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**PUBLIC PARTICIPATION: HEALTHCARE RATIONING IN THE NEWSPAPER MEDIA**

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**Background** It is impossible to meet all healthcare demands, but an open and fair rationing process may improve the public acceptability of priority-setting in healthcare. Transparent decision-making is subject to scrutiny by newspaper media. In Norway, healthcare rationing has been subject to public debate both before and after the establishment of ‘The National System for Managed Introduction of New Health Technologies within the Specialist Health Service’ (New Methods) in 2013.

**Aim** To describe and assess the development of the public debate on Norwegian healthcare rationing through three cases in print media.

**Methods** We purposively sampled Norwegian newspaper articles between 2012 and 2018 concerning three resolutions in the Norwegian system. The resolutions were ipilimumab (Yervoy, n=45) against metastatic melanoma, nivolumab (Opdivo, n=23) against non-small cell lung cancer, and nusinersen (Spinraza, n=68) against spinal muscular atrophy. Cases were analysed separately using the qualitative method of systematic text condensation.

**Results** Our analysis highlighted four common themes—money, rationales, patient stories, and process—and a unique theme for each case. Ipilimumab was uniquely themed by rationing rejection, nivolumab by healthcare two-tiering, and Spinraza by patients’ rights. We found wide media deliberation among a multitude of stakeholders. Perceptions of rationing were found to be chiefly aligned with previous empirical research. We assessed that the media reported more frequently on opposition to rationing compared to findings from previous studies on Norwegian healthcare decision-making attitudes. We think this was influenced by our selection of cases receiving extraordinary media attention, and from media sources being subject to political communication from special interest groups.

**Conclusion** The introduction of New Methods institutionalised Norwegian healthcare rationing and isolated the public debate into conversations between stakeholders and decision makers outside the political sphere. The findings from these three extraordinary debates are not generalisable and should be seen as a stakeholder learning opportunity.

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**DELIBERATIVE ENGAGEMENT AND HEALTH CARE PRIORITY-SETTING IN A RURAL SOUTH AFRICAN COMMUNITY**

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Objective Public engagement in priority setting for health is recognised as a means to ensure more inclusive, fair and legitimate decision making processes, especially in the context of Universal Health Coverage where demands outweigh available resources. Deliberative engagement approaches are often viewed as particularly useful in considering social values and balancing trade-offs, however, implementation of these approaches for priority setting is scant, especially in low and middle income settings. In order to address this gap we implemented a context specific public deliberation tool in a rural community in South Africa to determine priorities for a health services package.

**Methods** Qualitative data were analysed from seven group deliberations using the engagement tool. Content analysis was conducted and inductive and deductive coding was used. The analysis focused on understanding the deliberative process, what the participants prioritised, the reasons for these selections and how negotiations took place within the groups.

**Results** The deliberations demonstrated that the groups often prioritised curative services over primary prevention which related to perceived lack of efficacy of existing health education and prevention programmes in leading to behaviour change. The groups engaged deeply with trade-offs between costly treatment options for HIV/AIDS and those for non-communicable disease. Barriers to healthcare access were considered especially important by all groups and some priorities included investing in more mobile clinics.

**Discussion** South Africa is committed to public engagement in priority-setting for health, yet the views of communities are not considered in policy and programme development which largely involves top down decision making. This study demonstrates that deliberative engagement methods can be successful in helping communities balance trade-offs and in eliciting social values around health priorities. The findings from such deliberations, alongside other evidence and broader ethical considerations, have the potential to inform decision-making with regard to health policy design and implementation.

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**IDENTIFIABLE, ANONYMOUS, AND STATISTICAL VICTIMS**

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Health priority-setting must sometimes decide between the health needs of identified individuals and the health needs of merely statistical persons. For example, right to health litigation includes an identified litigant claiming resources which otherwise would be to an unknown individual. Preventive public health measures improve statistical health measures, but we cannot identify a token individual beneficiary as we can when resources are devoted to the treatment of current patients.

Psychologically, decision-makers are more likely to benefit identified individuals than to benefit individuals that are ‘merely statistical’. Normatively, writers are divided whether such an ‘identified victim bias’ is morally justified. There have been attempts to justify the moral relevance of identifiability. In my paper, I join critics in rejecting that identifiability is morally relevant. However, unlike these critics I argue