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.

**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.

**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.

**Abstracts**

**Priority Setting and Health Rights Litigation in Latin America**

Bernardo Aguilera. Medicine and Science; Universidad San Sebastian; Chile

10.1136/bmjgh-2022-ISPH.11

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