whether the charge intends to punish patients for non-attendance.

Objective Some beneficial reproductive health interventions affect who will be born and how many people will be born (e.g., providing contraception, treating avoidable causes of infertility like chlamydia). In order to decide whether these interventions should be included in health benefits packages a consistent methodology is needed for assessing their costs and benefits within a population. Such a methodology should enable cost-effectiveness analyses of interventions that affect birth rates so they can be compared with other health interventions. At present the health economic analyses of these interventions use apparently inconsistent methods. This presentation provides a taxonomy and ethical analysis of current methodologies used to assess the effects of interventions that affect birth rates.

Methods We reviewed the studies cited in two recent literature reviews of economic evaluations of interventions that affect fertility and childbearing. On the basis of this review, we developed a taxonomy of methods used for assessing the effects of interventions that affect birth rates. These methods were then evaluated for logical consistency, utility, and fit with defensible ethical principles.

Results and Discussion A number of the methodologies used appear to treat the benefits and costs of interventions that affect birth rates in inconsistent ways—for example, contraception is sometimes treated as averting infant deaths by preventing the infants from coming into existence but not as averting the creation of other individuals who would live long, healthy lives. Other methodologies are ethically indefensible—for example, putting a positive value on the reduction of fertility independent of whether the reduction is desired by the people who would otherwise reproduce. Consistent and ethically defensible methodologies fall into three categories: those measuring intermediate outcomes; those measuring total effects; and those focused on reproductive autonomy. Each has pros and cons for policy-makers designing health benefits packages.

Abstracts

ASSSESSING THE EFFECTS OF INTERVENTIONS THAT AFFECT BIRTH RATES

Joseph Millum, Jacob Zions, University of St Andrews; UK; National Institutes of Health

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STAKEHOLDER INVOLVEMENT IN THE COVID-19 PANDEMIC RESPONSE AND PREPAREDNESS PLANS: A SYNTHESIS OF FINDINGS IN 86 COUNTRIES

Julia Abelson*, Marcela Velez, Lydia Kapiriri, On behalf of the GPSet. M Master University (CAN)

Background The importance of stakeholder involvement in priority setting has been recognized in theoretical and empirical literature; however, there is a paucity of evidence reporting on stakeholder involvement in planning the response to public health emergencies. The COVID-19 pandemic provides an opportunity to explore how stakeholders are involved, and which groups are most engaged in these processes.

Methods This study is part of a global documentary analysis of COVID-19 national response plans. We assessed the degree to which pandemic plans from a sample of 86 countries adhered to twenty quality indicators of effective priority setting included in the Kapiriri & Martin’s framework. One of these is stakeholder involvement, viewed to enhance the legitimacy and acceptability of policy decisions by incorporating the interests of affected parties, and to enhance fairness through the inclusion of a range of values. We extracted information about individuals and institutions involved in the development of the plans, and any explanation of their level of involvement or contribution.

Results Overall, 68 countries reported stakeholder involvement in the development of COVID-19 response plans. Most of these plans were led by the ministries of health in each country. Eighteen plans briefly described the engagement of representatives from different health-related government organizations, forty-five countries mentioned the involvement

UNDERSTANDING PATIENTS’ VIEWS AND EXPERIENCES OF NHS SERVICES IN THE CONTEXT OF THE EVIDENCE-BASED INTERVENTIONS (EBI) PROGRAMME IN THE ENGLISH NATIONAL HEALTH SERVICE

Josie Morley*, Leila Rooshenas, Nicola Farrar, Carmel Conifrey, Amanda Owen-Smith, William Hollingworth. University of Bristol; UK

Objective New evidence about existing health technologies can raise questions about the benefits of continued provision. It may be possible to stop or reduce the technology use in people where benefit may not justify health system costs. The EBI programme was introduced in the English National Health Service (NHS) in April 2019. The programme provides guidance for local health system managers to stop or reduce certain procedures where evidence indicates limited or no benefit (for some or all patients). The aim of this study is to investigate patients’ understanding and experiences of care for symptoms where access to procedures may be constrained by the EBI programme.

