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**WHAT DOES COVID-19 TELL US ABOUT APPROACHES TO PRIORITY-SETTING IN HEALTH?**Bridget Williams\*. *Center for Population-Level Bioethics; Rutgers University; USA*

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**Introduction** Given the devastating effects COVID-19 has had, many may think it is obvious that more should have been spent on pandemic preparedness and mitigation measures. But this would have required investment to be taken away from existing health problems to be put towards a problem that may arise in the future at an uncertain time. When the resources available for health are finite, priorities need to be determined. How does pandemic preparedness fit into current approaches to determining health priorities?

**Methods** Conceptual analysis of how pandemic preparedness work compares against other global health priorities, using a framework of three common factors in discussion of the ethics of health-priority setting: scale, cost-effectiveness and justice.

**Outcome** The present-orientation of standard conceptions of burden of disease estimates omits the potential burden from new pandemics, and the uncertainty of pandemics makes it difficult to include them in projections of global disease burden. The use of high discount rates and relatively short time horizons may lead cost-effectiveness estimates to under-value pandemic preparedness work. Whether pandemic preparedness is considered a priority from the perspective of equity depends on how well-off we expect future generations to be relative to the present, and the scale of future pandemic events. Finally, many of the actions to reduce pandemic risks happen outside of the healthcare system. This suggests a need for increased focus on approaches to priority-setting outside of healthcare, including in health research and government and institutional attention.

**Conclusion** The uncertainty and future-orientation of pandemic preparedness activities mean that this area of work doesn't easily fit into traditional approaches to determining global health priorities. Approaches to determining global health priorities need to adapt to enable comparison of stochastic, future-oriented issues to problems of existing health burden.

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**A MULTI-COUNTRY COMPARATIVE ANALYSIS OF PRIORITIZATION OF HEALTH RESEARCH IN SUB SAHARA AFRICA**

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**Introduction** This analysis was conducted to assess the prioritization of health research by governments of four countries in Sub Sahara Africa.

**Methods** This was a retrospective comparative analysis of secondary data on prioritization of health research and development in Kenya, Rwanda, Malawi and the Kingdom of Eswatini. Non-random sampling was adopted in the selection of the countries. Secondary data on financing of health and research; legal and policy environment; and public and private sector contribution to research between 2015 and 2019, were pooled and analysed for the sampled countries.

**Results** All four countries had allocations to health below 15% of the general government expenditures during the focus period. Malawi had the highest at 9.2 to 11.5%; Rwanda at 7.9 to 8.9%; Eswatini at 6 to 9.5%; and Kenya at 5.8 to 6.6%. The Gross Expenditure on Research and Development was below the recommended 2% of GDP in all the countries; 1.06% for Malawi; 0.8% for Kenya; 0.7% for Rwanda; and 0.27% for Eswatini. Most research was donor driven and funded. There were varied levels of non-financial investments in health research including laws, regulations, and institutions. Eswatini had laws on research.

**Discussion** Low allocations to health limit the budgetary fiscal space for health and health research. This limits government's control of the research agenda. Anchoring research in law and critical government instruments ensures elevated prioritization and visibility of research to the policy makers. It allows for better coordination and alignment of stakeholders to the national research priorities and country beneficence. Designating public institutions to coordinate and fund research demonstrates policy prioritization of research. Increased investments (financial and nonfinancial) in research signal governments' commitment and can attract more investments.

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**DECISION PROCESSES TO PRIORITIZE HEALTH INTERVENTIONS: THE EXPERIENCE OF MASI DEVELOPMENT AND IMPLEMENTATION DURING THE COVID-19 CRISIS IN PERU**Camila Gianella\*, Benjamin Castañeda, Veronica Montoya. *Psychology; PUCP; Peru*

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Covid-19 pandemic has unveiled the major weakness of health systems across the world, being the shortage of intensive care beds and mechanical ventilators in low- and middle-income countries to provide acute care to critically ill patients one of this. Research has pointed to structural factors like the high cost of trained healthcare workers, infrastructure, and supplies. The main drivers of the limited development of intensive care units (ICUs) in low and middle-income countries. Based on the systematization of experience of the development and implementation of a mechanical ventilator based on a manual resuscitator with telemedicine capabilities for patients with ARDS (MASI) during the COVID-19 crisis in Peru, this paper argues that regulatory frames, including frameworks for prioritization of health interventions, including health technology assessment processes, are critical to guarantee the timely implementation of life-saving technology. The paper describes the regulatory gaps and challenges faced during the three steps of MASI's development and implementation (prototype development, massive production, and technology transfer and implementation). MASI's experience shows the negative effects of the lack of established decision processes to prioritize health interventions (including technology purchasing) on the efficient and transparent use of resources during a sanitary crisis, and in general on health system performance. MASI's experience provides evidence on the importance of having systems to determine the value of health technologies and innovations to the health systems.