

that there are good reasons to deprioritize merely statistical harms. This is because, as I show in my paper, the notion of a ‘statistical victim’ is ambiguous between various interpretations. I draw a distinction between ‘anonymous victims’ and ‘merely statistical victims’. I defend this distinction on two grounds. First, I argue that it is normatively attractive. Anonymous victims are morally alike identifiable victims and unlike merely statistical victims. Second, I argue that preliminary psychological evidence shows that decision-makers in fact treat anonymous victims differently from merely statistical victims.

In the last part of my paper, I return to examples of health priority-setting and show what my view implies about these examples. It turns out that my view constitutes a middle path. In some cases it vindicates the preference for prioritizing identifiable persons over statistical persons while in others it condemns such a preference.

186:poster POVERTY DISCRIMINATION

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This paper examines a paradox arising in connection with an underexamined form of discrimination: socioeconomic discrimination. Recent evidence from the United States suggests that discrimination on basis of social class in health care delivery is common. Patients from poorer backgrounds, for example patients receiving care paid for by welfare programs, receive lesser quality care. Should such class discrimination be legally regulated?

It is generally believed that economically left- and right-wing convictions can unite in condemning paradigmatic forms of direct and indirect discrimination, e.g., race/caste/sex discrimination. However, we challenge this picture. We argue that it is difficult to condemn paradigmatic forms of direct discrimination and at the same time embrace the sort of economically regressive policies that in effect amount to indirect discrimination against the poor. This includes the myriad of policies which exacerbate unfair social determinants of health ranging from housing policies, infrastructure policies, education policies to health policy. Our argument appeals to the fact that each of the following three claims seem appealing:

P1. Paradigmatic discrimination should be prohibited by law.

P2. If direct paradigmatic discrimination should be prohibited by law, then so should indirect paradigmatic discrimination.

P3. If indirect paradigmatic discrimination should be prohibited by law, then so should indirect socioeconomic class discrimination.

However, together they entail a very radical claim:

C. Hence, indirect socioeconomic class discrimination should be prohibited by law.

C would allow for substantial litigation on health policy and social policy more broadly – in effect it would allow for many policies causing social gradients in health outcomes to be challenged. Our main aim is not to defend C, but to show that we need to respond to it in one way or another which for many will require significant revisions of their beliefs.

140:poster THE ETHICS OF GLOBAL COVID-19 VACCINE ALLOCATION

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Introduction Policies to increase global vaccine access involve HICs making ethically fraught tradeoffs between saving lives at home or abroad. Such policies should be justifiable to the affected populations. Yet there is little robust data on whether HIC residents endorse their countries’ policy choices. Most existing data asks highly simplified questions, without providing background on the ethical tradeoffs involved. These data do not capture the public’s informed views, giving policymakers limited guidance on how to craft international vaccine policy. This paper provides the first nuanced data on the informed views of a representative sample of the U.S. public about providing COVID vaccine to poorer countries.

Methods This study involved two interventions: a description of ethical arguments for/against providing vaccine to poorer countries and visual depiction of ethically relevant tradeoffs about providing vaccine to poorer countries at different time points in the US vaccination campaign. A representative sample of 4000 U.S. adults were surveyed, divided evenly into four arms: 1) arguments only; 2) tradeoffs only; 3) both interventions; 4) no interventions.

Results Across all four arms, people are more willing to donate vaccines than previously reported, with generosity increasing over time. 43% of respondents were willing to share at an early timepoint when supply was extremely limited, increasing to 54% and 71% at intermediate and current timepoints, respectively. Some specific variables (e.g., political affiliation, age, acceptability of masks) were predictive of willingness to donate and endorsement of specific arguments.

Discussion These data can guide policy about providing or keeping U.S. vaccine doses as the world navigates the effects of new variants and the potential need for booster shots in the coming months. Given high levels of willingness to donate, U.S. policy could have initiated global vaccine donations earlier and could be more generous currently.

105:oral CLINICAL PRIORITY SETTING DURING THE COVID-19-PANDEMIC – NORWEGIAN DOCTORS’ EXPERIENCES

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Introduction Although Norway had lower infection rates and fewer patients hospitalized during the first year of the covid-19 pandemic, measures taken to avoid anticipated pressure on health care involved hard priorities of patients and staff. How did doctors experience this situation? We studied doctors’ knowledge about, and adherence to, guidelines and regulations on priority setting, and whether the actual priorities were considered reasonable and justifiable.

Method 2316 members of a representative panel of doctors practicing in Norway received a questionnaire in December 2020. Data were analysed by descriptive statistics and regression analyses.

