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BETWEEN POWERFUL PATIENT STORIES AND "DEATH CALCULATOR"

How do the media cover the difficult dilemmas of priority-setting in the healthcare system, and how can journalists balance the perspectives of the patient, the public finances and democracy when a healthcare system under pressure must choose what to do — and what not to do?

CONSTRUCTIVE INSTITUTE
Journalism for tomorrow

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1. Introduction. On August, Ditte Giese and powerful patient angles in the middle of healthcare's priority-setting storm

I cried my way through the 48-minute documentary about little August in the wheelchair. I assume many other television viewers did the same when the documentary *The Price of August* was broadcast on Denmark's national public service channel, DR-TV, in early November 2025.

Seven-year-old August suffers from an extremely rare genetic disease, SPG50, which breaks down his nervous system so that his body is gradually paralysed and he loses his speech, his mobility and his cognitive abilities. There is no treatment for the rare disorder, and in 2022 doctors told August's powerless parents that August would die before reaching adulthood.

But since the spring of 2023, August's parents have found hope. A hope that has made them very frequent guests in the Danish media:

A completely new experimental gene therapy developed in the United States may be able to help August. The treatment cannot cure him, but the hope is that it can slow any further progression of the disease. So far, the treatment has been tested only on a very small group of primarily American children with the same genetic defect as August, and the preliminary results suggest that there may be an effect.

But the treatment is expensive. Very expensive. The price of one treatment runs into several million kroner, and because there is still no clear research-based documentation that the treatment works, the Danish healthcare system will not pay for the very expensive treatment.

Yet August's parents do not give up the attempt to help their son. Through a private fundraising campaign, the family is trying to raise the DKK 7 million it will cost both to treat August and another boy with the same disease and to set up a research study, so that doctors at Rigshospitalet can test and assess the medicine's effect in parallel — for the benefit of other and future patients as well.

It is because of this fundraising campaign that, over the past couple of years, we have encountered August and his parents in numerous Danish media outlets.

The family has, among other things, appeared on the front page of *Politiken* to draw attention to August's situation and the fundraising campaign. His parents have appeared on *Aftenshowet* and *TV-Avisen*. On P1. In *Jyllands-Posten*. On TV2 Østjylland. In *Ugebladet Skanderborg*. In *Nyhederne*. In *Ude og Hjemme*. In *Horsens Folkeblad*. In *Vejle Amts Folkeblad*. In *Frederiksborg Amts Avis*. In *Ebeltoft Folketidende*. And in a great many other local, regional and national media outlets. The family has appeared in television and radio segments, just as support and fundraising groups have been created on Facebook, Instagram and elsewhere, where sympathetic citizens and companies can donate money for August's treatment.

In articles and broadcasts, we hear how the crisis-stricken family is, of course, desperate because time is working against them and because the Danish healthcare system will not offer the treatment to their sick son.

The newspaper headlines include: “August has only one chance. Every krone and every second count.”

“Six-year-old August suffers from a rare disease. The cure has been invented, but it is astronomically expensive.”

“Desperate father believes he can save society millions of kroner.”

“A race against death: in nine months, time runs out for the seven-year-old boy.”

On top of the many articles and news items, DR has produced the 48-minute documentary film *The Price of August* about the family’s struggle.

So far, the effort has borne fruit. The family is approaching the target. According to the website “Sammen for August” — Together for August — the family has so far collected just over DKK 4.5 million, and the plan is for August to receive his treatment at Rigshospitalet in 2026.

The story of August is moving and dramatic. It is full of emotion, desperation and hope. It is not difficult to understand why his loving, strong, sorrowful, hardworking and sympathetic parents are fighting this fight for their son.

Nor is it difficult to understand why so many media outlets tell the story of August and his family. It contains every element needed for a compelling, striking and dramatic journalistic human story:

It calls on our compassion and fellow feeling. It touches our worst fears as parents and our most heartfelt hopes. At the centre is a sweet and smiling little boy and his sympathetic mother, father and sister, fighting against time and death. Against superior forces and injustice. There are victims, villains and heroes in the story — and many ups and downs. The Danish healthcare system will not pay, and even U.S. President Donald Trump has thrown a spanner in the works for August’s treatment with his decision to stop certain research funds. The resourceful parents tirelessly invite journalists and photographers into their home, and we feel for them when they cry and rejoice.

But why am I writing all this about August?

Why should you, as a journalist or healthcare professional, read about this case?

You should because the story of August matters — not only to the family, but also to us journalists. For it is not unique.

These years, readers, viewers and listeners are being presented in the media with more and more stories of fate in which desperate, seriously ill patients and their relatives fight to make the healthcare system pay for new, expensive medicine or a newly developed treatment in the hope that it may save

them or prolong their lives. Who would not do the same if they themselves were a desperate patient or relative with little hope left?

We all know that in recent years several new types of promising and effective medicines have been developed — for example immunotherapy, which has almost revolutionised the treatment of certain cancers. There are several examples of people with the very serious skin cancer known as stage 4 melanoma actually becoming completely cancer-free through immunotherapy targeted personally at them.

The pharmaceutical industry is working intensively to develop more effective treatments of this kind, but that takes time, it is extremely costly, and far from all newly developed treatments end up having the same marked effect.

But when, as a patient, your back is against the wall — when you have been declared incurably ill or have a severely disabling chronic disease — you are often willing and desperate to try new medicine that can rekindle the hope that is otherwise slipping away.

In cases of this kind, the road to the ears, attention and purse of politicians and the healthcare system often runs through the media, and patients and relatives therefore contact us journalists to an increasing extent in order to create attention around their case. They may want, for example, to start a fundraising campaign for treatment abroad or to put public pressure on politicians in the hope of being granted a specific new and expensive treatment. A treatment that is often these patients' only hope.

In the past couple of years, among others, three younger women with metastatic and incurable breast cancer have each appeared in the media to describe their desperation over the Danish Medicines Council's refusal to recommend new types of breast-cancer medicine aimed precisely at their form of breast cancer.

Medicine that the seriously ill women and their doctors believed they might benefit from, and medicine that has been approved by the European Medicines Agency and taken into use in, among other places, Sweden and Norway.

The three women — Lena Rosenkilde, Zenia Funch and Ditte Giese — all had children, and all three suffered from particularly stubborn and aggressive forms of breast cancer that had already spread in their bodies. In other words, the women were incurably ill with their cancer, and there were no other, or only very few other life-prolonging, treatment options for them.

According to the pharmaceutical manufacturers and the research, it was likely that the new medicine could prolong the lives of women with metastatic breast cancer. But the documentation was not sufficiently clear, the Danish Medicines Council believed, and at that time it therefore said no to Danish hospitals taking the medicine into use as standard cancer treatment. Patient organisations sharply criticised the fact that in Denmark we denied patients the medicine while other countries had already adopted it.

Two of the women with breast cancer who stepped forward in the media with their frustration and desperation were themselves doctors, and the third, Ditte Giese, was a journalist and commentator.

All three women decided to start private fundraising campaigns in order to afford to pay for the million-kroner treatment themselves. Each of them succeeded in raising enough money so that — with delay — they could buy the treatment in Sweden or at private clinics in Denmark. Since then, the relevant types of medicine have been recommended by the Danish Medicines Council in Denmark and are now standard treatment for these forms of breast cancer. Research shows that, on average, the medicine can prolong patients' lives by six months, and it costs roughly DKK one million per treatment.

How long — and whether — the medicine prolonged the lives of the three specific women, I cannot establish.

Sadly, all three have now died of their cancer.

A few days before one of the three women, Ditte Giese, died of breast cancer in January 2026, she said her public farewell from her hospital bed in an op-ed in *Politiken*. In it, she issued a sharp criticism of the Danish healthcare system and of the Danish Medicines Council's priorities, which, she believed, had had a decisive impact in limiting and delaying her treatment options. In fact, she expressed the view that the lack of medicine approval was the reason she now had to die.

She wrote, among other things:

> "I can see that there are all sorts of treatments in other countries that I cannot get anywhere near in my own country. We all believe that we have a fantastic hospital system. Lars Løkke Rasmussen, in his role as minister of health, introduced the cancer packages, and then there is money for prevention and aftercare. But not much has happened to secure new cancer medicine quickly. And that is now in the process of killing me and destroying my family."[1]

A few months after her death, *Weekendavisen* published an article about Ditte Giese's case and the Danish Medicines Council's assessments under the title "Death's Calculator".

As a long-standing health reporter at the Danish national newspaper *Jyllands-Posten*, I myself have written stories about desperate and seriously ill patients who, in the same way as the three women, fought to get the healthcare system to recommend new, expensive medicine more quickly — medicine they hoped would prolong their lives by weeks, months or perhaps even years.

I would be lying if I claimed that the patients' stories did not move me deeply.

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[1] https://politiken.dk/debat/klummer/art10699722/Farvel-k%C3%A6re-l%C3%A6sere

But there are other reasons too why the story of August and the stories of the incurably cancer-stricken women are important for us journalists to confront.

The stories represent the difficult dilemmas we journalists face when we move into the ethical crossroads that can best be described as a journalistic minefield:

On the one hand, we have a healthcare system under financial and staffing pressure, which is increasingly forced to prioritise some healthcare services and some patient groups over others. On the other hand stands the individual patient or relative with their understandable and heartfelt wish to try the best, newest, most expensive — or only — treatment option available to them. The treatment that can give them hope of improvement, relief or perhaps even cure, no matter how fragile that hope may be.

How do we approach this, and where do we place ourselves as media and journalists if we are to embrace both the individual patient's perspective at the level of the individual and society's — and taxpayers' — broader perspective: namely, the necessity of setting priorities in a pressured healthcare system and ensuring that we get as much health as possible for the healthcare tax kroner we have?

The dilemma is almost crystal clear and loudly insistent:

If politicians, the healthcare system or the Danish Medicines Council choose to say yes and offer a new, extremely expensive cancer medicine for a specific type of cancer — one for which the evidence may be uncertain, or which may only prolong a cancer patient's life by a few weeks or months, with continued suffering and intensive treatment — the consequence is necessarily that the money must be taken from something else. In other words, there will be other patients or patient groups whom we, as a society, will have to deselect or say no to helping. In future, these patients will therefore not receive the medicine, examination, care or treatment they otherwise would have received. For money, as we know, cannot be spent twice.

The journalistic dilemma is not made any smaller by the fact that the patients or patient groups we must deselect in the future as a consequence of prioritising another patient group cannot be precisely identified. We cannot point to who these deselected patients concretely are; we cannot put faces to them; we cannot interview them on an equal footing with the patients who receive a yes to the extremely expensive medicine.

And so we cannot balance our journalistic coverage. The pressing questions are therefore now these:

Can we as journalists meaningfully cover both perspectives in the priority-setting dilemmas, and if so, how? Who should decide, and how should we decide, which patients receive a yes and which receive a no? Can we as media play a role in illuminating the difficult priority-setting dilemmas in which doctors, economists and politicians often find themselves? Can constructive journalism perhaps play a role in ensuring a democratic and inclusive debate about the difficult dilemmas and the best use of the healthcare system's resources?

That is what I will try to examine in the following pages.

2. How the report is structured

In this report, I will delve into the pressing priority-setting choices that the Danish healthcare system, patients and politicians increasingly face and must address or take a position on.

The report concerns only the Danish healthcare system and should therefore be understood in a Danish context, with a healthcare system that is mainly tax-financed and rests on principles of free and equal access to healthcare services. From international media and from teaching in the course Health Politics at the Department of Political Science at Aarhus University, I know that many other countries around us struggle with similar problems to a greater or lesser extent.

In Denmark, no one can be in any doubt that the healthcare system is under steadily growing pressure, and priority-setting has truly been put on the agenda. The Danish Medicines Council was established in 2017 to prioritise among the many and very expensive new medical treatments being developed for the joy and benefit of seriously ill patients, and in the reports of both the Resilience Commission from 2023 and the Health Structure Commission from 2024 — as well as in the political agreement on a new health reform the same year — the necessity of priority-setting has been stressed again and again.[2]

The government decided, among other things, that a completely new National Priority-Setting Council should be established. Its establishment has now, however, been postponed until autumn 2026 because of the general election in spring 2026.

The new priority-setting council is to "create transparent and systematic prioritisation of healthcare interventions, medicine and treatments, so that resources are used where they do the greatest good for patients".[3] In other words, the council must ensure that we obtain as much health as possible for the healthcare kroner. It must, among other things, take a position on whether new treatments should be introduced and whether existing treatments should be phased out.

In this report, I will examine and describe the cross-pressure on the healthcare system and its resources in these years. I will do so using data from, among others, the Resilience Commission and the Health Structure Commission, as well as interviews with a wide range of experts and organisational representatives in the field.

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[2] https://www.ism.dk/Media/638545635292256419/Hovedrapport-tilg%c3%a6ngelig-fil.pdf

and https://www.ism.dk/Media/638336462586551242/Robusthed-Samlet-Rapport-TILG.pdf

[3] https://regeringen.dk/media/ktllkbtp/01-aftale-om-sundhedsreform-2024.pdf

I will also examine and describe how priority-setting is carried out today.

I will then examine how we as media typically cover the difficult priority-setting dilemmas and decisions in the field of health today. I will do this, among other things, through a case: media coverage of the Danish Medicines Council's decisions. Through searches in an article database, I will retrieve the articles written in Danish media over the past five years about the Council's decisions on the use of new, expensive hospital medicine. Subsequently, I will analyse and code/categorise the articles according to whether they predominantly take a critical, neutral, positive or nuanced/explanatory angle on the Council's decision to recommend or not recommend newly developed medicine and treatments.

Finally, I will offer a number of ideas and proposals for how we as journalists can concretely cover the difficult priority-setting choices and dilemmas also with a constructive angle or approach.

3. A current temperature reading: the healthcare system under massive cross-pressure

For decades we have heard about the shortage of doctors and specialists. It is difficult — indeed almost impossible — to lure general practitioners to peripheral areas, and young doctors have no desire to train as specialists in psychiatry, geriatrics, general practice or radiology.

For many years we also heard about years-long waiting times for planned operations and about cancer patients who have to wait longer than the maximum waiting times that clinical guidelines and the treatment guarantee state they may wait.

At the same time, warnings have for years sounded from, among others, patient organisations about a lack of coherence for patients when highly specialised hospitals discharge fully treated or post-operative patients earlier and earlier without municipalities and general practitioners being ready to receive them with the necessary care and continued treatment.

That the healthcare system is challenged is neither new nor surprising.

Nevertheless, the worried frowns of health economists, politicians and healthcare organisations alike have become markedly deeper in recent years.

From many sides, warnings are now being issued about a healthcare system in danger of collapsing. This is not due simply to individual factors such as the shortage of doctors or the lack of coherence for patients. It is due to a formidable cross-pressure on the healthcare system, where a wide range of factors — demography, politics and social trends — interact and reinforce the pressure on the health service.

Within the past couple of years, both the Resilience Commission and the Health Structure Commission have produced thick reports that analyse and describe in detail the state and challenges of the healthcare system. The commissions provide a series of recommendations to politicians about what must be done to future-proof our healthcare system.

Let us take a closer look at the cross-pressure:

According to the Health Structure Commission, there are overall three important trends that are fundamentally changing the conditions for the Danish healthcare system. The graphics and tables are taken from the commissions' reports. In addition, several health economists point to a fourth significant factor that is also at play.

The following pages on the cross-pressure are written partly on the basis of the two commissions' reports and partly on the basis of interviews with Jakob Kjellberg, professor of health economics at VIVE, and Jes Søgaard, professor emeritus of health economics at SDU.

a) A changed disease picture — we live longer and develop more chronic diseases

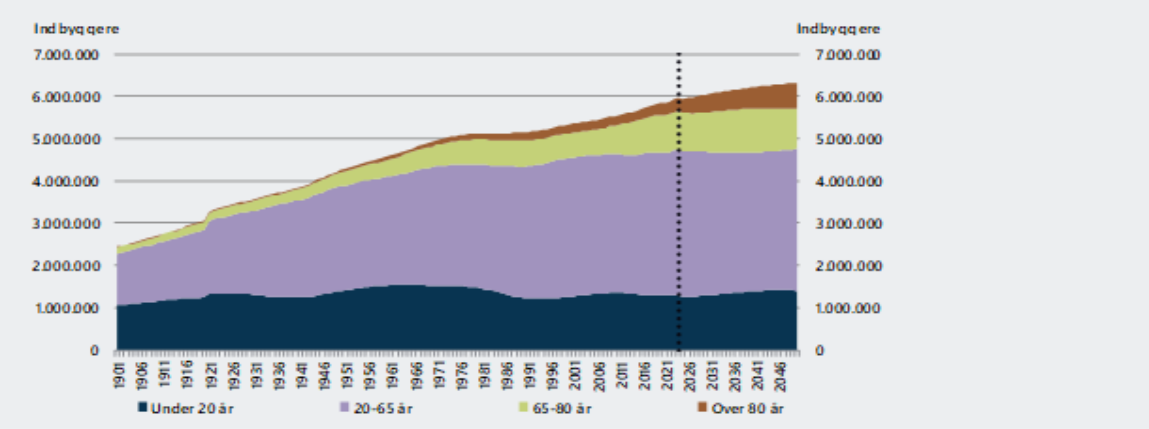
First, the disease picture in the population is changing markedly, for both young and older people. Let us take the latter group first: in future there will be far more older people and far more people with multiple diseases in our society.

By 2035, the proportion of the population aged 80 or older will increase by 14 per cent.

