

Open and inclusive: Fair processes for financing universal health coverage



© 2023 The International Bank for Reconstruction and Development / The World Bank

1818 H Street, NW Washington, DC 20433

www.worldbank.org

All rights reserved.

This volume is a product of the staff of the International Bank for Reconstruction and Development / The World Bank, with external contributions. The findings, interpretations, and conclusions expressed in this volume do not necessarily reflect the views of the Executive Directors of The World Bank or the governments they represent.

The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

Citation

Please cite this work as follows: World Bank. 2023. *Open and Inclusive: Fair Processes for Financing Universal Health Coverage*. Washington, DC: World Bank.

Rights and Permissions



The material in this work is subject to copyright. Because The World Bank encourages the dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given.

Any queries on rights and licenses, including subsidiary rights, should be addressed to the Office of the Publisher, The World Bank, 1818 H Street NW, Washington, DC 20433, USA; fax: 202-522-2422; e-mail: pubrights@worldbank.org.

Cover design: Publicis Kitchen

Cover image: © Panuwat Sikham/GettyImages

Editorial design: Publicis Kitchen

Contents

Acknowledgments	5
List of abbreviations	7
About this report	8
Executive summary	9
1. Introduction	12
1.1 The case for fair process in health financing for universal health coverage	12
1.2 Human rights as the moral and legal foundation for fairer processes in health financing	14
1.3 Fair processes in health financing: strengthening decision support	15
1.4 Report objectives, methodology, and structure	16
2. Health financing decisions with equity implications	17
2.1 Revenue mobilization	17
2.2 Pooling	18
2.3 Purchasing	20
3. What is a fair process?	22
3.1 Principles and criteria for fair processes in financing UHC	22
3.2 Policy context	27
3.3 Implementing participation and inclusiveness: differentiating between directional and technical decisions	29
4. Principles and criteria in practice: examples from country experience	31
4.1 Legislative and regulatory instruments	32
4.2 Organizational arrangements	33
4.3 Financing and capacity strengthening	35
4.4 Information management and monitoring	36
4.5 Global initiatives and external support	37
4.6 General observations from country experience	37
5. The way forward: working together for fairer decisions on the path to UHC	39
References	41

List of Figures

Figure ES1	Principles and operational criteria of procedural fairness.....	10
Figure 1	Principles and criteria for procedural fairness.....	23

List of boxes

Box 1	In focus: Public participation and inclusiveness	27
--------------	--	----

List of Tables

Table 1	Revenue mobilization decision types and equity implications	18
Table 2	Pooling decision types and equity implications.....	19
Table 3	Purchasing decision types and equity implications.....	21
Table 4	Principles for fair processes	24
Table 5	Criteria for fair processes.....	25
Table 6	Policy instruments for promoting procedural fairness	31

Acknowledgments

This report was prepared by a team from the Health, Nutrition and Population (HNP) Global Practice of the World Bank (WB), the Norwegian Institute of Public Health (NIPH), and the Bergen Centre for Ethics and Priority Setting (BCEPS) at the University of Bergen in Norway, under the overall guidance of the HNP Global Director Juan Pablo Uribe. The core report team comprised Christoph Kurowski and David B. Evans (WB); Unni Gopinathan, Elina Dale and Trygve Ottersen (NIPH); Ole F. Norheim and Alex Voorhoeve (BCEPS). The extended team included Steve French, Espen Movik and Elizabeth Peacocke (NIPH).

The report would not have been possible without extensive inputs from the following experts during successive expert consultations: Kalipso Chalkidou (The Global Fund to Fight AIDS, Tuberculosis and Malaria); Lydia Baaba Dsane-Selby (National Health Insurance Authority, Ghana); Yuriy Dzhygyr (independent consultant); Tessa Tan-Torres Edejer (WHO); Getachew Teshome Eregata (Federal Ministry of Health of Ethiopia); Oyebanji Filani (Ministry of Health & Human Services, Government of Ekiti State, Nigeria); Karen A. Grépin (School of Public Health, University of Hong Kong); Eduardo Gonzalez-Pier (Palladium, USA); Ayako Honda (Hitotsubashi Institute for Advanced Study, Hitotsubashi University); Gita Sen (Ramalingaswami Centre on Equity & Social Determinants of Health, Public Health Foundation of India); Peter C. Smith (Centre for Health Economics, University of York); Viroj Tangcharoensathien (International Health Policy Program, Ministry of Public Health, Thailand); and Alicia Ely Yamin (Harvard University). Their participation in expert consultations played a key role in determining the direction and topics addressed by the report. The core report team benefited from their valuable guidance and their extensive comments on multiple iterations of the report. We especially thank Alicia Ely Yamin for providing the first draft of the section about the relationship between human rights and fair process and guiding subsequent revisions.

The team also would like to thank Claudia Chwalisz (OECD), John S. Dryzek (Centre for Deliberative Democracy and Global Governance, University of Canberra), and Erik Oddvar Eriksen (ARENA Centre for European Studies, University of Oslo) for reviewing early drafts and discussing their comments during digital consultations. Their contributions on key concepts in deliberative democracy and new ways of engaging with citizens played an important role in informing the report.

