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DEVELOPING AND IMPLEMENTING A FRAMEWORK FOR PRIORITY SETTING IN HEALTH AND SOCIAL CARE IN SCOTLAND

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10.1136/bmjgh-2022-ISP.H.71

There is a move, internationally, towards greater integration of health and social care. In principle, integration reduces budgetary boundaries which can facilitate sharing of resources across health and social care. Part of the agenda is for local delivery organisations to alter the balance of care from acute to community environments. To facilitate this shift, against a background of increasing austerity, there is a need for robust processes for making difficult resource allocation decisions which meet the standards of disciplines such as economics, ethics, law and decision science. In 2014, the Scottish Government established 31 Health and Social Care Partnerships (HSCPs) acting as single commissioners to deliver this agenda.

The aim was to develop and implement an enhanced, multi-disciplinary framework for priority setting, for use by four HSCPs, and assess its impact on processes, decision-making and resource allocation.

Methods To develop the framework, a literature review was conducted. The findings from the review were combined with input from key stakeholders including, academics, local and national-level stakeholders. During implementation of the framework, Participatory Action Research was undertaken to explore how the framework functioned within HSCPs, to document how participants engaged with the framework and to consider how the framework could be adapted to an integrated institutional setting. Interviews were conducted before and after working with the framework.

Results The framework is underpinned by principles from economics (opportunity cost), decision-analysis (good decisions), ethics (justice) and law (fair procedures). Three sites worked through the process and made recommendations. Proposed recommendations include disinvestment and reallocations within budget areas. Despite challenges, stakeholders' views were that such a framework is required to move from resource allocations being based on historical budgets and service provision and encourages transparent decision making involving wider stakeholders. Increased pressure on resources has made such frameworks even more critical for decision making.

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SEVERITY AND EQ-5D: WHEN HEALTH STATE VALUE AND MORAL VALUE DIFFER

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10.1136/bmjgh-2022-ISP.H.72

Objectives An array of government white papers and scholarly works have raised concerns that a purely utilitarian (QALY-based) approach to health prioritisation is ethically inadequate. To accommodate this, various severity criteria have been

suggested and attempted operationalised in e.g. Norway, the Netherlands, Sweden, and recently the UK. However, what severity is remains elusive, and is an ongoing topic of debate.

Some empirical research has attempted to identify how the severity of disease plays a role, in addition to cost-effectiveness, when people make priority decisions. The definition of severity in these studies varies, but in most cases does not adequately quantify health state utility values and severity or rely on abstract numeric representations. These practices allow for misinterpretation.

This study aims to investigate whether people divert from QALY-maximizing strategies in priority setting DCE tasks based on individual-level TTO values for the states used in comparisons.

Methods Data collection is about to start. 500-600 participants will first be administered 10 EQ-5D-5L health states for valuation using a R/Shiny-based EQ-VT-equivalent cTTO task, with dynamic state selection to ensure substantial variation in elicited values. Using the same EQ-5D-5L health states, respondents will then be presented with a set of discrete choice tasks with varying degrees of discrepancy between utility maximisation and severity. The severity component will have different operationalisations. This way, we know the utility values associated with each health state without relying on a numeric representation of utilities.

Results The data collection will be completed by Q1 2022.

Discussion We hypothesise an aggregate inclination towards concern for the worse off, sacrificing some utility maximisation, and expect substantial between-respondent heterogeneity, both in the presence and strength of preferences for concerns other than utility-maximisation. Evidence of such inclinations may be informative when operationalising severity criteria in health priority processes.

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PRIORITY SETTING IN NORWEGIAN MUNICIPAL HEALTH AND CARE SERVICES: A CONTENT ANALYSIS OF POLICY DOCUMENTS

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10.1136/bmjgh-2022-ISP.H.73

Introduction Norway has a long tradition of open priority setting in health care services. However, the principles and instruments for priority setting have mainly been used in specialist health care. In 2017, an official committee was commissioned to evaluate if and how to adopt the three Norwegian priority-setting criteria – health benefit, resources, and severity – in the municipal health and care services. The aim of this article was to examine the arguments for and against implementing the current criteria in municipal health and care services, using documentary data from the ensuing political process.

Methods Data consisted of Norwegian policy documents discussing prioritisation principles for municipal health and care services: The Official Norwegian Report 2018:6 (green paper), the written consultation responses from the hearings, and the Report to the Parliament 38 (2020-2021) (white paper). The documents were analysed using a predefined conceptual framework where arguments were categorised by their level of abstraction and the degree of (dis)agreement with the recommendations in the green paper.