162:oral ASSESSMENT OF THE ROUTINE IMMUNIZATION PROGRAM DURING THE COVID-19 PANDEMIC AT THE MAIN HEALTH CENTER, IN UNRWA'S BAQA'A REFUGEE CAMP, JORDAN

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The WHO pulse survey found that 80 out of 105 countries reported varying disruptions to their health services sector. During the COVID-19 pandemic, many governments implemented lockdowns, which subsequently affected residents' daily lifestyles and access to essential health services. In April 2020, the Jordanian government implemented one of the world's COVID-19's strictest lockdown. This study assesses the effect of such measures on the routine immunizations program at the main health center in the Baqa'a refugee camp, managed by UNRWA.

Our assessment of the program's performance quantifies the gap in service provision using the number of vaccine doses provided. The gap was compared to the COVID-19 mitigation measures quantified through the OxGRT Stringency Index. Therefore, a LOESS regression model was developed to represent the predicted values for 2020, using data from the previous years. Our model was then compared to the observed 2020 doses provided through the health center.

We found a correlation between the increase in the stringency index and the increase in the gap, where the strictest values of the index were associated with the highest gaps. Additionally, the 2020 values were much more dispersed with a wider range than our predicted model, reflecting the effect of the mitigation measures and the countering activities conducted by the health center staff. Overall, using the monthly values, a gap of 1199 doses (8.75%) in 2020 was calculated between the predicted and observed values. Furthermore, we found that the first dose of the 3-dose hexavalent vaccine showed a higher and earlier peak than the other doses after the lockdown period.

In conclusion, the implemented activities by UNRWA's health center staff, use of a mobile application, and refugees-embracing health systems have successfully minimized the gap in service provision and provided alternative outlets to maintain an overall high coverage of routine immunizations.

163:poster AN INSURANCE-THEORY OF OUR PANDEMIC OBLIGATIONS

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Our demanding obligations to protect the vulnerable in pandemics vastly surpass what we owe each other in ordinary circumstances. In this paper, I defend the novel explanation that our obligations in public health emergencies are the premium we pay for insuring against a sudden and significant event, of which the current pandemic is just one instance. Since we are all vulnerable, the stakes are significant, and help is urgent in these situations, it is rational pre-pandemic to be part of an 'informal insurance scheme' that imposes very demanding obligations in an emergency. This theory explains the discrepancy between the extraordinary and ordinary obligations, why the relatively protected young should bear heavy burdens to protect the vulnerable, and why the primary obligation in a pandemic is to maintain the pre-pandemic status quo, not solve background injustices. Finally, the theory has implications for our changing obligations when pandemics become endemic and frequent.

173:poster TOWARDS ALL-INCLUSIVE HEALTHCARE ALLOCATIONS

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In practice and in the philosophical literature on health priorities, the standard view is to ignore the third party and non-medical effects when allocating scarce healthcare resources. In this paper, we argue against this exclusionary view and propose an inclusive view instead. We argue that, in principle, every foreseeable effect of a decision should matter when prioritising healthcare resources and that indirect and direct effects and medical and non-medical effects should count equally. We thus propose widening the scope of attention from patients qua patients to everyone affected by the allocation of healthcare resources.

The inclusive view is compatible with several principles for healthcare priority setting. However, for clarity of exposition, we make our case on the background of a prioritarian view, which states that healthcare resources should be allocated with a special emphasis on the worst off. We defend the inclusive view against objections that it is ageist, ableist and unfair.

93:oral PRIORITY SETTING AND NET ZERO HEALTHCARE: HOW MUCH HEALTH CAN A TONNE OF CARBON BUY?

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A global movement is currently underway, spearheaded by the National Health Service (NHS) in England, to decarbonise healthcare. In this paper we explore some of the trade-offs involved by framing the path to 'net-zero' emissions within the language and practice of priority setting, a discipline centred on the efficient allocation of scarce financial resources to improve health. First, we consider the potential to reduce healthcare's carbon footprint through clinical decision making ('On the margin'), national resource allocation ('The Priority View') and an international perspective ('A Global Outlook'). We then locate the broader 'net-zero' healthcare agenda within the Paris Agreement and highlight the need for scholars in priority setting to more fully consider the implications of carbon emissions for the fair distribution of healthcare. Our aim is to help healthcare workers, health system leaders and policy makers to identify optimal pathways to protect and improve health on the low-carbon transition.