And by 2050, the proportion will have doubled compared with today.[4]

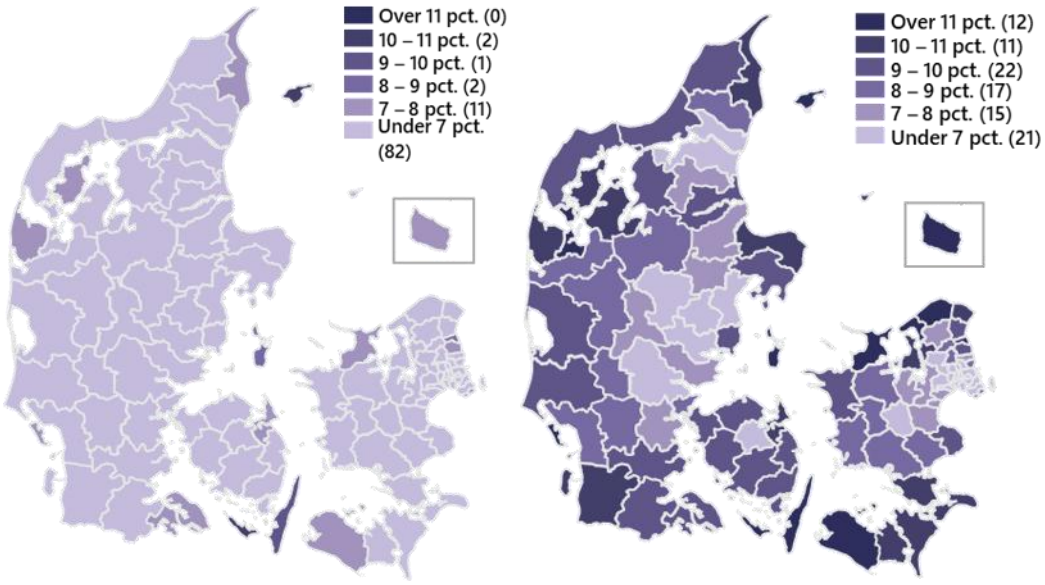
The following six figures in this chapter are also reproduced from the report of the Danish Health Structure Commission.

Population by Age, 1901–2050



[4] https://www.ism.dk/Media/638545635292256419/Hovedrapport-tilg%C3%A6ngelig-fil.pdf

Share of the Population Aged 80 and Above in the Municipality

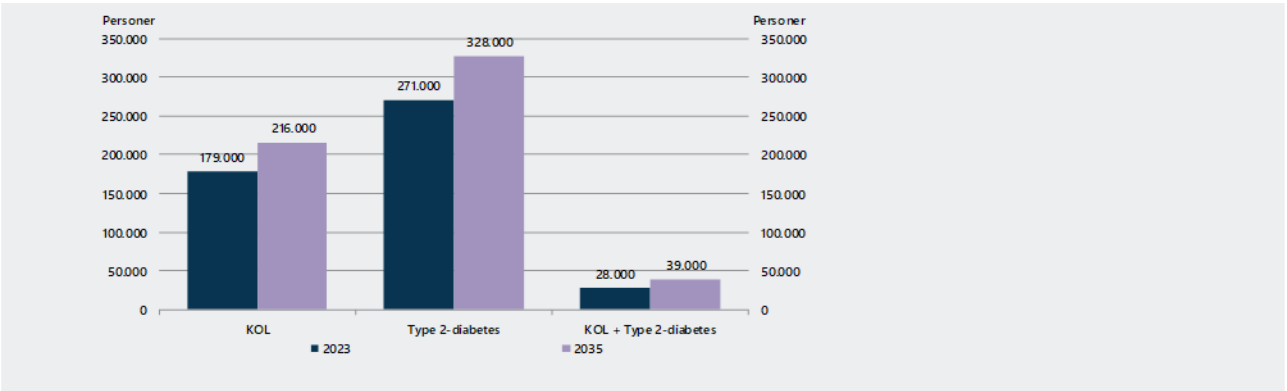


When the population as a whole grows older, more citizens will develop age- and lifestyle-related diseases, just as more citizens can expect to live longer with chronic diseases such as dementia or COPD.

Today, one in five Danes suffers from at least one chronic disease. Over the past ten years, the group has grown by 160,000 citizens. That corresponds to an increase of 20 per cent. At the same time, the number of people suffering from several different chronic diseases has doubled.

Even more citizens will therefore need treatment and care in connection with dementia, heart disease, COPD, diabetes and so on.

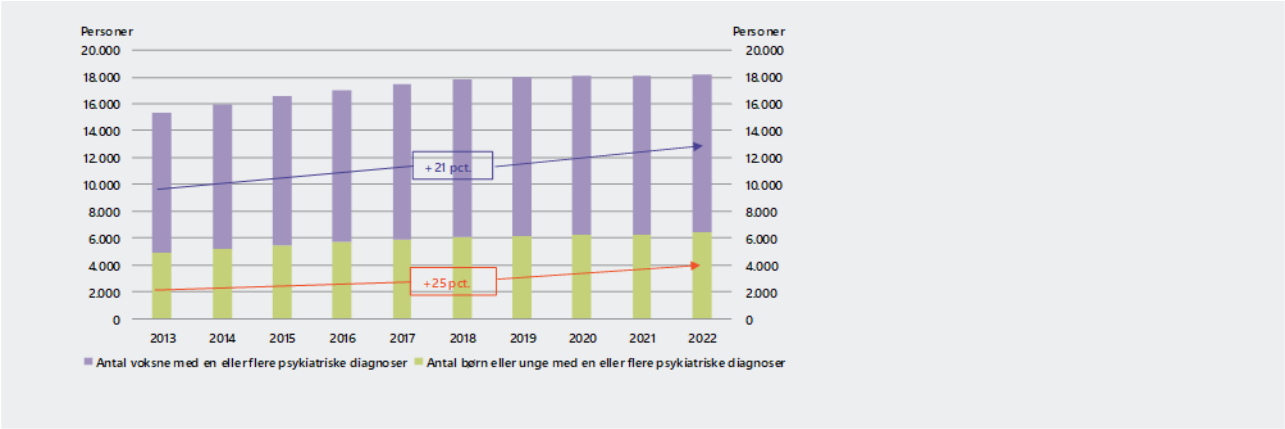
Projection of the Number of People with COPD and Type 2 Diabetes, 2022 and 2035



At the other end of the age spectrum, there are also significant shifts. More and more children and young people are receiving psychiatric diagnoses — especially anxiety and developmental disorders such as ADHD are increasing. Today, around 74,000 children and young people under the age of 18 have such diagnoses. That corresponds to 6.4 per cent of all children and young people, and the number has grown by 25 per cent in less than ten years. There is no indication that the increase will stop. Quite the opposite. A projection shows that in 2035 there will be 78,000 children and young people with a psychiatric diagnosis.

Among adults, the diagnosis curve has moved in the same direction.

Trends in Psychiatric Diagnoses



b) The shortage of important healthcare-trained professional groups is increasing

The shortage of specialists has been a topic for decades. Significantly more doctors are now being trained, and there is a prospect that we will reach a point with too many doctors, but there is still currently a shortage of specialists. The challenge now is to turn doctors into the specialists the healthcare system lacks. It will therefore take quite a few years before the alarm over the shortage of specialists can be called off.

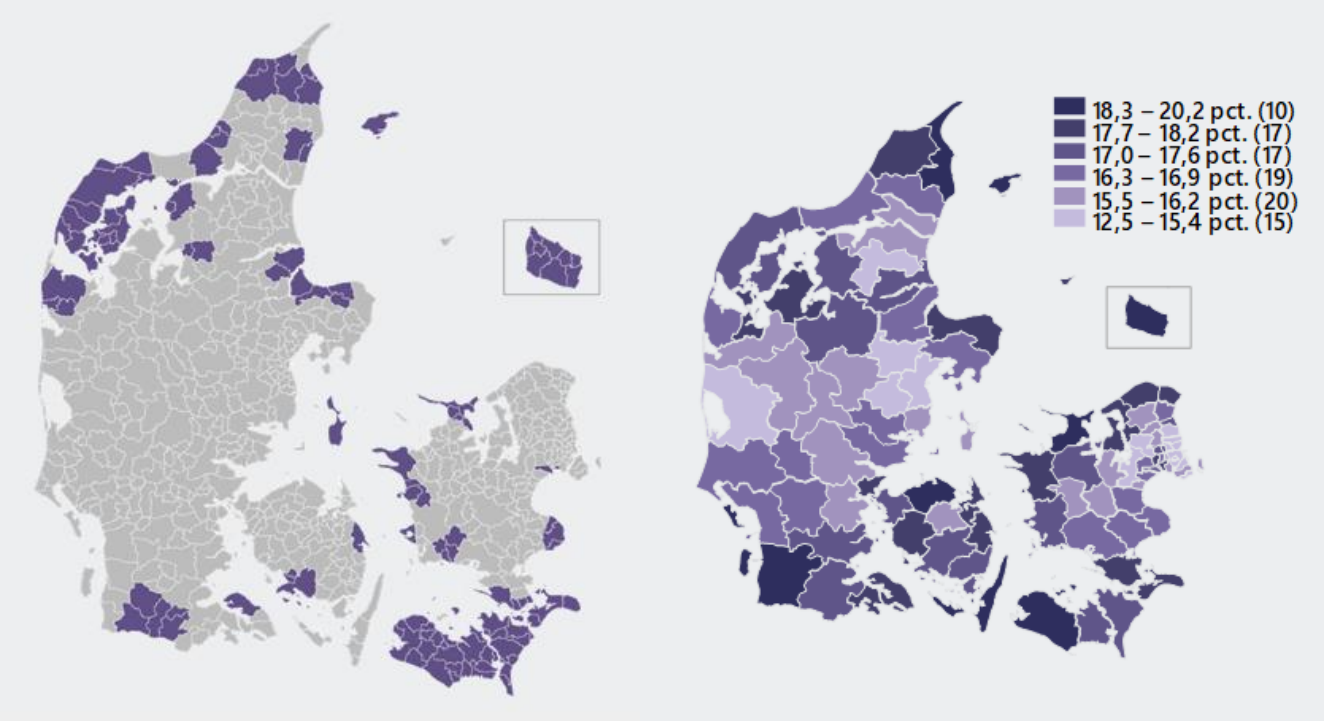
At the same time, it remains a major challenge to get specialists — both general practitioners and hospital specialists — trained and rooted in the parts of the country where they are most needed and where they are most lacking. It is also lagging behind when it comes to training enough specialists within the medical specialties where the existing shortage is greatest and within the specialties where the patient population is currently growing most — such as psychiatrists, radiologists, geriatricians and so on.

A glaring paradox is that the parts of the country — typically peripheral and rural areas — where there are most older and chronically ill patients are also the places where there are fewest specialists.

The two maps of Denmark below show very clearly the challenges created by the uneven geographical distribution of doctors.

Areas at Risk of Shortages of GP, 2021–24

People with Chronic Disease per 1,000 Population, 2022



When it comes to nurses and social and healthcare assistants and helpers, the recruitment problems are actually even more pronounced.

And there is no immediate prospect of improvement: the number of applicants for welfare education programmes has fallen rapidly. It is difficult to get young people to choose the care and nursing professions. Trade organisations frequently appear in the media with descriptions of low wages, heavy workloads and lack of prestige.

At the same time, the healthcare system is facing a significant generational change in the coming years. Many doctors, nurses and not least social and healthcare assistants and social and healthcare helpers will reach retirement age and leave the labour market. This will aggravate the shortage of care staff.

According to the Danish Medical Association's labour-force analysis, the Danish healthcare system will be short of 40,000 healthcare workers in 2030.[5]

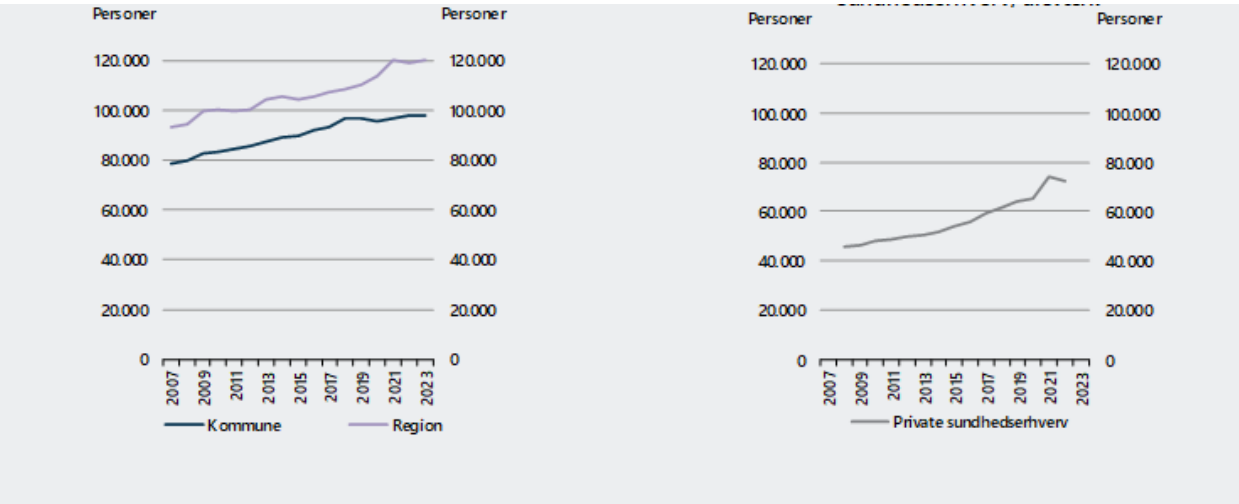
But the data also reveal another paradoxical challenge:

Although we have for years had marked difficulties recruiting enough staff to treat and care for the growing patient group, the healthcare system has never employed more staff than it does today.

Denmark is among the OECD countries with the most employees in the healthcare system relative to total employment. Today, about 290,000 people are employed in the Danish healthcare system if the elderly-care sector is included. That corresponds to about one in ten people employed in Denmark. By comparison, 3 per cent of the workforce was employed in the healthcare system in 1966.

In other words: we cannot solve the problems simply by training and employing more and more people in the health sector. From a national economic perspective, that would be inappropriate. Many sectors are crying out for labour — the armed forces, the primary school, industry and the skilled trades.

Left: People Primarily Employed in Healthcare and Elder Care. Right: Trends in Healthcare and Elder Care Personnel Primarily Employed in the Private Healthcare Sector (Full-Time Equivalents)



[5] https://laeger.dk/foreninger/laegeforeningen/politik/laegeforeningens-analyser/arbejdskraftsanalyse-2023

c) Higher expectations and demands from patients

A third challenge, highlighted by the Health Structure Commission, is that our expectations of what the healthcare system can and should deliver are increasing. As we as a society become richer and richer, our demand for welfare — including healthcare services — also rises.

Researchers even speak of a new type of healthcare consumer, which also includes older people, and which makes significant demands: as citizens, we want to live a good, active and long life; we have the capacity to find information and knowledge about health and treatment; and we demand quality, better treatment, service improvements, technology and involvement.

The digital development with smartphones, health apps and AI tools means — together with the media's cultivation of, among other things, research news — that it has become easy to find information about diseases and treatments, also through many private channels outside the healthcare system.

We have extensive knowledge about our own illness, we have access to our own health data, and we measure and check our blood pressure, pulse, oxygen saturation, sleep, menstrual cycle and so on. We arrive well prepared at the doctor or the nurse, and we expect an equal dialogue with healthcare staff.

In the same way, we as patients are better organised in groups through, among other things, social networks. Patient organisations can mobilise members and put pressure on the healthcare system. We can quickly gain knowledge about new medicine, new technology and new forms of treatment — and we expect them to be adopted as quickly as possible.

Our readiness for digitalisation also opens the possibility that more citizens can treat and examine themselves at home — of course under the guidance of healthcare staff.

d) New expensive treatments and technological advances

In addition to the three fundamental trends described above, which create cross-pressure on the healthcare system, rapid medical and technological development also plays a role.

As mentioned in the introduction, the pharmaceutical industry is fortunately developing a wide range of new, modern and potent medicines and technologies for the benefit of patients. Without the industry's research into and development of new medicines, we as patients would be in a bad position.

But it is, as we know, expensive to research, develop and test new medicine and new treatments, and the price of newly developed gene therapies, biological medicines and tailored medicine — precision medicine — is often extremely high.

New medicines for, among other things, rare diseases or cancers often cost many millions of kroner per patient, which can blow apart existing hospital medicine budgets.

Once a treatment has been recommended as standard treatment by the Danish Medicines Council, it must be introduced throughout the country and offered to the relevant patient groups.

Since 2018, the regions' expenditure on medicine has increased by more than DKK three billion, and in the past year it has especially been expenditure on hospital medicine that has grown. Last year, hospital medicine cost the regions more than DKK 10.6 billion.[6] However, the expenditure curve has flattened over the past three or four years.

In addition to hospital medicine, the regions also pay medicine subsidies for prescription medicine that Danes buy at their pharmacies. Overall, the regions had medicine expenditure of more than DKK 18.2 billion last year.

[6] https://www.regioner.dk/services/nyheder/2025/maj/voksende-udgifter-til-hospitalsmedicin-kan-traekke-taeppet-vaek-under-sundhedsvaesenet/

4. Priority-setting in many forms — how priorities are set today

Money, as we know, cannot be spent twice. That also applies to the healthcare kroner.

So how is priority-setting carried out in the healthcare system today, and what development and priority-setting trends have we seen?

Priority-setting takes place at many levels.

Central and decentralised priority-setting

When politicians have to agree on how much money should be allocated in the Finance Act to, for example, the regions' hospital operations, they are making a macroeconomic prioritisation. They weigh different policy areas against each other and decide which ministerial areas should receive more or less money: should the healthcare system this year, for example, be prioritised higher or lower in relation to areas such as schools, transport, defence, drinking water, elderly care or climate? In the healthcare area, the allocation takes place concretely through negotiations between the government — that is, the Ministry of Finance and the Ministry of the Interior and Health — and Danish Regions, and Local Government Denmark, on the overall framework for the healthcare system in the coming year. Once the agreement is in place, the state's grant to the healthcare system is allocated in the annual Finance Act, which is adopted by the Danish Parliament, the Folketing.

The money is then passed on to the four regions and the municipalities, which operate the healthcare system.

Political priority-setting then also takes place at meso level. This happens when regional politicians distribute the healthcare kroner among, for example, hospitals, the practice sector, psychiatry and so on in their region. They can, for example, also decide to establish a new arthritis centre or an outreach psychiatric team.

It is also a prioritisation of healthcare kroner when members of Parliament or the government adopt legally secured patient rights or decide centrally that, for example, all women aged 50-69 should be offered breast-cancer screening every three years; that all patients should be covered by a treatment guarantee for surgery with a maximum waiting time of 60 days; that cancer patients should wait no more than 14 days to be examined; that everyone with chronic conditions should be assured a better and more coherent course of care; and that all first-time mothers should have the right to stay in hospital for two days after giving birth or receive a home visit within 24 hours after the birth.

When a patient right is enshrined in law, it must be offered — and since resources in the health sector are not unlimited, this will typically happen at the expense of something else.

The Danish Health Authority's national clinical guidelines can also be said to be a form of priority-setting, because when it is explicitly determined centrally which treatments and courses various patient groups should be offered out at the hospitals, it inevitably means that there are other patients who cannot receive something. Again: we cannot spend the money twice.

