

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-ISP.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-ISP.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-ISP.62

Background Inequalities in the health and non-health benefits of public health interventions are a key challenge on the path to universal health coverage, particularly in LMICs. The design of HBP creates an opportunity in selecting interventions through established criteria. A quantitative analytic method was employed for integrating the distributional health and financial protection impact during the prioritization of interventions.

Methods Data on average health benefits, costs, disease prevalence, and population size were extracted from the GBD and latest Ethiopian essential health service package (EHSP) database, survey, and published sources. Benefits were distributed across quintiles using a combined adjusted risk of disease prevalence and coverage, with the latter used to distribute total costs. For each intervention (30 in total), a 95% target coverage (applied to current coverage vs. to the gap in coverage across quintile) was analyzed. Inequality and social welfare indices, and financial protection metrics were estimated.

Results Twenty-four interventions were found to improve population health and reduce health inequality, 4 interventions to reduce population health and increase health inequality, and 2 interventions to improve population health and increase health inequality. In the case of the latter two, social welfare analysis using inequality aversion parameters ($\alpha=10$) revealed that the health benefit outweighs the negative impact of health inequality.

Overall, the selected EHSP interventions provide 0.021 HALE per person in Ethiopia, with 0.034 (32% in the poorest) and 0.01 (9%) HALE gained in the richest. Similarly, a total of 76,726 cases of CHE were averted, with 46,123 cases in the poorest and 15,151 cases in the richest.

Conclusion We found that improving access to the EHSP by reaching the uncovered population groups across each income group improves health equity; however, adding incremental coverage to existing coverage amplifies the existing health inequality more.

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'WICKED' PRIORITY-SETTING CHALLENGES: LIQUID BIOPSIES FOR CANCER SCREENING

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10.1136/bmjgh-2022-ISP.H.63

GRAIL has created a liquid biopsy [blood] test called 'Galleri' to screen for fifty different very early cancers. Widespread use of the test could save 100,000 lives per year in the US from a cancer death at a cost of \$950. Grail recommends annual screening for everyone over age fifty, plus screening for anyone at elevated risk for cancer related to genetic, environmental, or behavioral factors. That represents 100 million individuals in the US at a cost of \$95 billion annually. I argue that such an expenditure should be a low priority item, not warranted for both reasons of justice and financial prudence. The cost per life saved would be \$950,000. No American insurance company or European government would likely see that as 'high value' care, given that 99% of the tests each year would be negative.

This is a 'wicked' challenge because every proposed allocation would create a different mix of injustices. If these costs were simply added to the cancer budget, we risk the injustices of 'onco-exceptionalism.' If these costs were subtracted from

the US cancer budget of \$211 billion, most metastatic cancer care (targeted therapies) would have to be foregone. If family history alone determined elevated cancer risk, younger individuals at elevated risk for cancer related to complex, polygenic risk factors would be denied this screening at social expense (and risk premature death). Whole genome sequencing could identify those individuals at a one-time cost of \$500 billion, still requiring identifying a risk cutoff. Imagine the complexity of identifying environmental carcinogenic risk factors significant enough to justify the Galleri test. Imagine the publicly perceived injustice of paying for Galleri for smokers and sun-worshippers. I argue that a process of rational democratic deliberation is needed to achieve 'rough justice' regarding the screening use of liquid biopsies.

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WITHDRAWING OR WITHHOLDING TREATMENTS IN HEALTH CARE RATIONING DECISIONS: AN INTERVIEW STUDY

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10.1136/bmjgh-2022-ISP.H.64

Objective As more new- and high-cost treatments become available, there will be a greater need to decide whether the healthcare should withdraw and withhold these treatments from patients or not. When rationing health care, a commonly held view among ethicists is that there is no ethical difference between withdrawing or withholding medical treatments. This view has been questioned with reference to the discrepancy between active- and passive acts, or implicit promises, and does not generally seem to be supported among practitioners. Our objective was to explore physicians' and patient organization representatives' experiences- and perceptions of withdrawing and withholding treatments in a reimbursement priority setting.

Methods Fourteen semi-structured interviews were conducted with Swedish physicians and patient organization representatives from areas with high influx of new treatments, such as oncology, hematology, and neurological diseases, and were analyzed using a thematic analysis.

Results We identified eight different themes which demonstrate relevant factors when withdrawing/withholding treatment: patients' need of treatment, treatment effect in relation to alternative treatments, patient-professional communication, patient-professional relationship, healthcare responsibility, ethical values, professional support, and reimbursement system.

Discussion We find that practitioners perceive it to be a clinically and ethically significant difference between withdrawing and withholding treatments. We expand on the previous research as we find important ethical values among practitioners, such as perceiving it to be more important to make individual assessments for patients with previous access to treatments than to withdraw it to uphold patient equality. We also identify potential strategies to handle this situation practically. Such strategies could be to: have agreements between the physician and patient about potential future treatment withdrawals, evaluate the treatment's effect, and to provide guidelines on a national level.