The report was greatly enriched by the insights and expertise of the authors of the case studies from India, Mexico, South Africa, Tanzania, Thailand, The Gambia, and Ukraine: Ramachandran Anju (Health Action by People, India); Ravi Prasad Varma (Sree Chitra Tirunal Institute for Medical Sciences and Technology, India); Krishnapillai Vijayakumar (Health Action by People, India); Rekha Melathuparambil Ravindran (Department of Health and Family Welfare, Government of Kerala, India); Rajeev Sadanandan (Health Systems Transformation Platform, India); Mariana Barraza-Lloréns and Rafael Adrián Arceo-Schraivesande (Blutitude, Mexico); Eduardo González-Pier (Palladium, USA); Petronell Kruger, Susan Goldstein and Karen Hofman (South African

Medical Research Council/ Wits Centre for Health Economics and Decision Science, University of the Witwatersrand, South Africa); Peter Binyaruka and John Maiba (Ifakara Health Institute, United Republic of Tanzania); Gemini Mtei (USAID Public Sector Systems Strengthening Plus (PS3+) Project, United Republic of Tanzania); Shaheda Viriyathorn, Saranya Sachdev, Waritta Wangbanjongkun, Walaiporn Patcharanarumol and Viroj Tangcharoensathien (International Health Policy Program, Ministry of Public Health, Thailand); Waraporn Suwanwela (National Health Security Office, Thailand); Hassan Njie (Ministry of Health, The Gambia); Yuriy Dzhygry and Katya Maynzyuk (independent consultants, Ukraine).

The report benefited from inputs provided by the WBG HNP team, in particular Tseganeh Amsalu Guracha and Patrick Hoang-Vu Eozenou, during the internal consultation process.

The authors also would like to thank the teams at the Department of Health Systems Governance and Financing and the Special Programme on Primary Health Care, Universal Health Coverage/ Life Course Division, World Health Organization for their detailed comments during the preparation of the report. We especially thank Fahdi Dkhimi for coordinating this engagement.

The authors would like to express special thanks to Alexander Irwin for thorough editing of the report. Without his support, the report would have been difficult to publish.

Carmen del Rio Paracolls (WB) provided overall coordination to finalize the report. Alexandra Humme, Christina Michelle Nelson, and Dasan Norman Bobo (WB) supported external communications.

The report benefited from questions and comments received during various consultation and dissemination events, including the 13th International Society for Priorities in Health Conference (2022); the Annual Health Financing Forum (2022); an internal consultation event with Global Fund staff (2022); the London School of Economics Department of Philosophy, Logic and Scientific Method Workshop "Citizen Panels and Health Policy" (2022); and, finally, a public seminar on "Open and Inclusive: Fair Processes for Financing Universal Health Coverage" (2023) convened by the Norwegian Institute of Public Health, the World Bank and the Bergen Centre for Ethics and Priority Setting in partnership with the Norwegian Agency for Development Cooperation and the University of Oslo.

Generous financial support was provided to the University of Bergen and the Norwegian Institute of Public Health by the Norwegian Agency for Development Cooperation (Norad) under the programme "Decision support for universal health coverage" (grant no. RAF-18/0009).

The authors regret any individuals or organizations that may inadvertently have been omitted from these acknowledgments and express their gratitude to all who contributed to this report.

List of abbreviations

A4R	Accountability for Reasonableness
PBAC	Pharmaceutical Benefits Advisory Committee (Australia)
CHF	Community health fund (Tanzania)
CHSB	Council Health Services Boards (Tanzania)
CSO	Civil society organization
CBTS	County Budget Transparency Survey (Kenya)
EHIF	Estonian Health Insurance Fund
HITAP	Health Intervention and Technology Assessment Program (Thailand)
HPL	Health Promotion Levy (South Africa)
HTA	Health technology assessment
IHPP	International Health Policy Program (Thailand)
IBP	International Budget Partnership
iCHF	improved Community Health Fund (Tanzania)
JCVI	Joint Committee on Vaccination and Immunisation (United Kingdom)
NHIS	National Health Insurance Scheme (The Gambia)
NHSO	National Health Security Office (Thailand)
NHSU	National Health Service of Ukraine
NICE	National Institute for Health and Care Excellence (United Kingdom)
NLGFC	National Local Government Finance Committee (Malawi)
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket payments
PEFA	Public Expenditure and Financial Accountability
PMG	Program of Medical Guarantees (Ukraine)
SDGs	Sustainable Development Goals
SHI	Social health insurance
SIS	Comprehensive Health Insurance (Peru)
SSA	Sub-Saharan Africa
SSB	Sugar-sweetened beverages
UCS	Universal Health Care Coverage Scheme (Thailand)
UHC	Universal health coverage
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

About this report

Who is this report for?

This report is written for policy makers and health financing experts in ministries of health and finance, other relevant government agencies, such as national purchasing agencies, and international development partners supporting health financing reforms.

It also addresses members of civil society and researchers in the fields of economics, ethics, health financing policy, and political theory who are interested in interdisciplinary work that aims to support fairer processes in decision-making.

What does this report contribute?

This report has been developed to support countries across different income levels and regions in building a fairer process around health financing decisions for universal health coverage (UHC). Its overarching aim is to provide policy makers with evidence on why fair processes matter; what constitutes a fair process for health financing decisions; and policy instruments that countries have used to advance fair processes in health financing.

The report makes four main contributions. First, it clarifies the case for fair processes in decisions about health financing on the path to UHC. To do so, it draws on sources from diverse research disciplines, synthesizes their arguments, and contextualizes them to health financing decision-making. Second, it describes key health financing decisions that can improve or worsen inequalities across individuals or groups in health service coverage or financial protection. The report argues that because of the important equity implications, it is critical for policy makers to consider aspects of procedural fairness as they make these decisions. Third, the report offers principles and criteria for designing and assessing health financing processes and making them fairer. It anchors its proposals in interdisciplinary research, expert consultations, and country case studies. Finally, the report shows how countries are using diverse instruments to operationalize fair process principles and criteria in health financing, something that policy makers in other countries can use or adapt to their own settings to improve procedural fairness under real-world conditions.

How was this report developed?

