boundaries and for highlighting where potential efficiency gains may lie.

Methods A global survey was conducted by WHO in 2020/2021 and coordinated through WHO regional and country offices with respondents frequently collaborating with members of relevant national/subnational health insurance/benefit package organizations. Health benefit package information was answered for a country's largest public-sector-financed benefit package. To develop the survey, relevant experts in health category areas at WHO were consulted to identify four proxy interventions ranging from simplest and least resource intensive to most complex and most resource intensive and covered 37 different intervention categories. The data was analyzed descriptively to evaluate coverage patterns among countries from different geographic regions, income groups and arrangement of health financing schemes.

Results The results provide a detailed picture of the nature of benefit packages with regards to the inclusion of interventions that can be considered non-cost effective. We also observe a preliminary gradient of coverage with fewer lower-middle-and low-income countries reporting inclusion of high-cost interventions in their benefit package. This work seeks to fill the gaps in the knowledge base, and highlight country-specific coverage decisions regarding the inclusion of non-cost-effective services, with an implication for affordability. Future work should understand how the affordability and other criteria link with decision-making, which can help countries design packages for UHC.

167:poster TRUSTWORTHY RESOURCE ALLOCATION IN HEALTH: PROMOTING FAIRNESS BY MITIGATING UNJUST USE OF POWER

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10.1136/bmjgh-2022-ISPH.60

Objective During the last decades a vast body of literature has emerged on how to promote fair resource allocation of health resources (1-5). Accordingly, a broadly held view stresses the importance of achieving legitimacy in health prioritization to build trust, including processes based on reasonable values, transparency and inclusion (6). In this piece, we discuss how the reverse also holds, i.e, already established trust in existing institutions promotes conferred legitimacy in health resource allocation. As a consequence, we argue for a shift of perspective on what is required to justify fair priorities; from promoting legitimacy through fair processes to establish trust based on mitigation of unjustly distributed and implemented use of powers.

Method This paper is based on theoretically and empirically informed reflections.

Results Findings from the Comparative Covid Response study, suggest that not only is ' trust in a nation's public health system…contingent on the specifics of each country's institutional arrangements', but also that '(t)rust in official advice correlates with trust in government'(7). These observations support our argument that placing in trust in difficult health priority settings to be fair, depends on the country's institutions and correlate with existing, supportive trust in government. When such trust is lacking, policymakers can establish it by mitigating unjust use of powers. Based on an analytical approach to power, we suggest a reconceptualization of fair priority-setting that can promote this crucial trust.

Discussion Our conclusion has substantive implications for health priority-settings and health technology assessments: When trust in decision-making authorities and/or institutions is absent, organizing decisions-making processes according to frameworks for achieving legitimacy 'in isolation' from how the society is otherwise organized, is not sufficient for decision-making authorities to achieve fair priority settings. Policy-makers must also address and mitigate socially unjust implementation of powers to justify health priorities as 'fair'.

104:oral SHOULD THE ASSESSMENT OF SEVERITY HAVE A 'PANDEMIC-PREMIUM'?

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10.1136/bmjgh-2022-ISPH.61

The assessment of severity plays an essential role to conceptualize ideals about equity in several distributive theories and in mid-level operational principles in a number of healthcare jurisdictions, like Sweden, Norway and The Netherlands. Exactly how severity should be assessed is a matter of dispute, and it has been observed that several central issues concerning underlying rationales and operationalization are unresolved. One aspect, raised by the ongoing pandemic, but largely unanalyzed is how severity of a pandemic, like covid-19 should, be assessed. Within the ongoing Norwegian project SEVPRI, Horn et al made an interesting analysis of the severity of covid-19, raising several issues that do not seem to be fully covered by the Norwegian perspective on severity – and I would say generally so. One such issue is the indirect effect a pandemic has even for patients suffering mild disease, in terms of potential spread of disease to patients that will suffer individually severe conditions.

In this talk I will explore whether the assessment of severity should take into account indirect effects in a pandemic and give a 'pandemic-premium' even to a mild condition, given the risk of spread and hence potentially severe consequences for other people. By comparing patient-populations where we in both cases effectively can avoid development of severe disease, in one case by treating people with mild disease and in one by treating people with severe disease, I will argue that we have a prima facie reason to either include a pandemic-premium to severity or add a further pandemic factor to consider. I will further explore how such a pandemic-premium should (and should not) be interpreted and explore some pros and cons of such a premium.

86:oral EQUITY IMPACT OF A PACKAGE OF INTERVENTIONS ADDRESSING INFECTIOUS DISEASES IN ETHIOPIA (WORK IN PROGRESS)

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10.1136/bmjgh-2022-ISPH.62