But whom have we assigned the concrete task of officially prioritising between, for example, disease groups and specific patients — of saying yes to some and no to others, and of ensuring that "we as a society get as much health as possible for the money"?

If we are speaking about the period up to 2017, the answer is, roughly: not really anyone.

There has been little appetite for an open and nuanced political debate on priority-setting.

There are many explanations:

A "free" healthcare system for all: Our welfare model is built on a solidaristic idea that everyone has a right to the best and the same treatment. It can therefore appear ethically and politically problematic to talk about some treatments not being worthwhile. Fundamentally, it is difficult to reconcile the principle in the Health Act[7] of "easy and equal access" to healthcare with the necessity of priority-setting that arises when the money does not stretch to everything.

Political fear of touching the issue: In politics, it is popular to distribute benefits — for example, to secure waiting-time guarantees and legally protected patient rights for all patients. It is rarely popular to be the person swinging the savings axe or taking something away from someone. Politicians therefore often avoid making the difficult decisions about what the healthcare system should not offer. Especially in cases involving life-prolonging but very expensive medicine, politicians find it difficult to say no.

The difficult choices are pushed out to frontline staff: When there are no clear overarching political priority-setting criteria, decisions are taken in the links closer to patients. This may be in the regional councils, in hospital managements, but also in the day-to-day work of nurses and doctors who, as frontline employees in a pressured everyday setting with tight budgets, must make the difficult choices about who should receive treatment, and who must wait or go without.

"Everything is important": When new, expensive treatments — such as new targeted biological medicines — arrive, hospital expenditure rises, but there is rarely willingness or interest in removing old treatments in order to finance the new ones.

Media focus on individual cases: As is well known, we in the media often focus on tragic individual cases, isolated scandal cases and the powerful personal patient story, such as the one about little

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[7] https://danskelove.dk/sundhedsloven

August described in the introduction to this report. That makes it more difficult to hold a nuanced public debate about overarching principles of priority-setting.

All of this is presumably part of the background to why in Denmark we have had only very few official priority-setting institutions tasked, on society's behalf, with making concrete priorities about which treatments and healthcare services we should offer and which we should not offer.

On this point, Denmark differs quite a lot from the countries with which we normally compare ourselves.

We have a far less formalised and less institutionalised approach to priority-setting in the healthcare system than our neighbouring countries.

We will return to the comparison with other countries later.

For decades, Denmark has had, roughly speaking, only the Danish Health Authority's visitation guidelines and the Medicines Reimbursement Committee with a certain priority-setting function. The committee decides which medicines should receive reimbursement — and which patient groups should receive it.

As mentioned, priority-setting has largely taken place, and still does take place, administratively, decentrally and all the way out among hospital directors, doctors and nurses in hospitals and clinics. This prioritisation is important, because it is necessary for hospitals and healthcare staff to have the flexibility to make the daily choices about which patient should be seen first, how much time should be spent on the individual patient, who should be admitted and who should be discharged.

But that form of priority-setting is often also more indirect, more random and less transparent — borne by the clinical judgement of healthcare staff and by the individual hospital's priorities and finances.

At the same time, we in Denmark have had rather strong resistance to prioritising and saying no to treatment for economic reasons.

The political slogan has been that we have the world's best healthcare system and that we can and must afford everything.

The then prime minister, Helle Thorning-Schmidt of the Social Democrats, said during the 2015 election campaign:

> "I cannot imagine a situation in which we are forced to prioritise. Citizens expect world-class treatment in the Danish healthcare system."[8]

[8] https://www.information.dk/moti/2015/06/blankocheck-medicinalindustrien

But seven to ten years ago a change took place in the healthcare system. Until then, politicians and health economists had always meant financial resources — money — when they talked about scarce resources in the healthcare system.

But suddenly resource scarcity was not about money but about hands: healthcare staff. For suddenly we were facing an entirely new problem. Politicians could no longer solve the challenges of long waiting times simply by allocating more money in the Finance Act so hospitals could hire more staff. Because we could no longer obtain enough nurses and doctors.

At the same time, more research articles began to appear showing that much of what we offer in the healthcare system either has no beneficial effect on patients — or is actually harmful.

That message first came from the OECD in the report *Tackling Wasteful Spending on Health*.[9] It concluded that 20-30 per cent of all treatments offered by healthcare systems are unnecessary and, in the worst case, harm patients. The OECD estimated that in Denmark we could potentially save DKK 30-40 billion annually by eliminating unnecessary and harmful treatments.

Since then, other studies in Denmark and abroad have pointed in the same direction, and at a patient-safety conference held in spring 2026 by the Danish Society for Patient Safety, Professor Anders Perner of Rigshospitalet presented a theory currently being discussed in healthcare circles: only around 60 per cent of all treatment in the Danish healthcare system rests on relatively solid evidence or clinical guidelines, while 30 per cent is described as "low-value care" — that is, examinations or treatments that are wasteful, unnecessary or of very little value to the patient. The remaining 10 per cent is directly harmful to patients.[10]

After attention turned to the many unnecessary or even harmful treatments and healthcare services, agreement spread: there was a need for significant priority-setting in the Danish healthcare system, and the solution was not — as had previously been done — to take out the lawnmower in times of austerity and generally shave, for example, 2 per cent off hospital budgets so all departments and all medical specialties were hit.

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[9] https://www.oecd.org/content/dam/oecd/en/publications/reports/2017/01/tackling-wasteful-spending-on-health_g1g72f29/9789264266414-en.pdf

[10] https://patientsikkerhed.dk/kun-60-procent-af-sundhedsvaesenets-ydelser-hviler-paa-sikker-evidens/

and https://sundhedspolitisktidsskrift.dk/nyheder/sundhedsokonomi/7110-oget-investering-i-klinisk-forskning-kan-spare-sundhedsvaesnet-for-milliarder.html

It became clear that instead there is a need for clear choices and deselections.

In 2017, the Danish Medicines Council was established. This council assesses whether newly developed and very expensive hospital medicine should be taken into use at Danish hospitals. I will return to that shortly.

A couple of years later — in 2019 — came Vælg Klogt, or Choosing Wisely Denmark, a joint priority-setting project behind which stand Danish Patients, the Organisation of Danish Medical Societies and Danish Regions.[11]

Here, the focus is on identifying the areas where unnecessary examinations or treatments are performed that do not benefit patients and may, in the worst case, do more harm than good.

The Treatment Council came into being in 2021, the Danish Medical Association's Healthcare Sector Priority-Setting Council was established in 2023, and in 2024 the Danish Healthcare Quality Institute was established.

Around the same time, in the wake of the Resilience Commission's report, it was politically decided to establish the National Priority-Setting Council. The council is, however, still on the drawing board, but the idea is that it will assess healthcare services and measures in the health area more broadly.

The Danish Medicines Council — a much-criticised gatekeeper. And a glance at neighbouring countries

But back to the Danish Medicines Council. What is interesting about the Council is that it has a very direct priority-setting function.

Since 2019, when it made its first assessment, the Danish Medicines Council has played an important role in assessing whether new, expensive hospital medicines should be recommended as standard treatment in the country's hospitals.

The Council's task is, roughly speaking, to weigh the effect, side effects, documentation and price of medicines — and to hold this up against the existing, and cheaper, treatments that hospitals already offer patients today. On that basis, should we take the new medicine into use?

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[11] https://vaelgklogt.dk/

The weighing must take place on the basis of seven overarching politically adopted principles and ends with the Danish Medicines Council either recommending or rejecting the use of the investigated medicine in the public system.[12]

The Council has not been given an overall national priority-setting framework within which to set priorities — for example, that we should prioritise medicine for patients with the most serious diseases over medicine for patients with chronic diseases, or that we may spend at most, for example, DKK 9 billion a year on hospital medicine in Denmark. Nor has the Council been equipped with fixed limits for how much new medicines may cost per life-year gained or improved, for example.

But if we turn our gaze to England, Sweden and Norway, these countries have a number of far stronger formal priority-setting institutions.

In England, for decades there has been a strong priority-setting body, the National Institute for Health and Care Excellence, NICE, which plays a central role in the healthcare system. NICE assesses treatments on the basis of how cost-effective they are. This is calculated using so-called QALY, which is a measure of what a quality-adjusted life year costs — that is, the price of giving one patient one extra quality life-year. In England, there is also a fixed upper limit on how much the new treatments may cost English society overall year by year. An expenditure ceiling has been introduced, making prioritisation absolutely necessary.

The advantage of this model is that there is great transparency about how and why priorities are set as they are, and NICE has both the competence and the political backing to make the prioritisation. If NICE has said no to a treatment, it is not introduced anywhere in the country. The individual hospital cannot decide to find the money in its budget anyway to give some patients the new, expensive medicine.

If we look to our Scandinavian neighbours, Norway has introduced a number of politically established national criteria according to which healthcare kroner should be prioritised:

- Severity
- Benefit (effect)
- Resource use

In Sweden, too, they work with a politically adopted “ethical platform”.

Three criteria have been established according to which treatments and medicines must be assessed:

- Human dignity

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[12] https://medicinraadet.dk/media/1oxfmhsz/ad-pkt-4-folketingets-7-principper-for-prioritering-af-sygehuslaegemidler_final-a.pdf

- Need/solidarity
- Cost-effectiveness

In Denmark, we have not yet adopted this kind of overarching priority-setting principles, but there is great pressure from the Danish Medical Association, Danish Patients, researchers and other organisations to do so. The Danish Association of the Pharmaceutical Industry, Lif, also supports clear criteria.

The organisations point out, among other things, that the seven overarching principles for the Danish Medicines Council's work cannot stand alone and must therefore be supplemented as quickly as possible by a number of overarching priority-setting criteria that can weed out dilemmas and prevent inconsistent decisions when the Council sets priorities.

The organisations want politicians to step onto the field and indicate which direction we should take:

- Should we, for example, weight equality over effect? Should all patients receive the same, or should resources be distributed according to the greatest possible effect?
- Should we weight acute or life-threatening diseases over chronic diseases? Should the cancer patient with the life-threatening disease be prioritised over the diabetes patient?
- Should we weight expensive and perhaps not fully tested new gene-therapy treatments for small patient groups with rare disorders and few treatment options over cheaper treatments for large patient groups with common diseases and reduced quality of life?
- Should we weight standard treatments over individually tailored medicines?
- Should children be weighted ahead of older patients?

These ethical questions are directed very specifically at the prioritisation of new medicines in the Danish Medicines Council, but in reality, according to the organisations and researchers, there is also a need to formulate a series of completely overarching priority-setting rules.

In the opinion piece "Ethical perspectives on the discussion of resource allocation in the Danish healthcare system",[13] which four Danish researchers from Aarhus University and the University of Copenhagen have published in *Ugeskrift for Læger*, four bioethical principles are described which, they believe, should be weighted in an ethical dilemma, including when it comes to new medicines:

The four principles are beneficence, non-maleficence, respect for autonomy and justice.

[13] https://ugeskriftet.dk/debat/etiske-perspektiver-pa-diskussionen-om-fordeling-af-ressourcer-i-det-danske-sundhedsvaesen

The researchers point out that it is possible both to ensure that all citizens have equal rights to basic healthcare services and to distribute resources in a way that allows society to achieve maximum benefit for the money.

The researchers point out that the four ethical principles should be included when money and resources are to be distributed in the healthcare system. This will ensure that doctors and decision-makers have a shared foundation from which to work and on which to rely.

> "All four principles — beneficence, non-maleficence, respect for autonomy and justice — should be considered in order to make an ethically defensible choice. By this we mean that ongoing and future discussions about the use of expensive biological therapy can find a constructive form," the researchers write in the opinion piece.

An overview of the Danish Medicines Council and its decisions

In 2016, the Danish Parliament decided to establish the Danish Medicines Council in order to ensure that Danish patients have access to the most effective medicines at the right prices.

The rationale included the following:

> "There is agreement among the parties of the Danish Parliament that the healthcare system must ensure free and equal access to high-quality treatment. Patients must have access to treatment with safe, effective medicines while at the same time ensuring as much health as possible for the money. Expenditure on hospital medicine has risen in recent years, and focus is therefore directed at measures that can curb expenditure growth and at the same time ensure patients treatment of high professional quality."[14]

The Council was established in 2017, and since 2019 the Danish Medicines Council has therefore assessed new medicines for which the pharmaceutical industry applies to have them taken into use in Denmark.

It is not the Council's task to prioritise between different patient groups and disease areas. Its task is, roughly speaking, to assess a new medicine against the treatments already available to the patients in question.

The Danish Medicines Council, which consists of a council, a secretariat and 60 specialist committees with more than 500 experts — doctors, patient representatives, pharmacists and nurses — works

[14] https://www.regioner.dk/media/4119/folketingets-7-principper-for-prioritering-af-sygehuslaegemidler.pdf

according to seven overarching principles for priority-setting adopted by the parties in the Danish Parliament in 2016:[15]

1. **Professionalism:** When medicines are assessed, there must be a thorough and systematic assessment of the treatment benefit for patients and of the documentation on which it is based.
2. **Independence:** The assessment of medicines must be made according to objective criteria and on the basis of professional assessments, thereby ensuring an independently prepared decision-making basis and thus arm's length from the political level.
3. **Geographical equality:** Medicines must be introduced and used uniformly across the whole country.
4. **Openness:** There must be the greatest possible openness in the assessment of medicines. That is, there must be openness about processes, methods, criteria and the material prepared in connection with the assessment of medicines. Openness is also intended to facilitate public debate.
5. **Rapid use of new, effective medicine:** Patients must benefit from therapeutic advances. Denmark must continue to be one of the countries that most quickly adopts new medicines where documented added effect exists.
6. **More health for the money:** Resources in the healthcare system, including for hospital medicines, must be used carefully, otherwise there may be consequences for prevention, treatment or care in other parts of the healthcare system. New medicines with a well-documented added effect must not be rejected solely on economic grounds.
7. **Access to treatment:** Equal access must be ensured for both large and small patient groups, and patients' individual needs must be taken into account. On the basis of a concrete medical assessment, it must be possible to treat with medicines that have been rejected for standard treatment.

In addition, the Danish Medicines Council may include principles of severity and precaution in its decisions.

Since its establishment, the Danish Medicines Council has assessed almost 500 new medicines — medicines developed for patients with various forms of cancer, COPD, Alzheimer's, osteoporosis, haemophilia, eye diseases, heart diseases, multiple sclerosis and so on.

The new medicines and treatments assessed by the Council are often so-called personalised medicine — precision medicine, immunotherapy or gene therapy. This is medicine developed for the individual patient, and in many ways it has revolutionised the treatment of a number of serious diseases. The

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[15] https://medicinraadet.dk/media/1oxfmhsz/ad-pkt-4-folketingets-7-principper-for-prioritering-af-sygehuslaegemidler_final-a.pdf

medicine often works by targeting specific mutations or by reactivating the body's own immune system, and it can prolong patients' lives by weeks or months and in some cases several years. There are also examples of some patients being cured.

Each year, the Council recommends somewhere between 50 and 65 per cent of the medicines that pharmaceutical manufacturers apply to have taken into use.[16] The rest are rejected — with reasons such as the effect not being strong enough, the price being too high or the documentation too weak, all assessed against the treatments that may already exist.

It goes without saying that the Danish Medicines Council's decisions matter to the patients who could potentially benefit from the new medicines and to the doctors who would like to treat their patients with new promising medicine.

It also goes without saying that the pharmaceutical industry has a strong interest in the Council ultimately recommending the manufacturers' newly developed medicines. A recommendation ensures that the medicine is taken into use as standard treatment throughout the healthcare system for all relevant patients. The individual hospital may not deselect it, for example because of the price, once the Danish Medicines Council has recommended it.

In general, as on all markets, marketing and secure use of medicines will give manufacturers a positive return on their often long and large investment in development and testing.

It also goes without saying that the regions, which operate the hospitals, have a strong interest in the Danish Medicines Council's decisions. A recommendation of a new medicine can mean additional expenditure of millions, indeed billions, of kroner in the regions' hospital budgets — but, conversely, it can also increase patients' level of functioning so that their need for care and treatment is reduced.

There is therefore much at stake for everyone when the Danish Medicines Council's decisions arrive. From the beginning, the Council's decisions have attracted considerable attention.

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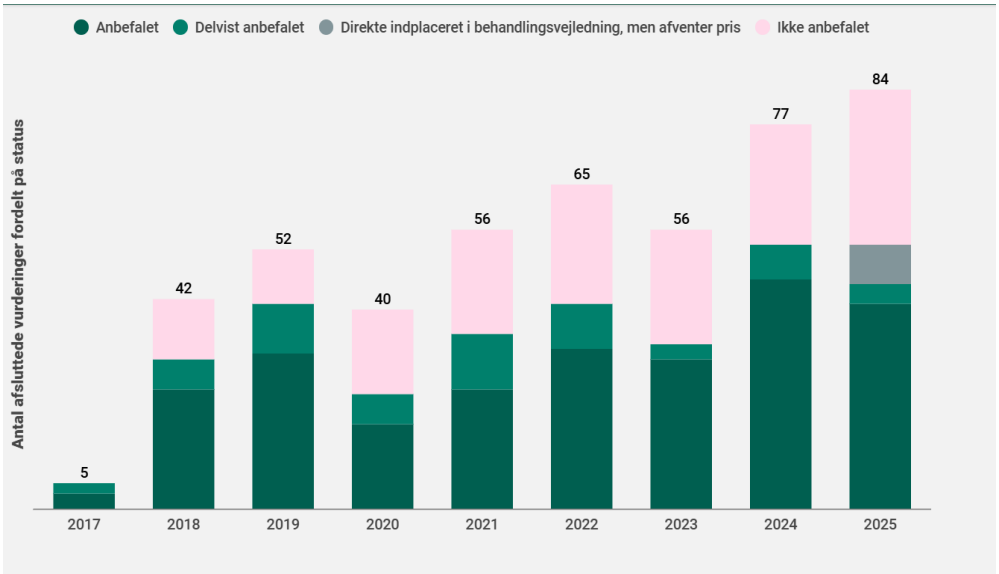
[16] https://medicinraadet.dk/om-os/organisation/aarsberetninger/medicinradets-arsberetning-2025

Decisions by the Danish Medicines Council — broken down by recommendations/partial recommendations and non-recommendations (2017–2025)



5. How do the media cover the difficult dilemmas? The Danish Medicines Council as a case

Health is a fantastic beat for journalists who appreciate stories that are important, close to people's lives, principled, socially relevant, full of dilemmas, local, dramatic and moving. One can throw oneself into every genre: news, patient stories, reportage, revelations, background stories, analyses, data deep dives, confrontational minister interviews and so on. And health coverage interests a great many people. We Danes care a lot about our health, illness, treatment options and so forth, just as society spends a very large amount of money on hospitals, treatment, care, medicine and more.

