COVID-19 VACCINE PROCUREMENT STRATEGY IN THAILAND: POLITICAL ECONOMY PERSPECTIVE

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The availability of COVID-19 vaccines is gradually changing the world, allowing countries to combat the pandemic using an offensive rather than defensive approach. The decision to procure and manage the vaccines is influenced by a country's health system, its economic status, international politics as well as national interests. This study looks at this dynamic in Thailand through the lens of a political economy analysis to understand the distribution and influence of power and resources in procuring vaccines for an upper-middle income country.

Methods We conducted a document review and interviews with key stakeholders to gain insights into the health system and political economy implications of Thailand’s COVID-19 vaccine procurement strategies. The data was analysed using a framework developed by Fritz, Kaiser, and Levy in 2009 on political economy analysis focusing on structural, institutional and stakeholder-related factors.

Results Thailand had been successful in containing COVID-19, however, a proactive approach to planning and procuring COVID-19 vaccines was not employed. Thailand did not join the multi-lateral COVAX Facility, and instead relied on two manufacturers. It also pursued a vaccine security policy by changing the world, allowing countries to combat the pandemic using an offensive rather than defensive approach. The decision to procure and manage the vaccines is influenced by a country’s health system, its economic status, international politics as well as national interests. This study looks at this dynamic in Thailand through the lens of a political economy analysis to understand the distribution and influence of power and resources in procuring vaccines for an upper-middle income country.

Conclusion The results provide insights into the political economy implications of Thailand’s COVID-19 vaccine procurement strategy. The findings highlight the need for a more proactive and inclusive approach to vaccine procurement in Thailand.

Paving the Road for the Institutionalization of a National Priority Setting Mechanism to Advance UHC

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Introduction Rwanda, an East African country with a 12.9 million population, is committed to sustaining significant Government Pharmaceutical Organization, private hospitals, medical associations and the public among others. The study is at an early stage of analysis and results will be available in September 2021.

Conclusion The complexities of COVID-19 vaccine policymaking necessitate a nuanced, multidisciplinary approach. Political economy analysis can be a useful tool in informing the various stages of the policy making process such as agenda-setting, policy design, adoption, implementation and evaluation.
Health gains of the MDG era while tackling the emerging challenges including the COVID-19 pandemic. The past achievements were thanks to Rwanda’s universal health coverage (UHC) model, characterized by expansion of health service delivery at all levels, with emphasis on primary health care, and more than 85% health insurance coverage through the Community Based Health Insurance (CBHI). The challenge now for Rwanda is to ensure CBHI sustainability and coverage of more services, which requires both more resources mobilization and priority setting systems that maximize health outcomes within available resources. This paper was prepared to document and share the Rwandan experience of priority setting reforms for UHC.

**Methods** This is a policy analysis case study, describing the context, process, and key actors in the priority setting reforms for CBHI in Rwanda, using a policy analysis triangle by Walt and Gilson. Information was collected through observation and desk review.

**Results** The priority-setting reforms for UHC were dictated by the increasing pressure on the resource-constrained CBHI to cover more tertiary-level services. In 2019 stakeholders led by the Rwanda’s Ministry of Health and Rwanda Social Security Board (managing the CBHI scheme) started discussing how health-economic evidence can contribute to priority setting decisions for CBHI. After several meetings and workshops, the Government decided, through a ministerial instruction published in August 2021, to change the process of defining CBHI benefits packages, and established new criteria and an appraisal committee. In November 2021 a 3-days workshop was organized to develop 1-year implementation roadmap, after learning from other country’s experiences.

**Discussion** The initiation of Rwanda’s priority-setting reforms was characterized by Government ownership and stakeholder engagement. The next steps will require strong coordination, and long-term capacity building through learning by doing.

**Abstracts**

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**DESIGNING HEALTH BENEFIT PACKAGES FOR UNIVERSAL HEALTH COVERAGE – SHOULD COUNTRIES FOLLOW A SECTORAL, INCREMENTAL OR HYBRID APPROACH?**

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Countries around the world are increasingly rethinking the design of their health benefit package to achieve universal health coverage. Countries can periodically revise their packages by performing sectoral analyses, i.e. by evaluating a broad set of services against a ‘doing nothing’ scenario using a budget constraint. Alternatively, they can carry out incremental analyses, i.e. to evaluate specific services against current practice using a cost-effectiveness threshold. In addition, countries may employ hybrid approaches. This paper compares these approaches in terms of the nature of allocative inefficiencies, quality of analysis, political feasibility of reallocation decisions, and integrated health system analysis. Sectoral analysis is especially suited in contexts with large allocative inefficiencies in current service provision and can, in theory, realize large efficiency gains. However, it may be challenging to implement a comprehensive redesign of the package in practice. Incremental analysis is especially relevant in contexts where specific new services raise challenges to the allocative efficiency and sustainability of the health system. It may potentially support efficiency improvement, but its focus has typically been on new services while existing inefficiencies remain unchallenged. The use of hybrid approach may be a way forward to address the strengths and weaknesses of sectoral and incremental analysis.

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**MONITORING THE IMPACT OF HEALTH SYSTEM STRENGTHENING FOR MOTHER AND CHILD HEALTH IN GUINEA-BISSAU: FOCUS ON UNIVERSAL HEALTH COVERAGE REMOVES FOCUS FROM STAGNATING PERINATAL MORTALITY**

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Objective To investigate coverage of antenatal care (ANC) and facility births and perinatal mortality before and during the stepwise implementation of the ‘Integrated Programme for the Reduction of Maternal and Child Mortality’ (PIMI), a health system strengthening programme which included free care, health worker training and infrastructure rehabilitation in Guinea-Bissau.

**Methods** We used data from Bandim Health Project’s rural health and demographic surveillance system from three 24-months birth cohorts: pre-PIMI (2011-13), during PIMI’s pilot phase (2014-16) and its nation-wide full-scale implementation (2017-19); and two areas: pilot regions (PIMI since 2013) and scale-up regions (PIMI since 2017). Using generalized estimating equations, we compared service coverage (first/fourth ANC consultation (ANC1/4) and facility births) and perinatal mortality over time and across areas. We also assessed associations between perinatal mortality and cluster-level ANC4 and facility birth coverage.

**Results** Across the three cohorts, 23,828 births were included. Pre-PIMI, approx. 1/3 women obtained ANC4 and facility birth in both areas. ANC4 and facility birth coverage increased to approx. 1/2 in both areas. Relative increases were largest in the scale-up area for ANC4 (p=0.007 for same development), and comparable across areas for facility births (p=0.16). Perinatal mortality was around 8% pre-PIMI and did not decline over time. Higher cluster-level ANC4 (both areas) and facility birth coverage (pilot area) were associated with a tendency towards lower perinatal mortality pre-PIMI, but this association disappeared over time.

**Conclusion** While universal access to quality maternal and child health services is considered essential to improve maternal-perinatal survival, increases in ANC and facility birth coverage did not translate into reduced perinatal mortality. Hence, measures of health outcomes cannot be replaced by...