The report builds on a series of consultations conducted with a wide range of country policy makers, health financing experts, and researchers from low-, middle- and high-income countries. The scholars and experts engaged span different disciplines and areas of expertise (e.g., health

financing and economics, law, ethics and philosophy, health policy). The report incorporates a comprehensive literature review and original country case studies reflecting different country income groups, geographic areas, health financing arrangements, and types of health financing decisions.

This report complements two earlier milestone publications on fairness in health financing. The first, *Making fair choices on the path to universal health coverage* (World Health Organization 2014), analyzed critical choices that countries face when advancing UHC across three key dimensions: expanding priority services, including more people, and reducing out-of-pocket payments. The second, the World Bank's 2018 report *Equity on the Path to UHC: Deliberate Decisions for Fair Financing*, extended the logic of the World Health Organization (WHO) publication to address equity in all areas of health financing (resource mobilization, pooling, and purchasing) and identified specific types of decisions in these domains that may worsen inequalities. We recommend that our report be read with these earlier publications as a companion document.

How does this report address the diversity of cultural and political contexts?

For many, the question of what a fair process involves cannot yield a single, universal answer, but is shaped by historical, political, and cultural conditions. Thus, what is proposed in this report may not be universally agreed. To be more responsive to the diversity of interpretations, this report has pursued expert consultations involving wide geographic, cultural, political, and disciplinary representation and framed its literature review and case studies to span diverse contexts.

The report is based on the premise that it is valuable to understand what criteria could be used to define a fair process, even when political realities in some settings prevent these criteria from being fully applied. Deliberation and decision-making about health financing are shaped by the political environment and power asymmetries in society — which differ widely between settings. An understanding of stakeholder interests, value systems, and institutional structures in each setting is critical to be able to apply the principles and criteria proposed by this report. Focusing on fair process does not mean that political dynamics and power imbalances are ignored. On the contrary, designing decision-making processes that are fair and legitimate can help to address some of these imbalances in the search for fairer outcomes.

Executive summary

Does fairness matter? This report argues that, in key areas of public policy making, it does. And that, in policy decisions related to health financing, there are reliable ways for countries to bring fairness about.

The report offers decision support on fair processes for policy choices relating to health financing for universal health coverage (UHC). It opens by making the case for why fair processes matter for health financing. It argues that procedural fairness contributes to fairer outcomes, strengthens the legitimacy of decision processes, builds trust in authorities, and promotes the sustainability of reforms on the path to UHC. The report then describes key health financing decisions with an impact on equity in service coverage and financial protection, where issues of procedural fairness are particularly important. Next, it offers principles and criteria for designing and assessing the processes around these health financing decisions and provides suggestions for how to make them fairer. Finally, the report examines country experiences with diverse instruments that can be used to operationalize principles and criteria for fair processes in health financing decision-making.

The case for fair process

UHC means that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose people to financial hardship. Health financing is pivotal for progress towards the two pillars of UHC – coverage with services and financial protection. How well health financing arrangements can support progress towards these goals depends on choices in the three health financing functions of revenue mobilization, pooling, and purchasing. The overall level of health spending and the sources of revenue matter. Without adequate and sustainable levels of public spending on health, progress towards UHC goals will stall. Policies which promote sufficiently large pools to allow cross-subsidization and spreading of financial risks enable progress towards UHC. In purchasing, efficient use of resources, equitable service coverage, and financial protection for all people can be promoted through the development of guaranteed packages and the definition of payment methods, contracting conditions, and benefits.

The concern for a fair process is motivated by the many potential benefits such a process can deliver. This report highlights four. First, fair processes can contribute to more equitable outcomes because they can help address common sources of *inequitable* outcomes. Specifically, a fair process can prevent powerful stakeholders from shaping the decision process to suit their own interests and instead help promote the voices of the poor and marginalized. Second, procedural fairness can strengthen the legitimacy of processes by encouraging decision-making that follows accepted rules and procedures and by requiring authorities and institutions to justify policy choices through public reasoning, the rational exchange of ideas, and public communication. Third, fair processes can build trust in authorities across society at large. Trust is built by treating people affected by decisions with respect; explaining the rationale for decisions reached; and ensuring that all affected constituencies are heard, with no one's interests misrepresented or neglected. Fourth, fair processes promote the implementation and sustainability of reforms. By creating space for voice from all constituencies, including those whose preferred solutions are not finally adopted, support for carrying through decisions is increased.

Key decisions for equity

Key health financing decisions across revenue mobilization, pooling, and purchasing have especially important equity impacts.

