European Journal of Health Policy, Humanization of Care and Medical Ethics

EJoHP 2(5)/2025

DOI: https://doi.org/10.21697/ejhp.0707.04
e-ISSN 2957-2002

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2025, 5, 2: 31-47

Dealing with Overtreatment in Regional Politics: An Interview Study in Region Zealand, Denmark

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Received: 16 Oct 2025; Revised: 15 Nov 2025; Accepted: 18 Nov 2025

Abstract

Background: Overtreatment in healthcare is a growing concern, not only due to rising costs but also due to the potential harm to patients. This issue is particularly complex within political decision-making frameworks, where the expectations of citizens and the reality of resource limitations collide. In Region Zealand, Denmark, the challenges of overtreatment are amplified by a combination of high patient expectations, political pressures, and resource scarcity.
Aim: This study investigates how overtreatment is perceived and addressed by regional politicians in Region Zealand, focusing on the interplay between patient expectations, political decision-making, and healthcare resource management.
Methods: A qualitative study was conducted involving interviews with regional politicians, healthcare professionals, and patient representatives. Thematic analysis was used to identify the key factors influencing overtreatment and the way that these factors shape political decision-making in the healthcare sector.
Results: Three major themes emerged from the data: (1) the role of patient expectations in driving overtreatment, (2) political constraints and the complexity of decision-making, and (3) the influence that vocal citizens with many resources have on healthcare policies.
Conclusion: Addressing overtreatment requires a balanced approach that considers both the medical needs of patients and the broader political and economic context. The study highlights the need for differentiated healthcare policies that align with the varying needs of citizens in different regions.

Keywords: overtreatment, health policy, political decision-making, patient expectations, healthism, defensive medicine, public healthcare systems, regional healthcare governance

Introduction

Healthcare systems across the globe are facing increasing strain – not only from escalating costs, demographic shifts, and inequalities in access, but also from the rise in overtreatment and overdiagnosis. Overtreatment, often leading to overdiagnosis, refers to medical interventions being applied without a clear clinical benefit, and in many cases with the potential to do harm rather than to heal (Brodersen et al., 2018). This burdens healthcare budgets while exposing patients to unnecessary procedures, side effects, and psychological distress (Braithwaite et al., 2020). In the context of aging populations and chronic staff shortages, such as in Denmark, these inefficiencies pose critical threats to the sustainability of the healthcare system (Fredriksson et al., 2013).

Importantly, the consequences of overdiagnosis extend beyond individual and economic costs: they also have significant environmental implications. As Barratt and McGain (2021) argue, overdiagnosis contributes directly to healthcare's carbon footprint by proliferating carbon-intensive assays and treatments without any corresponding health benefits. In an era of climate emergency, this amounts to an ecological problem in addition to a clinical and ethical one. Tackling overdiagnosis, therefore, is not only about better medicine, but also about climate responsibility and sustainability in the provision of care.

These patterns of excess coexist with persistent underuse of care in marginalized groups – a duality encapsulated by Julian Tudor Hart's inverse care law, which holds that those in greatest need of healthcare often receive the least (Hart, 1971). This phenomenon amplifies existing health inequities and underscores a paradox in modern healthcare: while some receive too much care, others receive too little (Berwick, 2017). Addressing both overtreatment and underprovision is thus central to building a healthcare system that is equitable, efficient, and environmentally sustainable.

Research on political decision-making in health policy has traditionally focused on structural factors such as institutional frameworks, economic incentives, and evidence-based guidelines. Much of the existing literature emphasizes rational prioritization and technocratic governance in the allocation of healthcare resources. Other studies have explored the role of stakeholders, bureaucratic actors, and lobbying efforts by professional groups.

However, considerably less attention has been paid to how politicians' personal values, cultural backgrounds, and individual perceptions of illness, treatment, and health shape their decisions. Moreover, there is a notable lack of research examining how contemporary concerns – such as overtreatment – are perceived and addressed in political processes, and to what extent these concerns influence actual policy choices.