Often, we journalists choose health angles that work together with the five classic news criteria, where identification, conflict and significance carry the greatest force.[17]

We all know this kind of story very well. They matter, and they revolve around angles such as:

"Patient association says it is not good enough that…"

"Scandal doctor mistreated…"

"It is a pity for 88-year-old Gerda, who now…"

"New revolutionary medicine saves lives…"

"Cuts hit hard and spark anger…"

"Hospital failed hundreds of patients…"

So how have the media covered the Danish Medicines Council's decisions over the years?

I have examined this through article searches and subsequent analysis and categorisation of the articles according to their angle/focus and their use of any case persons.

About my study of media coverage

The article search was carried out in the article database Infomedia, now Retriever, and a time delimitation was made for the articles' publication period. I searched for articles published in national, regional and local media in the period from 1 January 2000 to 31 December 2025, using the following

[17] https://www.dmjx.dk/aktuelt/nyhed/nyhedskriterierne-skulle-sikre-bedre-journalistik-saadan-blev-de-til

search terms in relation to “Medicinrådet”: “decision/has decided”, “says yes to”, “recommends”, “says no to”, “does not recommend”, “rejects”, “approves”, “prioritis*“.

Articles that quite obviously concerned something other than the Danish Medicines Council’s concrete or general decisions were sorted out. The same applied to duplicate articles — that is, identical articles published by several cooperating media outlets at the same time.

It is important to stress that the search was hardly performed perfectly. It was not carried out according to a foolproof research design, and this is not a scientific mapping of all articles on this subject. There are neither resources nor search access for that. My search net probably does not catch every article published about the Danish Medicines Council’s decisions during the period.

I have nevertheless chosen to cast the search net in this way in order to catch as large a sample as possible from the article database of articles dealing with both the Council’s rejections and recommendations of medicines — either concretely or more generally.

One important limitation of this method is that articles from DR and TV2 are not included in the analysis, as the articles of these public service broadcasters are not covered by the Infomedia/Retriever agreements. Nor can television and radio segments or podcasts be searched through Infomedia/Retriever, and they are therefore not included in this analysis.

What was in the article-search net when I hauled it ashore? The result of the article search

In total, through the article search I found 122 articles/opinion pieces published in written national, regional or local media during the chosen period.

I read and coded/categorised these articles according to the following categories:

- Article with a critical angle on the Council’s assessment, possibly taking a specific patient case as its starting point
- Article with a neutral, descriptive/news angle on the Council’s assessment
- Article that attempts to nuance/explain the dilemmas around priority-setting and describe the Danish Medicines Council’s basic task
- Opinion piece criticising the Council’s decision
- Opinion piece defending the Council’s decision
- Articles discarded because of irrelevance or duplication

The results can be seen in the Excel sheet in the appendix at the end of the report, but here is a brief summary:

30 of the 122 articles were sorted out because they were either irrelevant to the issue or turned out to be duplicate articles.

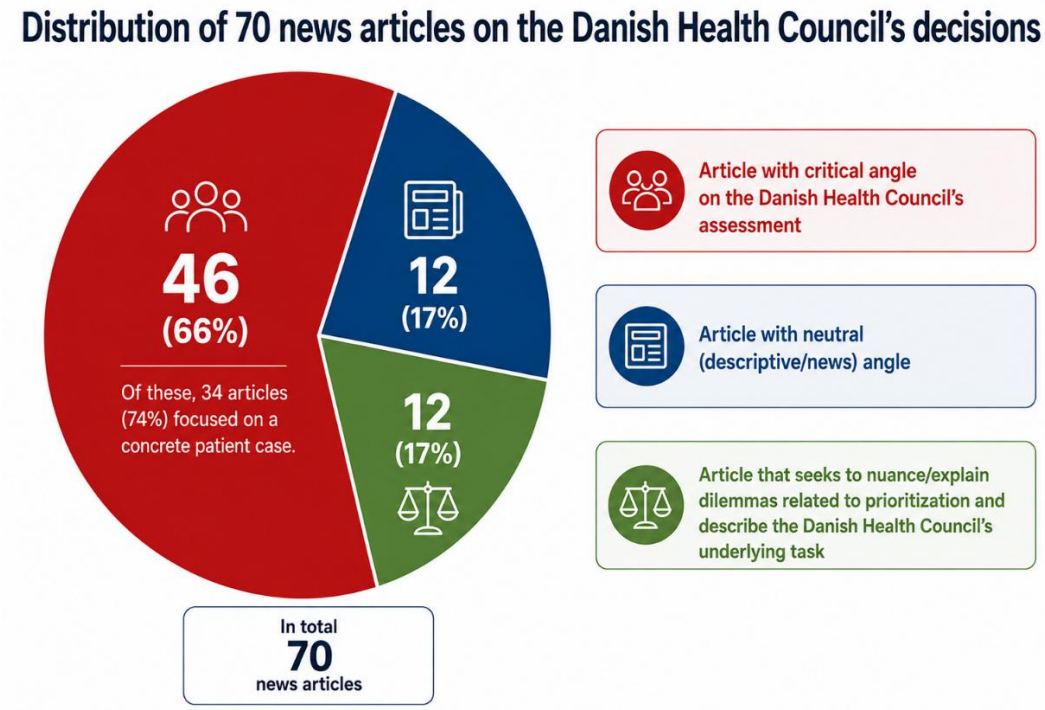
22 articles were opinion pieces - not journalistic articles but opinion pieces written by patients, relatives or organisational representatives in order to express their views on the Danish Medicines Council's decisions. Of these, **15 opinion pieces** contained criticism of the Council's decision, while **7 were written in defence** of the Council's decision.

This leaves a total of **70 journalistic news articles** dealing with the Danish Medicines Council's decisions.

Of these, by far the majority — **46 articles in total** — have a clearly critical angle in relation to the decision made by the Danish Medicines Council. In headline, standfirst and lead, the critical articles are sharply angled on criticism of the Council, which has said no to recommending a specific medicine for a particular group of patients. **Of the 46 critically angled articles, 34 are written on the basis of criticism from, or consequences for, a specific patient case or that person's relatives.**

12 other articles have the character of a neutral news article describing what the Danish Medicines Council has concluded, while **12 articles** have been placed in the category of articles that attempt to describe/nuance/explain the dilemma around prioritising healthcare kroner and the Danish Medicines Council's tasks.

In other words, there is a very marked preponderance of articles that are critically angled and at the same time carried by and angled around a specific patient case, where the patient, the patient's relatives or the relevant patient organisation criticises the Danish Medicines Council for saying no to recommending a new medicine.



What can we draw from the results? Discussion and perspectives

As a long-standing news and investigative journalist, I am not particularly surprised — nor, for that matter, outraged — that we journalists primarily angle in on the critical sources.

As journalists, we have an important task, as is well known, in being critical of power and in uncovering and describing the areas where society's problems, injustices, inequalities or errors are found.

When it comes to priority-setting questions in which some people receive a no to something as significant as medicine, the injustice angle lies close at hand.

Experience also shows that stories in which a person has something at stake, and in which the personal narrative is unfolded, attract many readers.

At the same time, priority-setting questions in the healthcare system are stretched across an extremely large number of actors and rules; the area is highly complex and full of dilemmas, and it is difficult to include all nuances in the coverage or in every article.

But when one dives deeper into the analysis of the articles, quite interesting things become visible.

The critical articles are typically not merely sharply angled on criticism of a no to new medicine, after which the nuances are unfolded further down the article and the balance is "restored" along the way by adding other perspectives.

In the great majority of the articles, the weight throughout the article is placed entirely or mainly on criticism of the Danish Medicines Council's decision and on the concrete patient perspective. The seriously ill patient and that person's relatives are given ample space, and the patient's course of illness, lack of treatment options and fear of the consequences of a no to the medicine — for example death or disability — are described in depth.

In addition, the article is most often accompanied by a photo or photo series of the patient, so identification comes easily. The criticism from the patient side is most often that the healthcare system, or society, is stingy or cynical because it will not spend money to save seriously ill people.

The patient criticism is often backed up further down in the article by patient-organisation representatives who are surprised that in Denmark we do not allow this patient group to receive a medicine or treatment that EMA — the European Medicines Agency — may already have approved.

Further down the article, the pharmaceutical manufacturer or pharmaceutical industry, in some articles, joins in the criticism of the Danish Medicines Council's refusal to take the new medicine into use in Danish hospitals. And now and then doctors or researchers are also quoted — often doctors who research precisely this area — who would like patients to be allowed to try the new medicine.

Is the Danish Medicines Council, as the criticised party, then not heard in these articles?

Yes. But far from always. In fact, the criticised party, the Danish Medicines Council or the regions, is not heard at all in more than every third of the critical articles. In a few articles it says at the bottom that it has not been possible to obtain a comment from the Council on the criticism. In those cases, the journalist has at least tried to put the criticism to the criticised party.

In the remaining cases, the chair or deputy chair of the Danish Medicines Council — or representatives of the regions — is quoted, but typically only with a couple of defensive sentences at the bottom of the article after several other sources have delivered marked criticism.

Only in relatively few of the critically angled articles has the journalist made an attempt to explain to readers the complex background to the Danish Medicines Council's refusal in the concrete case. Why politicians created the Council, and why the Council from time to time — and in this specific instance — says no to taking new, expensive medicine into use.

Only in a few of these articles is it explained that the documentation for the effect, for example, is still too thin for us as a society to say yes to introducing the medicine throughout the healthcare system when it may cost many millions of kroner per patient.

The Danish Medicines Council's no may, for example, concern the fact that medicine already exists with the same effect as the new medicine but at significantly lower cost than the newly developed product. The no may also be justified by the effect not matching the price of, for instance, several million kroner per patient, when the average prolongation of life for incurably ill patients is only a few weeks. It may also be that the medicine has been tested only on a small group of patients and that the documentation submitted by the manufacturer is still too uncertain. Or a combination of all of this.

As a reader of these critically angled articles, one is often left with the sense that something unfair and objectionable is going on in the meeting rooms of the Danish Medicines Council. Perhaps that is actually the case. Perhaps it is not. But the journalist has apparently not dug any deeper into the matter in order to examine this.

Instead, the roles in these articles are typically distributed as follows: the seriously ill patients are victims, failed by a stingy healthcare system and an overzealous Danish Medicines Council, and the patients must fight in vain side by side with the good forces — doctors, the pharmaceutical industry and patient organisations.

In none of the articles is there any indication that the journalist has asked critical questions of the pharmaceutical manufacturer about why the medicine must cost, for example, DKK 22 million for a single treatment. Or why the manufacturer has applied to have the medicine taken into use already now, even though it has only been tested on a small patient group and solid documentation of the effect is still lacking. One could imagine, for example, a question to the manufacturer asking whether it is reasonable for society to bear the entire financial risk that the medicine may not have the desired effect.

But is there no reason at all to criticise the Danish Medicines Council's decisions?

Yes, certainly.

Are we always quick enough in Denmark to take new medicines into use?

No, we certainly are not.

Does the Council always make the correct, thoroughly analysed and unassailable decision?

Hardly.

First, as mentioned, there are no politically adopted and clearly defined priority-setting criteria describing precisely how the Danish Medicines Council should make the balance between price, documentation and effect.

In Denmark, no upper limit has been set for what it may cost on average, for example, to prolong an incurable cancer patient's life by six months or to secure a patient with arthritis an extra year of good quality of life. They work with this kind of approach in England, but not in Denmark.

Nor have rules been made for whether the Danish Medicines Council, in its weighing, should take into account, for example, whether the new medicine can improve quality of life for very large groups of people with chronic disease; whether it is aimed at very vulnerable patient groups such as children; or whether it concerns patients with very rare and serious disorders who have no other treatment options.

When clear priority-setting principles of this kind have not been drawn up, it opens the possibility that the Danish Medicines Council's assessments are not based exclusively on transparent calculations from data and fixed criteria, but to some extent also rest on the ethical judgements and compass of its members.

Second, several organisations have criticised Denmark for being too slow to take new medicines into use compared with our neighbouring countries. According to the Danish Medicines Council itself, processing times have indeed been too long at times.[18]

In addition, there is not full openness about which calculations and data the Danish Medicines Council bases its concrete recommendation or rejection on. This is not made public. Nor can the public find out how large the discounts are that the public procurement authority Amgros may negotiate with the medicine manufacturer during the application process. Manufacturers often wish to keep these discounts secret. According to the Danish Association of the Pharmaceutical Industry, this is done with

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[18] https://medicinraadet.dk/nyheder/2024/medicinradet-ma-udskyde-ansogninger-i-november-og-december

and https://medicinraadet.dk/nyheder/2024/nye-mal-for-medicinradets-sagsbehandlingstid

regard to international pricing. If discounts to Danish hospitals are openly described, it will put pressure on the price of the same medicine in other countries.

In other words, there are many good reasons why we journalists should keep a more critical eye on the Danish Medicines Council's work.

But for me, the article analysis has revealed that there is a major imbalance in which sources we give the floor to when we cover priority-setting questions in the healthcare system. Critics of the Danish Medicines Council's work apparently have a far easier time being given ample space in the media to criticise medicine rejections than the Council and Danish Regions have if they wish to explain the difficult balances and nuances — or to correct the criticism.

As described, the article-search analysis shows that Danish Regions and the Danish Medicines Council are not cited in a significant share of the critically angled articles and therefore have not had an opportunity to provide another and more nuanced perspective. And in the articles where the Danish Medicines Council is actually heard, there are several examples of the journalist simply writing that the Council rejects the criticism to the media outlet — or even to another media outlet — and then giving the chair of the Council a few lines to explain the Council's position.

The analysis also points in the direction that we journalists often resort to the "easy" and "effective" story, where we give voice to the exposed patient — the case story that contains criticism, identification and strong emotions — but too often we also fail to examine and describe the nuances and dilemmas.

According to, among others, Danish Regions, important perspectives therefore do not emerge, just as incorrect assumptions are left unchallenged.

For example, medicine manufacturers and patient organisations have in several opinion pieces and articles criticised the Danish Medicines Council for being too restrictive and slow in adopting new expensive medicines. The critics argue that Denmark in several cases has rejected medicines already approved by the European Medicines Agency, EMA, and already taken into use in our neighbouring countries.

That is in itself correct.

But according to Danish Regions, an important point is that approval from the European Medicines Agency is not automatically the same as the medicine being better than the medicines already on the market for the patient type in question.

> "EMA's task is to assess whether a medicine is safe enough to come onto the market — and whether the effect outweighs the side effects. That is an important task — but EMA does not look at whether there are already similar medicines on the market that have a better effect, just as EMA does not include the price at all. This means that there may well be similar medicines on the market that are both better and cheaper," the then chair of Danish

> Regions, Anders Kühnau of the Social Democrats, wrote in an opinion piece after a specific article in which the Council was criticised.[19]

The article search also shows that, in the wake of critically angled articles about the Danish Medicines Council's decisions, the then chair in several cases wrote opinion pieces in which he pushed back against criticism of the Council's decision.

Very currently, and outside the time period I have examined, the Danish Medicines Council has been the subject of fierce criticism.

Without otherwise taking a position on the merits of the criticism, I note that the same skew in the coverage of perspectives could be observed in the current criticism.

About a week before the parliamentary election on 24 March 2026, the Danish Medicines Council and its decisions were brought into the election campaign by Liberal Alliance party leader Alex Vanopslagh. On X and in major interviews, he criticised the Council for being too restrictive and too slow to adopt new medicines. He demanded that Danish patients receive the right to all new medicine approved by EMA and recommended by a specialist doctor in Denmark, and he sharply criticised the fact that Danish cancer patients, because of too little willingness to pay and too long processing times in Denmark, are cut off from "the best" and "most innovative cancer medicine".[20]

> "For of course state stinginess and bureaucratic slowness must not cost anyone their life in one of the world's most highly taxed countries," he subsequently wrote on X, thereby implying that the Danish Medicines Council rejects new medicine that can cure cancer patients and save their lives.[21]

Alex Vanopslagh referred to a 2025 survey by the European pharmaceutical organisation EFPIA. According to it, only 63 per cent of all EU-approved cancer medicines are offered to patients in Denmark, while the share in Germany is 96 per cent.

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[19] https://www.regioner.dk/services/nyheder/2026/januar/effektiv-medicin-kraever-ansvarlige-valg-for-patienternes-skyld/

[20] https://www.berlingske.dk/politik/la-vil-bruge-en-milliard-om-aaret-paa-bedre-adgang-til-ny-kraeftmedicin

[21] https://x.com/AlexVanopslagh/status/2032913864589705642

Alex Vanopslagh called the figures “worrying” and stated that Danish citizens should have the right to the best available medicine.

But according to both the chair of the Danish Medicines Council and Danish Regions, EMA approval, as mentioned, is not synonymous with the new medicine therefore being the best on the market and thus better than the medicine already offered. EMA approval is essentially an expression that the medicine is considered safe to use — that the side effects do not outweigh the effect, which may otherwise be very small, the two actors said.

The chair of the Danish Medicines Council, Birgitte Klindt Poulsen, says in an interview with me that if journalists had called and asked her in the ongoing debate, she would at the same time have said that the pharmaceutical industry’s comparisons between EU countries are not accurate — indeed, actually misleading.

First, Denmark and Germany have completely different approval systems. If the Danish Medicines Council recommends a new hospital medicine in Denmark, one that EMA has approved, the medicine must be introduced throughout the hospital system — in all Danish hospitals — within 14 days. Danish patients are therefore guaranteed to receive the medicine if it has been recommended by the Council. But when new medicine receives the approval stamp in Germany, there is not the same certainty that the medicine is actually taken into use in all hospitals and for all relevant patients.

That is decided to a greater extent locally at hospitals in the various federal states. The same applies in, for example, England and Sweden, where it is finally decided locally whether and when the medicine will be taken into use if it has been recommended/approved by the national health authorities or priority-setting bodies. According to Birgitte Klindt Poulsen, this mechanism — where decisions on the use of new medicine are delegated locally — creates more inequality in health, because not all relevant patients are guaranteed the medicine.

