Method 2316 members of a representative panel of doctors practicing in Norway received a questionnaire in December 2020. Data were analysed by descriptive statistics and regression analyses.

Results 1617 of 2316 (70%) responded. A majority reported familiarity with the official priority criteria, but not with the particular legislation on priority setting (the Priority Regulation/Prioriteringsforskriften), or the Directorate of Health's Guidelines for priority setting during the pandemic. 60-74% did not use guidelines for priority setting. 60,5% experienced that some of their patients got lower priority for treatment. Of these, 47% considered this medically indefensible to some/a large extent. We saw a significant difference between GPs, hospital doctors and private specialists in considering the lower priority indefensible: 42,6% (hospital doctors), and 57,8% (GPs). Regression analysis showed that increased age involved fewer claims of lower priority, controlling for age and workplace, while working in primary care increased the probability of considering the priorities medically indefensible, controlling for age and gender.

Discussion If priority setting in clinical practice is to proceed in accordance with priority setting principles and guidelines, doctors' familiarity with them must improve. Apparently, the clinical priority setting in response to the pandemic was considered medically indefensible by many doctors. One interpretation is that doctors have judged that the rationing of care went too far; another is that the society, including politicians, patients, and doctors, find it hard to accept rationing of care for particular patient groups.

97:oral PRIORITY SETTING AND HEALTH RIGHTS LITIGATION IN LATIN AMERICA

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High- and middle-income countries in Latin America have taken important steps towards the recognition of the right to health and towards universal health coverage (UHC). In the last two decades, however, the same countries (e.g. Argentina, Brazil, Chile, Colombia, Costa Rica, Uruguay) have seen a sharp increase in rights-based litigation to demand access to medical treatments not covered by the state, and the region now has the highest proportion of rights-based litigation in the world.

As countries progress towards UHC, they have had to make difficult choices about how to prioritise limited health resources. Institutional priority setting (IPS) is crucial to ensure transparent, consistent, and fair decisions, particularly in a region facing multiple health needs. The litigation of health rights, however, can threaten IPS, equity, the financial sustainability of the system, and ultimately efforts to achieve UHC. (Although some commentators have suggested that litigation can play a role in advancing the right to health when existing policies fail to uphold this right).

In this paper I examine the case of Chile, a country that has recently joined the wave of rights-based litigation in Latin America. Despite having implemented three IPS schemes (Plan of Explicit Health Guarantees for health care, Ricarte Soto Plan for high-cost diseases, and High-Cost Drugs Committee for cancer medicines), the number of litigations has risen from 23 between 2014-2018, to 87 in 2019. To date, 85% of these legal claims have received favorable rulings with costs to the state rivaling the budget of the mentioned IPS schemes. Drawing on local data, I discuss some causes that are common to the region, as well as particularities of the Chilean case: most litigation involve relatively new high-cost drugs (for cancer and rare/orphan diseases) not included in IPS plans, greater expectations regarding health care, and strong pharmaceutical lobby.

179:oral PRIORITY-SETTING FOR EFFECTIVE PANDEMIC PREPAREDNESS: A CASE STUDY OF PRIORITY SETTING FOR COVID-19 IN THE WESTERN PACIFIC REGION

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Background There have been divergent approaches used by countries to curb and control the spread, impact and burden of COVID-19. While priority setting – defined as decision-making about the allocation of resources between competing claims of different services, populations and elements of care – is recognized as critical for promoting accountability and transparency in health system planning, its role in supporting rational, equitable and fair pandemic preparedness planning is less well understood. Our multi-country project investigates the effectiveness of priority setting for pandemic preparedness planning. This study aims to describe how priority setting guided the COVID-19 responses implemented in the sub-set of countries in the Western Pacific Region.

Methods Guided by the adapted Kapiriri and Martin Framework, we purposively sampled a subset of countries in the WHO Western Pacific Region (WPRO) and undertook a critical document review of national-level pandemic preparedness plans. A pre-specified, validated tool guided data extraction on twenty quality parameters of PS. A critical synthesis was completed.

Results Nine plans were included (41% WPRO countries), including: Papua New Guinea, Tonga, Philippines, Fiji, China, Australia, New Zealand, Japan, and Taiwan. There was evidence of strong political will to quickly and effectively combat the pandemic. With 8/9 countries being islands, an emphasis on securing boarders was reflected in the plans. A limited number of quality indicators of effective priority setting were described. Most commonly, plans described resource needs (n=8), stakeholder engagement (n=8), and responsibilities of legitimate institutions (n=7). Consideration of health inequalities, fair financial burden, or public engagement/acceptance of priorities was not evident in any plans.

Discussion This project advances understanding of how priority setting has been used in the WPRO region to support COVID-19 responses. It provides a basis for examining the relationship between effective priority setting for pandemic preparedness and country-level outcomes in future work.