This study aimed to explore how regional politicians in Region Zealand perceive and navigate the issue of overtreatment in healthcare, with a particular focus on the role of cultural expectations, political constraints, and pressure from citizens in shaping decision-making processes. In this paper, we report the results using a thematic analysis.

Background: Health Policy-Making in Denmark

The Danish healthcare system is a universal, publicly financed system primarily funded through taxes. It is built on the principle of equal access to care for all citizens and is characterized by a high degree of decentralization. Responsibility for providing and organizing healthcare services lies mainly with Denmark's five regions, each governed by an elected regional council (Greve, 2022).

The regions hold the operational and financial responsibility for most healthcare services, including hospitals, mental health care, specialized services, and agreements with private providers. They also coordinate with family doctors, who function as gatekeepers to secondary care. This means that although the national government sets the overall policy frameworks and allocates block grants to the regions, it is the regions that make concrete decisions about service delivery, resource allocation, and the priorities of care (Greve, 2022).

Each regional council consists of 41 elected politicians who are responsible for strategic leadership and overall management of healthcare services within the region. These regional politicians make crucial decisions about budgets, hospital planning, service levels, and healthcare infrastructure. They must balance national policy directives and fiscal constraints with regional healthcare needs and the expectations of citizens, professionals, and interest groups (Sørensen et al., 2011).

Regional politicians thus play a dual role: they are both implementers of national policy and autonomous decision-makers within their own jurisdictions. They operate in a politically complex environment where healthcare delivery must be adapted to local conditions, demographic changes, and shifting public expectations. At the same time, they are held accountable by voters and are responsive to stakeholder pressures, including patient groups, professional associations, and the media (Sørensen et al., 2011).

Methods

Study Design

This study was designed as an exploratory qualitative study using semi-structured interviews. The exploratory approach allowed for a deeper understanding of the perceptions of overtreatment from the perspective of regional politicians in Region Zealand. Semi-structured interviews were chosen to provide flexibility in exploring participants' views while maintaining the focus on key topics related to overtreatment and healthcare decision-making.

Participants

The participants were selected using purposive sampling among regional politicians from different political parties in Region Zealand. A total of 7 politicians representing a diverse range of political perspectives participated in the study. This approach allowed for an exploration of how political ideologies and affiliations influence perceptions of overtreatment and healthcare decision-making.

Politician	Gender	Interview type	Regional political experience	Party affiliation	Date(s) of interview(s)
Politician A	Male	Explorative + Semi-structured	2+ years	Left-wing	January 11, 2024; April 2, 2024
Politician B	Female	Explorative + Semi-structured	2+ years	Left-wing	January 17, 2024; March 4, 2024
Politician C	Female	Explorative	10+ years	Right-wing	January 18, 2024
Politician D	Female	Semi-structured	10+ years	Center	March 8, 2024
Politician E	Female	Semi-structured	2+ years	Right-wing	March 15, 2024
Politician F	Male	Semi-structured	2+ years	Right-wing	March 26, 2024
Politician G	Male	Semi-structured	6+ years	Right-wing	April 5, 2024

Data Collection

The data were collected through both face-to-face and virtual interviews conducted via Microsoft Teams. Each interview lasted approximately 60 minutes and was audio-recorded with the participant's consent. The semi-structured format allowed the interviewers to explore the participants' views on overtreatment, healthcare decision-making, and patient expectations while maintaining the flexibility to follow emerging themes. The interviews were conducted in Danish; the transcripts were later translated into English for the purposes of this article. All participating politicians were assured anonymity to encourage openness during the discussions.

Data Analysis

Thematic analysis was conducted using NVivo software to manage and analyze the interview data. The transcribed interviews were imported into NVivo, where they were coded by three researchers independently. This process identified key themes and patterns within the data. The researchers then compared and refined their codes through an iterative process, ensuring consistency and reliability. The use of NVivo facilitated the organization of large amounts of qualitative data, making it easier to explore complex themes such as political decision-making, patient expectations, and overtreatment.