Second, she points out that a large share, 31 per cent, of the medicines included in EFPIA’s survey are not marketed in Denmark at all. The manufacturer has therefore not applied to have the medicine taken into use in Denmark.

Had we journalists asked Danish Regions for a comment on the current criticism of the Danish Medicines Council, the answer would have sounded, among other things, like this:

> For every krone spent on expensive medicine with uncertain or limited effect, there are fewer resources for nursing, diagnostics and treatment of the patients already waiting in line.

> Priority-setting is therefore not an expression of an unwillingness to help patients. It is an expression of responsibility — and of respect for both patients and the community's resources.[22]

In March 2026 — in connection with Alex Vanopslagh's criticism of the Danish Medicines Council's slowness and restraint — Danish Regions wrote a note on the consequences of approving more new medicines. In the note, Danish Regions stresses that when the Danish Medicines Council rejects a medicine, it does so on the basis of an overall assessment of effect and price. Many rejections are about the added effect delivered by the new medicine being very small.

> "If the Danish Medicines Council were to recommend more medicines with very small added effects, much more money would have to be set aside for medicine. Money that could then, for example, not be used elsewhere in the healthcare system.
>
> As much health as possible for the money also means that there must be money for, for example, cancer surgery, which saves many lives. Just as there must be money for our healthcare staff. If, for example, one wants to increase the regions' expenditure on hospital medicine by 10 per cent, it will cost DKK 1.1 billion a year. For the same money one can get about 1,150 doctors and about 1,750 nurses."[23]

Summary

If I am to summarise, media coverage of the Danish Medicines Council's decisions is generally not particularly balanced or nuanced. For the sake of good order, I should stress that my article search and analysis also include some of my own articles.

We journalists typically angle sharply on the fact that a specific patient, and patient group, has been denied important and expensive medicine by the Danish Medicines Council and that this will have major consequences for the patient's life and health.

As described, the Danish Medicines Council has been tasked with weighing new medicines according to three defined factors: the Council must assess the medicine's effect, including the documentation

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[22] https://www.regioner.dk/services/nyheder/2026/januar/effektiv-medicin-kraever-ansvarlige-valg-for-patienternes-skyld/

[23] https://www.regioner.dk/media/za2pj1xi/fakta-danskernes-adgang-til-ny-medicin.pdf

of that effect, the medicine's side effects and its price, and the Council must at the same time compare this with the medicine or treatment already on the market today.

But the media's focus is typically only on one of these factors, namely the price. If the Council says no to a new medicine, the angle therefore typically becomes: a seriously ill patient cannot receive a new promising medicine because, according to the Danish Medicines Council, it is too expensive.

In the coverage, we do not spend much space describing that the documentation that the medicine actually works is uncertain, that the side effects are significant or that the long-term effects are unknown.

Our choice of sources is often biased, and we often fail to give the Danish Medicines Council, as the attacked party, the opportunity to be heard. We also very rarely ask critical questions of patient organisations and medicine manufacturers, who are the ones setting the price.

We rarely have an eye for describing that the consequence of a yes from the Danish Medicines Council would be that other patients and patient groups would not receive treatment or would receive poorer treatment. Because these patients are not concrete patients who can be identified or pointed out, their perspective does not emerge, just as we only to a limited extent try to explain thoroughly to readers why priority-setting is necessary and why, in the concrete cases, a no has been given.

Conversely, in the media we have to an almost vanishingly small degree uncovered the lack of openness around, and insight into, the Danish Medicines Council's decisions and the reasons for them. Nor do we often describe that in Denmark — unlike several comparable countries — we have not defined clear priority-setting criteria according to which the Council must work.

My analysis of the coverage of the Danish Medicines Council's task captures only a small share of the many articles, television segments, radio programmes and podcasts produced in Danish media about our health and healthcare system.

It also captures only a small part of what is produced precisely about priority-setting in the healthcare system.

For the prioritisation of the healthcare system's resources is about much more than what takes place around the recognition of new medicines in the Danish Medicines Council and what will take place in a new national priority-setting council.

It is also an expression of prioritisation if in future we decide to launch a new screening programme for, for example, lung cancer, as is currently being concretely considered in Denmark. In that case, the adoption of the new screening programme is an expression of us as a society prioritising the use of money to offer a very broad group of healthy citizens scans of their lungs at regular intervals because we believe it is important to detect such a serious disease as lung cancer as early as possible.

But it is also prioritisation if we as a society decide that lung-cancer scans should be offered only, for example, to people who are or have been heavy smokers for a number of years — because the

screening programme is expensive, and it is among heavy smokers that the greatest effect can be obtained.

In the same way, it is also an expression of prioritisation when we choose to spend relatively little money on psychiatry and thereby accept that people with severe psychiatric disorders move in and out of psychiatric wards as so-called revolving-door patients because we have neither enough beds, psychiatrists nor care staff to complete their treatment.

Priority-setting in the form of choices and deselections takes place all the time — both consciously and unconsciously — and at many levels. And the priorities have enormous significance for all of us as patients, relatives, healthcare employees, politicians and civil servants.

6. An inside-out view of media coverage

How do the sources and actors in the healthcare system experience the media's handling of this difficult field?

I have set out to examine this through a series of longer interviews with experts and organisational representatives.

In the following section, I ask respectively the health economist, the patient chair, the director of the pharmaceutical industry association, the chair of the Danish Medical Association, the chair of the Danish Medicines Council, the commission chair and a screening professor how each of them experiences cooperation with the media, the media's role, and how they more specifically experience media coverage of the Danish Medicines Council's decisions.

Can they recognise the conclusions I have reached in my article analysis? The interviews were all conducted in the period from November 2025 to May 2026. I have made a journalistic selection, editing and synthesis of each interview, which follows below.

Jakob Kjellberg: "It is a bottomless pit"

First, we let **Jakob Kjellberg, professor of health economics at VIVE**, provide an overview of what is pressuring the healthcare system these years and offer his analysis of why the priority-setting question is so urgent.

He begins by establishing that Danes' appetite for healthcare services is insatiable — and accelerating.

> "In reality, there is no limit to what we citizens could wish for from the healthcare system. Our demand for healthcare services is enormous. It is a bottomless pit," Jakob Kjellberg states.

But our resources are, as we know, limited, he points out, and therefore the need for priority-setting is fundamental, pressing and unavoidable.

According to him, our massive appetite for healthcare services is not due to a single factor but to an interplay between our human nature, economic development, the supply of doctors and nurses, and major technological and medical advances.

Humans, according to him, have a fundamental and insatiable need for "more", and we have a drive towards optimisation: "We want to be healthier, more beautiful, richer, run faster, live longer — just as we want to go to the moon and into space, drive self-driving cars, fly drones and so on. That is simply how we are as human beings. It is our drive and our nature."

At the same time, health is an area to which citizens attach great and increasing value, and where new treatments are constantly being developed, creating further demand. When there is no real

market mechanism to regulate this demand — because treatments are to a large extent publicly financed — it becomes necessary for someone to make priority-setting decisions, he states.

He also highlights that our rising prosperity in itself drives the development. In economic terms, healthcare services function as a "luxury good": we spend an increasing share of our resources on healthcare services the richer we become. If the public sector cannot deliver, we buy the services privately. And thus the need accelerates.

Demographic changes — especially an ageing population — similarly mean that more of us live longer with chronic diseases and therefore need treatment over a longer period. Technological development plays a corresponding role: new and expensive treatment options make it possible to do more for more people, and precisely because it is possible, an expectation pressure also arises that everything that can be done should be done.

A central aspect of his analysis is that expectations of the healthcare system are constantly expanding.

> "There is nothing too small for us to think the healthcare system should take care of it. Especially if we do not have to pay ourselves," the health economist says with a mischievous remark. Thus our demand for healthcare services does not grow only with serious illness. It also grows when it comes to less serious conditions and perhaps even marginal needs.

He also points out that our ability to handle illness ourselves — or to accept uncertainty about our health and physical condition — is declining. And that further increases the pressure on the healthcare system.

On that background, priority-setting does not appear as a political choice but as a structural necessity, Kjellberg states. If political decisions are not actively made about which treatments and interventions should be prioritised and offered, development will, according to him, become completely unsustainable.

> "Priority-setting is the name of the game when one runs a healthcare system. The challenge is not whether priorities must be set, but how — and this recognition has not yet sufficiently broken through in the public debate," he states.

We then move on to talk about the part of the public debate facilitated by the media. Here, he is not impressed.

He describes media coverage of the Danish Medicines Council's tasks and decisions as "rather predictable and conflict-oriented".

According to him, precisely the Council's decisions to say no to new medicine are made "popular and flat". They lend themselves to person-driven angles that can easily be conveyed in broad media. The coverage typically starts from specific patients — and not infrequently children and young people — with serious diseases, where a new treatment is presented as potentially life-prolonging or decisive for the patient's health and survival, even though the medicine's actual effect in many cases is much more limited.

> "Then we suddenly have a critical popular narrative in which complex health-economic assessments are reduced to a simple moral problem of help or refusal."

Kjellberg points out that the coverage of these kinds of stories often forms part of an interplay — an unfortunate triangle — between the press office of patient organisations, the press office of the pharmaceutical industry and journalists at the traditional media. All three actors have incentives to highlight individual cases with strong emotional appeal.

The result, according to him, is a media dynamic in which conflict, identification and responsibility are placed clearly: there is a victim, a possible solution and a decision-maker who is criticised.

> "It is, in other words, a rather lazy dramaturgy," is Kjellberg's conclusion. He also calls it effective, because the template fits media's need for human stories with an edge.

A central criticism from the health economist is that we in the media only to a limited extent use energy on conveying the background to the Danish Medicines Council's decisions. The reasons for a rejection — including assessments of the medicine's effect, costs and prioritisation in relation to other treatments — are often reduced to brief remarks at the end of the segment or article, he points out. Thus the public loses insight into the considerations for and against that lie behind the Danish Medicines Council's no. Instead, the story about the individual patient who does not gain access to a treatment dominates. The narrative becomes one-sided, and the nuances of the priority-setting discussion disappear.

And what is worse: the consequence is that the public debate about priority-setting in the healthcare system stands still. When the media repeatedly focus on individual cases in which a specific unhappy and worried patient does not receive the desired treatment, this, according to Kjellberg, does not lead to greater understanding of the structural dilemmas. "On the contrary. We simply do not become wiser. So we take the debate again from the beginning, and from exactly the same place, every time a new rejection of a new expensive medicine comes. It seems more like entertainment than information."

Another central point is that the media and politicians only to a limited extent accept and articulate the premise that we have scarce resources available.

> "If the budget constraint is not internalised, every priority-setting decision appears random or unfair in the public eye. It becomes a political losing issue to argue openly that some treatments must be deselected. Politically, it is very difficult to win support by saying that there are limits to what one can pay for a given patient."

At the same time, Kjellberg's view is that the media's consistent and critical angle on individual patients indirectly influences the Danish Medicines Council's decisions:

> "The media's focus on specific patients' illness stories — so-called 'rule of rescue' — reinforces willingness to pay in individual cases without regard to the whole."

Morten Freil: "The media push us into an unwanted victim role"

At the patient organisation Danish Patients, which is represented on the Danish Medicines Council, one also encounters a critical view of media coverage. But **Morten Freil, chief executive of Danish Patients,** has another standpoint and perspective.

He believes that the media play a decisive, but often problematic, role in the public understanding of the Danish Medicines Council's work and of priority-setting in the healthcare system. His criticism is primarily directed at a fixed and rigid distribution of roles in the coverage of the Council's decisions. The debate is typically framed around three archetypes: "the victim", "the expert" and "the villain".

While politicians, and occasionally the Danish Medicines Council's leadership, typically occupy the villain role in media coverage, Morten Freil experiences that journalists consistently frame or push patient organisations into a victim role. When a case about refusal of medicine is covered, the media often turn to the patient or the patient organisation to get them to provide cover for an emotional personal angle with the patient as victim of an unfair decision. He experiences that technical, medical and economic "expert knowledge" is reserved for medical experts, the Danish Medicines Council and health economists.

A good example is the case of Ditte Giese, described in the introduction to this report, who had metastatic breast cancer and herself raised money to obtain the treatment that the Danish Medicines Council had refused.

> "When the media in that and other similar cases contact us for comments, we as a patient organisation have clear patient-professional perspectives, assessments and proposals for solutions, including on which criteria should count in the decisions of the Danish Medicines Council. In the Ditte Giese case, among other things, we made a great effort to describe to journalists the significant inequality perspectives that arise when, unlike our neighbouring countries, we say no to new medicines, and to describe that Danish patients have now begun travelling abroad. We also supplied proposals for solutions to the same challenges — including proposals for negotiations with the EU and common rules in the Nordic countries on the use of new expensive medicine — and for more transparency in medicine prices. But when the articles are then published, only economists, doctors and the Danish Medicines Council are framed as experts with knowledge and professionalism. It is they, and only they, who provide professional assessments and perspectives, while we as a patient organisation are pushed into the victim role and quoted only as the patient's mouthpiece. My point is that we as a patient organisation actually have expert knowledge, professionalism and a patient perspective that are relevant, important and different from the economic perspective. It is a huge problem for the public debate that those who represent patients and possess unique expert knowledge about the patient perspective and societal consequences are seen as victims and rarely given space in a real debate."

He too points out that the very widespread case-based coverage limits the debate about priority-setting.

He recognises that the human angle is journalistically necessary, but he believes that it too often stands alone and therefore overshadows the underlying priority-setting dilemmas. It becomes a debate about “yes” or “no” to a specific treatment rather than a discussion about how society’s resources are used in the best possible way.

According to Freil, this form of coverage creates a false premise that it is either about “sympathy for the victim” or “cold realism” on the part of economists and hospital administrators.

And he believes that it leaves the public with the impression that the Danish Medicines Council’s decisions are purely objective, professional facts, when in reality they are often based on hidden normative and political value choices that never become the subject of debate because the media do not dig into them. Nor do the secret price agreements with the pharmaceutical industry find their way into the columns.

In that way, the public does not gain concrete insight into how willing the Danish Medicines Council is to pay in the different cases.

Nor do we gain knowledge of which patient groups the Council is most or least willing to pay for.

As described in the section on the Danish Medicines Council, the Council’s decisions to recommend or reject new medicines are based on evidence and economics, but according to Danish Patients and Morten Freil, the Council’s decisions inevitably also rest on normative priorities among the members about when society should have a higher or lower willingness to pay for the new medicines. Can one, for example, accept a higher medicine price if it concerns medicine for children and young people — or for patients with rare diseases?

> “A normative assessment necessarily enters into what society is willing to pay more for, what society is willing to pay less for, how uncertainty about the medicine’s effect affects the Council’s willingness to pay, and which considerations should raise or lower society’s willingness to pay,” he points out, among other things, referring to a draft note from Danish Patients, “Political and professional framework mandate for the Danish Medicines Council — indicators for willingness to pay, consistency and transparency”.

According to Danish Patients, the Danish Medicines Council’s priorities are not today framed sufficiently clearly by politicians. Admittedly, the Council is based on the Danish Parliament’s seven principles for the prioritisation of hospital medicines, but the principles are formulated so generally and are in internal conflict to such an extent that they provide only limited backing for the Council to make uniform and consistent decisions. Nor do they guard against politicians interfering in individual cases, says Morten Freil.

At the same time, he points out that the Danish Medicines Council is not democratically and representatively composed. Its members are appointed by the regions, Danish Patients, the Council itself and medical professional communities. The members therefore by no means represent the broad population and its overall value priorities.

Freil therefore believes that there is a need for a broader societal debate about the "framework mandate" under which the Danish Medicines Council works. And he calls for more nuanced and constructive media coverage that can lift the debate from the micro level to an overarching societal level. He suggests, for example, that the media facilitate a debate based on a series of dilemma cases that "force" citizens and politicians to confront the difficult choices. It might be questions about whether one should prioritise a new expensive treatment for a small patient group of children, or rather spend the money on medicine that can provide a smaller quality-of-life improvement for a very large group of patients with chronic diseases. The debate could also concern whether our willingness to pay for new expensive medicine should be higher in Denmark if one of our neighbouring countries has already recommended the medicine.

As things are now, politicians and administrators thrive with an arm's length to the difficult decisions. They conveniently leave it to the Danish Medicines Council to make the difficult choices, and the media support this by focusing on individual cases rather than the lack of transparency in the Council's decision-making process or the lack of democratic anchoring of the priorities.

For Freil, it is essential that the media help make clear that priority-setting is not only about saving money, but about choosing which values should weigh most heavily.

Thomas Senderovitz: "We hear mostly about the negative stories, and that the price is far too high"

At the **Danish Association of the Pharmaceutical Industry, Lif, director Thomas Senderovitz** finds it difficult to hide his frustration with the Danish Medicines Council and what he believes are far too many refusals to take new innovative medicines into use in Danish hospitals.

According to him, both the Danish Medicines Council and the media focus far too narrowly on limiting medicine expenditure at all costs, while broader consideration of innovation, the national economy and patients' access to new treatments is given too little weight.

> "The Danish economy is fundamentally dependent on the pharmaceutical industry. Twenty per cent of our goods exports and all growth in gross domestic product come from the pharmaceutical industry. Without it, we as a society would be flat, and we actually would not have had the fiscal room that the new government now wants to spend. I miss more focus on that from the media," says Thomas Senderovitz.

He experiences that the media generally present the pharmaceutical industry as "the dark side": those with evil intentions and greed.

> "I have been in the healthcare system and the life-science industry for 30 years, and there is a tendency to look for the negative stories, the scandals and the problems. Fear is created, and it feels unbalanced. I experienced it myself during the corona pandemic. It was fantastic how vaccines and treatment were developed in record time, but it was often the negative

> that came out in the media. That is a pity, because there are plenty of good and important stories. So many new innovative and effective medicines are being developed for the benefit of patients and the national economy. But we hear mostly about the negative stories, and that the price is far too high," says Thomas Senderovitz.

He recognises that there have over time been bad apples and scandals in the pharmaceutical industry, but in recent years a great deal has been cleaned up, and the pharmaceutical industry is, according to him, the most heavily regulated and controlled sector.

But is it not part of the truth that the prices of new medicines are too high when new medicines risk overturning hospital budgets?

According to the Lif director, the answer is no. It costs, on average, USD 4.5 billion to develop a new medicine. That money must be earned back. And medicine production must not only secure return on investment. Production must also generate enough profit that money can be reinvested in new research and new medicine development for the benefit of other patients.

At the same time, shareholders must receive their gain.

