LESSONS FROM THE U.S. EXPERIENCE WITH REGULATORY ANALYSIS

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In the United States, for major regulations benefit-cost analysis has been required for over 40 years, and distributional analysis has been required for over 30 years. The impacts of these regulations typically range from over $100 million to well over $1 billion (USD) annually. They address public health across numerous policy areas, such as environmental quality and transportation, workplace, and food safety. As the focus of UHC broadens to include interventions outside of the health care system, benefit-cost analysis is likely to be increasingly useful to capture the full range of health and non-health impacts and to understand how these impacts are distributed across the advantaged and disadvantaged. This presentation will discuss what we have learned about the application of benefit-cost analysis and distributional analysis across sectors and the usefulness of the results for decision-making in the U.S., and the implications for the use of these analytic methods globally.

EMOTION REGULATION AS PROTECTIVE FACTOR ON HEALTHCARE WORKERS’ MENTAL HEALTH DURING THE COVID-19: A LONGITUDINAL STUDY

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Introduction Healthcare workers usually deal with several risk factors that make them prone to some psychological problems, such as anxiety, depression, burnout, or even PTSD. During the COVID-19 pandemic, this situation worsened, so many studies were conducted to highlight the impact of the pandemic on healthcare professionals’ mental health. However, just a few of them focused on vulnerability and protective factors. The present study aimed to explore the role of emotion regulation processes on healthcare workers’ mental health.

Methods A longitudinal study was conducted with Spanish healthcare workers sample (n=57). Data were collected two times: t1 was assessed during the first wave of COVID-19 in Spain (April-May, 2020), and t2, two months later. Symptoms of depression, PTSD, and emotional exhaustion were assessed as symptomatology, whereas demographics, job conditions, and trait and state emotion regulation variables were collected as predictive factors.

Results Regression analyses showed that participants with dysfunctional beliefs about sharing and expressing emotions, higher self-criticisms, suppression, negative emotions, lower levels of self-acceptance and reassuring toward themselves, and a lack of the ability to relax in their leisure time in t1 experienced higher levels of depression, PTSD, and emotional exhaustion in t2, controlling for baseline levels. Moreover, results also pointed out a significant decrease over time in self-support and reappraisal and a significant increase in lack of empathy and having a distant attitude toward others.

Discussion Our results suggest that some emotion regulation processes, such as acceptance, self-reassuring, and being able to relax in leisure time could be relevant in the prevention of psychological problems among healthcare professionals. Practical implications of the results will be discussed as these results may help to design psychological intervention programs and promote healthy job conditions that enhance better mental health not only in a critical context but also in their daily work.

CRITERIA FOR PRIORITY SETTING IN THE COVID-19 PANDEMIC PLANS: A GLOBAL COMPARATIVE ANALYSIS

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Background During the COVID-10 pandemic, governments worldwide were faced with priority setting challenges as the resource needs outpaced the available resources. Explicit criteria and ethical principles are recommended since they improve the consistency, transparency and the fairness of the priority setting and resource allocation processes.

Objectives To identify the criteria and the degree to which COVID-19 pandemic plans included explicit criteria, including equity considerations.

Methods We retrieved and reviewed COVID-19 pandemic plans from a sample of 86 countries from the six WHO regions. We abstracted information on criteria and equity considerations, from each of the retrieved reports. We conducted comparative analysis of the criteria that were abstracted between regions and the priority setting criteria discussed in the literature.

Results Only 32% (n=28) of the sampled countries identified explicit criteria and guiding principles in their pandemic plans. The most common criteria identified included: disease burden, severity, health sector capacity (in low income countries) and justice or equity. Several plans explicitly identified equity as a criterion, while other plans identified varied groups of vulnerable populations which should be prioritized including: those at risk for severe disease, risk of infection or risk of spreading the disease; immigrants/refugees, sexual minorities.

Discussion and Conclusion The limited number of countries that included explicit PS criteria and equity considerations in their pandemic plans, highlight a need for PS researchers and policy makers to collaborate on how to meaningfully integrate these aspects into their pandemic plans. However, the documentation of the criteria is just an initial step. There is a need for studies that empirically examine the criteria which were actually implemented during the response phase of the pandemic.

WAS THERE ALIGNMENT BETWEEN INTEGRATING PRIORITY SETTING AND USE OF THE WHO DISEASE PANDEMIC PLANNING FRAMEWORK IN THE NATIONAL COVID-19 PLANS?

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Background During previous disease outbreaks, the World Health Organization developed a framework to guide national pandemic planning. The degree to which this framework
supported the development of the current COVID-19 pandemic planning is not well understood. While there are opportunities for integrating priority setting in the four stages of the WHO pandemic planning framework, the degree to which its use supported countries to include priority setting in their plans has not been assessed.

**Objective** The purpose of this paper is to discuss the degree to which a sample of countries that used the WHO pandemic planning framework when developing their COVID-19 pandemic plans integrated priority setting and resource allocation in their plans.

**Methods** We retrieved and reviewed a sample of 86 COVID-19 pandemic plans from the six- WHO regions. We abstracted information on the degree to which they included quality indicators for priority setting. We also identified plans that explicitly mentioned that they based their plans on the WHO framework. We analyzed any alignment between the use of the framework and the inclusion of priority setting, further analysis focused on the aspects of priority setting that were included, and their alignment with the phases of the WHO framework.

**Results** Preliminary analysis indicates that only 19 countries reported to have used the WHO framework, most of these countries are from the AFRO-, EMRO- and SEARO regions. There was limited alignment between the countries that used the framework and those that integrated PS in their plans. This is a missed opportunity which could have been mitigated by integrating PS in the four phases of the WHO pandemic planning framework. This would extend and strengthen integrating PS in pandemic planning.

**Conclusions** We identified that citizens’ rationales to prioritize technologies to be publicly funded depend on the patient’s characteristics, type of disease, type of technology, and features of the health system. Those arguments and rationales for prioritization are coupled and founded on discussions about social justice from egalitarian, utilitarian and Rawlsian approaches.

**Background** Citizen participation in health policy decision-making is an issue of global interest. In Colombia, since 2015, a law ordered the Ministry of Health to establish a technical-scientific and participatory procedure to determine services and technologies that should not be publicly funded. The objective of this research was to explore and understand what factors and rationales influence Colombian citizens’ perceptions about which technologies and services should be prioritized to be publicly funded?

**Methods** A sequential mixed-methods study. In the qualitative case study, we collected information through semi-structured interviews with 46 citizens belonging to five groups (i.e., plain citizens, patients, health workers, healthcare managers, and health policymakers). Interviews were audio-recorded and transcribed, with thematic analysis conducted of all transcripts.

**Results** Eight themes explain the citizens’ rationale to prioritize health technologies or services that the Colombian health system should publicly fund. Those were: 1) coverage depends on the socio-economic conditions of the person; 2) prioritize technologies supported by evidence of efficacy; 3) coverage should depend on the patient’s necessity and prescription of the doctor; 4) technologies or services that improve quality of life should be publicly funded; 5) coverage depends on the vulnerability of the person; 6) instead of general rules about inclusion/exclusion, each case need to be analyzed; 7) all technologies and services should be covered because is better spend the money in patients needs than in corruption, and 8) all technologies and services should be covered and the health systems should not consider any exclusion.

**Conclusion** We identified that citizens’ rationales to prioritize technologies to be publicly funded depend on the patient’s characteristics, type of disease, type of technology, and features of the health system. Those arguments and rationales for prioritization are coupled and founded on discussions about social justice from egalitarian, utilitarian and Rawlsian approaches.