The findings were examined through the lens of *healthism*, a concept that frames health as both an individual moral responsibility and a societal value (Crawford, 1980). In Denmark, where public health culture is deeply embedded and preventive healthcare is prioritized, healthism helps explain why citizens increasingly seek medical services even when there is no clear clinical need. This ethos promotes self-optimization, amplifies demand, and contributes to the normalization of overtreatment (Kristensen et al., 2016).

Results

1. The Role of Patient Expectations in Driving Overtreatment

One of the central themes that emerged from the interviews with regional politicians from Zealand is the significant influence that patient expectations have on healthcare provision. Though it is not directly linked to their work as politicians, the data revealed how concerns over growing patient expectations are present among politicians as healthcare policymakers. Across multiple interviews, the interviewees expressed concern that patients often expect access to the most advanced or comprehensive care, regardless of clinical necessity. As Politician C put it: "Expectations of what people can get are sky-high." This mismatch between public expectations and medical judgment places considerable pressure on healthcare providers, who must navigate demands for interventions that may not offer a clinical benefit.

The data also showed that politicians refer to healthcare professionals and patient experiences when explaining why overuse is present in healthcare provision, thus linking it directly to the healthcare encounters and not just the structural policies that surround them.

Politician C elaborated: "When it's your father or your mother, you see it differently. You want everything possible to be done." This personal dimension reinforces how emotionally charged situations can override more abstract understandings of overtreatment. The tendency to equate more interventions with better care reflects a broader societal narrative, where medical treatment becomes a moral entitlement.

Politician B, another interviewee, observed that "people come into the clinic already convinced that they need a scan or a prescription… and it's difficult for doctors to say no when the patient believes it's their right." This dynamic illustrates a common challenge for healthcare professionals, who must reconcile their clinical judgment with patient satisfaction and the increasing consumer orientation of healthcare.

1.1 Cultural Pressures

Politician D explained the cultural trend of individual prevention through an exaggerated focus on one's health, while also pointing out how this would divide the population and enforce health inequities: "We have many citizens who listen too much to the signals from their bodies. If they feel something is wrong, they demand that it be checked. But at the same time, there are others who ignore symptoms altogether." This interviewee concluded that such behavior results in uneven healthcare-seeking and increased pressure on providers to respond to subjective concerns.

Politician F emphasized the fear-based decision-making that results from this cultural context. "People would prefer one treatment too many rather than too few. Even when a doctor says there's nothing more to be done, patients still push for more tests or treatments." This fear of missing something reflects both cultural ideals of health vigilance and the emotional weight of potential illness.

The cultural pressure was mentioned in the context of patients, but also as something that would influence their position in policy decisions. Politician D described how rising medical capabilities, longer life expectancy, and public expectations have led to unsustainable patterns of overtreatment: "We overtreat. Professionally, we are becoming more and more capable. And we have a population that lives longer, which means more years where treatment is needed. […] The medical assessments show that we allocate a relatively large portion of resources to overtreatment. And this is not sustainable unless we, as the regional council, address it. It is a sensitive issue because it touches something in all of us – overtreatment." This illustrates how cultural and emotional dimensions of health – such as longevity, expectations for care, and discomfort with setting limits – interact with structural constraints and professional concerns. Policymakers find themselves caught between public demand and medical sustainability.

Politician G emphasized how public resistance to denial of care reinforces this cultural trend:

"I'm quite convinced that many citizens won't accept being told no. There would likely be many who would file complaints. I mean, we already have many complaints today about all kinds of things, right?" This highlights how political decisions are constrained not only by clinical considerations, but also by an anticipatory logic of public dissatisfaction. The cultural expectation of access to care, combined with a strong tendency to contest limits, contributes to a political environment in which avoiding overtreatment becomes both technically and politically difficult.