> "We must remember that the shareholders are not only rich executives in the pharmaceutical companies. Most Danes actually have pension savings or share and private savings invested in, among other things, the pharmaceutical industry."

He points out that if industry does not make money developing medicines, there will be no new innovative medicines.

> "That affects us both as patients and as pension savers. Most Danes, for example, have benefited from Novo Nordisk's fantastic success. We have to realise that this is a symbiosis. Industry is part of society and also contributes very large tax revenues, and instead of seeing one another as opposites, we should view each other as part of the same ecosystem."

Thomas Senderovitz experiences that the media, politicians and the Danish Medicines Council all have a "laser-sharp" focus on keeping medicine prices down — both the price of newly developed patent medicines and of medicines that have gone off patent. It has almost become a mantra, and doctors have joined in as well.

But it is not necessarily a good idea to press the price hard, he points out. It backfires.

In recent years we have seen many medicines go into shortage, making it difficult for patients to obtain the prescription medicine on which they depend. This applies, for example, to hormone preparations, antibiotics, ADHD medicine, inhalation medicine and painkillers.

According to Thomas Senderovitz, the explanation is that the manufacturers of these medicines experience fierce price competition from generic producers and are therefore forced to keep expenses down by moving production to China, India and elsewhere. The price pressure also means that it has become too expensive to build and maintain medicine stocks. Patients therefore

increasingly go to the pharmacy in vain — or must run a gauntlet between several different pharmacies to get their medicine.

> "A system has been created that on the one hand pushes prices down and on the other hand makes things much more uncertain and creates supply difficulties."

When it comes to the new, innovative medicines on which the Danish Medicines Council must take a position, they can, as we know, run to several million kroner per patient.

But according to Thomas Senderovitz, both the Danish Medicines Council — and the media in their coverage — look too narrowly at the expense for the regions' coffers, that is, hospital budgets. There is no focus on the so-called dynamic effects.

When assessing new medicines, the Danish Medicines Council should also look at the broader societal gains from taking them into use: does the treatment mean, for example, that the patient can return to work and thereby once again support themselves, pay taxes and increase productivity? Does the treatment mean that the older patient can manage more things without help from home care and thereby stay a couple of years longer in their own home rather than having to move into a nursing home?

According to him, a medicine can create value far beyond the regions' medicine budgets by, for example, reducing sickness absence or postponing the need for extensive care. There should be a broader understanding of value in which the socioeconomic gains and innovation considerations are also included. Senderovitz wants the story about medicine and pharmaceuticals to change from being primarily about an expense to also being about an investment in society.

But according to him, the Danish Medicines Council and the public procurement organisation Amgros focus unequivocally on bringing medicine prices down.

> "They would probably deny that, but that is what they do. We can see it, among other things, in the fact that the Danish Medicines Council recommends far fewer medicines in Denmark than is done in, for example, Germany or the United States. We take only around half of the possible new medicines into use in Denmark. I am not saying that everything that comes as new medicine will be revolutionary. But all else being equal, Danish patients get fewer opportunities under that practice," he says.

His criticism, however, is not only about the outcome of the Council's decisions but also about the Council's decision-making processes. He is pleased that Danish Regions will now evaluate the Danish Medicines Council. There is plenty to address, Lif believes.

> "We have plenty of points of criticism concerning how the Council is built and how it works. It is closed in on itself. There is a lack of transparency. We see conflicts of interest. Our members perceive the Danish Medicines Council as markedly stricter, markedly more conservative, markedly more demanding than medicines councils in other countries. We maintain that criticism. It has to be examined."

According to the director of the Danish Association of the Pharmaceutical Industry, a more nuanced public debate about medicines and priority-setting is needed. Here, he believes, the media have a significant role.

In his view, the gains from new treatments, innovation and investment in health emerge too little in the public conversation.

Correspondingly, he believes that the Danish Medicines Council too rarely communicates the positive consequences of the opportunities created by new treatments. According to him, the result is a public debate in which the focus is on high prices, conflicts and refusals, while the broader societal perspectives take up less space.

When the industry wants to keep secret the discounts and price agreements made between Amgros/the Danish Medicines Council and the pharmaceutical manufacturer in the application process, it is, according to the Lif director, because of international pricing. The mechanisms are complex, but roughly speaking it is about the fact that if prices officially become too low in Denmark, this will put pressure on the price of the medicine in other countries. And if prices in Denmark are low, pharmaceutical manufacturers will bypass Denmark when they are to research, develop and launch medicine. That would be bad for Danish manufacturers, Danish patients and the Danish economy alike.

Camilla Rathcke: "Priority-setting is mistranslated as savings"

Camilla Rathcke is (now former) chair of the Danish Medical Association and one of the clearest advocates of a national priority-setting council and of sharper prioritisation of how both healthcare kroner and healthcare staff should be used.

She stresses that she recognises and understands the journalistic logic of using patient cases to make complex material relevant to users.

> "Journalistically, it is completely understandable that one wants to put a face on the story and show who is affected by the decisions. It makes sense to have an empathetic story about a specific patient with whom one can identify. But the problem with these stories is that it is cumbersome and technical to include the nuances, facts and the opposite perspective," she says, pointing to a central problem:

The media's focus on "the face of the story" risks overshadowing the necessary technical, medical and socioeconomic considerations that lie behind the Danish Medicines Council's decisions. When a case is presented through a specific patient case, it becomes more difficult to convey the nuances that concern whether a treatment truly creates value for the population and society as a whole, or whether it merely "slows death" for the individual patient for an often very limited period and without improving the patient's quality of life.

She also experiences that the media increasingly look for conflict: “It is because, journalistically, one looks for the wedge, the disagreement or the opposition that can become a debate, that can become a big disagreement, that can become a big quarrel on which one can angle sharply.”

Rathcke believes it is a challenge that the media rarely ask the critical question of, for example, politicians or patient associations: if we choose to finance this very expensive treatment for all relevant patients with this disease, what is it that we as a society must then deselect elsewhere? Instead, the Danish Medicines Council often ends up alone having to answer for the difficult deselections, which, according to the chair of the Danish Medical Association, creates a skewed debate dynamic.

At the same time, the media miss the opportunity to focus on something very important, namely that the healthcare system’s resources are not infinite, and that every choice inevitably entails a deselection.

A significant criticism from the chair of the Danish Medical Association concerns the “populist” way in which complex medical and economic questions are often translated in the public debate and in the media. She experiences a tendency toward black-and-white presentation, where the fronts are typically drawn up between patients and the pharmaceutical industry on one side and the Danish Medicines Council’s chairmanship on the other.

Camilla Rathcke points out that this polarisation of the debate benefits no one. On the contrary, it makes it harder to have a factual debate about how we secure as much health as possible for the money.

One of the major problems with the debate, according to her, is that the media consistently angle stories about priority-setting as stories about savings and cuts.

> “That angle creates a negative narrative that someone wants to remove rights, reduce access or worsen health services for patients, and that makes it politically risky for politicians and other decision-makers to support the priority-setting agenda.”

She argues that in the media we must also remember to focus on what creates the greatest overall value and how we use our shared resources best. Priority-setting is not necessarily about saving money, but about ensuring that both money and staff are used where they make the greatest difference for citizens and patients. When the media seek oppositions and “quarrels” in order to create a good story, we lose the nuances.

To counter the current media dynamic, Rathcke supports, for example, the media working with concrete dilemma cases that can illustrate the necessary choices without exposing individual patients. By presenting readers, listeners and viewers with a series of scenarios where the choice of one measure — for example a new postnatal clinic, an expensive medicine or a new screening programme — is directly linked to consequences for other patient groups, such as waiting times for patients with incontinence or psychiatric patients, a more reflective debate can be created.

Birgitte Klindt Poulsen: “One can experience it as if the media are playing the industry’s game”

At the **Danish Medicines Council, chair Birgitte Klindt Poulsen** experiences that media coverage often misses the mark when it comes to the Council’s decisions and the ethical dilemmas associated with prioritising medicine in the Danish healthcare system.

She points out that there is great focus on the Council’s “visible no” and almost never on “the invisible yes” — that is, when the Council recommend new medicine. The Danish Medicines Council experiences a marked asymmetry in media coverage of its work.

> “The angle is often a specific, desperate patient story, and that forces us at the Danish Medicines Council into a defensive position in which we have to defend a decision made on the basis of complex professional and economic assessments,” is the verdict.

By contrast, the media rarely take an interest in the cases where the Council says yes. There is no visible conflict.

> “It creates a skewed picture of reality, because the consequences of a yes — namely the resources that must be taken from other parts of the healthcare system — remain invisible to the public. When the Council recommends an expensive treatment, it implicitly means that there are fewer resources for other patient groups, for example geriatric patients or nurses on hospital wards, but these ‘victims’ of the priority-setting are never interviewed in the media.”

A central criticism from the chair of the Danish Medicines Council is that the pharmaceutical industry is almost entirely absent from the critical coverage.

> “While the Danish Medicines Council comes under fire when it gives a refusal, the pharmaceutical companies that single-handedly set the high prices or deliver inadequate data foundations are rarely held to account by journalists,” is her assessment.

Birgitte Klindt Poulsen experiences that the companies are riding on “free wheels” in the debate, even though they are a decisive participant in the question of priority-setting.

> “We probably see a tendency for industry to ‘sell hope’ rather than evidence-based effect. And we see a tendency for the media to take over that premise by focusing on patients’ hope rather than the actual, often marginal, results of the new medicine according to the studies.”

Birgitte Klindt Poulsen therefore issues a quiet warning that the media risk becoming an instrument for the industry’s strong lobbying, which through concrete patient cases puts pressure on political decision-makers.

She and the rest of the Danish Medicines Council also experience that the otherwise critical media lack a source-critical approach when it comes to the experts and patient associations that speak critically about the Council's decisions.

> "We do not experience that the media make an effort to check the conflicts of interest of the doctors who appear as critical experts, even though many of them have close financial ties to the pharmaceutical industry, for example through advisory boards."

In the same way, she often experiences an uncritical approach from the media to data that, for example, compare Denmark's use of new medicine with that of other countries.

> "The media often use figures generated by the pharmaceutical industry itself, and which do not take into account that there are fundamental differences in countries' healthcare systems and calculation methods. This leads to a mistaken discourse that Denmark is slower or more restrictive than our neighbouring countries in adopting new treatments," she believes, while calling for a more nuanced debate about priority-setting in the healthcare system.
>
> "The media have an important task in communicating the difficult dilemmas behind a decision — and thereby also describing the uncertainty associated with new treatments, the risk of serious side effects and the necessary weighing of how our resources should be used."

She acknowledges that the Danish Medicines Council has at times had too long processing times, and that the secrecy surrounding price agreements with pharmaceutical manufacturers can be problematic from a patient and democratic perspective.

Jesper Fisker: "One gets the impression that treatment miracles are waiting just across the border"

Jesper Fisker, director of the Danish Cancer Society, wears several hats in this context. He represents cancer patients, of course, but he was also chair of the government's Health Structure Commission, which was appointed to scrutinise the healthcare system and launch models for how we should organise it better and more coherently in future. He has previously been, among other things, permanent secretary at the Ministry of Health, director general of the Danish Health Authority and chief executive of the Health and Care Administration in the City of Copenhagen, and he has very detailed knowledge of the healthcare system.

According to Jesper Fisker, the urgent and unavoidable need for priority-setting in the Danish healthcare system is driven by a fundamental imbalance between the financial framework and the population's rising expectations. Like Jakob Kjellberg and Jes Søgaard, he describes how the healthcare system is facing a future in which personalised medicine and new forms of treatment will

become markedly more expensive, while demographic development puts pressure on hospitals and the rest of the healthcare system.

If we do not manage to handle the priority-setting task, we risk ending in a downward spiral in which the public healthcare system is hollowed out and the wealthiest citizens buy treatment privately or abroad. Jesper Fisker points out that the goal of setting priorities is not to save money but to ensure a sustainable and fair system in which we get as much health as possible for the resources we have available.

He argues for the establishment of a National Priority-Setting Council and sees the Danish Medicines Council's role as that of an institution tasked with making difficult decisions on behalf of the community in order to ensure that new medicine has a documented effect before it is taken into use.

Although the Danish Medicines Council is often the subject of criticism and debate, Fisker calls the Council a "well-functioning construction". He believes that the Council is crucial for resisting the pressure that the pharmaceutical industry's pricing policy places on the national economy.

> "The Danish Medicines Council ensures that there is a professional body that dares to say no when the effect of a treatment is too small in relation to the price," he says.

On the other hand, he criticises the lack of transparency around the Council's work, so that citizens can gain better insight into the basis for the decisions the Council makes, and he also believes processing times are too long.

> "If in Denmark we are unable to recommend medicine at the same pace as our neighbouring countries, it can lead to destructive inequality and a loss of trust in the Danish system," he points out.

When it comes to the media's focus on individual cases and "the patient victim", he — like several of the other professionals interviewed — experiences that the press has a tendency to accelerate conflicts and focus one-sidedly on individual cases when a patient receives a no to a new treatment.

Fisker points out that the media rarely describe the positive consequences of priority-setting: namely, that the community's resources are used where they do the greatest good for the largest possible number of people.

> "When the media cover patients travelling abroad for treatment one-sidedly, a picture is created that miracles are waiting just across the border, even though the actual medical outcomes often fail to appear," he says.

And then he brings cutbacks and the crisis in the media industry into the debate.

He sees a connection between the relatively one-sided coverage and a general decline in the number of specialised beat journalists at the major media. He calls for more journalists with deeper professional insight, able to explain the nuances of the difficult dilemmas rather than simply chasing "clicks" through personal tragedies.

> "The media do have a responsibility to draw a balanced picture of the healthcare system. But positive stories about solutions, recovery plans or improvements in the system are often overlooked because they do not contain the same drama as a scandal. That helps create unnecessary insecurity among patients and can, in the worst case, lead to political decisions being made on a non-professional basis."

He encourages the media to take a greater interest in the areas and places where things succeed — for example, new initiatives where hospitals and nursing homes cooperate to reduce the number of avoidable admissions.

Berit Andersen: "One can feel a little bruised after meeting the press"

Berit Andersen is head of the University Clinic for Cancer Screening, UNICCA, at Regionshospitalet Randers and clinical professor at the Department of Clinical Medicine, Aarhus University. She is an expert in screening programmes, and at the same time she has for several years been a member of the Danish Council on Ethics. I have chosen to speak with her with both hats on in order to benefit from both her health-professional knowledge of screening programmes and her ethical perspectives on priority-setting.

When it comes to screening programmes, there is, as we know, great professional debate and disagreement these years about the effects of, for example, breast-cancer screening, cervical-cancer screening and bowel-cancer screening. Do screening examinations lead us to overtreat, misdiagnose and overdiagnose, partly because in screening we also find small insignificant tumours that would never have led to cancer disease in the person examined? Or do screening programmes lead us to save many lives because we detect cancer at an early stage?

Berit Andersen's research suggests that the answer is complex. There is no unambiguous answer. Both statements are valid. There are many nuances and dilemmas. Yes, the programmes can save lives, and yes, the programmes lead to overtreatment.

And it is precisely this complexity that Berit Andersen experiences as difficult to get through in the media when we discuss screening.

She has several times agreed to interviews to explain what the research shows about the different screening programmes. But her experiences with journalists have not been unequivocally good.

> "In fact, I often feel a little bruised when I have been in the media," says Berit Andersen, who is now more reluctant to be interviewed about the field in which she is an important expert. It therefore required many considerations for her to say yes to this interview.
>
> "I have become a little shy about putting myself forward because I think it can become too polarised and sharply edited. I myself think that I am reasonably nuanced in my approach to screening issues, but when I meet a journalist, that person will often want me to take one position against someone else's position — a bit back and forth — where it then turns out

> that I am to be set up as the counterpoint to one of my professional colleagues who argues clearly either for or against something that has to do with screening."

She has experienced only afterwards — when the segment was broadcast or the article published — discovering that she had been used as a kind of opponent of opinion to, for example, a colleague, and that only one part of her argumentation was used in the segment or article as a counterweight to the colleague.

> "It had not dawned on me, and perhaps I should have been more alert. But it was edited together in such a way that I actually did not think that what I said was what I meant."

One example is what she had understood as an expert interview on a radio station, where she was to explain some screening data and research data used by health authorities in their information material about a screening programme. Afterwards, however, it turned out that she did not participate as an expert but rather experienced herself as a target in the programme. In the finished broadcast, the journalist played excerpts of the interview with Berit Andersen and then let a screening-critical professor criticise it piece by piece.

Berit Andersen did not know that the interview with her would be used in that way, and she was not given an opportunity to respond.

That the media's critical focus and hunt for "scandals" and sharp headlines can hit healthcare staff hard is something she has also experienced. She stresses that she believes the media play a very important role in bringing failures and breaches of the law to light. Also when the failures and breaches of the law take place in hospital corridors or in doctors' clinics.

But she experiences that the desire to "reveal scandals" sometimes goes too far.

She connects her own experiences with media coverage of the health area to the development taking place in the media landscape — the intensified battle for users, sharper angles, faster news. In her view, over the years there has been less room to explain complex connections. She experiences that news is increasingly becoming short and sharply angled, and that makes it difficult — for journalists and experts alike — to explain the dilemmas facing the healthcare system. The result, according to her, is that the public is presented with a more polarised picture than professionals themselves see.

Therefore, the discussions about which treatments and medicines we should choose and deselect must be lifted to a more overarching level and create greater openness about the principles according to which we should set priorities in order to get as much health as possible for the money. This is where the National Priority-Setting Council and the Danish Medicines Council enter the picture, Berit Andersen believes.

But the economic calculations cannot stand alone. Quality of life, the severity of the illness and social consequences should also be included, she says. The same applies to inequality in health. Berit Andersen points out that if we focus one-sidedly on "as much health as possible for the money", we risk increasing inequality, because the most resourceful citizens are often best able to make use of the

healthcare system's offers, while it requires more resources to include vulnerable citizens in the same offers.

7. Constructive journalism and constructive tools for facilitating a broader public debate

If one wakes a trained journalist in the middle of the night and asks him or her to describe how to select the best journalistic story, he or she will immediately recite the classic news criteria:

Timeliness. Significance. Identification. Sensation. Conflict.

If a story is to be given high priority and "perform" well with many readers, it must contain one and preferably several of these criteria. This is basic knowledge for us journalists and has been so for decades.

