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 is 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