1.2 Legal and Institutional Pressures Fueling Defensive Medicine

According to our interviewees, legal frameworks and institutional structures also play a significant role in shaping overtreatment. In the interviews, the politicians kept bringing up what they thought healthcare professionals would feel or how and why patients acted in particular ways, thus revealing underlying notions that may inform their own political practice. For instance, Politician B explained that healthcare professionals are under pressure not only from patients, but also from a system that fosters defensive medicine: "As a nurse or doctor, you don't want to miss anything because it could cost you your medical license."

According to the participants, this defensive mindset leads to excessive tests or procedures being ordered, as a safeguard against complaints or litigation rather than out of medical necessity. Politician F added that "doctors say they fear complaints. It's happening more and more, and they're afraid that if they don't [order extra tests], they might face a lawsuit."

This legal insecurity, combined with the pressure to meet patient demands, results in a clinical environment where the safest course of action is often to overtreat, according to the politicians. Politician B also discussed what they expected to be professional uncertainty among younger doctors: "They'll take an X-ray, and then they'll also order scans – both a CT and an MRI. They do it because they're uncertain and don't have the professional confidence that comes from having had good mentors."

1.3 Misinformation and the Unequal Impact of Health Literacy

Another amplifying factor in the patient-driven overtreatment mentioned by our interviewees is the widespread access to health information online. According to the politicians, this can empower patients, but it can also lead to misinformation and incorrect self-diagnoses. Politian B remarked that "patients often come in with pre-diagnosed conditions they've read about online. They demand scans or treatments, believing they know what's wrong."

Politician D pointed out that this dynamic challenges clinical authority and reinforces social inequalities: "Well-educated citizens are often more articulate and persistent when they demand care. They argue convincingly with doctors, pushing for tests and treatments that others might not." Thus, those with greater health literacy and confidence are more likely to secure services – whether necessary or not – underscoring how healthism interacts with class and education.

1.4 Over-Specialization and Fragmented Care

Finally, several of the politicians pointed to over-specialization and poor coordination as systemic contributors to overtreatment. Because patients receive care from multiple specialists, the risk of duplicate or conflicting treatments increases. Politician E highlighted this issue in relation to cancer care in Denmark: "We've focused so much on cancer, but there are also other life-threatening diseases being sidelined. If a patient has 2 or 3 diseases, there's a lack of coordination between them. This means that patients might receive treatments that actually work against each other."

Politician D echoed the need for better interdisciplinary collaboration: "Overtreatment often happens because our healthcare system is siloed. We need stronger cross-disciplinary collaboration to ensure that treatments are holistic and necessary."

2. Political Constraints and the Complexity of Decision-Making

A recurring theme across the interviews was the complexity of political decision-making and its impact on addressing overtreatment. Regional politicians expressed frustration with the bureaucratic and systemic limitations they face, which often hinder their ability to implement meaningful changes. As Politician B, a first-term regional member, put it: "It's not easy… we can't just do what we want because there are so many layers to the decision-making process."

This sentiment was echoed by Politician E, who reflected on the ethical and practical dilemmas inherent in health policy: "It's a sensitive issue because it touches something within all of us. We understand that we're using the resources wrongly, we distribute them wrongly." Although the inefficiencies are widely recognized, the challenge lies in balancing competing priorities with tight budgets and high public expectations. "We want to give everyone the best care possible, but the reality is that we can't do everything for everyone. It's a matter of prioritization, and that's never an easy choice," Politician E added.

2.1 Navigating National Constraints and Operational Responsibility

One of the key structural barriers to reform identified by the interviewees is the division of authority between national and regional governments. While the regions are responsible for implementing care, many key healthcare priorities – such as the national cancer treatment packages – are mandated at the national level. As Politician C explained, "there are so many national standards we have to meet… we can't change those even if we wanted to prioritize differently." This limits the flexibility of regional policymakers and leaves them little room to reallocate resources or implement reforms tailored to local needs.

