

111:oral DESIGNING A HEALTH BENEFITS PACKAGE FOR HONDURAS: FROM THEORY TO PRACTICE

¹Ursula Giedion*, ²Pamela Gongora, ³Natalia Jorgensen, ³Rodrigo Muñoz. ¹Coordinator CRITERIA Network of the Inter-American Development Bank and non-resident fellow at CGD; ²Health Economics Research Centre of the University of Oxford and consultant CRITERIA Network of the Inter-American Development Bank; ³Consultant CRITERIA Network of the Inter-American Development Bank

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Introduction Honduras is a LMIC with a fragmented health system with less than 100 US\$ per capita per year to meet its health needs. Under its commitment with UHC, the government decided to design one common health benefits package (HBP) for the population.

Methods The design of the HBP was carried out in five distinctive steps: i) The fundamental characteristics of the HBP (key goals, structure, scope, target population) were defined together with an interinstitutional team of the Honduran Ministry of Health and the Social Security Institute. ii) The universe of the potential candidates for inclusion were identified by taking advantage of previous work carried out in the country and the HBPs developed by the Disease Control Priorities Project. iii) Prioritization criteria (equity, efficiency and financial protection) and decision rules were discussed and operationalized. iv) A 'bottom-up' approach was used to cost the HBP with the current low coverage and with different targets of improved coverage levels. v) Fiscal impact analyses were elaborated and alternative expansion paths were discussed with the government putting forward ethical criteria on the road towards UHC.

Results The resulting HBP includes 74 essential health interventions. Honduras is currently allocating \$29 USD annually for the services included in the HBP while a 100% coverage would require an additional \$44 USD, an amount that accounts for over 50% the current health budget and that cannot be realistically reallocated from elsewhere. A progressive expansion path was suggested instead whereby marginal increases in the health budget would be allocated to the HBP. **Discussion** Designing a HBP is a multistep context-specific process that goes beyond the implementation of health technology assessment methods. It requires time intensive technical and participatory work, and substantial pragmatism to adapt the technical recommendations from the literature to the data and time restrictions on the ground.

200:oral HOW COUNTRIES AND GOVERNMENTS TACKLE THE COVID-19 PANDEMIC – AN ANALYSIS OF THE EFFECT OF COVID-19 INDICATORS ON COUNTRIES' STRINGENCY

^{1,2}Vera Pinheiro*, ^{2,3,4}João Vasco Santos, ⁵Jon Cylus. ¹Public Health Unit, ACES Arco Ribeirinho, ARS Lisboa e Vale do Tejo, Portugal; ²Public Health Unit, ACES Grande Porto VIII – Espinho/Gaia, ARS Norte, Portugal; ³MEDCIDS, Department of Community Medicine, Information and Health Decision Sciences, Faculty of Medicine, University of Porto, Porto, Portugal; ⁴CINTESIS, Centre for Health Technology and Services Research, Porto, Portugal; ⁵London School of Economics and Political Science

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Introduction The global spread of COVID-19 has led to a wide range of pandemic response measures, with great heterogeneity between countries, varying mostly in time and duration of implementation. The stringency level of measures was

based on different epidemiological and health services indicators. In this work, we aimed to assess the association between these indicators and the stringency level imposed by countries.

Methods We performed a retrospective observational and methodological study, using daily data on 22 EU countries between April and December 2020. The main outcome used was a composite indicator on the level of stringency of government response measures from the Oxford COVID-19 Government Response Tracker which comprises information on containment and health measures, economic response measures, health systems measures and vaccine policies measures. Lagged independent variables used were death rate, hospital bed occupancy rate, ICU occupancy rate and 14-day cumulative COVID-19 incidence. A panel data random-effects regression analysis was performed.

Results COVID-19 death rate showed the largest effect on the level of stringency of these EU countries, followed by ICU occupancy rate, hospitalization rate and COVID-19 incidence.

Discussion We show that epidemiological and health services indicators impacted the adoption of response measures to the COVID-19 pandemic differently. This highlights the different relative importance of incidence, death and pressure on health services when choosing between health and economic growth.

80:oral IS THERE SOMETHING SPECIAL ABOUT RARE DISEASES? EXAMINING SOCIETAL PREFERENCES FOR EXEMPTING ORPHAN DRUGS FROM COST-EFFECTIVENESS CRITERIA FOR REIMBURSEMENT

Vivian Reckers-Droog*, Lucas Goossens, Job van Exel, Werner Brouwer, Vivian Reckers-Droog. Erasmus School of Health Policy and Management, Erasmus University Rotterdam, The Netherlands

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Objectives Orphan drugs are increasingly available, but often do not meet cost-effectiveness criteria for reimbursement. Consequently, policymakers are regularly faced with deciding on exempting orphan drugs from these criteria, knowing that they do apply to non-orphan drugs. Our aim was to examine whether and, if so, why there would be societal support for such a waiver.

Methods We conducted a discrete choice experiment in a representative sample (n=1,172) of the public in the Netherlands. We elicited preferences for reimbursing a new drug for patients with a rare disease, whilst a similar drug would not be reimbursed for patients with a common disease for it being cost-ineffective. The circumstances were identical regarding patients' age, disease severity, health benefits, and treatment costs, but different regarding disease type and—in relation—patient number, budget impact, and health-insurance premium increase. After completing ten choice tasks, respondents explained why they had a consistent or varying preference for reimbursement. We applied random-intercept logit regression models and the Framework Method for analysing the data.

