

pandemic. In the face of a seemingly never-ending waves of variants that cause hospitalization rates to skyrocket each time, and as numerous observational studies have demonstrated that being unvaccinated is significantly associated with increased mortality and hospitalizations, it is tempting to 'attribute personal responsibility to the unvaccinated' and deprioritize these individuals for scarce medical resources, or, as President Emmanuel Macron argues, 'making life as difficult as possible.' At first blush, there are at least two separate questions: (1) are the unvaccinated squarely responsible for the continuing spread of the virus and (2) are the unvaccinated squarely responsible for the continuing burden on the healthcare system? The focus in this paper is on the second question, and I will interrogate the underlying values at stake in such a question.

I will argue that using vaccination status as a factor in scarce resource allocation is not defensible, though other ways of using responsibility may be. I argue that given the diversity of reasons for COVID-19 vaccine hesitancy, using vaccination status alone for scarce resource allocation may in some scenarios contravene widely accepted allocation principles. Recognizing objections to vaccines is critical to the first-order task of working out the relationship between vaccination and responsibility for burdening health systems in the pandemic. It may be defensible, however, to collectivize responsibility for vaccination through other mechanisms, through collective taxation for all unvaccinated individuals, for example. Increasing vaccine uptake will be central to the future of the pandemic, and policymakers must seek to understand the nature of vaccine hesitancy in their respective societies, as many have already sought to do.

#### 198:poster USING THE BENEFIT-OF-DOUBT APPROACH FOR HEALTH SYSTEM EFFECTIVENESS: A GLOBAL CASE STUDY ON AMENABLE MORTALITY

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**Introduction** Many different indicators can be used for health system effectiveness. Therefore, using composite indicators is a good way to summarize them all. One example of such efforts is the Healthcare Access and Quality Index (HAQI) from the Global Burden of Diseases study, for which different causes of mortality amenable to health care are summarized in this index through principal component analysis and exploratory factor analysis. While these approaches use the variance of the indicators, they do not consider room for improvement, i.e. distance to the frontier. Thus, in this study we present the Benefit-of-Doubt (BoD) approach as a solution for combining frontier analysis and composite indicators, using amenable mortality estimates for 189 countries.

**Methods** We performed a retrospective observational and methodological study, using data on 32 causes of mortality amenable to health care for 189 countries in 2015. As these indicators can be summed up (they all have the same units), there is a gold-standard to compare with. However, this is not the case for most of the health system effectiveness

indicators or other analyses. For analyzing effectiveness through the BoD approach, countries were divided by regions, either by WHO regions and by socio-demographic index (SDI).

**Results** We have found important differences, highlighting those causes of death that contributed more to effectiveness by WHO and SDI region. There were wide heterogeneities across causes of death. Additionally, overall analysis showed that the composite indicators were correlated but with some specific important differences.

**Discussion** We show that the BoD approach is a good option for computing composite indicators, also when using information on 'room for improvement', i.e. distance to the frontier. The use of BoD in health systems performance assessment, specifically in effectiveness and efficiency dimensions, can be an interesting step towards priority setting.

#### 185:poster THE IDEAS BEHIND CHARGING FOR NON-ATTENDANCE IN HEALTHCARE: AN ANALYSIS OF KEY POLICY DOCUMENTS IN DENMARK AND NORWAY

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**Objective** Patients who miss their appointments without giving notice burden healthcare systems. Longer waiting lists and unused resources, which could have benefited other patients, are the ramifications. To amend this problem of non-attendance, a charge—sometimes called a fee or fine—has been considered and in some places implemented. While Denmark declines, so far, charging for non-attendance, in public hospitals, Norway charges patients. Moreover, the charge in Norway has increased the latter years, amounting to three times the user fee for outpatient services. We desired to investigate the underlying ideas of such charging. There are different conceivable justifications for charging for non-attendance and these justifications are treated differently, in as much as the two countries have reached different conclusions.

**Methods** We conducted a qualitative document analysis. A conceptual framework was constructed and key policy documents from the two countries were deductively analysed. The framework consisted of ideal type justifications for utilising non-attendance charges: from being an inducement, that the charge should compensate losses incurred, to being a punishment.

**Results** There is considerable attention towards the problem of non-attendance in both Denmark and Norway, because non-attendance negatively affects efficient healthcare delivery. Nonetheless, we found conflicting ideas behind using a non-attendance charge between the countries and, interestingly, within the policy documents themselves. While the charge is above all understood in a purely utilitarian sense in the Norwegian documents, there are more considerations about charging as a retributive stance in the Danish documents.