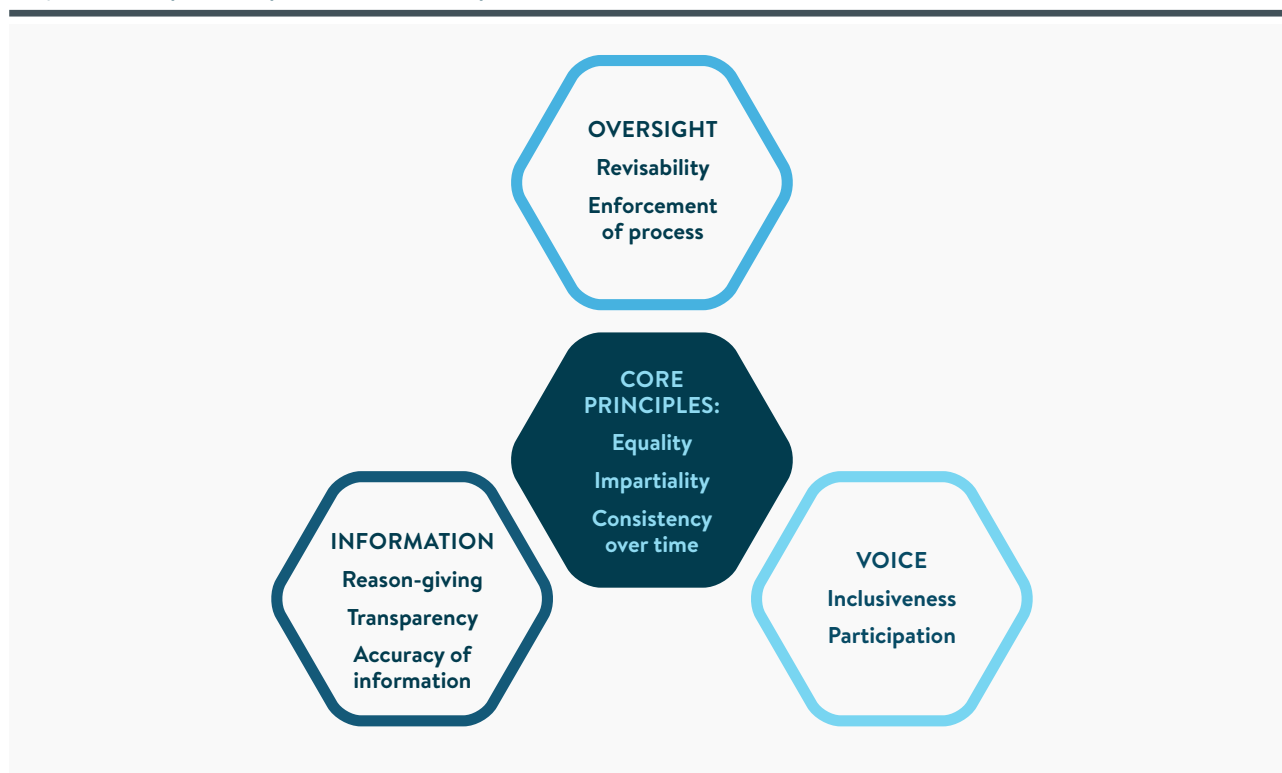
In revenue mobilization, such decisions include:

- changes to the range of taxes and charges, their rates, and any exemptions from payment
- decisions on eligibility for public/state transfers to households and the size of these payments or in-kind transfers
- choices on budget allocations to health at all levels of government.

In pooling, equity may be affected by changes in:

- who is covered from pooled funds
- out-of-pocket payments on services in a guaranteed set
- differences across pools in the range of services covered or out-of-pocket payments levied on the package, or changes in risk equalization procedures or the size of government subsidies to different pools in an effort to equalize benefits
- decisions to develop a new pool(s), where the new pool has different benefits or contributions.

Figure 1. Principles and operational criteria of procedural fairness



In purchasing, areas especially important for equity include:

- decisions on what personal services are specified and delivered (range, location, quality) under the guaranteed set, including conditions of access
- choices that modify the range, location, or quality of essential public-health operations
- changes in provider contracting, monitoring, payment methods, and rates.

Principles and criteria for fairer processes

This report proposes principles and criteria for fairer processes in financing UHC (*Figure ESt*). Three principles – equality, impartiality, and consistency over time – form the foundations of a fair process. Equality calls for equal access to information, equal capacity to express one’s views, and equal opportunity to influence decisions. Impartiality requires that vested interests – including corporate powers – do not unduly influence the outcomes of decision-making processes. Consistency over time requires rules and procedures by which decisions are made to be stable and predictable, at least over the medium term, and not to change on an ad hoc basis and without justification.

Guided by these principles, the report proposes seven criteria organized in three domains that can help design and assess decision-making processes (*Figure 1*). The first domain, information, is concerned with reason-giving,

transparency, and accuracy of information. The second domain, covering participation and inclusiveness, is about creating opportunities for the public to express diverse opinions and perspectives. The third domain, which includes revisability and enforcement, is about oversight of the process.

Country experiences and lessons

Examining diverse country experiences, the report identifies a variety of instruments that countries have used to develop or strengthen fair processes across the three health financing functions. These tools, which address the range of procedural fairness principles and criteria, can be organized into four broad types: legislative and regulatory instruments, organizational arrangements, financing and capacity-strengthening measures, and tools related to information management and monitoring.

Four general observations can be made about countries’ experiences in applying these instruments. First, legislative and regulatory mechanisms provide an important basis for promoting fairness in decision-making processes. These mechanisms include high-level legal frameworks like South Africa’s Constitution; laws governing the public sector like the Freedom of Information Law in Ukraine; and health-specific legislation like Thailand’s National Health Security Act. Second, countries can use a combination of instruments to improve procedural fairness. For example, countries like Ethiopia and Thailand have benefited from

applying organizational instruments for public participation together with capacity-strengthening measures for civil servants, aimed at enhancing their ability to generate and use evidence. Third, public participation is often elicited to a greater degree for decisions that set overall directions for health financing. In contrast, for some technical health financing decisions, like determining provider payment rates and making choices about the public financing of vaccines, countries draw to a greater extent on technical experts. In these cases, the importance of instruments promoting criteria beyond participation, such as transparency, accuracy of information, and reason-giving, becomes even more pronounced. Finally, the availability and applicability of diverse instruments to all parts of health financing, along with their successful implementation across different countries, indicate that every country can advance towards achieving fairer decisions for UHC.

The way forward

Fair process contributes to fairer outcomes, strengthens legitimacy, builds trust, and promotes the sustainability of health financing policies on the path to UHC. In closing, this report highlights opportunities for four key groups of actors to foster this agenda: governments, civil society, international partners, and scholars.

Governments can use the report's principles and criteria as a framework to review their existing regulations, institutions, and processes. While it may sometimes appear expedient to make decisions behind closed doors or to fast-track reforms, evidence suggests clear benefits of an open and inclusive process. Country examples in the report can facilitate knowledge sharing and illustrate how governments in diverse settings have strengthened procedural fairness in health financing.

