg* (Choosing Wisely Norway) campaign), withholding treatment and efficiency measures (Table 1) (4–6).

Table 1

Four approaches to improving resource use

Approach	Key principle	Definition	In the patient's interests?	Typical conflict of values
Priority setting	Fair distribution of scarce healthcare resources	Withholding potentially beneficial health care because limited resources should be used for something more important (4)	No[1]	Patient's wishes and needs versus fair distribution
Choosing wisely	Avoiding unnecessary interventions	Forgoing tests and treatments that patients do not benefit from and could cause harm (5)	Yes	Usually no conflict of values
Withholding treatment	Avoiding overtreatment at end of life	Stopping, or not initiating, a potentially life-prolonging treatment for a seriously ill patient (6)	Yes	Uncertainty or disagreement about the patient's best interests
Efficiency measures	More for the same, or the same for less	Modifying an intervention to improve health outcomes and/or reduce resource use	Neutral or yes	Increased burden on staff

[1] Other than the patient having a personal interest in being part of a society in which the health service manages its resources well and distributes them fairly

Priority setting

The following are three hypothetical examples of priority setting in everyday clinical practice.

The intensive care unit is at full capacity. The doctor in charge assesses which patients have the least need for monitoring and can therefore be moved to a ward, in order to accommodate newly admitted patients with a greater need.

At the emergency department, a patient with sudden, severe abdominal pain is given a high priority and is seen by the doctor within 15 minutes, while three others in the waiting room with less urgent symptoms are moved down the queue.

The senior consultant reviewing new outpatient referrals schedules patients according to a deadline set in line with the priority-setting guidelines. Some patients are deemed not to have a right to necessary health care under the priority-setting criteria and are therefore denied an appointment.

Priority setting in everyday clinical practice often means that patients receive *good (enough)* care rather than *optimal* care. In all three examples, there are patients who do not receive what, in isolation, would be considered the optimal care for them. The decisions here are based on the scarcity of resources and the need to allocate resources to patients with the greatest need. These examples therefore align with the narrow definition of priority setting in Table 1.

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In order to support decision-making in complex priority-setting cases, the health authorities have defined legally mandated priority-setting criteria for the specialist health service: *benefit*, *resource* and *severity*. The Norwegian Parliament (*Storting*) has approved use of these criteria throughout the health service (Box 1). We believe that doctors, managers and other healthcare personnel need to better understand priority setting (7), and we are in the process of publishing a textbook on the topic (4).

Box 1 The three priority-setting criteria (8).

Benefit criterion: The priority of an intervention increases in line with its expected benefit.

Resource criterion: The priority of an intervention increases the less resources it requires.

Severity criterion: The priority of an intervention increases in line with the severity of the patient's condition.

The priority-setting criteria have been developed to enable the health service to provide the best possible care within the limits of its available resources.

Choosing Wisely Norway campaign

The Choosing Wisely Norway campaign – an initiative of the Norwegian Medical Association – is the Norwegian version of the American *Choosing Wisely*. The campaign highlights overdiagnosis and overtreatment and encourages clinicians to refrain from carrying out diagnostics and treatments that offer little or no benefit and may cause harm in the form of side effects and complications.

At the core of the campaign are evidence-based recommendations from medical associations. For example, the Norwegian College of General Practice has issued the recommendation: 'Healthy people without symptoms or known risk factors do not need regular health check-ups, but may benefit from discussing their health'. The Norwegian Orthopaedic Association recommends: 'Refrain from referring middle-aged and older patients with knee or hip pain for MRI as the first imaging investigation'.

The campaign and its recommendations are explicitly *not* motivated by resource considerations. Nevertheless, the wise choice approach has positive implications for resource use in the health service. Forgoing unnecessary diagnostics and treatments frees up resources that can benefit other patients.

Choosing wisely benefits the patient by ensuring they do not receive care that is of little benefit and/or potentially harmful, while simultaneously benefiting the health service by freeing up resources.