Politician A reinforced this tension: "We are bound by what's been agreed upon nationally, but we also face local demands that don't always align with those policies. It's a balancing act we have to navigate constantly." The lack of local autonomy, combined with top-down targets, creates a governance environment that is resistant to adaptive or nuanced responses to overtreatment.

2.2 The Political Risks of Reducing Services

Another significant constraint is the political cost associated with reducing services, even when they are medically unnecessary. As Politician A noted, “It’s a difficult political decision to take something away from people – it’s always easier to add something.” This reflects a broader political logic where expanding healthcare offerings is viewed more favorably than restricting them, regardless of their clinical value.

Politician F raised a similar point: “There’s no doubt that many citizens will push for more treatment, but sometimes you have to be tough and say no. In politics, it’s all about prioritization.” The reluctance to limit access to care – even when such care is of low or no value – stems from a fear of public backlash, complaints, and political damage. […] This was brought up in our regional council… so why do we continue doing it?” The persistence of overtreatment, despite an awareness of its harms, highlights the difficulty of translating insight into action under political pressure.

2.3 The Influence of Vocal, Privileged Groups

A critical issue raised by several interviewees is the disproportionate influence of vocal people of means in shaping healthcare priorities. Politician B remarked: “It’s the people with the most resources who shout the loudest. They have the most airtime.” These groups, often better educated and more articulate, are more successful in advocating for access to healthcare services – even when the clinical justification is weak.

Politician E added that “when patients pressure doctors for more tests, it’s often those who are better at articulating their demands that get what they want.” This dynamic contributes to inequities in healthcare access, where more assertive individuals receive more care – sometimes unnecessarily – while less vocal populations may go underserved. As a result, political decision-making is not always guided by need, but by who can make the most noise.

2.4 Administrative Complexity and Structural Inertia

In addition to public and political pressures, many politicians pointed to the administrative complexity of the healthcare system as a major barrier to addressing overtreatment. The need to build consensus across political parties, follow established procedures, and adhere to numerous rules can slow down or block reform efforts. Politician F described this frustration clearly: “This was brought up in our regional council… so why do we continue doing it?” Despite recognizing the problem, the system’s structure often makes it difficult to act decisively.

This bureaucratic inertia means that even well-intentioned politicians may feel powerless to effect change. As Politician B noted, “We’re bound by the system. Even when we know something isn't working, changing it is incredibly slow." These systemic obstacles contribute to the continuation of practices that are recognized as unnecessary or even harmful.

2.5 Financial Pressures and Missed Opportunities for Reallocation

A final, but critical, issue raised by interviewees is the financial strain that overtreatment places on the public healthcare system. With limited resources and rising demand – particularly from an aging population – several politicians expressed concern about wasteful spending on treatments with little or no clinical benefit. Politician G emphasized the opportunity cost of overtreatment: "If 20% of what we do is completely useless, that's a billion kroner. We can't save that billion, but even if we could say that 5% or 10% of what we do has no value, we could redirect those funds to other areas in need."

This underscores the importance of evaluating and phasing out low-value interventions, not only to reduce harm but also to free up resources for more impactful care. Yet, as Politician G also pointed out, societal attitudes remain a barrier: "It's difficult because we live in a society where if people don't get what they want, there's a complaint." This culture of consumerism and entitlement, combined with legal fears and patient dissatisfaction, perpetuates overtreatment and diverts resources from areas of genuine medical need.

3. The Influence of Vocal, Privileged Citizens

A central theme emerging from the interviews is the disproportionate influence that vocal citizens with many resources have on healthcare policy and service delivery. These individuals – often from wealthier or more educated backgrounds – tend to have greater access to media platforms, political networks, and healthcare literacy. This allows them to advocate effectively for their personal healthcare needs, often at the expense of broader equity.

As politician B observed: "It's the people with the most resources who shout the loudest… they have the most airtime." This unequal access to platforms of influence can skew political and administrative attention toward the concerns of well-organized, articulate groups, even when their demands do not align with medical needs or system-wide priorities.