While oversight functions rest with governments, civil society actors play a key role. They can use the report's principles and criteria to monitor procedural fairness in health financing and hold governments accountable. To measure progress, civil society actors can collaborate

with other stakeholders to adapt indicators, making them locally meaningful and actionable. They can also work with governments to engage the public more actively and directly in decisions that will benefit from broad participation.

International partners can use the report's criteria to examine their own processes, particularly for decisions relating to what to fund and how to channel money to activities in recipient countries. Using the report's findings, international partners can provide technical and financial resources to enable countries to strengthen regulatory frameworks and set up robust institutional mechanisms to meet procedural fairness criteria. In some cases, this may mean longer timelines – for example, for developing a health financing strategy or a new tax law – but rushing timelines can result in unfair processes and inequitable outcomes.

Finally, scholars from different disciplines can use the report's interdisciplinary lens to consider how their respective fields can contribute to fair processes for financing UHC and expand their future contributions. This may involve gaining deeper understanding of how the principles and criteria proposed in the report can support fairer policies and outcomes; how they can be applied in various settings in a feasible and sustainable way; and how to improve them over time.

In sum, this report presents common ground and an opportunity for policy makers, practitioners, researchers, and civil society to come together, collaborate, and take forward fair processes for financing UHC. Building on previous publications that emphasize the value of public engagement and inclusive representation in building trust and enhancing the sustainability of political systems, this report takes a comprehensive view of procedural fairness. It describes how countries can apply the range of criteria proposed to improve the fairness of their health financing decision-making for UHC. In so doing, countries and partners can advance UHC through open and inclusive processes that are responsive to the needs of all.

1

Introduction

This introductory chapter explains why this report is needed, outlines its conceptual foundations, and describes its aims and structure. The chapter has four parts. First, it discusses why fair processes are vital for sound health financing decisions, showing the benefits that fair processes yield for the countries that implement them on the path toward universal health coverage (UHC). Second, it explains how the effort to strengthen fairness in health financing is grounded in and advances a human rights-based approach to health. Third, the chapter highlights gaps in currently available evidence and decision support for policy makers on how to achieve fairer processes in health financing. Finally, to show how this report will help bridge the gaps, the chapter summarizes the report's objectives, methodology, and structure.

1.1 The case for fair process in health financing for universal health coverage

This report speaks to a context in which economies and health systems face historic challenges. The dual impact of COVID-19 and the invasion of Ukraine by the Russian Federation has resulted in rising poverty, surging inflation, and reductions in real per capita government spending across much of the globe. Years of global progress in poverty reduction were abruptly reversed in 2020, with some evidence that inequality has also widened in many parts of the world (World Bank 2020). Forty-one countries where real per capita government spending has dropped are unlikely to see their spending reach pre-pandemic levels even by 2027 (Kurowski et al. 2022). In this context, while government health budgets are under pressure, the goals of UHC are more relevant than ever.

UHC means that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose people to financial hardship (WHO 2014). Progress toward UHC brings additional benefits that matter at all times, and particularly in a context of successive shocks and

global economic uncertainty. Advancing UHC contributes to more effective management of pandemics (Sachs et al. 2022); fosters sustainable economic growth (World Bank 2019); reduces poverty associated with out-of-pocket health payments (Das and Samarasekera 2011; World Bank 2019); and increases societal cohesion (Levy 2019).

Health financing decisions are critical for UHC goals, including equity

UHC is fundamentally about equity – all people receive the health services they need without financial hardship. UHC features as a prominent target in the Sustainable Development Goals (SDGs), adopted by all United Nations member states. On the path to UHC, however, inequities persist. Getting health financing strategies right across the functions of revenue mobilization, pooling, and purchasing is critical not only to making progress towards UHC but also to reducing those inequities (World Bank 2019).

This report uses the three health financing functions of revenue mobilization, pooling, and purchasing to organize its discussion of key health financing decision types affecting equity.¹ Decisions under all three functions have significant equity impacts. For example, in revenue mobilization, trade-offs between allocation to health care vis-à-vis other sectors can lead to decreased public spending on health as part of government budgeting processes. This is likely to result in increased reliance on direct out-of-pocket (OOP) payments for health services (Thomson et al. 2015). Increased OOP payments in turn impact equity in financial protection and service coverage, since poorer households have lower capacity to pay and are more likely to forego needed health services (Barasa, Maina, and Ravishankar 2017; Xu et al. 2003; Wagstaff et al. 2018). In contrast, increasing central government financial transfers for health to poorer sub-national units can reduce the gaps in service availability between richer and poorer areas.

In pooling, allowing richer people to opt-out of contributing financially to pools reduces the ability to cross-subsidize from rich to poor, and probably from healthy to sick.

¹ Questions about the nature of the guaranteed set of health services available to all, often termed the benefits package, are a critical component of health financing. In some analytical frameworks, they are seen as part of the purchasing function (Hanson et al. 2019; World Bank 2019), while others classify them as a separate function (Jowett et al. 2022; Kutzin 2013). In this report, decisions affecting the set of services available to everyone – e.g., benefit design – are summarized under purchasing.

On the other hand, countries can strengthen equity by harmonizing benefits across multiple funding pools in which some groups (e.g., people working in the informal sector) have access to a more limited set of services than other groups (e.g., civil servants) (McIntyre et al. 2013; Kutzin et al. 2010).

Purchasing involves a wide range of decisions that can directly improve or worsen existing inequities in coverage with health services or financial protection. An example relates to decisions on co-payments for outpatient prescription medicines: co-payments with no exemptions for the poor reduce their access and increase financial hardship when they need to purchase medicines. Exemptions for the poor reverse this effect, improving equity (Honda and Obse 2020; Ottersen and Norheim 2014; Thomson, Cylus, and Evetovits 2019).