But the media are, as we know, under significant financial pressure, and the media landscape is changing rapidly. Much suggests that there is a need to add a couple of extra news criteria or some new journalistic tools if the media are also in future to be relevant to their users and play a significant role in society. Not only for the sake of the media, but also for something as important as democracy.

I will return to that.

First, a little about our changed media consumption, the entry of the tech giants and accelerating news avoidance.

Never before has so much content and so much news been produced as today. We are bombarded with news on all platforms, and we can get news and stream content on all platforms and at all times of the day — exactly when it suits us.

But at the same time, another marked and opposite trend is running underneath: more and more people refrain from following the news.

Traditional media such as newspapers, television and radio stations and local news media have found it far more difficult to earn money and retain their audiences. There are many different reasons for this, but no one is in doubt that the rise of social media and tech giants plays a decisive role. So does the fact that a very large share of advertising money has moved to digital platforms such as Google, Meta and TikTok.

The competition for the attention of viewers, listeners and readers is fierce. Facebook, YouTube, Instagram, X, TikTok, LinkedIn and others have in a very short time taken over the role of news distributors, and many people get all their news, information and entertainment through algorithm-driven social media, via streaming services, Instagram reels, AI news agents and so on.

According to the latest report from the Reuters Institute, June 2026, social media and video platforms have now for the first time overtaken television and traditional news media as the primary source of news worldwide.[24]

The fierce competition for audiences creates fertile ground for clickbait stories, sensationalist headlines, sharply angled conflict stories and fake news.

This increases mistrust of the media.

The classic news media are experiencing a marked decline in both subscription and advertising revenue. Audiences are increasingly turning their backs on them. And according to several media-consumption studies — including the latest from Roskilde University and from the Reuters Institute at the University of Oxford — it is especially the classic conflict-oriented news coverage that people increasingly avoid.

Their motivations are interesting. They state, among other things, that they experience the news as focused on the negative, that they do not trust the media, and that they feel overwhelmed and exhausted by the amount of available news.

The many negative news stories about war, violence, problems, scandals, climate disasters, conflicts, fraud, crime, poor well-being, illness and so on put them in a bad mood and even make them apathetic. Respondents experience that they have no opportunity to do anything about all the many problems and evils presented to them in the news, and they feel they are drowning in the ever-growing news stream.[25] [26]

In Denmark, according to the Roskilde University study *Danes' use of news media 2024*, 23 per cent of citizens are so-called conscious news avoiders. This is an increase of five percentage points in just one year. In other words, about every fourth adult Dane states that they "often or sometimes" consciously

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[24] https://reutersinstitute.politics.ox.ac.uk/sites/default/files/2026-06/DNR%202026%20FINAL_2.pdf

[25] https://constructiveinstitute.org/app/uploads/2025/10/CI_Haandbog_konstruktiv_journalistik_FINAL.pdf

[26] https://reutersinstitute.politics.ox.ac.uk/sites/default/files/2026-06/DNR%202026%20FINAL_2.pdf

avoid news. They simply turn off the news broadcast on television and radio and stay away from newspapers and digital news sites.

In addition, 29 per cent say that they "sometimes" consciously avoid news.

The study also shows that 35 per cent of Danes, across all age groups, state that they strongly or somewhat agree that the total amount of news is overwhelming.

If one asks Morten Skovsgaard, professor MSO at the University of Southern Denmark, and Kim Andersen, assistant professor at the University of Southern Denmark and the University of Gothenburg, news avoidance is a problem for both news media and democracy as a whole.

In an article published on the Constructive Institute's website, they point out that in addition to the growing group of people who are conscious news avoiders, there is also a group of people who more unintentionally avoid news.[27]

They are not driven by a specific aversion to news but rather by the fact that the supply of news content is growing dramatically and seems unmanageable. They then end up — instead of watching, reading or listening to news — choosing precisely the content that matches their own preferences, often entertainment, which in practice displaces their news consumption.

When researchers from Roskilde University and the University of Southern Denmark alike take an interest in news avoidance, it is not only out of concern for the well-being of the news media. It is also because it is considered an important precondition for a well-functioning democracy that citizens follow the news flow.

Citizens must be informed about what is moving in society, what is discussed at Christiansborg and in the municipal council chamber, what the public debate concerns, and they must be able to familiarise themselves with the different views that drive the debate and ideally participate in it themselves.

> "Media organisations need readers, listeners and viewers to generate advertising revenue, sell subscriptions and maintain their societal relevance. But news avoidance is also a problem for democracy. In general, news consumption has a positive effect on people's knowledge about society and politics as well as on their political engagement and participation. So how do we get people to participate in the news cycle?" ask Morten Skovsgaard and Kim Andersen in the article published on Constructiveinstitute.com.[28]

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[27] https://constructiveinstitute.org/how/contributions/solutions-to-news-avoidance/

[28] https://constructiveinstitute.org/how/contributions/solutions-to-news-avoidance/

Their answer is that constructive, fact-based, transparent and slow news can be possible solutions.

This is where constructive journalism comes into the picture. The question is whether constructive journalism can help increase citizens' knowledge of and engagement in the society in which they live.

And in relation to the subject of this report: can constructive journalistic tools help ensure that we get more nuanced and fact-based media coverage when it comes to priority-setting in the healthcare system? Can constructive journalism and the media push forward a much-needed democratic debate about how we use our healthcare kroner best, so that we get as much health as possible for the money?

But first, a brief introduction to constructive journalism.

Constructive journalism and the three pillars

> *"Independent journalism is the core of society's conversation and progress. It provides facts. Uncovers problems. And inspires potential solutions to the challenges facing all of us.*
>
> *Today, people do not need more news, they need better news. That's what we call constructive journalism."*
>
> — Ulrik Haagerup, CEO and founder of Constructive Institute

Constructive journalism is a genre within journalism that many media already work with in one form or another. It exists in many versions and guises, but here I let Ulrik Haagerup, CEO and founder of Constructive Institute at Aarhus University, briefly describe the thinking behind the model for constructive journalism that Constructive Institute has developed and works from:

> "Constructive journalism is a response to the growing sensationalism and negativity bias in today's news media. Its most important mission is to restore trust in the idea that shared facts, shared knowledge and shared conversations are the pillars on which our society rests.
>
> Constructive journalism is not positive or uncritical journalism, not an alternative to critical watchdog journalism and not a quick fix for the media industry's problems. On the contrary, it recognises that quality journalism, in order to serve democracy, must be critical, inspiring, nuanced and engaging."[29]

Explained in a slightly different way: constructive journalism always takes its starting point in a problem or challenge in society. But instead of only uncovering, revealing and describing the problem and identifying those responsible, constructive journalism, popularly speaking, takes one step further and also tries to point to possible solutions and to promote the democratic conversation in public.

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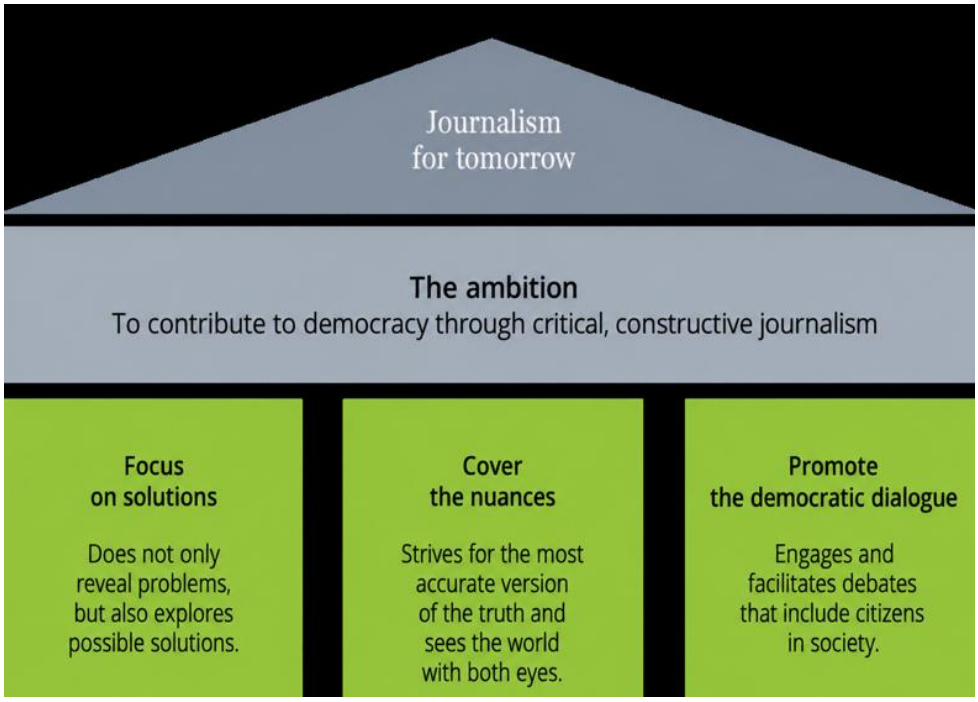
[29] https://constructiveinstitute.org/why/

Constructive journalism is characterised by three pillars. They can be described as follows:

1. **Solutions-oriented:** Journalism should not only uncover problems and crises; it should also help examine and point to possible solutions, initiatives and answers to the problems and challenges society faces. Constructive journalism is thorough and critical in its approach — both when it reports on problems, progress and solution opportunities. It moves the focus of the story from the problem itself to the work of solving it.
2. **Focus on facts and nuances:** Journalistic coverage should show an accurate picture of reality and avoid bias, unnecessary polarisation or sensation. Constructive journalism is fact-based and gives nuances space. Instead of presenting issues in black and white, constructive journalism also embraces complexity — with confidence that audiences prefer a holistic and nuanced story to a simplified version.
3. **Promotes democratic conversation and involves citizens:** In this pillar, the media seek to strengthen democracy and counteract political polarisation by promoting a decent culture of debate, engaging audiences and building trust in the media. Constructive journalism invites citizens in and facilitates a constructive and critical public debate. It involves citizens and seeks ideas and perspectives from them.

The Three Pillars of Constructive Journalism



At the beginning of this chapter, I wrote that much suggests there is a need to add a couple of extra news criteria when journalists and media are to plan, develop and select the best stories. The three

pillars of the Constructive House — the solutions-oriented, the fact- and nuance-based and the involvement of citizens — are obvious for the media to keep in mind as extra news criteria when production is planned.

8. Proposals for how we can cover healthcare and priority-setting dilemmas more constructively

As described earlier in this report, we in the media have a number of biases and blind spots when it comes to coverage of the prioritisation of our healthcare services and resources. There are perspectives and sources that almost never find their way into media news coverage, and several experts point out that the prioritisation of healthcare services contains an element of randomness and is far from always based on criteria that have been politically adopted and enjoy broad popular support.

And when it comes to the Danish Medicines Council's decisions to reject or recommend new, expensive hospital medicine, the population and politicians lack insight into the basis for the decisions.

In the following, I will sketch ideas for how the three pillars can be concretely incorporated into coverage of the healthcare system's services and the prioritisation of money, resources and staff.

The main focus will be on pillar three: involving citizens and promoting the democratic conversation.

Proposal, pillar 1 — focus on solutions

But we start with pillar 1. In journalism, we have an important task in uncovering problems in society and revealing failures and abuses of power. But once we have done that, it is natural to take a constructive approach to the story and examine whether there are possible solutions to the problem. In the first pillar, it is therefore obvious for health beat journalists such as myself to produce journalism that examines, for example, how other countries approach the task when they must decide whether new, expensive medicines and treatments should generally be implemented in their healthcare systems.

A constructive approach in this context would be to examine and focus on possible solutions either in Denmark or abroad. For example, one could research and describe how the other Nordic countries, as well as Germany and England, handle the dilemmas in their national priority-setting institutes.

In Norway and Sweden, a series of politically adopted criteria has already been formulated on which priorities throughout the healthcare system must be based. In Germany, there is a system in which the state virtually never blocks the adoption of new medicine by referring to the price. It is obvious to examine and describe how the system works in these countries and whether we can be inspired by them.

In England, there is many years of experience with giving the entire decision-making competence to a state assessment institute, NICE, which makes the decision — and enjoys broad support.

Here it would be obvious to examine and describe how the decision-making process has been for, for example, two specific new medicines that have been assessed in Norway, Germany, England and

Denmark alike, and where the medicine has been taken into use in some countries but not in others. What lies behind this, and could one of the other countries' models be an obvious source of inspiration?

The solutions-oriented approach can clearly also be used in far more health stories in general. If, somewhere in the country, a solid project has been run in which good results have been achieved by treating many patients at home, or if it has succeeded in reducing the number of avoidable readmissions of older medical patients, it is obvious to go there on reportage and talk to patients, doctors and relatives about why it succeeded.

Stories of this kind, with a focus on the good example or on solutions, are already sometimes produced in Danish media, but there is plenty of scope to do much more. There are many municipal and regional projects in which new ways of treating or organising the healthcare system are tested in research-based ways, so there is often evidence on which to build these kinds of stories. There are also often good human stories and reportage opportunities in these angles, just as many patients will be very interested and motivated to watch or read such stories.

A couple of examples of journalistic projects that examine possible solutions to significant problems include DR, which in *TV-Avisen* had a segment about the challenges of obtaining doctors for peripheral areas. In that connection, the journalist had gone to northern Norway, where they have succeeded in attracting more doctors with, among other things, higher pay, good working and housing conditions, and focus on finding jobs in the area for accompanying spouses.

Another example in the same doctor-shortage genre is a series of articles I published together with a colleague some years ago. We did reportage from Thy, which for years has had great difficulty obtaining enough general practitioners, but which has now cracked the code. Young future doctors are now almost queuing to obtain training positions and later settle with their own practice in the area — drawn by strong professional and research environments built around Thisted Hospital and by the surfing scene at Klitmøller and Nørre Vorupør.

Proposal for pillar 2. Focus on facts and nuances

It should be — and fortunately often is — a matter of course for all journalists and for all journalistic productions within all beats to focus on both facts and nuances.

Also when it comes to health coverage.

But this constructive pillar, too, is obvious to use far more when we cover the health area.

We can benefit from living in a country with very strong data and health registers. We can obtain data on everything from medicine consumption, the number of doctor visits, diagnoses, waiting times for planned operations, compliance with the examination guarantee and maximum cancer waiting times, and so on. We can compare across municipalities, regions, hospitals, general practitioners and more.

These data are often an excellent starting point for producing concrete health stories and news.

We can also use data to produce so-called “what is up and down” stories, where, with the help of expert knowledge and research, we try to answer the questions that press themselves forward in a specific case or debate and thereby try to make people wiser and pass on knowledge.

We can also use data collections to produce “myth-buster stories” along the lines of “We thought the world was put together in one way, but now statistics show that reality looks different”.

When it comes to the Danish Medicines Council’s decisions, it is obvious that we as health journalists should draw valid data that reveal whether Denmark really is slower and more reluctant to take new, expensive medicines into use compared with other EU countries, and whether relatively fewer Danish patients gain access to new promising medicines and treatments than patients in other Scandinavian countries. The pharmaceutical industry’s data point in that direction, while the Danish Medicines Council’s data point the other way.

Here, solid fact-based journalism that cuts through haze and spin could be important and desirable.

When it comes to securing the nuances, it is obvious to point to the need to include more perspectives and nuances — those we rarely unfold — when we write about the Danish Medicines Council’s refusals of new medicines. We should make a greater effort to describe why the Council has said no to new medicines: for example, because the effect of the new expensive medicine is not sufficiently documented, because there are too many side effects, because the price is extremely high in relation to the fact that an existing product is already on the market that is far cheaper and just as effective. And conversely, explain why the Danish Medicines Council has said yes: that it is because the medicine can secure treatment for patients with rare diseases who otherwise have few treatment options, or because the medicine is an entirely new type of one-time treatment that cures and can therefore spare patients and the healthcare system the many repeated treatments that would otherwise have had to be carried out.

An obvious tool here is also to make so-called explainers, where we as journalists ask a series of clarifying questions about a given case or issue and then, through research or experts’ knowledge, answer those questions. This tool gives room for nuance.

Proposal for pillar 3. Focus on citizen involvement and debate

The last pillar in the Constructive House, as mentioned, is about involving citizens and about promoting democratic debate and conversation.

It is my assessment that this pillar is especially obvious to use in the coverage of priority-setting dilemmas and the Danish Medicines Council’s work. It contains refreshing and exciting possibilities for journalists and media outlets to enter into dialogue with users, to ask what occupies them and to take on a societal task by facilitating democratic conversation and critical debate about how we use our tax kroner and healthcare resources best.

Already here, someone will surely ask whether it can really be the task of journalists to do more than simply report and convey information, views and knowledge from experts, politicians and others. Can

and should journalists and media also be facilitators of debates and take on the role of moderators? Can it really be the task of a media house to arrange debate meetings, for example?

In my view, the answer in both cases is yes.

If we are to see the world with both eyes, we must give more space to disagreement and diversity and allow many different perspectives to emerge in our coverage.

Moreover, there is a separate point that at a time when we all increasingly allow ourselves to be advised, guided and influenced by AI, there is a serious need to facilitate conversations and debates between people. As media, we can offer real meetings and real conversations where people are not merely confirmed in their assumptions and worldviews by an artificial intelligence coded to flatter them.

The whole priority-setting dilemma in the healthcare system is an obvious subject to put up for debate — to ask users for input on. As several sources point out in this report, in Denmark we still need to take a political position on which criteria and principles should guide the prioritisation of our increasingly pressured healthcare budgets. Such political positioning is impossible for politicians to carry out without a prior broad public debate about values, ethics, inequality, quality of life and so on.

I do not imagine that we in the media can or should lift that task alone. But I am convinced that we as media can help make a series of dilemmas visible and put them into focus, and cut them down concretely. In that way we can help facilitate the introduction of several different views and alternatives, just as we can ensure that our users meet in conversations and debates. We involve them, activate them and bind them more closely to us. That is a win-win-win situation, because users, society and the media all benefit from it.

I see a wealth of opportunities, as a journalist, to put healthcare priorities and ethical dilemmas up for debate in our media, whether they are written media, television, radio or podcast. I have done this myself for years as a health journalist when writing articles about assisted dying, gene therapy, fertility treatment, palliation, fetal reduction and so on. There are plenty of opinions and value sets that collide around these topics, and that we as a society and as human beings must confront. Over the years I have interviewed experts with very different opinions on these subjects and in that way brought different perspectives into the debate.

But pillar three in constructive journalism contains, as I see it, much more than this. It contains the possibility of inviting readers further into the engine room and involving them very actively.