3.1 Healthcare Navigation and Strategic Advocacy

Several politicians emphasized how privileged citizens are better equipped to navigate and challenge the healthcare system, using their knowledge and confidence to secure services more easily. Politician D noted that “there’s a difference in how people interact with the system. If you’re well-educated, you’re also well-spoken. You know how to communicate with health professionals and ensure that your needs are met.” In areas such as the Capital Region, she added, these citizens are often more assertive, resulting in disproportionate access to advanced diagnostics or specialist care.

This dynamic leads to a skewed allocation of services, where those already advantaged are more likely to receive frequent or high-level interventions – even when they are not clinically necessary. Politician F captured this pressure from patients: “People would prefer one treatment too many rather than too few.” This mindset, which is particularly prevalent among the vocal, privileged groups, fosters a healthcare culture that favors intervention over restraint.

3.2 Defensive Medicine and Legal Pressures

The fear of legal consequences also plays a critical role in this dynamic. When vocal citizens demand care, healthcare professionals often feel compelled to comply – not out of clinical judgment, but to avoid complaints or litigation. As Politician F explained, “many doctors say they’re afraid of complaints. It’s getting worse, and they worry that if they don’t do one more scan or take one more test, they’ll get a complaint.” This environment contributes to defensive medical practices, where overtreatment becomes a means of legal self-protection rather than patient benefit.

Such practices not only strain healthcare resources, but also undermine the principle of evidence-based medicine. When doctors are pressured to act against their clinical instincts, the result is a system that prioritizes patient satisfaction and legal safety over quality and necessity.

3.3 Political Challenges in Maintaining Equity

Politicians expressed frustration with the challenges of balancing these unequal demands. As Politician B noted, “it’s difficult… certain groups with resources and organization can make their voices heard much louder, which puts pressure on us.” This creates a policy environment where decisions are influenced more by who can advocate effectively than by who is most in need.

Politician E shared similar concerns, emphasizing that “we’ve seen cases where certain communities receive more attention and resources because they know how to make noise, while other, perhaps more vulnerable groups, don’t get the same level of care.” This systemic inequity reflects the inverse care law, where those with the greatest needs often receive the least attention, while the most organized groups receive more than their fair share.

3.4 Equity Through Differentiation

In grappling with this imbalance, Politician B argued for a differentiated approach: "If you want equity in healthcare, you must differentiate healthcare." This statement suggests that equal treatment is not necessarily equitable, and that targeted policies may be required to ensure that vulnerable populations receive adequate care, even if they are less able to articulate or advocate for their needs.

However, in practice, this vision is difficult to realize. Policymakers are often caught between competing pressures to satisfy public demands and uphold principles of fairness and need-based allocation. As Politician G summarized, "healthcare resources are often allocated not based on medical necessity, but on who can make the most noise."

Discussion

The findings from this study highlight how overtreatment in the Danish healthcare system is not merely a clinical or organizational issue, but a deeply embedded sociocultural phenomenon. Through the lens of healthism – as defined by Crawford (1980) – the moralization of health, and the individualization of responsibility, we gain insight into the underlying drivers of patient behavior, healthcare policy, and systemic responses that sustain overtreatment. Health is increasingly perceived as a symbol of self-discipline and success, encouraging individuals to pursue extensive preventive measures and self-monitoring.

Healthism and the Moral Imperative to Seek Care

The growing societal influence of healthism – the belief that individuals are morally responsible for achieving and maintaining optimal health – helps to explain these elevated expectations. Health is increasingly perceived as a symbol of self-discipline and success, encouraging individuals to pursue extensive preventive measures and self-monitoring.

One of the most pervasive themes emerging from the interviews was the role of patient expectations in driving unnecessary medical interventions. Healthism encourages individuals to view health as a personal achievement and moral obligation, prompting them to seek out screenings, tests, and treatments – even in the absence of a clear medical need. As noted in the literature (Kristensen et al., 2016), this ideology positions health as a "super-value," intertwining it with identity, citizenship, and self-worth.