Health financing policy does not operate in isolation from the rest of the health system or the broader socioeconomic and political environment. For example, introducing financial incentives to improve performance among health workers is unlikely to result in improved service coverage without ensuring adequate supply of medicines or basic equipment (Engineer et al. 2016). Wider governance and economic contexts, including the influence of international finance and trade, play an important role in determining a country's capacity to mobilize revenues for financing public services, including health (International Monetary Fund 2018). However, the focus of this report is on health financing decisions at national or sub-national levels—where crucial policy levers remain in country decision-makers' hands and, with them, the opportunity to implement fairer processes towards UHC.

Health financing decisions are often contested, underscoring the importance of fair process

Many health financing decisions are subject to disagreements shaped by the values and interests of people with a stake in these decisions. Recent country experiences help bring the practical importance of this consideration into focus. For example, the financial sustainability of small hospitals in the rural or remote areas of many countries is one domain where such debates frequently occur (Rechel et al. 2016). On the one hand, there are concerns about efficiency in terms of both capital expenditure and running costs for these hospitals, which typically serve very small portions of a population. Tied to population size is the challenge of securing high-quality services when patient volumes are low. On the other hand, local populations often resist the closure of hospitals, arguing that such closures undermine their equitable access to services (Rechel et al. 2016; Milne and Sullivan 2014; Moore 2009).

On a different but related front, the imperative to strike a balance between individualism and solidarity has been a prominent feature of recent discussions around health financing reform in Chile. On the one hand many citizens have historically placed high value on free individual choice, meaning that they prioritized being able to join private health insurance plans, which were also viewed as an “indicator of improvement in [people’s] economic status and their social mobility” (Vélez et al. 2020, 188). On the other hand, there has been a growing dissatisfaction with inequality in access to services, which government policies have not been able to address (Bossert and Villalobos Dintrans 2020; Ayala and Alarcon 2020).

Such examples underscore the political importance of health financing decisions, as well as their complexity and the potential for conflict. In such cases, it is not only the final policy choices that matter for stakeholders, but the processes through which decisions are reached.

The benefits of fairer processes for health financing and UHC

Value- and interest-driven disagreements around health financing choices, as in the examples just considered, suggest how important fair processes in this area can be. Pursuing that insight, this report identifies four key benefits of fair processes in health financing.

First, existing evidence suggests that fair processes can contribute to more equitable outcomes because they ensure that steps are taken to address common sources of *inequity* (Bartocci et al. 2022; Bollyky et al. 2019; Touchton and Wampler 2014; Williams, Denny and Bristow 2017; Woolcock and Gibson 2007). A key source of inequity is power differences among stakeholders, which can lead to powerful stakeholders' shaping the decision process to suit their own interests, at the expense of the voices and interests of the poor and marginalized (Kim and Lee 2022; Sparkes et al. 2019). By broadening participation and representation in the decision-making process and by promoting respect among people, fairer processes can contribute to leveling the playing field towards greater equity. Empirically, studies on participatory budgeting, for instance, suggest that it can lead to more pro-poor spending decisions. In Brazil, participatory budgeting contributed to higher allocations for health and sanitation in local budgets and less waste due to more effective monitoring of publicly funded projects (Gonçalves 2014). Another source of inequity is corruption, which can undermine public decisions and benefit those with the power to influence choices. Key features of fairer processes, like transparency, have been shown to curb the potential for corruption (Onwujekwe and Agwu 2022). Evidence from procurement

processes of medicines suggests that by improving oversight by auditors and civil society, transparency can reduce corruption and prevent the waste of limited public resources (Brown 2016; McDevitt 2022).

Second, fair processes strengthen the legitimacy of a decision process, which generally refers to the level of acceptance people have towards the authority of the government and of a polity's laws and institutions (Rawls 2012; Langvatn 2016). Legitimacy is shaped by authorities, laws, and institutions coming about through well-established and accepted procedures (Langvatn 2016; Rawls 2012). Justification of policy choices through public reasoning, the rational exchange of ideas, and public communication plays a vital role in enhancing legitimacy (Chambers 2018; Habermas 1996). Evidence from social psychology suggests that people are more likely to accept decisions when choices are made through participatory procedures, with authorities perceived as neutral, honest, and trustworthy (Nakatani 2021; Tyler 2000). The value of procedural fairness is also highlighted in the literature on tax compliance: decisions made by tax authorities that are perceived as impartial, based on factual information rather than personal opinions, are more likely to be accepted and complied with by taxpayers (van Dijke, Gobena, and Verboon 2019; Murphy 2005).

Third, fair processes help build trust in public institutions by treating people affected by decisions with respect, explaining the underlying core rationale for the decisions, and ensuring that all affected constituencies are heard, with no group's interests misrepresented or neglected. While definitions of trust vary across disciplines, the term generally refers to whether "political authorities or institutions are performing in accordance with the normative expectations held by the public" and whether they will continue to do so, "even in the absence of constant scrutiny" (Miller and Listhaug 1990, 358). In terms of trust in government, research in social psychology and taxation literature indicates that people's perceptions of fairness in the decision-making process is as important as their perceptions of the outcomes (OECD 2017; Prichard et al. 2019). The COVID-19 pandemic has highlighted afresh the importance of trust in government (Bollyky et al. 2022; Norheim et al. 2021), with several contributions underscoring the value of inclusive, transparent, and accountable decision-making to ensure trust in political and scientific authorities and adherence to public-health recommendations (Norheim et al. 2021; Sachs et al. 2022).

