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

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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 form 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.

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

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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.

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

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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.

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Results Data suggested general agreement to use the same criteria in all levels of Norwegian health service. However, disagreement was identified when considering the lack of feasible implementation processes. Recurrent themes in the data were the municipalities' legal and financial lack of scope to set priorities under constraints, challenges regarding operationalising a supplementary physical, psychological and social mastery criterion, and prioritising in situations where the benefits are difficult to measure.

Discussion The many duties and responsibilities of municipal health and care make priority setting decisions more complex than in specialist health care. In summary, the Norwegian green paper on priority setting in municipal health and care services has presented a well-received recommendation. However, how to inevitably tackle the many complex, and sometimes wicked, prioritisation problems in practice remain unanswered.

81:oral EQUITY FOR ALL? A POLICY ANALYSIS OF PRIORITY TO REFUGEES AND ASYLUM SEEKERS' SEXUAL AND REPRODUCTIVE HEALTH IN NORWAY (2010–2019)

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Objective Migrants' health is conditioned by individual, social and structural determinants of health that are shaped by policies. Refugees and asylum seekers are of particular risk of sexual and reproductive health (SRH) issues, but few have studied whether and how their health is prioritized in policies. This study aims to assess how the SRH of refugees and asylum seekers is addressed in Norwegian health policies. Acknowledging that migration health is impacted by social determinants of health, this was given particular attention.

Methods A document review of relevant policies (2010-2019) on SRH and refugees and asylum seekers in Norway was conducted. Documents were analysed systematically in four steps, informed by the READ approach (Read, Extract, Analyse, Distil).

Results 14 policy documents were included. While migrants' health receives increased policy attention, this attention remains general in character. The national migrant health strategy (2013) was not followed by a specific policies or action plans. SRH issues of refugees and asylum seekers is not policy priority. This contrasts the decade long distinct policy priority and financial support to female genital mutilation (FGM) and forced marriage among migrants. FGM is seen as an area of concern across different policies on health alongside specific attention within violence polices. While social determinants of health and equality underpins general health policies in Norway, this was less prominent when polices discuss migrants and refugees' health, including their SRH. Addressing migrant health, including SRH and in particular FGM, was often presented as a matter of language problems, cultural barriers and harmful norms and practices. Other higher-level determinants, such as poverty and low education were rarely a focus in policies and in actions suggested for change.

Conclusion The SRH of refugees and asylum seekers is not a policy priority in migrant health policies nor in general health policies in Norway.

78:oral THE FAIR ALLOCATION OF SCARCE MEDICAL RESOURCES: A COMPARATIVE STUDY FROM JORDAN

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Objective Several studies have analyzed allocation strategies among different society groups based on 9 allocation principles; sickest-first, waiting list, prognosis, youngest-first, instrumental values, lottery, monetary contribution, reciprocity and individual behavior. Sometimes combinations, youngest-first and prognosis for example, can be considered. Our aim was to study the most important prioritization principles groups in Jordan.

Methods An online survey handling 3 situations of medical scarcity; (1) organ donation, (2) limited hospital beds during influenza epidemic, and (3) allocation of novel therapeutics for lung cancer, and a free comment option constituted the survey.

Results Seven hundreds and fifty-four responses were analyzed from five groups including religion scholars, physicians, medical students, health allied practitioners and lay people. The most important priority principle was 'Sickest-First' for the three scenarios among the surveyed groups, except for physicians in the first scenario where 'Sickest-First' and 'Combination-criteria' were of equal importance. In general, there were no differences between the examined groups compared to lay people in the preference of options for all scenarios, however physicians were more likely to choose the 'Combination-criteria' in both the second and third scenarios (OR 3.70, 95% CI = 1.62-8.44, and 2.62, 95% CI = 1.48-4.59; p-value = 0.00, 0.00 respectively), and were less likely to choose the 'sickest-first' as the single most important priority principle (OR 0.57, CI = 0.37-0.88, and 0.57; 95% CI=0.36-0.88; p-value = 0.01, 0.01 respectively). Out of 100 free-comments, 27 (27.0%) thought the 'social-value' of the patients should be considered, adding the 10th potential allocation principle.

Conclusion Our findings are concordant with literature in terms of allocating scarce medical resources. However, 'social-value' should be addressed when prioritizing scarce medical resources in Jordan, and probably other LMICs.

157:poster INTEGRATING HEALTH TECHNOLOGY ASSESSMENT AND THE RIGHT TO HEALTH IN SOUTH AFRICA: A QUALITATIVE CONTENT ANALYSIS OF SUBSTANTIVE VALUES IN LANDMARK JUDICIAL DECISIONS

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Objective Some have raised questions about potential tensions between health priority-setting and the right to health. South