Results Data suggested general agreement to use the same criteria in all levels of Norwegian health service. However, disagreement was identified when considering the lack of feasible implementation processes. Recurrent themes in the data were the municipalities’ legal and financial lack of scope to set priorities under constraints, challenges regarding operationalising a supplementary physical, psychological and social mastery criterion, and prioritising in situations where the benefits are difficult to measure.

Discussion The many duties and responsibilities of municipal health and care make priority setting decisions more complex than in specialist health care. In summary, the Norwegian green paper on priority setting in municipal health and care services has presented a well-received recommendation. However, how to inevitably tackle the many complex, and sometimes wicked, prioritisation problems in practice remain unanswered.

Objective Migrants’ health is conditioned by individual, social and structural determinants of health that are shaped by policies. Refugees and asylum seekers are of particular risk of sexual and reproductive health (SRH) issues, but few have studied whether and how their health is prioritized in policies. This study aims to assess how the SRH of refugees and asylum seekers is prioritized in Norwegian health policies.

Methods A document review of relevant policies (2010–2019) on SRH and refugees and asylum seekers in Norway was conducted. Documents were analysed systematically in four steps, informed by the READ approach (Read, Extract, Analyse, Distil).

Results 14 policy documents were included. While migrants’ health receives increased policy attention, this attention remains general in character. The national migrant health strategy (2013) was not followed by a specific policies or action plans. SRH issues of refugees and asylum seekers is not policy priority. This contrasts the decade long distinct policy determinants of health and equality underpins general health and reproductive health (SRH) issues, but few have studied whether and how their health is prioritized in policies. This study aims to assess how the SRH of refugees and asylum seekers is prioritized in Norwegian health policies. Acknowledging that migration health is impacted by social determinants of health, this was given particular attention.

Methods An online survey handling 3 situations of medical scarcity; (1) organ donation, (2) limited hospital beds during influenza epidemic, and (3) allocation of novel therapeutics for lung cancer, and a free comment option constituted the survey.

Results Seven hundreds and fifty-four responses were analyzed from five groups including religion scholars, physicians, medical students, health allied practitioners and lay people. The most important priority principle was ‘Sickest-First’ for the three scenarios among the surveyed groups, except for physicians in the first scenario where ‘Sickest-First’ and ‘Combination-criteria’ were of equal importance. In general, there were no differences between the examined groups compared to lay people in the preference of options for all scenarios, however physicians were more likely to choose the ‘Combination-criteria’ in both the second and third scenarios (OR 3.70, 95% CI = 1.62-8.44, and 2.62, 95% CI = 1.48-4.59; p-value = 0.00, 0.00 respectively), and were less likely to choose the ‘sickest-first’ as the single most important priority principle (OR 0.57, CI = 0.37-0.88, and 0.57; 95% CI=0.36-0.88; p-value = 0.01, 0.01 respectively). Out of 100 free-comments, 27 (27.0%) thought the ‘social-value’ of the patients should be considered, adding the 10th potential allocation principle.

Conclusion Our findings are concordant with literature in terms of allocating scarce medical resources. However, ‘social-value’ should be addressed when prioritizing scarce medical resources in Jordan, and probably other LMICs.