Finally, fair processes can promote the implementation and sustainability of adopted policies. For example, many health financing decisions are intended to be long-term solutions, with the benefits of adopted policies and created institutions being felt over an extended period. By creating space for voice and buy-in to the decision-making process from potential opponents and the people they represent, including those whose preferred solutions are not finally adopted, fairer processes can contribute to the sustainability of decisions (Chwalisz 2020).² The literature on deliberative democracy, and frameworks inspired by it, contend that processes characterized by public reasoning, including securing participation and inclusiveness when decisions are considered and justified, can generate broad popular support even under conditions of disagreement (Gutmann and Thompson 1998; Daniels 2008c).

1.2 Human rights as the moral and legal foundation for fairer processes in health financing

A foundational argument for UHC and fair process comes from a human rights perspective. Health is a fundamental human right "indispensable for the exercise of other human rights" (CESCR 2000). This section clarifies the links between countries' human rights commitments and the pursuit of UHC through fair processes, including in health financing.

The right to health and UHC

The right to health is enshrined in multiple international and regional treaties, and there is no state in the world that has not ratified and agreed to be bound by at least one treaty that embeds aspects of the right to health (UNHCR 2008, 660). These legal standards are underpinned by a strong philosophical foundation for claiming a moral right to health. Health is considered to be "among the most important conditions of human life," while "any conception of social justice that accepts the need for a fair distribution as well as efficient formation of human capabilities cannot ignore the role of health in human life and the opportunities that persons, respectively, have to achieve good health" (A. Sen 2002, 660). Therefore, health has special moral value, as it enables people to participate as full and equal members of their polities.

The right to health provides an overarching framework for UHC.³ United Nations (UN) General Assembly and World Health Assembly resolutions on UHC have consistently reiterated the centrality of the right to health, often citing

² While the focus of this report is on health financing, some of these characteristics are clearly shared with public-policy decisions in other sectors.

³ According to WHO, "states should not allow the existing protection of economic, social, and cultural rights to deteriorate unless there are strong justifications for a retrogressive measure." For example, introducing user fees in primary care which was formerly free of charge would constitute a deliberate retrogressive measure. Therefore, a state would have to demonstrate and explain to the public that it had adopted the measure only after carefully considering all options, assessing impact, and fully using its maximum available resources. See: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>

the Universal Declaration of Human Rights (Nygren-Krug 2019). Therefore, the principles of non-retrogression, a minimum core content that must be provided regardless of resources, and equality and non-discrimination are central to the UHC agenda. Securing equitable financing and eliminating financial barriers to health, especially for poor people and other vulnerable populations, represent a significant contribution towards realization of the right to health (Rumbold, Baker, et al. 2017; WHO 2015).

Enforcing health rights through the courts

Since the 1990s, health-related rights have become increasingly subject to judicial enforcement, through interpreting the right to a life of dignity to include aspects of health, including healthy environmental conditions and specific medical therapies under certain circumstances. While some cases of the judicial enforcement of individual health care rights have revealed tensions between the right to health and the need for prioritization of scarce health care resources (Yamin, Pichon-Riviere, and Bergallo 2019; Andia and Lamprea 2019), international human rights law is generally consistent with fair priority setting and progressive realization of UHC (CESCR 2000; Rumbold, Baker, et al. 2017).

For example, high courts have struck down cuts to the budgets of subsidized health programs as impermissible retrogression. In some cases, differentiated benefit packages for contributory and subsidized insurance regimes have been determined inconsistent with guarantees of equality in countries' constitutions. In 2008, a landmark decision from the Constitutional Court of Colombia ordered equalization of the benefit plans for two health insurance schemes: the country's contributory regime for those formally employed or earning more than twice the minimum wage (the Plan Obligatorio de Salud, or POS) and a subsidized health insurance scheme that had offered a significantly less generous set of services (Plan Obligatorio de Salud Subsidiado, POSS) (Yamin and Parra-Vera 2009). This equalization had previously been promised, but funding had been deferred multiple times by Colombia's Congress. The decision was made on the grounds that the two-tiered system, where fewer than half the entitlements were accessible to the subsidized regime, violated norms of equality and non-discrimination (Arrieta-Gómez 2018).

Fair processes are vital to fulfill health rights

A human rights-based approach to health as articulated through international treaties and obligations puts

emphasis not only on outcomes, but also on the processes by which decisions are made (UNHCR and WHO 2008). The UN High Commissioner for Human Rights emphasizes that human rights standards and principles – such as participation, equality and non-discrimination, and accountability – guide the entire health policy cycle, from situation analysis to policy development and adoption, as well as implementation and evaluation. According to General Comment 14 on the Right to the Highest Attainable Standard of Health,⁴ when facing trade-offs between health interventions, states need to make these decisions fairly (CESCR 2000; Rumbold, Baker, et al. 2017). Important trade-offs may concern, for example, investments in expensive curative health services that typically benefit a small, privileged fraction of the population, as compared to primary and preventive health care accessible to a far larger population share.

Procedural fairness is especially important in relation to health rights because epidemiological and demographic trends are constantly evolving, as are innovations in diagnosis, prevention, and treatment. This makes it vital to interpret the contents of the right to health through an open and inclusive process based on evidence (Yamin and Boghosian 2020). The choices for health financing to promote an equitable distribution of benefits across plural populations therefore require continual reevaluation and adjustments (Yamin and Boghosian 2020). Because reasonable people can disagree about normative priorities in health, the contours of health rights are inherently connected to the negotiation of competing claims and interests through fair and legitimate processes.

The human rights-based approach in health requires decision-making processes to respect reasonable substantive criteria, such as non-discrimination, as well as procedural criteria, including meaningful participation and transparency. Thus, for example, decrees or tokenistic legislative discussions without quorums have been found not to pass constitutional muster. In the above-mentioned example from Colombia, the Constitutional Court also included aspects of process in the remedies it ordered, calling for the then National Commission for Health Regulation to adopt a transparent, participatory, and evidence-informed approach that can be subject to revision and appeal when updating the benefits to be included in the contributory and subsidized schemes and in the process of unifying them (Yamin and Parra-Vera 2009; Arrieta-Gomez 2018).