This cultural logic was clearly reflected in the politicians' observations. Patients were described as appearing at consultations already convinced of their diagnosis and the necessity of specific treatments, often citing information found online. This aligns with the self-monitoring and self-diagnosing behaviors typical of a health-obsessed society shaped by market-oriented healthcare services. In such a context, “more healthcare” becomes equated with “better care,” reinforcing both public and professional tendencies toward overtreatment.

Systemic and Political Amplifiers of Healthism

While healthism operates at the cultural level, its effects are compounded by institutional and political structures. The regional politicians repeatedly described a healthcare system constrained by national standards, bureaucratic inertia, and risk-averse practices. The political reluctance to reduce services – even when clinically unjustified – is shaped in part by the public’s deeply internalized expectations around healthcare entitlement. As Politician F put it, “it’s easier to add something than to take it away,” reflecting the political cost of challenging the healthcare-as-a-right narrative central to healthism.

This reluctance is further intensified by legal pressures. The fear of complaints or litigation fuels a culture of defensive medicine, where clinicians prioritize precaution over necessity. Under the moral framework of healthism, failure to act can appear negligent – to legal and administrative systems as well as patients. Consequently, healthcare professionals often choose to over-intervene rather than risk professional sanction.

Unequal Access and the Inverse Care Law

Healthism’s emphasis on personal responsibility also exacerbates health inequalities, as it implicitly favors individuals with the education, resources, and time to navigate and advocate within the healthcare system. This was a recurring concern among the interviewees, who noted that vocal, privileged citizens exert disproportionate influence on healthcare policy and practice. These individuals are better positioned to demand care, sometimes unnecessarily – thereby distorting the equitable distribution of healthcare resources.

This dynamic reflects Tudor Hart’s inverse care law (1971), where those most in need of care often receive less and those with the least need consume more services. In the Danish healthcare context, this plays out in two ways: firstly, affluent individuals use their social capital to access more care, and secondly, healthcare services are increasingly tailored to meet the demands of these groups rather than broader public health priorities. The cultural and systemic normalization of overtreatment thus risks deepening existing disparities, undermining the equity goals of a publicly funded healthcare system.

The Paradox of Empowerment

Although patient empowerment and health literacy are often celebrated, the findings suggest a paradox: empowered patients may inadvertently drive overtreatment by insisting on interventions that align with their understanding of "good care," but not necessarily with clinical guidelines. This form of empowerment, shaped by healthism and fueled by digital health culture, challenges the authority of clinicians and complicates efforts to rationalize care. As some politicians noted, citizens often reject the label of "overtreatment," yet consistently push for more services when their own health is at stake.

Toward a More Reflective Health Culture

Addressing overtreatment therefore requires more than policy reform or clinical restraint. It demands a cultural shift: a rethinking of what constitutes responsible health behavior and appropriate care. This includes fostering public awareness of the risks of unnecessary interventions and encouraging trust in professional discretion, as well as providing political and institutional support for healthcare professionals to say no to interventions that lack medical justification.

At the systemic level, promoting cross-disciplinary coordination and revisiting national care standards – such as the rigid focus on specific diseases – may help reduce fragmentation and encourage more nuanced, person-centered care. However, such changes must be accompanied by broader conversations about the limits of medicine, the meaning of health, and the collective responsibility for sustainable healthcare.

Practical Implications

This study highlights several practical implications for healthcare policy and decision-making. Policymakers should account for patient expectations and sociocultural pressures when designing interventions to reduce overtreatment. Healthcare professionals need institutional support to prioritize medically justified care over unnecessary interventions. Public awareness initiatives may help recalibrate patient expectations and promote trust in clinical discretion. Ensuring equitable access to care can prevent citizens with more resources from disproportionately influencing healthcare provision.

At the policy level, strategies to address overtreatment should move beyond purely economic or clinical rationales and acknowledge the social drivers of medical demand. Policy frameworks that recognize these moral and cultural dimensions can better support realistic expectations for what medicine can and cannot provide.

