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.

81:oral EQUITY FOR ALL? A POLICY ANALYSIS OF PRIORITY TO REFUGEES AND ASYLUM SEEKERS' SEXUAL AND REPRODUCTIVE HEALTH IN NORWAY (2010–2019)

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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 addressed in Norwegian health policies. Acknowledging that migration health is impacted by social determinants of health, this was given particular attention.
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 priority and financial support to female genital mutilation (FGM) and forced marriage among migrants. FGM is seen as an area of concern across different policies on health alongside specific attention within violence polices. While social determinants of health and equality underpins general health policies in Norway, this was less prominent when polices discuss migrants and refugees' health, including their SRH. Addressing migrant health, including SRH and in particular FGM, was often presented as a matter of language problems, cultural barriers and harmful norms and practices. Other higher-level determinants, such as poverty and low education were rarely a focus in policies and in actions suggested for change.
Conclusion The SRH of refugees and asylum seekers is not a policy priority in migrant health policies nor in general health policies in Norway.

78:oral THE FAIR ALLOCATION OF SCARCE MEDICAL RESOURCES: A COMPARATIVE STUDY FROM JORDAN

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Objective Several studies have analyzed allocation strategies among different society groups based on 9 allocation principles; sickest-first, waiting list, prognosis, youngest-first, instrumental values, lottery, monetary contribution, reciprocity and individual behavior. Sometimes combinations, youngest-first and prognosis for example, can be considered. Our aim was to study the most important prioritization principles groups in Jordan.
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.

157:poster INTEGRATING HEALTH TECHNOLOGY ASSESSMENT AND THE RIGHT TO HEALTH IN SOUTH AFRICA: A QUALITATIVE CONTENT ANALYSIS OF SUBSTANTIVE VALUES IN LANDMARK JUDICIAL DECISIONS

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Objective Some have raised questions about potential tensions between health priority-setting and the right to health. South

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Africa, which is moving toward HTA and also includes the right to health in its Constitution, is an ideal setting in which to explore whether HTA priority-setting and an existing rights framework can be mutually reinforcing. This presentation discusses the findings of a content analysis that explored whether a focus on case rulings as a source of substantive values can advance understanding of the relationship between a rights-based approach to health care and national HTA efforts.

Methods We conducted a qualitative content analysis of eight South African court cases related to the right to health. Deductive coding reflected the substantive value framework provisionally developed by the South African Values and Ethics (SAVE) project to inform HTA in South Africa. The focus of analysis was to identify instances in the court's judgment and related reasoning that identified, interpreted, or balanced the substantive values and considerations included in this framework.

Results All but one substantive value included in the provisional SAVE framework were identified in the reasoning of at least one judgment. Equity was the most commonly identified value by number of judgments, followed by budget impact. The reasoning for each case judgment was interpretable in terms of the SAVE substantive values. The judgments offer several lessons regarding the interpretation of high-level SAVE values that could be applied in HTA practice.

Discussion The methodology described here could be applied in other countries where HTA operates in the context of a right to health. If an HTA body is established in SA, researchers should continue to assess the relationship between HTA and the courts to understand how each institution influences the other.

125:oral WHAT MAKES AN ILLNESS SEVERE? SUBJECTIVE ACCOUNTS OF SEVERITY IN THE NORWEGIAN POPULATION

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Introduction 'Severity' is one of three priority-setting criteria in the Norwegian priority-setting system. How we interpret and apply these criteria have a direct impact on which interventions are available in hospitals–and especially so for high-cost interventions, where the severity of a condition is often the justification for implementing a particularly costly treatment. However, severity is a multifaceted and incompletely defined concept. Our aim is to explore what severity means to the general, so at to better inform decision-makers on how to apply the severity criterion.

Methods We used Q-Methodology to explore subjective views on severity in the population. We conducted focus group interviews across Norway and extracted statements from participants which will be used for a Q-sorting exercise: asking a second set of participants do what degree they agree/disagree with those statements. These results will be subjected to factor analysis, which will identify certain 'clusters of opinion'–or factors–on the matter of severity.

Results The project is on-going, but our findings thus far suggest that matters such as death and young age are generally considered to be severe. The most interesting finding, however, is perhaps that participants tend to consider severity as an entirely subjective concept: that severity cannot be defined on a general basis, and is subject to what each individual feels is severe in their situation. We will explore this further in the Q-sort.

Discussion For priority-setting criteria to be applied fairly and effectively, we need a thorough understanding of what they mean. Our findings thus far suggest that severity is a concept the Norwegian public finds particularly complex, and unfit to be defined on a general level. This might suggest that the current application of the criterion is unsatisfactory, if the priority-setting system aims to have a democratically legitimate foundation.

49:oral COST AND COST-EFFECTIVENESS OF PEDIATRIC ONCOLOGY UNIT IN ETHIOPIA

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Background Despite the recently increasing global initiatives for childhood cancer, most recommended interventions to improve survival of children with cancers in Low Income Countries (LICs) are classified as either low or medium priority in the recently revised Ethiopia Essential Health Service Package (EEHSP), due to the limitation of local evidence on cost and cost-effectiveness.

Methods We collected historical cost data for the pediatric oncology unit, and all other (eighty-six) departments in Tikur Anbessa Specialized Hospital (TASH) from 8 July 2018 to June 2019, using mixed (dominantly top down) costing approach, and provider perspective. The direct costs of the oncology unit, costs at other relevant clinical departments, and overhead cost share are summed up to estimate the total annual cost. We used data on health outcome from other studies to estimate the net utility gain (DALY averted) of running a pediatric oncology unit compared to doing-nothing scenario. We applied the 50% of GDP/capita as a willingness-to-pay threshold.

Results The annual total cost of running the pediatric oncology unit in TASH during 2018-2019 was USD 797,458 (USD 964 per treated patient). Drugs and supplies (33%), and personnel (32%) constitute a large share of the cost. Sixty two percent of the cost is attributable to Inpatient Department (IPD) services, with the remaining 38% of costs related to Outpatient Department (OPD) services. The cost per DALY averted is USD 461 (range USD 346 to USD 753 on the one-way sensitivity analysis) which lies below the threshold for 'cost effective' interventions (USD 477/DALY averted).

Conclusions The provision of pediatric cancer services using a specialized oncology unit is most likely cost effective in Ethiopia and with an additional benefit on equity and financial risk protection. We recommend for reassessing the Childhood cancer treatment priority level decision in the current EHSPE.

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