141:poster THE RESILIENCE OF HEALTH CARE SYSTEMS AND PRIORITY SETTING ETHICS

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As a consequence of several changes in the world, health care systems are put under considerable strain. The ongoing pandemic is one example. The strained situation calls for several immediate actions. However, and perhaps more importantly, it raises questions about how to strengthen the robustness of health care systems to withstand future challenges. This talk focuses on the ethical dimensions of working with the resilience of a health care system, more specifically, the technical infrastructure of a hospital.

The concept of resilience is a graded, rather than binary, concept. A health care system can be resilient to a certain degree at a certain time against a specific set of disruptions. To strengthen the robustness of a hospital's technical infrastructure, may involve large investments, such as building back-up systems for electricity or water supply. This means that decisions about resource allocation must be taken when increased resilience is weighed against, for example, providing treatment for patients that are in current need of health care. Accordingly, the ethical question at stake when building resilience is what level of robustness that should be chosen.

The challenge for contemporary priority setting ethics when applied to building resilience arises from approaching priority setting as the ranking of different health conditions and their treatments (condition-treatment pairs). Contemporary principles for priority setting lack implications for several priority objects relevant for resilience that cannot be translated into condition-treatment pairs, for example, electricity and water supply. Much of the contemporary discussion in priority setting ethics have been presupposing that a certain technical infrastructure is already in place. However, these principles cannot be action guiding with regard to striking the right balance in the hospital's robustness. We argue that this challenge can be handled by introducing a dimension of precaution in priority setting ethics.

58:oral INCORPORATING CONCERN FOR HEALTH EQUITY INTO RESOURCE ALLOCATION DECISIONS: DEVELOPMENT OF A TOOL AND POPULATION-BASED VALUATION FOR UGANDA

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Health systems around the world aim to increase population health and to reduce health inequalities, but there are challenges in undertaking health economic analyses that simultaneously address these two concerns. Such analyses require information on whether the population support using healthcare resources to reduce health inequalities, and how much inequality reduction is valued relative to increase in total population health. Previous research has attempted to quantify this preference in the form of an inequality aversion parameter in a specified social welfare function. This study aimed to elicit general population's views on health inequality, and to estimate an inequality aversion parameter in Uganda. Adult respondents from the general population were quota-sampled based on age and sex and recruited from the Central region in Uganda. The survey was adapted from an existing questionnaire, and included trade-off questions between two hypothetical healthcare programmes. Data on participants' demographic and socioeconomic characteristics and health-related quality of life measured by EQ-5D-5L were collected. A nationally representative sample of 165 participants were included, with mean age of 37.1 years and mean EQ-5D-5L score at 0.836. The majority of respondents (79.4%) indicated willingness to trade-off some total population health to reduce health inequality. Translating the preferences into an Atkinson inequality aversion parameter (14.70) implies that health gain to the poorest 20% of people in Uganda should be given about 6 times the weight of health gains to the richest 20%. Our study suggests it is feasible to adapt questionnaires of this type for a Ugandan population, and reveals their strength of concern for health inequality. The results will enable the application of methods to integrate health inequality impacts into healthcare resource allocation and policy prioritisation in Uganda. This approach could be used to measure public aversion to health inequality in other settings.

196:oral EARLY-STAGE DECISION AID TO SUPPORT CLINICAL LEADERS WHO CONSIDER NEW INTERVENTIONS

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Objective Early-stage decision aid (EsDA), a generic form that guides clinical leaders who consider implementing a new intervention in their department, is currently under development at Haukeland University Hospital. In Norway, there is a lack of knowledge about how clinical leaders set priorities, a need to train leaders in systematic quality improvement and principles for priority setting, and for tools that enhance open and fair priority setting for new health interventions across medical specialties.

What EsDa does: EsDA is a digital form and involves two main tasks. 1) To synthesize evidence about the intervention by describing the perspective (patient, medical treatment, health service) and most relevant dimensions of heath care quality (safety, effectiveness, patient-centered and timely intervention, efficiency, equity), as well as expected benefit and resource use (including disinvestment) associated with the intervention compared to existing strategies, disease severity, ethical challenges and existing guidelines. 2) To summarize relevant reasons for and against adoption of the intervention, and conclude.

Results Having completed the form, the clinical leader should be able to decide to implement the intervention, or initiate another decision-making process, such as a national health technology assessment, experimental treatment in- or outside

of studies, further risk or economic evaluation, clinical ethics consultation, an expert panel evaluation, or other (depending on local circumstances).

