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.
support mechanisms. Priority-setting guidelines were also helpful.

Conclusion By including all medical specialties, nurses and physicians, and various institutions, the study provides information on how the COVID-19 mitigation also influenced those not directly involved in the COVID-19 treatment of patients. In the next stages of the pandemic response, support for healthcare professionals directly involved in outbreak-affected patients, those redeployed or those most impacted by mitigation strategies must be a priority.

159:oral SCALING UP NEUROLOGICAL INTERVENTIONS IN EAST AFRICA: A HEALTH ECONOMIC EVALUATION

Neurological disorders are currently among the top causes of disability adjusted life-years (DALYs) and deaths globally. A vast increase in disease burden is projected, particularly in low- and lower middle-income countries (LLMIC). Paradoxically, in LLMIC settings, neurological disorders are often neglected, underdiagnosed, receive insufficient funding, and limited research. To combat the growing burden of disease, increasing focus must be placed on management of neurological disorders. Cost-effectiveness analyses of epilepsy (acute and long-term management), migraine (first-line treatment, prophylaxis), Parkinson’s disease (drug treatment, physical therapy), and dementia (diagnosis and follow up, drug treatment, caregivers interventions) were performed to inform policy makers in Ethiopia, Malawi, and Tanzania. Health system costs were collected through a top-down microcosting method. Costing and coverage data were collected with expertise of East African neurologists and medical experts. Efficacy estimates were gathered by estimating the mortality or disability reduction, based on meta-analyses or systematic reviews. The cost-effectiveness analyses, calculating the incremental cost-effectiveness ratio (ICER), were conducted with FairChoices: DCP Analytics Tool. The health benefits of the interventions were estimated in DALYs averted. Cost-effectiveness analyses identified the long-term management of epilepsy (ICER: 0.35), self-managed treatment of migraine (ICER: 45.93), and support for dementia caregivers (ICER: 0.0004) as the best-buy interventions. Parkinson’s disease and the other dementia interventions were not deemed cost-effective in resource-constrained settings, because of its high costs or limited individual benefits. However, these interventions can be significantly impactful for patient’s families, indicating the need for further exploration of the non-health benefits using alternate methodology. The current findings support that an impact in managing neurological conditions can be made by scaling-up the identified cost-effective interventions in resource-constrained settings. By including these considerations carefully, a revision of the essential health benefit package can initiate a prime step forward in pursuit of poverty reduction and health equity.

199:oral SHOULD THE NETHERLANDS ALLOW VOLUNTARY ADDITIONAL HEALTH INSURANCE FOR EXPENSIVE CANCER TREATMENTS? A JUSTICE PERSPECTIVE

Objective In the Netherlands, an increasing number of effective but extremely expensive cancer treatments are (temporarily) not reimbursed through mandatory basic health insurance. It seems that access to such treatments is currently limited: patients are often not allowed to pay out of pocket, and health insurers do not offer voluntary additional health insurance (VAHI) to cover such cases (Calcoen et al., 2017). However, patient might benefit from and prefer such insurance. Why is this not provided?

Methods In this paper, we provide a normative analysis, specifically from the perspective of social justice, of the question whether the Netherlands (and countries with similar healthcare systems) should change this policy and allow VAHI.

Results While the Dutch healthcare system has a strong egalitarian ethos, and allowing VAHI will lead to unequal access to potentially beneficial treatments, we argue that there are no in-principle justice-based objections against the provision of additional insurance. As long as mandatory basic health insurance covers all medically necessary treatments that societies owe their members on the basis of justice, denying citizens access to additional treatments based on considerations of equality would invoke the raising-up objection (Eyal, 2013), and may not be just.

We then consider how the introduction of VAHI to cover expensive cancer treatments in practice might lead to objectionable changes to the healthcare system. We suggest that it should be possible to maintain the current Dutch full population coverage, extensive service coverage, and relatively moderate cost sharing. Yet, whereas only an affluent clear minority of citizens has the ability to pay for top-up payments, a considerable majority may be able to afford VAHI. This might lead to a problematic two-tiered healthcare system, that reinforces existing class differences and undermines equal social standing of citizens with low income that cannot afford VAHI (Cf. Fourie, 2016).

138:oral RESPONSIBILITY IN A PANDEMIC: SHOULD VACCINATION STATUS BE USED TO DISTRIBUTE SCARCE MEDICAL RESOURCES?

Should the unvaccinated be deprioritized for scarce medical resources when resources are scarce and when hospitals become overwhelmed? This, among others, has surprisingly been entertained in several contexts during the COVID-19 pandemic. In this paper, we focus on the ethical question raised by the unequal availability of vaccines. We argue that the use of further risk-based prioritization may be ethically justified, if the resulting unequal distribution is justified by the expectation of a better outcome for those who are vaccinated and if the consequences of the use of vaccines is deemed sufficiently beneficial. We draw on the use of vaccination status to prioritize scarce non-vaccine medical resources and to distribute scarce vaccines among healthcare professionals, when the latter are in short supply due to a pandemic. The paper highlights the need for clear ethical guidelines to prevent possible misuse of prioritization tools in crisis situations.