analysis involved assessing whether and how forcibly displaced people were prioritized in the COVID-19 national response plans. This was compared with the displaced populations identified in the host countries’ UNHCR Forced Displacement 2020 report.

Results Only five countries among 86 analyzed prioritized forcibly displaced people in their COVID-19 national response plans. Among the top ten forcibly displaced people hosting countries, Uganda was the only one with an explicit prioritization of this vulnerable group. Although Turkey, Colombia, and Germany account for nearly one-fifth (6.6 million) of refugees, asylum seekers and Venezuelans displaced abroad, none of the COVID-19 response plans of these countries prioritized these populations.

Discussion Few countries recognized forcibly displaced people as a vulnerable population in their COVID-19 response and preparedness plans. Governments may have incorporated actions and interventions for these vulnerable groups after publishing the COVID-19 response plans. It would be essential to evaluate the impact of this lack of prioritization on the health and wellbeing of these population groups.

Conclusion We found some emphasis on PS according to contextual factors. For instance, LMICs receiving international donations presented more detailed descriptions of resources required, plans for allocating resources and improving internal accountability. HICs more likely described stakeholder participation, mechanisms for public communication, and explicit PS processes. However, no country included all twenty parameters of PS.

Background The COVID-19 pandemic has imposed a burden on all health systems budgets and pushed policymakers to rapidly set priorities for resource allocation. This study aimed to identify quality parameters of priority setting (PS) incorporated in a sample of the national response plans.

Methods We reviewed a sample of COVID-19 national response plans from 86 countries across six regions of the WHO to assess the degree to which they included twenty quality indicators of effective PS. A quantitative descriptive analysis was used to explore the profile of PS according to independent variables.

Results The countries sampled represent 40% of countries in AFRO, 54.5% of EMRO, 45% of EURO, 46% of PAHO, 64% of SEARO, and 41% of WPRO. They also represent 39% of all HICs in the world, 39% of Upper-Middle, 54% of Lower-Middle, and 48% of LICs. No pattern in attention to PS quality indicators emerged by WHO region or country income levels.

As per the quality PS parameters, evidence of political will, stakeholder participation, use of scientific evidence/adoption of WHO recommendations were each found in over 80% of plans. Regarding the frequency of other parameters we found, description of a specific PS process (7%); explicit criteria for PS (36.5%); inclusion of publicity strategies (65%); mention of mechanisms for enforcing decisions, either for appealing decisions or implementing strategies to improve internal accountability and reduce corruption (20%); explicit reference to public values (15%); description of means for enhancing compliance with the decisions (5%).

Trade-offs abound in health care yet depending on where one stands relative to the stages of a pandemic, choice making may be more or less constrained. During the early stages of COVID-19 when there was much uncertainty, health care systems faced greater constraints and focused on the singular criterion of ‘flattening the curve’. As COVID-19 progressed and the first wave diminished (relatively speaking depending on the jurisdiction) more opportunities presented for making explicit choices between COVID and non-COVID patients. Then, as the second wave surged, again decision makers were more constrained even as more information and greater understanding developed. A similar pattern emerged in the third and fourth waves. Moving out of the pandemic to recovery, choice making becomes all the more paramount as there are no set rules to lean back into historical patterns of resource allocation. In fact, the opportunity at hand, when using explicit tools for priority setting based on economic and ethical principles, is significant. This paper focuses on how an explicit priority setting process can be applied both during a pandemic and in the aftermath as the pieces are being put back together. Differences in application relative to the given stage of the pandemic need to be understood so realistic expectations can be placed on those making the resource allocation decisions. In all cases, accountability must be upheld as a key objective even when timelines are seriously constrained and similarly explicit criteria must guide decision making in order to get the most in return for the limited resources available.

Over the last two decades, economic evaluation of health technologies has developed enormously, affirming its importance within the pursuit of efficiency in the management of health care systems. One concern that has been raised with...
health technology assessment (HTA) has been its impact on decision making. A key aspect of this has been the pursuit of increasingly sophisticated modelling and technical details at the expense of an oftentimes lack of appreciation of how decisions are made in practice. Here we suggest a mechanism by which HTA can be understood as an input into a broader framework for priority setting and resource allocation.

