

Methods We conducted a prospective cohort study from August 2014-2015 at Mnazi-Mmoja Hospital, Zanzibar. EPTB patients were interviewed for demographic and socioeconomic information and pre-diagnostic cost of EPTB was ascertained. Finally, regression analysis was used to identify factors predicting the high pre-diagnostic total cost for patients.

Results EPTB patients were predominantly children (35%) and young adults (50%); 55% were male. Average monthly income was US\$ 136 with no significant difference by gender. The median total cost for all patients was US\$ 98, mainly due to average indirect costs (65%). Around 58% of the patients suffered from catastrophic costs. On average, patients faced 67 days of reduced-productivity due to EPTB illness. Increase in average monthly income was the significant predictor of high total patient cost for all and male patients respectively, while increase in reduced working capacity led to a decrease in total cost for the female patients.

Discussion The calculated out-of-pocket and opportunity-costs caused significant socio-economic burden as compared to the developed-countries. Alarming, pre-diagnostic costs are linked with patients' ability to pay which highlights potential gaps in available UHC and a significant barrier to end-TB goals. The higher catastrophic-costs pushes the worse-off further into poverty and major barrier to achieve UHC. These findings highlight the need of affordable early interventions to tackle EPTB and avoid inequity by reducing socioeconomic burden.

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ACCESS TO EFFECTIVE BUT EXPENSIVE MEDICAL TREATMENTS: AN ANALYSIS OF THE CONCEPT OF SOLIDARITY

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Objective Personalized medicine is an increasingly prominent approach in many disease areas, including oncology and rare (genetic) disorders, but is often associated with high costs. The development of effective but (very) expensive medical treatments leads to discussions about whether and how such treatments should be allocated in solidarity-based universal access healthcare systems. In such discussions, the concept of solidarity is often used, but considered elusive. What does it mean?

Method We have conducted a conceptual analysis of the concept of solidarity as it is used in the literature on the allocation and funding of expensive medical treatments.

Results In this presentation, we identify and discuss four uses of the concept of solidarity: 1) the assistance of patients in need, 2) the upholding of the universal access healthcare system, 3) the willingness to contribute, and 4) the promotion of equality. We distinguish normative and descriptive uses of the concept, and analyze the overlap and differences between the concepts of solidarity and justice. Our analysis shows that the various uses of the concept of solidarity point to different, even conflicting, ethical stances on whether and how access to effective, expensive treatments should be provided.

Conclusion Although the concept of justice may serve as the decisive principle in the allocation of healthcare resources,

solidarity does have a role to play in discussions on funding of expensive medical treatments, requiring, for instance, that healthcare policies promote and maintain societal willingness to contribute to the care of others and the value of assisting patients in need.

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PRIORITY SETTING ACROSS DIFFERENT LEVELS OF DECISION-MAKING: THE WAY FORWARD

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Background Priority setting involves the practice of ranking interventions in order of their importance. In principle, the same priority setting criteria may be used across all levels of decision-making in health care. This may include decision-making on the macro (cabinet and the health ministry), meso (resource allocation within hospitals and health trusts) and micro level (bedside rationing).

Objective The aim of this article is to present a systematic discussion of priority setting across different levels of decision-making. Should different criteria for priority setting apply at the different levels? How can we decide which criteria fall into which category? And what should count as a sufficient argument for having different principles at different levels?

Methods We present the current literature on the topic through a scoping review. We expand on the literature to suggest useful definitions of levels of priority setting and candidate reasons for significant differences between the levels.

Results We found that definitions and the suggested number of levels differ, but the most favoured approach was two or three levels of priority setting. We present descriptive differences between the levels and suggest what we believe are useful definitions of levels of priority setting. We further present and discuss candidate reasons for ethically significant differences between the levels with applications for priority setting.

Discussion We consider this article to be a first step towards a more rigorous approach to priority setting across levels of decision-making in health care. We recommend that the levels of priority setting are more consistently and comprehensively defined. We argue in favour of further systematic discussion of this topic in future and conclude that this topic should be unavoidable in further discussions.

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THEORETICAL ASSUMPTIONS BEHIND THE COST-EFFECTIVENESS OF IVF TREATMENT

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In vitro fertilization (IVF) is a medical procedure in which an egg is fertilized outside the body before being placed inside a womb. Some countries have chosen to cover IVF through public spending, but there is usually a limit to the number of cycles being publicly covered. Ultimately, the willingness to public IVF-coverage will depend on its cost-effectiveness. Several attempts have been made to provide