Results Of the respondents, 22% had a consistent preference for not reimbursing the orphan drug, because 'this was unfair to patients with a common disease', and 33% had a consistent preference for reimbursing it, because 'patients are entitled to access new drugs'. The remaining 45% had varying preferences and was more likely to prefer reimbursement when patients were aged >1 and <70 years, had mild disease severity, and benefited relatively well from treatment.

Conclusions Large part of the public would likely support exempting orphan drugs from standard cost-effectiveness criteria. However, our results indicate considerable preference heterogeneity and the preferences of many depend on patients, disease, and drug characteristics. The results provide insight into the circumstances in which offering a waiver to orphan drugs may receive public support and inform reimbursement decisions in healthcare.

121:poster **PRIMARY CARE PHYSICIANS AS A GATEKEEPER AND PATIENTS' AMBASSADOR: AN INTERVIEW STUDY IN ENGLAND AND JAPAN**

¹Yuri Hamashima*, ¹Amanda Owen-Smith, ²Tim Jones, ¹Joanna Coast. ¹University of Bristol; ²NIHR ARC West

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Background Gatekeeper is one approach to efficiently allocating healthcare resources in primary care. In Japan, there has been an ongoing argument that the absence of gatekeeping might have contributed to excess demand in specialist or hospital care. By contrast, general practitioners (GPs) in England have played the role of gatekeeper since the establishment of the National Health Service (NHS). This study investigated how primary care doctors in both countries manage patients' demands during the consultation while acting as a patients' advocate.

Method We conducted in-depth interviews with primary care doctors in England and Japan via an online videoconferencing platform or face-to-face between July and December 2021. We elicited participants' experiences and views about rationing and managing patients' demands in practice; hypothetical consultation scenarios were also used. Interview transcriptions were thematically coded and analysed in the original language. Emerging codes and themes were constantly compared to develop understanding and build analytic frameworks.

Results In total, 8 GPs in England and 15 primary care doctors in Japan participated in the interviews. Most UK GPs expressed their frustrations over the growing pressure to handle rationing by the NHS. They had to manage patients' expectations and offer alternative options when expecting a long wait or difficulty in accessing services within the NHS. Some of them shared the local guidance on referral during discussions with patients. By contrast, primary care doctors in Japan rarely mentioned their need to commit to priority setting. However, several physicians reported struggling to decline patients' requests for unnecessary care and tended to use implicit judgement criteria in the absence of an explicit gatekeeping system.

Discussion Although clinicians in both contexts struggled to manage patient demands, the presence of explicit gatekeeping seemed to increase the prominence of priority setting in practitioners' minds and give them an additional mandate for action.

122:oral **PRIORITY SETTING IN VACCINE ALLOCATION IN JAPAN**

¹Yuri Hamashima*, ²Satoshi Kodama. ¹University of Bristol; ²Kyoto University

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Background The COVID-19 pandemic highlighted the necessity of allocating limited healthcare resources both fairly and effectively. Like many other countries, Japan decided to set priorities for the distribution of COVID-19 vaccines. Prior to this, priority setting had not been common in the healthcare setting in Japan. Japan's vaccination programme was initiated in February 2021 and is carried out by local governments and social health insurers, following national guidelines which state that priority should be given to members of high-risk groups according to their age and clinical condition. We investigated how local governments in Japan apply this policy and how, through their websites, they describe it to local communities.

Methods We reviewed and analysed the official websites of 47 prefectures and 20 municipalities in Japan. The contents were reviewed to see (1) what priority framework they applied (2) whether municipal governments explained how priority was set and (3) how they implemented their policy. We also investigated how the terms 'priority' and 'fairness' were used on their websites.

Results Due to the limited supplies of vaccine provided by the central government, many local governments needed to set their own priorities within the framework provided by the government. Examples include Osaka City, which prioritised elderly people living in care homes. At least 40 prefectures decided to allocate vaccines first to their capital city. Kagawa prefecture decided not to announce which cities they allocated vaccines to, out of a sense of 'fairness'.

Discussion Although Japan achieved high vaccination acceptance in the short term, the government's guidance on priority setting for vaccines lacked specificity and it was unclear how important it was to follow their guidance. The government left many decisions to local municipalities and did not clarify the concept of 'fair allocation', leading to geographical inequalities in the distribution of vaccines.

210:oral **PROCEDURAL FAIRNESS AND UHC RESILIENCE: THE CASE OF HEALTH FINANCING REFORM UKRAINE**

Yuriy Dzhygyr*. Ukraine's Minister of Finance and Minister of Health

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Across the globe, the pandemic has struck social compacts no less than individual lives. Falling incomes and escalating healthcare needs have amplified public concerns over government choices in healthcare financing, stimulating new research on what could be realistically done to increase the perceived fairness of these decisions. This case study is part of a series of case studies contributing to development of guidance for policy makers on procedural fairness in health financing. The study examines applicability of the newly proposed criteria to the experience of the 2016-2017 health reform in Ukraine, focusing on the decisions of the Government to choose general taxation as the funding source for a newly established benefit package and the decision to replace a highly decentralized health financing system with a single-purchaser model.

The study is based on qualitative methods. Using a desk review, it examines the evolution of regulations and supportive documents, expert analysis and media content. This is supplemented by semi-structured interviews with the reform stakeholders, deliberately covering respondents with diverse opinions on the process and outcomes of the reform. The