Methods We conducted a prospective cohort study from August 2014-2015 at Mnazi-Mmoja Hospital, Zanzibar. EPTB patients were interviewed for demographic and socioeconomic information and pre-diagnostic cost of EPTB was ascertained. Finally, regression analysis was used to identify factors predicting the high pre-diagnostic total cost for patients.
Results EPTB patients were predominantly children (35%) and young adults (50%); 55% were male. Average monthly income was US$ 136 with no significant difference by gender. The median total cost for all patients was US$ 98, mainly due to average indirect costs (65%). Around 58% of the patients suffered from catastrophic costs. On average, patients faced 67 days of reduced-productivity due to EPTB illness. Increase in average monthly income was the significant predictor of high total patient cost for all and male patients respectively, while increase in reduced working capacity led to a decrease in total cost for the female patients.
Discussion The calculated out-of-pocket and opportunity-costs caused significant socio-economic burden as compared to the developed-countries. Alarmingly, pre-diagnostic costs are linked with patients' ability to pay which highlights potential gaps in available UHC and a significant barrier to end-TB goals. The higher catastrophic-costs pushes the worse-off further into poverty and major barrier to achieve UHC. These findings highlight the need of affordable early interventions to tackle EPTB and avoid inequity by reducing socioeconomic burden.

119:poster ACCESS TO EFFECTIVE BUT EXPENSIVE MEDICAL TREATMENTS: AN ANALYSIS OF THE CONCEPT OF SOLIDARITY

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Objective Personalized medicine is an increasingly prominent approach in many disease areas, including oncology and rare (genetic) disorders, but is often associated with high costs. The development of effective but (very) expensive medical treatments leads to discussions about whether and how such treatments should be allocated in solidarity-based universal access healthcare systems. In such discussions, the concept of solidarity is often used, but considered elusive. What does it mean?
Method We have conducted a conceptual analysis of the concept of solidarity as it is used in the literature on the allocation and funding of expensive medical treatments.
Results In this presentation, we identify and discuss four uses of the concept of solidarity: 1) the assistance of patients in need, 2) the upholding of the universal access healthcare system, 3) the willingness to contribute, and 4) the promotion of equality. We distinguish normative and descriptive uses of the concept, and analyze the overlap and differences between the concepts of solidarity and justice. Our analysis shows that the various uses of the concept of solidarity point to different, even conflicting, ethical stances on whether and how access to effective, expensive treatments should be provided.
Conclusion Although the concept of justice may serve as the decisive principle in the allocation of healthcare resources, solidarity does have a role to play in discussions on funding of expensive medical treatments, requiring, for instance, that healthcare policies promote and maintain societal willingness to contribute to the care of others and the value of assisting patients in need.

170:poster PRIORITY SETTING ACROSS DIFFERENT LEVELS OF DECISION-MAKING: THE WAY FORWARD

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Background Priority setting involves the practice of ranking interventions in order of their importance. In principle, the same priority setting criteria may be used across all levels of decision-making in health care. This may include decision-making on the macro (cabinet and the health ministry), meso (resource allocation within hospitals and health trusts) and micro level (bedside rationing).
Objective The aim of this article is to present a systematic discussion of priority setting across different levels of decision-making. Should different criteria for priority setting apply at the different levels? How can we decide which criteria fall into which category? And what should count as a sufficient argument for having different principles at different levels?
Methods We present the current literature on the topic through a scoping review. We expand on the literature to suggest useful definitions of levels of priority setting and candidate reasons for significant differences between the levels.
Results We found that definitions and the suggested number of levels differ, but the most favoured approach was two or three levels of priority setting. We present descriptive differences between the levels and suggest what we believe are useful definitions of levels of priority setting. We further present and discuss candidate reasons for ethically significant differences between the levels with applications for priority setting.
Discussion We consider this article to be a first step towards a more rigorous approach to priority setting across levels of decision-making in health care. We recommend that the levels of priority setting are more consistently and comprehensively defined. We argue in favour of further systematic discussion of this topic in future and conclude that this topic should be unavoidable in further discussions.