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Withholding treatment

A third approach is withholding treatment. In the course of many illnesses, a point is reached where the question arises of whether 'enough is enough', and whether it might be in the patient's best interest to prioritise quality of life in the time they have left over prolonging their life. Withholding treatment is a general term covering everything from decisions about 'DNR orders' and withdrawal of intensive care to forgoing cancer treatment or antibiotics. A couple of hypothetical examples are as follows: a patient with multi-organ failure receives advanced intensive care, but it is determined that the likelihood of survival with an acceptable quality of life is now so low that withdrawing treatment is appropriate. A patient with advanced dementia has stopped eating, and the nursing home doctor decides to discontinue artificial hydration and nutrition to avoid prolonging the dying process.

Withholding treatment can overlap with priority setting and choosing wisely, but it specifically relates to decisions for seriously ill patients and those in the final phase of life. When a treatment may have some benefit but that benefit is disproportional to the resources required, the decision to withhold or withdraw treatment is, by definition, a result of priority setting. However, withholding treatment is more often based *not* on resource considerations, but on the patient's best interests, values and preferences, as well as what is medically possible and professionally justifiable. In such cases, we can say that withholding treatment entails 'choosing wisely' in relation to life-prolonging treatment. Nevertheless, these decisions can still have major implications for resource use, as the two examples above illustrate.

Efficiency measures

Efficiency involves using the least possible resources to achieve the best possible outcome. Efficiency measures can result in achieving the same outcome with fewer resources, a better outcome with the same resources, or – ideally – a better outcome with fewer resources. Examples include shifting straightforward cases to day surgery, or using cheaper but equally effective medications or equipment.

‘Task shifting’ can illustrate the boundary between priority setting and efficiency measures. If staff with lower wages and fewer qualifications than doctors can take over some of their work and perform it with the same (or better) quality for the patient, this is an efficiency gain. However, if the patient would have been better served by seeing a doctor and the quality of care is slightly reduced, this is, by definition, a result of priority setting.

Varying rationale and conflicts of values

In practice, it can be difficult to distinguish clearly between priority setting, efficiency measures, choosing wisely and withholding treatment, and as shown, the concepts can overlap. Nevertheless, we believe that doctors should keep the four approaches separate because they are based on different principles and rationale (Table 1).

Priority setting, in the narrow sense, is not primarily for the benefit of the individual patient – the resources are given to others who need them more. Here, the ethical principles of autonomy and beneficence are weighed against fairness. The ethical rationale for prioritisation is grounded in equal treatment and the responsibility to manage society’s shared resources.

Conversely, the choosing wisely approach is primarily based on the patient’s best interests. Withholding treatment is guided by the principles of beneficence, non-maleficence and fairness. Unless the patient insists on receiving care, there is no conflict of values here.

Decisions on withholding treatment are common in the health service. They are often in the patient’s best interest as they prevent overtreatment and facilitate a peaceful death. Ethical issues sometimes arise when there is uncertainty or disagreement about what is actually in the patient’s best interest. Healthcare personnel and the patient’s family may have differing views. This is one of the most common ethical issues discussed in clinical ethics committees (9).

More efficient use of healthcare resources may, at first glance, appear to be an unequivocally positive measure and thus a ‘low-hanging fruit’ for managing resources in the health service. In practice, however, the flip side of the coin can be that doctors are expected to see more patients and stretch themselves beyond reasonable limits.

Priority setting is unavoidable

Priority setting, choosing wisely, withholding treatment and efficiency measures each contribute in different ways to improving resource use in the health service. The definitions, motivations, guiding principles and rationale all differ. It is therefore useful to keep them separate; if they are conflated, it can lead to misunderstandings and a loss of trust.

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One example is when families feel that treatment was withheld to save resources rather than in the patient's best interest (priority setting). Another example is when a cost-saving measure that reduces the quality of care is described by management as an 'efficiency measure'. This is problematic if the measure is actually a result of priority setting, and describing it as an efficiency measure conceals the decline in quality.

Priority setting involves 'saying no to benefit', whereas choosing wisely involves 'saying no to no benefit'. Unlike priority setting, choosing wisely is in all parties' best interests. This makes it easier to gain acceptance for among healthcare personnel and patients compared to priority setting.

However, even when all systems run smoothly, all time-wasting is addressed and all wise choices have been made, resources will still be scarce. Priority setting is inevitable for managers and doctors in everyday clinical practice (4).

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