This paper starts with a brief introduction to what HTA is and how it can be robustly applied within the context of a Canadian provincial Ministry of Health process for assessing new technologies. Limitations of the impact of HTA specifically as a ‘one-off’ assessment process are identified and in response a framework is put forward clearly outlining how HTA can fit in a broader priority setting framework. The framework enables trade-offs to be made and thereby relies on both assessment of new services as well as reassessment of existing services.

In fact, the explicit framework, when applied at the macro level within a health system allows for the broadest trade-offs possible while ensuring the highest quality evidence available at a given time and in a given place is incorporated into the decision making process. In this process the concept of disinvestment is dealt with directly as is the notion of relative decision making. A key aspect of this has been the pursuit of consensus about which values should guide the decision making process. The policy stream represents the process by which alternative policies are generated and selected. HTA can be put forward as a solution to the ‘problem’ identified above, along with ‘Proof of concept’ HTA projects to test the proposed policy. This stream can be influenced by local capacity; availability and quality of data sources; role of academic institutions in priority setting, etc. The politics stream explains how favourable macro-level political conditions could help set the agenda. Visible, and key policy actors such as the Health Minister are more likely to affect the policy agenda in line with the political priority. These three streams need to come together when a policy window, a moment in time when policies are more likely to come on to the government’s decision agenda, opens for the issue (i.e. HTA institutionalisation).

Although many countries across the globe have reaffirmed their commitments to achieve universal health coverage (UHC) by 2030, countries with very limited healthcare budgets struggle to provide UHC. The already stretched healthcare budget is further compromised by the current global economic crisis caused by COVID-19 and substantial reduction in external funding. Due to this, the use of a systematic approach to allocate scarce healthcare resource – such as via Health technology assessment (HTA) – has become more important than ever before.

In this work, we categorised the challenges and opportunities for HTA institutionalisation in Ethiopia using Kingdon’s multiple streams framework into Problem, Policy and Politics. The problem stream explains how conditions become problems and come to the attention of policy makers. In case of HTA, these include, among others: i) need for adequate, innovative, and sustainable healthcare financing to achieve UHC and reduce mounting OOP expenditure, ii) need for smart spending due to COVID-19 – induced economic contraction, and uncertainty in donor programming. The policy stream represents the process by which alternative policies are generated and selected. HTA can be put forward as a solution to the ‘problem’ identified above, along with ‘Proof of concept’ HTA projects to test the proposed policy. This stream can be influenced by local capacity; availability and quality of data sources; role of academic institutions in priority setting, etc. The politics stream explains how favourable macro-level political conditions could help set the agenda. Visible, and key policy actors such as the Health Minister are more likely to affect the policy agenda in line with the political priority. These three streams need to come together when a policy window, a moment in time when policies are more likely to come on to the government’s decision agenda, opens for the issue (i.e. HTA institutionalisation).

**188:poster WELLBEING AND HEALTHCARE PRIORITY SETTINGS IN SWEDEN AT THE BEGINNING OF THE COVID-19 OMICRON WAVE**

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10.1136/bmjgh-2022-ISPH.26

**Introduction** The COVID pandemic proves that a sustainable healthcare system is dependent both on resources and a consensus about which values should guide the decision makers to appropriately set priorities for resource allocation. There is no clear exactly how the decision makers choose the priorities for spending, but there were differences between and within countries. For example, in Sweden, where healthcare system has a pronounced public character and a declared emphasis on equity and solidarity, there was a high variation between and within regions with respect to how resources were used for treatment, prevention, and vaccination. This article is an explorative analysis of the respondents’ wellbeing and their preferences regarding priority-setting in healthcare in Sweden during December 2021, when the extremely high infection risk of the Omicron sparked significant concern among global experts and politicians.

**Methods** Our web-survey was answered by 1000 respondents from the web panel Userneeds. The sample is representative with respect age, gender, and geographical region for the adult population of Sweden. The respondents are invited to imagine that they are decision-makers in the health care system and decide for six hypothetical choice situations, where the resources are allocated to save the life of patients at risk of dying due to suicide, pancreatic cancer, breast cancer and acute heart attack. In addition to the choices, the survey also includes questions about the individual’s demographic and socio-economic characteristics, their well-being, their risk for and experience (their own and/or someone near them) with suicide, pancreatic cancer, breast cancer and acute heart attack.

**Results** Our preliminary results show that regardless of their age, people with a high value of life-satisfaction and with no experience related to suicide, pancreatic cancer, breast cancer and acute heart attack tend to allocate resources for relatively young patients suffering do to suicide and breast cancer.