Healthcare leaders and policymakers must collaborate to create a system that prioritizes sustainable, patient-centered care. This involves reducing unnecessary interventions while building trust in the system through transparency and equity. By addressing the systemic, cultural, and political drivers of overtreatment, Region Zealand has the opportunity to set an example of how healthcare can be delivered in a way that truly benefits all citizens, ensuring that resources are used where they are needed most.

Comparison with Related Studies

The findings of this study resonate with and extend a growing body of international research examining the cultural, political, and systemic factors that contribute to overtreatment within high-income healthcare systems. Several studies highlight the central role of healthism in shaping both patient behavior and healthcare policy. Crawford's (1980) foundational concept of healthism remains a critical analytical lens for understanding these dynamics. This is further reflected in the work of Kristensen et al. (2016), who demonstrated how Danish family doctors face increasing pressure from patients, who often moralize symptoms and demand tests based on digital self-diagnoses. Similarly, Armstrong (2020) explores how clinical autonomy is increasingly constrained, not only by managerial oversight but also by sociopolitical narratives that insist on action and responsiveness. These narratives reinforce a "more is better" ethos, which continues to shape healthcare practices. This study makes a unique contribution by exploring the political dimensions of overtreatment in a Danish context, illustrating how elected officials are caught in a "double bind" between national mandates and local voter expectations. This finding complements the work of Cupit and Armstrong (2021), who describe similar challenges faced by UK health policymakers. They highlight the difficulty in implementing restrictive policies due to political sensitivities and the public's perception of fairness. Our results suggest that these challenges are not unique to the UK, but rather reflect broader tensions within welfare-state health systems, which struggle to balance equity, efficiency, and public satisfaction.

In line with recent work on health inequalities and welfare state regimes, this study also resonates with the theoretical insights provided by Bambra (2011), who describes how different welfare state models produce different patterns of health inequality. Although Nordic welfare states aim to promote universalism and equity, Bambra argues that they can still reproduce inequalities when healthcare access and outcomes are mediated by social gradients such as education, income, and cultural capital. Our findings support this, showing that individuals with higher socioeconomic status are more likely to access – and demand – unnecessary healthcare interventions, contributing to a skewed allocation of healthcare resources.

From a systemic perspective, the influence of defensive medicine noted by our study participants echoes concerns raised by Hofmann (2022), who warns about “overdiagnosis creep,” a phenomenon driven by earlier detection and broader diagnostic criteria. This study confirms that risk-averse clinical behavior is amplified by legal pressures and administrative expectations; this makes it an important addition to the literature, which often underemphasizes the role of the legal/cultural context in shaping healthcare practices.

Finally, this study engages with the literature on healthcare inequalities, particularly the inverse care law outlined by Tudor Hart (1971). Our findings echo those from other Nordic and UK-based studies, which show that individuals with higher socioeconomic status often gain greater access to healthcare, including unnecessary interventions. This suggests a misallocation of resources that risks undermining health equity.

Conclusion

Overtreatment in healthcare is a nuanced, complex challenge that extends beyond clinical practices into the realms of societal expectations, political decision-making, and healthcare resource management. This study highlights how high patient expectations, political constraints, and the influence of vocal, privileged citizens contribute to the persistence of overtreatment in Region Zealand.

Therefore, reducing overtreatment requires more than technical reforms. It calls for a cultural and institutional reorientation. Politicians and healthcare leaders must confront the social and moral narratives that sustain excessive medicalization, while strengthening conditions that allow clinicians to rely on their professional judgment without fear of reprisal for their actions. Addressing inequities in voice and access, fostering trust in medical discretion, and encouraging a broader understanding of what constitutes “good care” are essential to achieving a more balanced and sustainable healthcare system.

By situating overtreatment within its political, cultural, and ethical contexts, this study highlights the fact that meaningful change will depend on aligning public expectations, professional practice, and political accountability around a shared commitment to necessity, equity, and care.

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