Discussion EsDA provides a systematic process for increasing awareness about principles for quality management and priority setting among clinical leaders, in order to develop safe, effective, efficient and patient-centered services. A database of completed EsDa forms facilitates comparison and harmonization of decisions and research, and documents how the hospital sets priorities to improve the quality and outcome of care. Further work includes a pilot project among clinical leaders, establishment of criteria for when they should use EsDA, evaluation of the digital platform and database, and implementation research.

89:poster EFFECTIVENESS OF PRIORITY SETTING IN HEALTH CARE

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Introduction In the past decades, several aspects of priority setting in health care have been addressed, but relatively little attention has been given to the question of its effectiveness. There may be several reasons for this, including the significant methodological challenges associated with such endeavor. However, raising the effectiveness issue could still be worthwhile. It could engender a debate as to what, exactly, is or is to be pursued by priority setting in health care, and it might increase our understanding of underlying mechanisms or preconditions for priority setting to work well.

Methods A review of policy analyses of the effectiveness of priority setting at the national level in the Dutch health care system.

Results As part of a wider evaluation, a recent study has shown that so far, governmental influence on the composition of the benefit package has been small. In addition, the National Accounting Office has shown that explicit priority setting has had only minor impact on the financial sustainability of the health care system. Finally, the Scientific Council for Government Policy has shown that the way resources are being spent results only to a small degree from explicit policy decisions. It argues that quality and accessibility of certain health care sectors (e.g., mental health, youth care) are insufficient, calling for more forceful explicit priority setting.

Conclusions Research into the effects of priority setting at the national level in the Dutch health care has been sparse, and rarely explicitly addresses equity issues. Such research could further advance the field of priority setting, particularly if priority setting were conceived as a practice, a practice that requires a culture of priority setting, and v.v.

83:poster COVID-19 AND THE PRECARIOUS SITUATION OF LESBIANS, GAYS AND BISEXUALS IN ETHIOPIA

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The burden of the pandemic is more pronounced among vulnerable and marginalized groups in the society, who, in the context of complex disadvantages, do not have the means to cope with the multifaceted disruptions in the labour market, food and health system, and their social networks. The pandemic and different measures taken by the Ethiopian government including State of Emergency (SOE) and strategies to contain COVID-19 affect all citizens in general and LGB in particular.

This mixed methods study seeks to assess the impact of COVID-19 and the wide socio-economic and political upheaval associated with the State of Emergency Proclamation on the lives of LGBs in Ethiopia. The research combines phone surveys involving 200 LGB and qualitative interviews with 12 LGB.

Most of the participants reported experiencing drastic changes in their lives since the advent of COVID-19. The most reported as well as the worst experiences include unemployment/reduced income and food/housing insecurity; fear of COVID-19 infection or death; inability to continue normal daily life, social and intimate relationship; and change in living arrangement. A small proportion of participants also mentioned violence. The study confirmed the precarious situation of sexual minorities in times of crisis. The ongoing war since Nov.2020 and resulting insecurity have led to disruption and destruction of the economy, social and health services; and deterioration of peace and security with significant bearing on marginalized groups.

Long standing and entrenched stigma and widely held notions of heteronormativity have relegated LGB in Ethiopia to the margins of society. The pandemic and subsequent SOE and internet interruptions have pushed LGB into further physical, social, and economic vulnerabilities and marginalization. Within the LGB group, the impact varies across individuals based on their socioeconomic and health standing. The situation calls for concerted policy measures to address economic, social, and health determinants.

73:poster LIVING SYSTEMATIC REVIEWS (LSR) AND PROSPECTIVE META ANALYSIS (PMA): A CALL-OF-DUTY FOR BAYESIAN ANALYSIS

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Background The recent Covid-19 pandemic has accelerated the use of LSRs and PMAs, viewed as the 'next generation systematic reviews and meta-analyses'. LSRs and PMAs are prospective designs that can reduce the problems of traditional retrospective meta-analyses (MA) such as selective outcome reporting and publication bias, missing data, etc., and thus offer a better option for incorporating and generating new evidence.

Objectives We propose the Bayesian approach as a method for analysing LSRs and PMAs. Bayesian Meta Analysis (BMA) is particularly appealing - actually, natural - for these designs as it clearly reflects the process of learning, defined as new evidence coming to update the previous knowledge, that is intrinsic to LSRs and PMAs.