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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

that there are good reasons to deprioritize merely statistical harms. This is because, as I show in my paper, the notion of a ‘statistical victim’ is ambiguous between various interpretations. I draw a distinction between ‘anonymous victims’ and ‘merely statistical victims’. I defend this distinction on two grounds. First, I argue that it is normatively attractive. Anonymous victims are morally alike identifiable victims and unlike merely statistical victims. Second, I argue that preliminary psychological evidence shows that decision-makers in fact treat anonymous victims differently from merely statistical victims.

In the last part of my paper, I return to examples of health priority-setting and show what my view implies about these examples. It turns out that my view constitutes a middle path. In some cases it vindicates the preference for prioritizing identifiable persons over statistical persons while in others it condemns such a preference.

186:poster POVERTY DISCRIMINATION

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This paper examines a paradox arising in connection with an underexamined form of discrimination: socioeconomic discrimination. Recent evidence from the United States suggests that discrimination on basis of social class in health care delivery is common. Patients from poorer backgrounds, for example patients receiving care paid for by welfare programs, receive lesser quality care. Should such class discrimination be legally regulated?

It is generally believed that economically left- and right-wing convictions can unite in condemning paradigmatic forms of direct and indirect discrimination, e.g., race/caste/sex discrimination. However, we challenge this picture. We argue that it is difficult to condemn paradigmatic forms of direct discrimination and at the same time embrace the sort of economically regressive policies that in effect amount to indirect discrimination against the poor. This includes the myriad of policies which exacerbate unfair social determinants of health ranging from housing policies, infrastructure policies, education policies to health policy. Our argument appeals to the fact that each of the following three claims seem appealing:

P1. Paradigmatic discrimination should be prohibited by law.

P2. If direct paradigmatic discrimination should be prohibited by law, then so should indirect paradigmatic discrimination.

P3. If indirect paradigmatic discrimination should be prohibited by law, then so should indirect socioeconomic class discrimination.

However, together they entail a very radical claim:

C. Hence, indirect socioeconomic class discrimination should be prohibited by law.

C would allow for substantial litigation on health policy and social policy more broadly – in effect it would allow for many policies causing social gradients in health outcomes to be challenged. Our main aim is not to defend C, but to show that we need to respond to it in one way or another which for many will require significant revisions of their beliefs.

140:poster THE ETHICS OF GLOBAL COVID-19 VACCINE ALLOCATION

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Introduction Policies to increase global vaccine access involve HICs making ethically fraught tradeoffs between saving lives at home or abroad. Such policies should be justifiable to the affected populations. Yet there is little robust data on whether HIC residents endorse their countries’ policy choices. Most existing data asks highly simplified questions, without providing background on the ethical tradeoffs involved. These data do not capture the public’s informed views, giving policymakers limited guidance on how to craft international vaccine policy. This paper provides the first nuanced data on the informed views of a representative sample of the U.S. public about providing COVID vaccine to poorer countries.

Methods This study involved two interventions: a description of ethical arguments for/against providing vaccine to poorer countries and visual depiction of ethically relevant tradeoffs about providing vaccine to poorer countries at different time points in the US vaccination campaign. A representative sample of 4000 U.S. adults were surveyed, divided evenly into four arms: 1) arguments only; 2) tradeoffs only; 3) both interventions; 4) no interventions.

Results Across all four arms, people are more willing to donate vaccines than previously reported, with generosity increasing over time. 43% of respondents were willing to share at an early timepoint when supply was extremely limited, increasing to 54% and 71% at intermediate and current timepoints, respectively. Some specific variables (e.g., political affiliation, age, acceptability of masks) were predictive of willingness to donate and endorsement of specific arguments.

Discussion These data can guide policy about providing or keeping U.S. vaccine doses as the world navigates the effects of new variants and the potential need for booster shots in the coming months. Given high levels of willingness to donate, U.S. policy could have initiated global vaccine donations earlier and could be more generous currently.

105:oral CLINICAL PRIORITY SETTING DURING THE COVID-19-PANDEMIC – NORWEGIAN DOCTORS’ EXPERIENCES

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Introduction Although Norway had lower infection rates and fewer patients hospitalized during the first year of the covid-19 pandemic, measures taken to avoid anticipated pressure on health care involved hard priorities of patients and staff. How did doctors experience this situation? We studied doctors’ knowledge about, and adherence to, guidelines and regulations on priority setting, and whether the actual priorities were considered reasonable and justifiable.