

**Objective** In fragile and conflict affected settings (FCAS) such as South Sudan, where health needs are immense, resources are scarce, health infrastructure is rudimentary or damaged, and government stewardship is weak, adequate health intervention priority-setting is especially important. There is a scarcity of research examining priority-setting in FCAS and the related political economy. Yet, capturing these dynamics is important to develop context-specific guidance for priority-setting. The objective of this study is to analyze the priority-setting practices in the Health Pooled Fund (HPF) of South Sudan using a political economy perspective.

**Methods** A mixed methods study was conducted combining document review, 30 stakeholder interviews, and a quantitative assessment of service delivery. An adapted version of the Walt and Gilson policy analysis triangle guided the study's design and analysis.

**Results** Priority-setting in the context of HPF takes place throughout program design, implementing partner (IP) contract negotiation, and implementation of the service package. The National Basic Package does not provide adequate guidance because it is too expansive and unrealistic given financial and health system constraints. Furthermore, power asymmetries between actors are pronounced. At the local level, IPs must manage the competing interests of the HPF program and local health authorities as well as challenging contextual factors, including conflict and shortages of skilled health workers, which eventually affect service provision. The resulting priority-setting process remains implicit, scarcely documented, and primarily driven by donors' interests.

**Conclusion** This study highlights power asymmetries between donors and national health authorities within a FCAS context, which drive a priority-setting process that is dominated by donor agendas and leave little room for government ownership. These findings emphasize the importance of paying attention to the influence of stakeholders and their interests on the priority-setting process in FCAS. Ultimately, the process of contracting out services is particularly political and requires guidance.

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#### HOW DID EUROPEAN COUNTRIES SET PRIORITIES IN RESPONSE TO THE COVID-19 THREAT? A COMPARATIVE DOCUMENT ANALYSIS OF 24 PANDEMIC PREPAREDNESS PLANS

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**Introduction** The COVID-19 pandemic has forced governments across Europe to consider how to prioritise the allocation of scarce resources. Many took decisions to increase funding for health services, and to redirect current fiscal, human and technical resource towards meeting the new threat.

**Methods** We conducted document analysis of pandemic preparedness plans in 24 countries across the regions of Europe, focussing on prioritisation and allocation of health-related resources. To be included, countries needed to have publicly available COVID19 preparedness plans. Where necessary, plans were translated into English before two members of the team

conducted data extraction. We adapted the Kapiriri and Martin (2010) framework as our organising data extraction tool. Following validity checks, these data were synthesised numerically and thematically.

**Results** COVID19 has engendered recognition on behalf of government of the scarcity of health care resources. However, many plans still fell short of identifying specific budgetary implications or trade-offs between COVID19 responses and other service priorities. Many plans describe use of evidence, expert involvement and decision making criteria. However, use of formal priority setting tools and frameworks was rare. The plans included very little engagement with citizens and service users, and equity considerations were often underdeveloped. The overall average compliance with quality parameters of priority setting was 29%.

**Discussion** The plans indicate a political commitment to priority setting but underline the relative failure of priority setting methodologies to become embedded in governmental decision making processes. In the balance between 'technocratic' elements of priority setting and 'processual' dimensions, there was an emphasis on the former, reflecting the enforced speed with which plans were drawn up. As difficult priority setting decisions will be required in the post-crisis phase (as care backlogs and unmet need are addressed) it is likely that a rebalancing towards the processual aspects of decision making processes will be required.

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#### PRIORITY-SETTING DILEMMAS, MORAL DISTRESS AND SUPPORT EXPERIENCED BY NURSES AND PHYSICIANS IN THE EARLY PHASE OF THE COVID-19 PANDEMIC IN NORWAY

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**Objective** The global COVID-19 pandemic has imposed challenges on healthcare systems and professionals worldwide and introduced a 'maelstrom' of ethical dilemmas. How ethically demanding situations are handled affects employees' moral stress and job satisfaction. The aim of this study was to describe priority-setting dilemmas, moral distress and support experienced by nurses and physicians across medical specialties in the early phase of the COVID-19 pandemic in Western Norway.

**Methods** A cross-sectional hospital-based survey was conducted from 23 April to 11 May 2020.

**Results** Among the 1606 respondents, 67% had experienced priority-setting dilemmas the previous two weeks. Healthcare workers who were directly involved in COVID-19 care, were redeployed or worked in psychiatry/addiction medicine experienced it more often. Although 59% of the respondents had seen adverse consequences due to resource scarcity, severe consequences were rare. Moral distress levels were generally low (2.9 on a 0-10 scale), but higher in selected groups (redeployed, managers and working in psychiatry/addiction medicine). Backing from existing collegial and managerial structures and routines, such as discussions with colleagues and receiving updates and information from managers that listened and acted upon feedback, were found more helpful than external