

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.

66:oral

CITIZENS' RATIONALES ABOUT HEALTH TECHNOLOGIES AND SERVICES THAT SHOULD BE PRIORITIZED TO BE PUBLICLY FUNDED BY THE COLOMBIAN HEALTH SYSTEM

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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.

79:poster

TREATMENT OF CHILDHOOD PNEUMONIA IN ETHIOPIA: SUB-NATIONAL COST-EFFECTIVENESS AND EQUALITY IMPACT

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Objectives In this study, we explored strategies for upscaling coverage of Community case management (CCM) of childhood pneumonia across the eleven regions of Ethiopia. Our first objective was to estimate the sub-national cost-effectiveness of upscaling coverage of CCM. Our second objective was to explore the costs, health effects, and geographical inequality impacts associated with three scale-up scenarios promoting different policy-aims: maximizing health, reducing geographical inequalities, and achieving 90% universal coverage.

Methods We collected data through literature review and used Markov modelling to estimate sub-national cost-effectiveness. Health effects were modeled as life years gained and under-five deaths averted. Inequality impacts were measured by the GINI index applied to health. In scenario analysis we explored three different scale-up strategies: 1) maximizing health by prioritizing the regions where the intervention was the most cost-effective, 2) reducing geographical inequalities by prioritizing the regions with high baseline under-five mortality rate (U5MR), and 3) universal upscaling to 90% coverage in all the regions.

Results The regional incremental-cost effectiveness ratio (ICER) of scaling up the intervention coverage varied from 26 USD per life year gained in Addis to 199 USD per life year gained in the Southern Nations, Nationalities, and Peoples' region. Universal upscaling of CCM in all regions would cost about 1.3 billion USD and prevent about 90,000 under-five deaths. This is less than 15,000 USD per life saved and translates to an increase in life expectancy at birth of 1.6 years across Ethiopia. In scenario analysis, we found that prioritizing regions with high U5MR is effective in reducing geographical inequalities, although at the cost of fewer lives saved as compared to the health maximizing strategy.

Conclusions Our model results illustrate a trade-off between maximizing health and reducing health inequalities, two common policy-aims in low-income settings.