Covid-19 vaccine allocation plans. The dominant model is the CDC's Social Vulnerability Index (SVI), developed for natural disaster response efforts (mapping well onto a conceptualization in the philosophical literature: Wolff/De-Shalit, 'Disadvantage', OUP 2007, as well as public preferences: Schmidt et al. 'US adults' preferences…' JME, 2021). Main DI uses: planning dispensing site locations, targeted outreach/communication, increasing vaccine quantities, and monitoring uptake/course-correcting. Adapted forms were also used for tests and antiviral treatment allocation. The scoping review of SVI uses is ongoing at the time of submission; preliminary findings are that around 50% of N=119 publications use DIs 'off-label', ie in non-emergency settings, indicating an unmet need. Emergent themes include: budgetary allocations, healthcare service access planning, targeted prevention.

Discussion In Spring 2020, the dominant theme in Covid-19 allocation frameworks was maximizing overall benefits—often risking exacerbating existing inequities. The rapid and widespread DI adoption opened a major new chapter, holds major potential to improve equity in allocation beyond Covid-19, and should be explored further.

183:oral VENTILATOR RATIONING UNDER CRISIS STANDARDS OF CARE: WHAT LESSONS HAVE WE LEARNED REGARDING IMPACT ON SOCIAL, RACIAL AND ETHNIC JUSTICE?

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Background Crisis Standards of Care (CSC) ventilator triage guidance often includes prediction models such as the Sequential Organ Failure Assessment score (SOFA) to assess patients' lCU survival. However, from Spring 2020, a number of publications and robust studies demonstrated inequitable outcomes across racial groups from using SOFA. For example, drawing on data of >100,000 patients, Ashana et al. 2021, showed that the metric erroneously overestimates the mortality of Black patients and wrongly excludes >9% from the highest prioritization. Removing SOFA's creatinine sub-score reduced the miscalibration.

Objective To assess whether US state-level CSC included the SOFA score in January 2022, when Omicron led to 20 US states at >85% ICU bed capacity; if so, with or without measures aimed at reducing the risk of inequitable outcomes.

Methods We reviewed SOFA use in all US states' publicly available CSC querying: a) the US Health Depts' Technical Resources, Assistance Center, and Information Exchange (TRACIE) database; b) state health department websites; complemented with c) webbrowser searches. Documents were retrieved January 14-16, 2022. 4 team members independently retrieved and coded documents using a structured extraction tool (capturing date of issue; use of SOFA or other prediction models; measures proposed/noted to adjust SOFA for equity; and whether/to what extent remaining life expectancy was included in algorithms).

Results The study is ongoing at the time of abstract submission (min. 8 states currently use SOFA).

Discussion While influential commentators recently argued that CSC 'cannot be expected to remedy historic and structural inequity' and should merely 'not exacerbate' them (Hick et al. 2021), and while states continue to the use the SOFA score and fail to meet even this minimalist criterion, we need to better understand why robust evidence on inequitable outcomes is ignored, and what alternatives can be offered to avoid them in future heath emergencies.

206:oral BUT SOMETIMES YOU END UP GIVING IN AND GIVING THEM WHAT THEY'RE NOT ENTITLED TO, BECAUSE IT'S TOO DIFFICULT TO SAY NO.'– A QUALITATIVE STUDY AMONG PHYSICIANS AND NURSES ON CLINICAL PRIORITY-SETTING IN ONCOLOGY

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Background Even in a generously funded health care system as the Norwegian, there are limits for what can be provided. Our objectives are to explore in which situations physicians and nurses find it hard to refuse the patients' requests or demand for treatment and care that is not prioritized or they are not entitled to, what kind of strategies they use in order to change the patients´ mind and how they justify their actions.

Methods Focus group interviews with interdisciplinary teams at Department of Oncology and Medical Physics and Department of Thoracic Medicine at Haukeland University Hospital, Norway. Findings were analyzed using systematic text condensation.

Results All the 63 participants had experienced patients asking for treatment, hospitalization or care which were not prioritized or the participants found to be less important to provide. While the nurses negotiated on issues like single room, longer hospital stay, earlier appointments or paid transportation, physicians reporting more disagreement when it came to the level of treatment. The physicians found it most difficult to refuse patients' request for promising new treatment available in other countries, but not prioritized by the Norwegian government. Strategies used to help patients accept their decisions included referring to policy and principles, introduce someone with more authority, focus on side effects and appeal to solidarity. Many lacked good, ethical acceptable strategies. All providers had experiences of giving in, and their justifications were lack of time to argue with the patients, that it was uncomfortable and to keep a good relationship with the patient.

Discussion How bedside priorities are done, and what strategies nurses and physicians are using when negotiating in these situations should get more attention and the providers should be trained to handle these challenges. Clear guidelines, leadership and meeting arenas to discuss and reflect with colleagues are important.

123:poster THE POLITICAL ECONOMY OF PRIORITY-SETTING FOR HEALTH IN SOUTH SUDAN: A CASE STUDY OF THE HEALTH POOLED FUND

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