When it comes to prioritising our shared healthcare services, we can, for example, ask our readers to provide examples of examinations, treatments or check-ups that they themselves have experienced as superfluous or ineffective. In that way we can get an indication of which healthcare services have value for patients and which do not.

A debate evening with users' own experiences and dilemma games

But what appears most obvious to me is to gather readers or citizens for one or more debate events, where they are not simply to show up and listen to experts' knowledge, organisational representatives' views and patients' experiences, but also to participate actively in the debate themselves and take a position on what they believe we as a society should prioritise and what we should reduce.

Such user events serve both as a tool to involve users/readers in the debate about significant societal challenges and as a tool to tie users more closely to us as a medium.

Along the way, I have become interested in arranging a series of dilemma-game events, where citizens are invited by my own media outlet, *Jyllands-Posten* — perhaps arranged in cooperation with researchers, Danish Patients, the Danish Medical Association and others — to an evening where they are presented with a number of different concrete but fictional patient cases, and where in groups they must discuss and choose which patient groups they would prioritise spending more money on if they were politicians.

In my work on this report, I have therefore asked for and received input on concrete priority-setting dilemmas from Danish Patients, the Danish Medical Association, Professor Emeritus of Health Economics Jes Søgaard and, not least, Professor of Health Economics Michael Bech from the University of Southern Denmark.

My brief was that the case descriptions and dilemma questions should be as realistic and representative as possible. In other words, in the dilemma games we should work with patient groups that exist and that in one form or another are in competition with one another for politicians' favour and thus the healthcare system's kroner.

I will briefly outline here the input I have received from Professor Michael Bech. As a health economist and researcher, he has worked extensively with priority-setting in the healthcare system, and he has previously participated in a theatre event, *The State*, about precisely priority-setting in healthcare. For that purpose, he developed a kind of dilemma game in which the audience was presented with different patient groups and had to prioritise between those groups.

I have been allowed to use part of his material and data for this report. The agreement with Michael Bech is that if I use the material from the theatre event for the planned reader debate evenings, it must be cleared with him and the theatre group.

For the reader event, I imagine that after a brief welcome and introduction, participants are invited to talk a little about their own experiences of the healthcare system's pressure and about how often they themselves go to the doctor. Michael Bech then takes them through the demographic development and the pressure on the healthcare system, as described in this report, and the finances of our healthcare system. He also provides knowledge about how many employees there are in our healthcare system, how much we on average draw on the healthcare system — that is, how often we

go to the doctor, dentist or physiotherapist or are admitted — and how many billions of kroner we spend on medicine, psychologists and so on.

Participants are invited to give their first and immediate suggestion as to where we should cut something away.

Then the plan is for Michael Bech to give participants basic knowledge about cost-benefit analyses and the Danish Medicines Council, which weighs, among other things, effect and price against one another. He introduces the concept of QALY, quality-adjusted life years, where in a cost-utility analysis of a specific treatment or medicine one can calculate the gains in the form of quality-adjusted life years won. By calculating the QALY for each treatment or new medicine, one can compare heart operations, rehabilitation, cancer medicine, psychotherapy, smoking cessation campaigns and more with one another and see where society in principle obtains the most health for the money — quality-adjusted years gained.[30]

We are now ready to begin the dilemma game.

Participants are divided into smaller groups, each of which must make its own proposal for priorities for our healthcare system for the next year. Each group "receives" DKK 100 billion, which they must distribute across five larger areas of health and care: prevention, emergency/prehospital services — that is, for example ambulances and medical helicopters — cancer treatment, psychiatry and elderly care. The DKK 100 billion broadly corresponds to the total amount we currently spend on the five areas.

Participants are then presented with five concrete but fictional patient cases — one for each of the five areas. To qualify the debate, Michael Bech provides a number of arguments for and against prioritising each of the five groups.

The five patient cases

The five cases prepared by Michael Bech are the following. The figures in parentheses show how much money we spend on the area, 2022.

Prevention: "A healthy start for future generations" — DKK 13.5 billion

My name is Anna, I am 12 years old and I live in a socially disadvantaged area. I struggle with obesity and have early signs of type 2 diabetes. I dream of a future in which children like me gain access to free exercise activities, healthy food at school and information about a healthy lifestyle. I know that

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30 https://vbn.aau.dk/ws/portalfiles/portal/19190570/Bilag_punkt_5_Introduktion_til_sundheds_konomi_Lars_Ehlers_1_.pdf

every krone invested in prevention can save the healthcare system a great deal of money and give us children a better future.

Emergency treatment: "A helping hand at life's most critical moments" — DKK 2.5 billion

My name is Peter, I am 56 and I recently collapsed with cardiac arrest at my workplace. It was the ambulance team that saved my life. But I can see that waiting times for ambulances are increasing and that emergency departments are under pressure. I want us to invest in more ambulances, better emergency preparedness and new acute treatment beds, so patients like me do not risk help arriving too late.

Cancer treatment: "Hope where before there was resignation" — DKK 12 billion

My name is Mette, I am 38 and mother to two small children. Recently, I was diagnosed with breast cancer. I need a new form of treatment with targeted immunotherapy that can give me a greater chance of survival and more years with my family. But the technology is expensive, and waiting lists are long. I hope we can invest in cancer treatment so families like mine can gain access to the best and newest treatments.

Psychiatry: "An invisible struggle that deserves attention" — DKK 10.5 billion in treatment psychiatry + DKK 13.3 billion in municipalities

My name is Jonas, I am 19 and I have struggled with depression for two years. I often feel alone and have considered giving up. I experience that psychiatry lacks resources, and waiting times for talk therapy and beds are far too long. I hope we can invest more resources in psychiatry so young people like me can get the support and treatment we need before it is too late.

Elderly care: "A dignified life when we grow old" — DKK 50-60 billion

My name is Else, I am 82 and I live alone with incipient dementia. I often forget to take my medicine and feel isolated. I want elderly care to receive more resources, so I can get regular visits from a home helper, technological solutions such as medicine robots and activities that keep me socially and mentally active. For me, a dignified old age should be a right, not a privilege.

After this, each group must together arrive at how the DKK 100 billion should be distributed between the five health areas. Should some areas receive more or less than they receive today, and why? It is crucial that I/we state in advance that there is no single right answer, and that the group should try to talk its way to agreement on the distribution.

One can, among other things, ask the groups to consider whether the principles should be that all people must be treated equally in the healthcare system, that everyone must be secured access to some form of treatment, that we should treat those with the most serious diseases first, whether we should first and foremost prioritise those we can save here and now — or whether we should prioritise children, who have a long life ahead of them.

I have no doubt that there will be many different opinions and perspectives in each group. People come with their own experiences and preferences. Some may show up at the debate meeting because they themselves are patients and miss more offers from the healthcare system, while others may have received fantastic treatment and be full of gratitude, and still others are relatives or politically interested in the topic.

I imagine that after a break, the second part of the event begins. It should concern the Danish Medicines Council's decisions and the dilemmas that arise when we acknowledge that the healthcare system cannot afford everything and that we are therefore forced to weigh price, effect, documentation and side effects against one another.

Along the way during the second part of the event, we should meet a couple of patients and get close to their course of illness — those around whom everything revolves. It could, for example, be a kidney or breast cancer patient who has received a no to a specific new type of very expensive medicine because the Danish Medicines Council rejects it due to insufficient documentation of the benefit. It could also be a family with a child with muscular atrophy — spinal muscular atrophy — that has received a yes to the latest product, Zolgensma. A product that only has to be given once in a lifetime, but costs DKK 18 million.

Then I imagine a conversation between the chair of the Danish Medicines Council, Birgitte Klindt Poulsen, the director of the Danish Association of the Pharmaceutical Industry, Thomas Senderovitz, and the director of Danish Patients, Morten Freil, who sits on the Danish Medicines Council and therefore knows the dilemmas and the reasons for recommendations/rejections.

This conversation should ensure that participants gain some insight into the possibilities in the many new medicines, the uncertainty of their effect and the relatively closed decision-making processes around the assessment of new medicine. The conversation should also open up the reasons why the Danish Medicines Council keeps discount agreements secret and why new medicines often cost millions of kroner per patient.

With the draft note from Danish Patients proposing a framework mandate for politicians[31] as a starting point, the attending readers/citizens should be presented with different proposals for criteria/values that should form the basis for the priorities made in the Danish Medicines Council and elsewhere in the healthcare system.

In Danish Patients' preliminary proposal, there are 26 different suggestions for criteria/indicators that they propose politicians should weigh against one another on the basis of a broad public debate. In this way, the criteria are to function as ethical and value-based guidelines for our decisions about

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[31] Draft note: Political and professional framework mandate for the Danish Medicines Council — indicators for willingness to pay, consistency and transparency.

priorities. The criteria concern, among other things, whether we as a society should be more willing to pay a higher price for new medicine if the medicine only has to be given once in a lifetime and thus means that the patient and the healthcare system avoid a series of recurring treatments and controls in the future. Another criterion concerns whether we should be more willing to pay if, for example, the medicine is for patients with very serious disease rather than patients with chronic common diseases, while a third criterion concerns whether we should be less willing to pay if there is great uncertainty about the effect of the medicine, or if the average expected extra survival time is relatively short.

I imagine that in the presentation five to seven criteria are selected, which the panel participants and citizens must debate in smaller groups and weigh against one another.

This debate in groups continues the discussions about the five health areas from the first part of the event, but with the difference that the final debate is about arriving at some overarching priority-setting criteria that we as a society can use each time we are to introduce new treatments or medicine.

Fertility, screening and overtreatment. Proposal for an article series on three concrete dilemmas

In my work on this report, I have also asked the Danish Medical Association to provide input on three dilemmas in the healthcare system where it is obvious to consider whether we should continue to offer the services or cut something away — whether we get enough health for the money.

These inputs can in the same way form the basis for a series of articles that work with pillars 1, 2 and 3 — where one delivers facts, nuances and solution opportunities, involves users and creates debate.

The three dilemmas from the Danish Medical Association are the following.

Fertility and the specialist-doctor ceiling

Politicians recently introduced a patient right to free fertility treatment for child number two. At the same time, there is a shortage of specialists in the fertility area, among other reasons because too few specialists have been trained over a number of years. At the same time, the specialist-doctor ceiling sets a limit on how many specialists the individual departments can employ.

This can create a dilemma between politically established patient rights and the medical resources that are actually available in the healthcare system.

Screening and vaccines

To prevent cervical cancer, HPV vaccination for girls from the age of 12 became part of the Danish childhood vaccination programme in January 2009, and from September 2019 the vaccination was also offered to boys. The vaccination prevents the vast majority of cases of cervical cancer. At the same time, women in Denmark aged 23-64 are offered free screening for cervical cancer, through which cell changes can be detected before they develop into cancer.

As more generations are vaccinated against HPV, fewer cases of cell changes and cervical cancer are expected in the long term. This raises the question of how long an extensive screening programme should continue when the disease potentially becomes rarer.

Overtreatment in the final period of life

In the final period of life, seriously ill patients can often be offered more examinations and treatments, for example scans, biopsies, operations or medical treatment. In some cases, the treatments may have limited effect on the course of illness and at the same time be burdensome for the patient.

The debate about treatment in the final phase of life concerns, among other things, the balance between offering all possible treatment options and prioritising relief and quality of life.

9. Conclusion

Hand on heart: do we believe that we as patients will in future gain access to every new treatment or every newly developed medicine?

No, surely not.

Everything suggests that we as a society will in future have to make far more sharp choices and deselections when it comes to treatments, examinations, medicines, check-ups, scans and so on, as the population ages, treatment options multiply and resources become more limited.

But paradoxically, while priority-setting becomes increasingly crucial for a sustainable healthcare system and society, the public conversation about priority-setting is often reduced to individual cases about patients failed by zealous, stingy and unempathetic decision-makers. Journalism therefore risks unintentionally overshadowing the principled dilemmas that decision-makers have been set to handle.

Several sources in this report point out that there is a great need for a broad public debate about which considerations should weigh most heavily when there is not enough money for everything. Journalism can and should contribute to that debate. Not by journalists giving up the powerful patient story — it will continue to be an important part of health journalism — but by at the same time placing the patient's perspective in the larger context where consequences, alternatives and priority-setting principles become part of the story.

If we journalists, to a greater extent, manage to combine the personal stories with facts, perspective and constructive tools, we can contribute to a more nuanced public debate about the choices and dilemmas that neither politicians, doctors, economists nor citizens can avoid encountering.

I have no doubt that there is an important journalistic task in developing formats and narratives that can contain both the patient angles and the societal consequences of the choices we face. Journalism should not merely describe the priorities, but also qualify and facilitate the democratic debate about the difficult dilemmas.

When resources are limited, nuance is not a luxury good but a democratic necessity. And the task of journalism is not to remove the dilemmas, but to make them understandable.

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Plus a large number of articles about August and his family — the boy with the rare genetic defect.

Among them these articles:

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11. Appendix

Appendix 1. Examples of medicines assessed by the Danish Medicines Council

Below are four descriptions of medicines assessed by the Danish Medicines Council.

The first three are examples of medicines the Danish Medicines Council has recommended, the first two for the treatment of cancer, while the last is an example of a medicine for pulmonary arterial hypertension in adult patients that the Council has not recommended.

The examples were provided by the Danish Association of the Pharmaceutical Industry, Lif.

1. The Danish Medicines Council's recommendation regarding larotrectinib for the treatment of NTRK fusion-positive cancer, version 2.0

The Danish Medicines Council recommends larotrectinib for children and adults with solid tumours with NTRK fusion who have no other satisfactory treatment options.

About NTRK fusion-positive cancer

NTRK fusion is a rare genetic alteration that can occur in many different forms of cancer. Patients' remaining survival time and symptoms vary markedly and depend on which cancer form the patient has.

Benefits of larotrectinib

Clinical studies have shown that larotrectinib can cause tumours to shrink in most patients.

The Danish Medicines Council assesses that larotrectinib can prolong life compared with not giving active treatment. The effect can vary between cancer types, and it is not possible to assess which patients will benefit most. The Danish Medicines Council estimates that treatment with larotrectinib compared with no active treatment can produce a health gain of approximately 3.7 quality-adjusted life years, QALYs, and a prolongation of survival of approximately 4.3 years.

The QALY gain compared with existing standard treatment is estimated at 3.7 QALY, quality-adjusted life years.

Cost per QALY calculated at list price, AIP: DKK 597,652.

Source: Larotrectinib (Vitrakvi) — NTRK fusion-positive cancer. The Danish Medicines Council's recommendation regarding larotrectinib for the treatment of NTRK fusion-positive cancer, version 2.0.

2. The Danish Medicines Council's recommendation regarding axicabtagene ciloleucel for second-line treatment of patients with DLBCL — patients who relapse within 12 months after completion of, or are refractory to, first-line chemo-immunotherapy, version 1.2

The Danish Medicines Council recommends axicabtagene ciloleucel, axi-cel, for patients with the cancer type diffuse large B-cell lymphoma, DLBCL, and high-grade B-cell lymphoma, HGBL, who relapse within 12 months after completion of, or are refractory to, first-line chemo-immunotherapy.

The recommendation applies only to patients who are in good general condition, performance status 0 and 1.

The Danish Medicines Council assesses that treatment with axi-cel postpones time to disease progression and increases patients' survival compared with a stem-cell transplant course, which is the current standard treatment. The overall burden of side effects is comparable, but the types of side effects for axi-cel and current standard treatment are different, though with significant haematological toxicity in common.

Treatment with axi-cel is more expensive than current standard treatment. Overall, however, the Danish Medicines Council assesses that the costs of the treatment are reasonable in relation to the effect.

The QALY gain compared with existing standard treatment is estimated at 3.6 QALY, quality-adjusted life years.

Cost per QALY, ICER, calculated at list price, AIP: DKK 646,763.

Source: Axicabtagene ciloleucel (Yescarta) — diffuse large B-cell lymphoma, second line.

3. The Danish Medicines Council's recommendation regarding exagamglogene autotemcel (exa-cel) for the treatment of patients aged 12 and over with transfusion-dependent beta thalassaemia (TDT), version 1.0 — non-cancer

The Danish Medicines Council recommends exagamglogene autotemcel, exa-cel, for the treatment of the blood disease transfusion-dependent beta thalassaemia, TDT, in patients aged 12 and over for whom haematopoietic stem-cell transplantation is suitable and where a human leukocyte antigen-matched related donor is not available.

TDT is a serious and life-threatening disease that typically debuts before the child turns one year old and results in chronic severe anaemia, iron accumulation and reduced average life expectancy. Patients are dependent on regular blood transfusions throughout life, as well as iron-chelating treatment, which counteracts the toxic iron accumulation caused by the blood transfusions.

The QALY gain compared with existing standard treatment is estimated at 8 QALY, quality-adjusted life years.

Cost per QALY, ICER, calculated at list price, AIP: DKK 1,539,299.

Source: The Danish Medicines Council's recommendation regarding exa-cel for TDT, version 1.0-x.

4. The Danish Medicines Council's recommendation regarding sotatercept for the treatment of pulmonary arterial hypertension in adult patients in functional class II and III, version 1.0 — non-cancer

The Danish Medicines Council does not recommend sotatercept for the treatment of pulmonary arterial hypertension, high blood pressure in the pulmonary circulation, in adult patients in functional class II and III.

The current standard treatment is a combination of up to three of the following medicine groups: phosphodiesterase-5 inhibitors, stimulators of guanylate cyclase, endothelin receptor antagonists and prostanoids. Sotatercept in addition to this standard treatment improves patients' functional level, reduces the risk of worsening of the disease and improves their survival compared with current standard treatment alone. Sotatercept may, however, cause side effects in the form of serious bleeding.

Sotatercept is a very expensive treatment, and the Danish Medicines Council assesses overall that the costs of the treatment are not commensurate with the expected effect.

The Danish Medicines Council encourages the pharmaceutical company to return with a lower price and data with longer follow-up time.

The QALY gain compared with existing standard treatment is estimated at 5.8 QALY, quality-adjusted life years.

Cost per QALY, ICER, calculated at list price, AIP: DKK 2,576,548.

Source: Sotatercept — pulmonary arterial hypertension, PAH. The Danish Medicines Council's recommendation regarding sotatercept for PAH patients, version 1.0 — confidential.

Appendix 2. Count and coding of articles on decisions made by the Danish Medicines Council

The analysis includes all national, local, and regional print media. (Search conducted in Infomedia in Week 4 of 2026; search period: 1 January 2000–31 December 2025.)