Africa, which is moving toward HTA and also includes the right to health in its Constitution, is an ideal setting in which to explore whether HTA priority-setting and an existing rights framework can be mutually reinforcing. This presentation discusses the findings of a content analysis that explored whether a focus on case rulings as a source of substantive values can advance understanding of the relationship between a rights-based approach to health care and national HTA efforts.

Methods We conducted a qualitative content analysis of eight South African court cases related to the right to health. Deductive coding reflected the substantive value framework provisionally developed by the South African Values and Ethics (SAVE) project to inform HTA in South Africa. The focus of analysis was to identify instances in the court's judgment and related reasoning that identified, interpreted, or balanced the substantive values and considerations included in this framework.

Results All but one substantive value included in the provisional SAVE framework were identified in the reasoning of at least one judgment. Equity was the most commonly identified value by number of judgments, followed by budget impact. The reasoning for each case judgment was interpretable in terms of the SAVE substantive values. The judgments offer several lessons regarding the interpretation of high-level SAVE values that could be applied in HTA practice.

Discussion The methodology described here could be applied in other countries where HTA operates in the context of a right to health. If an HTA body is established in SA, researchers should continue to assess the relationship between HTA and the courts to understand how each institution influences the other.

125:oral WHAT MAKES AN ILLNESS SEVERE? SUBJECTIVE ACCOUNTS OF SEVERITY IN THE NORWEGIAN POPULATION

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Introduction 'Severity' is one of three priority-setting criteria in the Norwegian priority-setting system. How we interpret and apply these criteria have a direct impact on which interventions are available in hospitals–and especially so for high-cost interventions, where the severity of a condition is often the justification for implementing a particularly costly treatment. However, severity is a multifaceted and incompletely defined concept. Our aim is to explore what severity means to the general, so at to better inform decision-makers on how to apply the severity criterion.

Methods We used Q-Methodology to explore subjective views on severity in the population. We conducted focus group interviews across Norway and extracted statements from participants which will be used for a Q-sorting exercise: asking a second set of participants do what degree they agree/disagree with those statements. These results will be subjected to factor analysis, which will identify certain 'clusters of opinion'–or factors–on the matter of severity.

Results The project is on-going, but our findings thus far suggest that matters such as death and young age are generally considered to be severe. The most interesting finding, however, is perhaps that participants tend to consider severity as an entirely subjective concept: that severity cannot be defined on a general basis, and is subject to what each individual feels is severe in their situation. We will explore this further in the Q-sort.

Discussion For priority-setting criteria to be applied fairly and effectively, we need a thorough understanding of what they mean. Our findings thus far suggest that severity is a concept the Norwegian public finds particularly complex, and unfit to be defined on a general level. This might suggest that the current application of the criterion is unsatisfactory, if the priority-setting system aims to have a democratically legitimate foundation.

49:oral COST AND COST-EFFECTIVENESS OF PEDIATRIC ONCOLOGY UNIT IN ETHIOPIA

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Background Despite the recently increasing global initiatives for childhood cancer, most recommended interventions to improve survival of children with cancers in Low Income Countries (LICs) are classified as either low or medium priority in the recently revised Ethiopia Essential Health Service Package (EEHSP), due to the limitation of local evidence on cost and cost-effectiveness.

Methods We collected historical cost data for the pediatric oncology unit, and all other (eighty-six) departments in Tikur Anbessa Specialized Hospital (TASH) from 8 July 2018 to June 2019, using mixed (dominantly top down) costing approach, and provider perspective. The direct costs of the oncology unit, costs at other relevant clinical departments, and overhead cost share are summed up to estimate the total annual cost. We used data on health outcome from other studies to estimate the net utility gain (DALY averted) of running a pediatric oncology unit compared to doing-nothing scenario. We applied the 50% of GDP/capita as a willingness-to-pay threshold.

Results The annual total cost of running the pediatric oncology unit in TASH during 2018-2019 was USD 797,458 (USD 964 per treated patient). Drugs and supplies (33%), and personnel (32%) constitute a large share of the cost. Sixty two percent of the cost is attributable to Inpatient Department (IPD) services, with the remaining 38% of costs related to Outpatient Department (OPD) services. The cost per DALY averted is USD 461 (range USD 346 to USD 753 on the one-way sensitivity analysis) which lies below the threshold for 'cost effective' interventions (USD 477/DALY averted).

Conclusions The provision of pediatric cancer services using a specialized oncology unit is most likely cost effective in Ethiopia and with an additional benefit on equity and financial risk protection. We recommend for reassessing the Childhood cancer treatment priority level decision in the current EHSPE.