Methods This is a qualitative study based on case study design. The data collection methods planned are semi-structured interview(s) with patients who are potential candidates for three case study procedures from the EBI programme. Alongside this, audio-recordings of these patients’ clinical consultations will be collected, with a focus on how treatment options are discussed. Data will be analysed thematically, using the constant comparative approach.

Results and Discussion A methodological framework is presented for assessing interventions that affect birth rates. This framework is based on a taxonomy of methods used for assessing the effects of interventions that affect birth rates. These methods were then evaluated for logical consistency, utility, and fit with defensible ethical principles.
of stakeholders from sectors other than health (e.g., transportation, finance, trading, international affairs); and seven countries reported detailed information about approaches used to involve stakeholders, as well as different stakeholder groups engaged from academia, medical organizations, religious institutions, or citizen groups.

Discussion In all reviewed plans, stakeholders were dominated by national government and expert representatives from the health sector. Direct involvement of citizens, community or patient groups was recorded in only a few plans. This low level of public participation may be related to the urgency with which plans were developed.

Background The Sustainable Development Goals (SDGs) aim to reduce Neonatal Mortality Rate (NMR) to 12 deaths per 1000 live births by 2030. Although India has made substantial progress in the last few decades in improving child health, achieving NMR targets remains a challenge.

Methods We conducted an overview of Systematic Reviews (SRs) published in the last three years which evaluated health systems (HS) interventions to reduce NMR. We searched two electronic databases and used the Cochrane Effective Practice and Organisation of Care (EPOC) classification to define HS intervention. Two reviewers independently conducted screening, full-text evaluation, data extraction and quality assessment (through AMSTAR-2). Disagreements were resolved by consensus. A narrative synthesis was conducted.

Findings We identified 20 SRs and two overviews of SRs meeting eligibility criteria. About half (n=10) of the SRs appraised were of critically low confidence as per AMSTAR-2 Criteria. Evidence on HS interventions was available for delivery arrangements domain (n=12, 54%), implementation strategies (n=9, 40.9%), one SR on multi-component interventions and none on governance and financial arrangement interventions. Community-based programmes of newborn care (1 SR, 5 studies), home visits by community health workers (1 SR, 9 studies), inter-professional education to healthcare providers (2 SRs, 20 studies), community mobilisation (1 overview, 7 studies), training in emergency obstetric care (1 overview, 5 studies) were found to decrease NMR. Interventions like self-management using home-based records (1 SR, 2 studies), targeted client communication via mobile (1 SR, 4 studies), hospitalisation in single family rooms vs common bay rooms (1 SR, 7 studies), clinical practice guidelines (1 SR, 5 studies), clinical incident reporting (1 SR, 4 studies) were reported to not have any significant impact on NMR.

Conclusion The overview identified HS interventions which might be used to decrease NMR although many SRs were of low quality. There is a need for more high quality updated SRs which can inform policy and practice to achieve the NMR SDG.

When people have equal claims to a non-divisible good, such as a life-saving drug or ventilator, a lottery procedure is sometimes used to ‘break the tie’ and determine who receives the good. However, within the context of healthcare resource allocation decisions, a lottery seems to do much more than provide a unique tie-breaking mechanism: it accounts for considerations of equal moral worth, promoting distributive fairness by providing equal chances to potential recipients, and procedural fairness by ensuring impartiality and transparency in the allocation decision. The so-called lottery principle, then, appears to be an important principle among other consequentialist and non-consequentialist principles, such as capacity to benefit, life-years saved, and severity, that ought to be considered when making resource allocation decisions.

This talk explores the consequences for moral deliberation of taking the lottery principle seriously as an expression of these values, and raises questions about its typical role as the last principle among many when deciding how to distribute scarce resources. The talk will explore questions such as how we ought to think about the lottery principle and its role within typical principilist decision approaches, such as balancing and lexical ordering, and how the relevance of the lottery principle may vary depending on the type of scarcity motivating the allocation decision, for example, when allocating ICU resources during a pandemic and prioritizing high-cost health care technologies. What constraints, if any, ought to be placed on the use of lotteries in these different contexts? While clarifying the role that the lottery principle might play, we conclude that, depending on the consequences one is willing to accept, the lottery principle should play either a larger or more restricted role in allocation decisions than is generally held.