Results 1617 of 2316 (70%) responded. A majority reported familiarity with the official priority criteria, but not with the particular legislation on priority setting (the Priority Regulation/Prioriteringsforskriften), or the Directorate of Health's Guidelines for priority setting during the pandemic. 60-74% did not use guidelines for priority setting. 60,5% experienced that some of their patients got lower priority for treatment. Of these, 47% considered this medically indefensible to some/a large extent. We saw a significant difference between GPs, hospital doctors and private specialists in considering the lower priority indefensible: 42,6% (hospital doctors), and 57,8% (GPs). Regression analysis showed that increased age involved fewer claims of lower priority, controlling for age and workplace, while working in primary care increased the probability of considering the priorities medically indefensible, controlling for age and gender.

Discussion If priority setting in clinical practice is to proceed in accordance with priority setting principles and guidelines, doctors' familiarity with them must improve. Apparently, the clinical priority setting in response to the pandemic was considered medically indefensible by many doctors. One interpretation is that doctors have judged that the rationing of care went too far; another is that the society, including politicians, patients, and doctors, find it hard to accept rationing of care for particular patient groups.

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PRIORITY SETTING AND HEALTH RIGHTS LITIGATION IN LATIN AMERICA

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High- and middle-income countries in Latin America have taken important steps towards the recognition of the right to health and towards universal health coverage (UHC). In the last two decades, however, the same countries (e.g. Argentina, Brazil, Chile, Colombia, Costa Rica, Uruguay) have seen a sharp increase in rights-based litigation to demand access to medical treatments not covered by the state, and the region now has the highest proportion of rights-based litigation in the world.

As countries progress towards UHC, they have had to make difficult choices about how to prioritise limited health resources. Institutional priority setting (IPS) is crucial to ensure transparent, consistent, and fair decisions, particularly in a region facing multiple health needs. The litigation of health rights, however, can threaten IPS, equity, the financial sustainability of the system, and ultimately efforts to achieve UHC. (Although some commentators have suggested that litigation can play a role in advancing the right to health when existing policies fail to uphold this right).

In this paper I examine the case of Chile, a country that has recently joined the wave of rights-based litigation in Latin America. Despite having implemented three IPS schemes (Plan of Explicit Health Guarantees for health care, Ricarte Soto Plan for high-cost diseases, and High-Cost Drugs Committee

for cancer medicines), the number of litigations has risen from 23 between 2014-2018, to 87 in 2019. To date, 85% of these legal claims have received favorable rulings with costs to the state rivaling the budget of the mentioned IPS schemes. Drawing on local data, I discuss some causes that are common to the region, as well as particularities of the Chilean case: most litigation involve relatively new high-cost drugs (for cancer and rare/orphan diseases) not included in IPS plans, greater expectations regarding health care, and strong pharmaceutical lobby.

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PRIORITY-SETTING FOR EFFECTIVE PANDEMIC PREPAREDNESS: A CASE STUDY OF PRIORITY SETTING FOR COVID-19 IN THE WESTERN PACIFIC REGION

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Background There have been divergent approaches used by countries to curb and control the spread, impact and burden of COVID-19. While priority setting – defined as decision-making about the allocation of resources between competing claims of different services, populations and elements of care – is recognized as critical for promoting accountability and transparency in health system planning, its role in supporting rational, equitable and fair pandemic preparedness planning is less well understood. Our multi-country project investigates the effectiveness of priority setting for pandemic preparedness planning. This study aims to describe how priority setting guided the COVID-19 responses implemented in the sub-set of countries in the Western Pacific Region.

Methods Guided by the adapted Kapiriri and Martin Framework, we purposively sampled a subset of countries in the WHO Western Pacific Region (WPRO) and undertook a critical document review of national-level pandemic preparedness plans. A pre-specified, validated tool guided data extraction on twenty quality parameters of PS. A critical synthesis was completed.

Results Nine plans were included (41% WPRO countries), including: Papua New Guinea, Tonga, Philippines, Fiji, China, Australia, New Zealand, Japan, and Taiwan. There was evidence of strong political will to quickly and effectively combat the pandemic. With 8/9 countries being islands, an emphasis on securing borders was reflected in the plans. A limited number of quality indicators of effective priority setting were described. Most commonly, plans described resource needs (n=8), stakeholder engagement (n=8), and responsibilities of legitimate institutions (n=7). Consideration of health inequalities, fair financial burden, or public engagement/acceptance of priorities was not evident in any plans.

Discussion This project advances understanding of how priority setting has been used in the WPRO region to support COVID-19 responses. It provides a basis for examining the relationship between effective priority setting for pandemic preparedness and country-level outcomes in future work.