**Discussion** Use of non-attendance charges challenges the role of law and formal sanctions in healthcare, as well as—some critics allege—threaten universal access to healthcare. There is an important distinction, with ethical implications, whether a charge is an incentive, utilised to motive patients to attend, or

whether the charge intends to punish patients for non-attendance.

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### ASSESSING THE EFFECTS OF INTERVENTIONS THAT AFFECT BIRTH RATES

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**Objective** Some beneficial reproductive health interventions affect who will be born and how many people will be born (e.g., providing contraception, treating avoidable causes of infertility like chlamydia). In order to decide whether these interventions should be included in health benefits packages a consistent methodology is needed for assessing their costs and benefits within a population. Such a methodology should enable cost-effectiveness analyses of interventions that affect birth rates so they can be compared with other health interventions. At present the health economic analyses of these interventions use apparently inconsistent methods. This presentation provides a taxonomy and ethical analysis of current methodologies used to assess the effects of interventions that affect birth rates.

**Methods** We reviewed the studies cited in two recent literature reviews of economic evaluations of interventions that affect fertility and childbearing. On the basis of this review, we developed a taxonomy of methods used for assessing the effects of interventions that affect birth rates. These methods were then evaluated for logical consistency, utility, and fit with defensible ethical principles.

**Results and Discussion** A number of the methodologies used appear to treat the benefits and costs of interventions that affect birth rates in inconsistent ways—for example, contraception is sometimes treated as averting infant deaths by preventing the infants from coming into existence but not as averting the creation of other individuals who would live long, healthy lives. Other methodologies are ethically indefensible—for example, putting a positive value on the reduction of fertility independent of whether the reduction is desired by the people who would otherwise reproduce. Consistent and ethically defensible methodologies fall into three categories: those measuring intermediate outcomes; those measuring total effects; and those focused on reproductive autonomy. Each has pros and cons for policy-makers designing health benefits packages.

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### UNDERSTANDING PATIENTS' VIEWS AND EXPERIENCES OF NHS SERVICES IN THE CONTEXT OF THE EVIDENCE-BASED INTERVENTIONS (EBI) PROGRAMME IN THE ENGLISH NATIONAL HEALTH SERVICE

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**Objective** New evidence about existing health technologies can raise questions about the benefits of continued provision. It may be possible to stop or reduce the technology use in people where benefit may not justify health system costs. The EBI programme was introduced in the English National

Health Service (NHS) in April 2019. The programme provides guidance for local health system managers to stop or reduce certain procedures where evidence indicates limited or no benefit (for some or all patients). The aim of this study is to investigate patients' understanding and experiences of care for symptoms where access to procedures may be constrained by the EBI programme.

**Methods** This is a qualitative study based on case study design. The data collection methods planned are semi-structured interview(s) with patients who are potential candidates for three case study procedures from the EBI programme. Alongside this, audio-recordings of these patients' clinical consultations will be collected, with a focus on how treatment options are discussed. Data will be analysed thematically, using the constant comparative approach.

**Results** Data collection will commence in January 2022 with preliminary findings presented. The topics that will be covered in the interviews and audio-recordings include patients' experiences of their initial referral by primary care and their pathway leading to specialist consultation; any expectations they may have had for their care and what the implications were if these were not met; and their general views on access to NHS care.

**Conclusion** Research on the impact of initiatives that aim to reduce healthcare use from stakeholders' perspectives is lacking. This study is one of the first to focus on patients' understanding and perspectives of care in this context. Findings from this study will provide timely information on the implications of these initiatives on patients' experiences of care.

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### STAKEHOLDER INVOLVEMENT IN THE COVID-19 PANDEMIC RESPONSE AND PREPAREDNESS PLANS: A SYNTHESIS OF FINDINGS IN 86 COUNTRIES

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**Background** The importance of stakeholder involvement in priority setting has been recognized in theoretical and empirical literature; however, there is a paucity of evidence reporting on stakeholder involvement in planning the response to public health emergencies. The COVID-19 pandemic provides an opportunity to explore how stakeholders are involved, and which groups are most engaged in these processes.

**Methods** This study is part of a global documentary analysis of COVID-19 national response plans. We assessed the degree to which pandemic plans from a sample of 86 countries adhered to twenty quality indicators of effective priority setting included in the Kapiriri & Martin's framework. One of these is stakeholder involvement, viewed to enhance the legitimacy and acceptability of policy decisions by incorporating the interests of affected parties, and to enhance fairness through the inclusion of a range of values. We extracted information about individuals and institutions involved in the development of the plans, and any explanation of their level of involvement or contribution.

**Results** Overall, 68 countries reported stakeholder involvement in the development of COVID-19 response plans. Most of these plans were led by the ministries of health in each country. Eighteen plans briefly described the engagement of representatives from different health-related government organizations, forty-five countries mentioned the involvement