182:poster THEORETICAL ASSUMPTIONS BEHIND THE COST-EFFECTIVENESS OF IVF TREATMENT

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In vitro fertilization (IVF) is a medical procedure in which an egg is fertilized outside the body before being placed inside a womb. Some countries have chosen to cover IVF through public spending, but there is usually a limit to the number of cycles being publicly covered. Ultimately, the willingness to public IVF-coverage will depend on its cost-effectiveness. Several attempts have been made to provide

cost-effectiveness analyses (CEA) of IVF, a surprisingly difficult task. The aim of this article is to examine the theoretical underpinnings for CEA of IVF-treatment. I argue that at least two theoretical questions must be answered. First, what is the desired outcome of an IVF? It could be to cure biological infertility, or to cure unwanted childlessness. The former may imply the latter, but not vice versa. Curing unwanted childlessness can be achieved by other means than IVF. However, curing biological infertility is also problematic, as many of those who require IVF to become parents do not have infertility issues. Other reasons, such as sexuality or not having a partner, can also be a driving force behind IVF. Depending on how we understand the desired outcomes of IVF, it may lead to different CEA-results. Second, who is the IVF treatment for? IVF treatment is quite different from the majority of medical treatments, given that it entails two lives rather than one. While the IVF-procedure concerns an existing individual or couple, the aim of the procedure is to procreate a new individual. Therefore, one needs to take a stance on whether the benefits of IVF-treatment belong to the pregnant woman, the procreated child– or both. Finally, I show that there is a high elasticity in the chosen philosophical assumptions behind any CEA of IVF-treatment.

99:oral RIGHTS PERSPECTIVE OF A DOCTORS' STRIKE IN KENYA

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Objective In December 2011 doctors employed by the government of Kenya in public service went on strike. The strike involved total withdrawal of all services including emergency lifesaving treatment. The strike went on for a period of six weeksThis research seeks to critically examine the strike from a rights perspective to determine any justification or lack thereof.

Methodology The study is based on desktop and library materials. It examined the circumstances and contexts of the strike to enable an understanding of the status of health services and the nature of the demands by doctors. The obligations of the medical profession and ethical codes and rules of conduct for doctors were examined in relation to the strike. The right to health as provided for in the Constitution of Kenya 2010 and international instruments were critically analyzed. The rights of doctors and patients were explored while obligations of the government, the doctors and patients were scrutinized.

Discussion Analysis of the reasons for the strikes and status of public health services revealed violations of the right of patients to health as provided for in the Constitution of Kenya 2010. From a rights perspective the doctors strike action was within their rights as provided for in the Constitution of Kenya 2010. However, harm resulting from suspension of emergency services provided an argument against moral justification of the strike.

Conclusion The doctors were within their rights to go on strike as provided for in the Constitution of Kenya 2010 and labour laws of Kenya. The government failed in their obligation to provide acceptable standard of healthcare considering the resources available. However, comprehensive justification of the strikes was difficult, considering the professional and ethical obligations of doctors to society and to patients.

144:poster QUALITY OF PANDEMIC PRIORITY SETTING IN THE U.S

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Priority setting during public health emergencies presents an enormous challenge for federal and state decision makers in the U.S.

Objectives We describe the degree to which U.S. priority setting adheres to established quality indicators and explore relationships between such indicators and states' demographic characteristics.

Methods Data includes the U.S. COVID-19 preparedness and response plan of January 2021 and individual state plans. Purposive sampling of 22 states from multiple geographic regions considered total population,% rural residents, income per capita, health ranking, and political leanings. State plans were sought online and using multiple contacts with state health and emergency preparedness departments.

We analyzed plans using a tool based on an established framework of quality indicators to evaluate priority setting, for example principles and criteria, stakeholder and public participation, publicity and accountability.

Results The national plan included 7 of 20 quality parameters, including attention to at-risk populations, a comprehensive list of resources and interventions to which priority setting would apply, publicity, and the use of (and efforts to improve) evidence for priority setting decisions. The US plan describes the importance of 'engag[ing] the American people' and various stakeholders to inform the federal response. Enforcement, accountability, incentives, and assessment of impact were not identified in the plan.

We obtained pandemic plans from 4 states and documents from 6 states that, while not explicitly labelled as pandemic plans, include priority setting. Analysis is in process; we expect to present results for 4-10 states.

Discussion The US plan's consideration of various scarce resources, public engagement, and equity concerns recognizes the disproportionate impact of COVID-19 among racial and ethnic minorities and low-income communities. However, its lack of accountability and assessment of impact on outcomes may hinder achievement of goals. Difficulty finding and obtaining state plans suggests a lack of publicity and transparency.

146:oral SETTING PRIORITIES FOR CONNECTIONS AND ACTIVITIES DURING A PANDEMIC

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