⁴ The UN human rights treaty-monitoring bodies, including the Committee on Economic, Social and Cultural Rights, publish documents known as General Comments or General Recommendations, which explain their interpretations of the provisions of their respective human rights treaties. These documents provide guidelines for states on the interpretation of specific aspects of a human rights treaty and clarify the content of the rights set out in the treaty in question. They sometimes outline potential violations of those rights and offer advice to states parties on how best to comply with their obligations under the given human rights treaty.

In short, respecting, protecting, and fulfilling health rights involves due consideration of procedural fairness when deciding on the financing and delivery of health services. Further, a human rights framework in relation to health calls for effective oversight and regulation of both process and outcomes, together with provision of adequate information that allows decisions affecting health (made by governments and commercial actors alike) to be subjected to democratic scrutiny.

1.3 Fair processes in health financing: Strengthening decision support

Despite growing evidence of the multiple benefits of fair decision-making processes, health policy makers and experts do not currently have access to a unified, comprehensive, and clear set of principles and criteria for fair decision processes, described in practical terms that policy makers can readily adapt to country contexts, with examples of their application to health financing. This report aims to help bridge these gaps.

To date, the most comprehensive and conceptually clear discussion of procedural fairness is found in the literature on deliberative democracy (Bachtiger et al. 2018; Gutmann and Thompson 2004; Chambers 2018). However, this body of work has not been widely accessed to inform the process of health financing decisions. The primary framework for examining procedural fairness in health financing has been the Accountability for Reasonableness (A4R) framework, which has been applied to examine decisions for determining health benefit packages across different settings, including Mexico (Daniels 2008a), Tanzania (Maluka, Kamuzora, San Sebastian, Byskov, Olsen, et al. 2010; Byskov et al. 2014), and the UK (Rumbold, Weale, et al. 2017; Mitton et al. 2006; Daniels and Sabin 2008). This is an ethical framework that specifies key criteria for a fair process, namely: publicity, relevance, revision and appeals, and enforcement (Daniels 2008b). However, some have argued that the A4R framework places insufficient emphasis on public participation and that there is a lack of clarity about how different kinds of arguments are meant to be included or excluded in a deliberative process guided by A4R (Rid 2009; Friedman 2008). Moreover, there has been little systematic thinking about whether A4R criteria apply equally well to revenue mobilization and pooling, or to the aspect of purchasing that concerns how to contract and pay for inputs or services. It remains debatable whether additional criteria, applied to processes for other public policy decisions, should also be considered (World Bank 2018). In sum, there is a need to further specify what constitutes a fair process in health financing; detail the benefits that fair process can bring across the three core health financing functions; and deliver decision support to policy makers and partners as they work to institutionalize fairer health financing.

1.4 Report objectives, methodology, and structure

The primary aim of the report is to provide policy makers with evidence on why fair processes matter; what constitutes a fair process for health financing choices on the path to UHC; and policy instruments that countries can use to advance fair processes in health financing. In pursuit of this aim, the report makes four main contributions. First, informed by an interdisciplinary evidence base, it shows how fair processes can improve results in decision-making around health financing. Developing that argument has been the main task of this introduction. Second, the report describes key health financing decisions with an impact on equity. Doing so is a necessary step toward identifying priority health financing policy decisions to which procedural fairness criteria can be applied. Third, the report offers principles and criteria for designing and assessing decision processes in health financing and guiding how to make them fairer. Finally, it presents a diverse range of policy instruments that can be used to implement fair process principles and criteria for health financing decisions.

The report builds on a series of consultations conducted with global and country experts; a comprehensive literature review; and a set of case studies in countries and jurisdictions including India, Mexico, South Africa, Tanzania (Mainland), The Gambia and Ukraine. These case studies were selected to reflect a variety of income groups, geographic areas, health financing arrangements, and types of health financing decisions.

The structure of the remaining parts of the report is as follows. Chapter 2 describes the key health financing decisions with equity implications, with a view to illustrate a wide range of health financing decisions where fair processes merit greater attention. Chapter 3 examines the meaning of “fair process” as a concept guided by three main principles: equality, impartiality, and consistency over time. The realization of these core principles relies on the implementation of seven criteria that decision-making processes can be compared against. These criteria are reason-giving, transparency, accuracy of information, inclusiveness, public participation, revisability, and enforcement of the process. Chapter 4 examines country experiences with a diverse selection of instruments, applied across the core health financing functions of revenue mobilization, pooling, and purchasing, that can enable countries to better meet the principles and criteria for procedural fairness. Finally, Chapter 5 provides a broad outline of the agenda for action to support progress towards UHC through a fair process.

2

Health financing decisions with equity implications

Health financing policies have important equity implications, and there are frequent disagreements about the substantive fairness of outcomes associated with them. This underscores the importance of creating decision processes in health financing that stakeholders can recognize as fair. Indeed, the more substantial the potential equity impact of a health financing policy choice, the more important a fair process around the decision becomes.

The aim of this chapter is to identify policy decisions under the three core health financing functions of revenue mobilization, pooling, and purchasing that have high stakes for equity. Such decisions will be priority candidates for applying the fair-process principles and criteria that are derived later in this report. The point for now is not to debate the substantive fairness of specific policy options, but to set the scene for the subsequent analysis of how fair process criteria can inform health financing decisions. In this chapter, we identify key equity-relevant decision types under the three health financing functions in turn. To keep the conceptual discussion grounded in political reality, for each of the health financing functions, we present country examples that illustrate how the decisions discussed can influence substantive equity.

2.1 Revenue mobilization

The road to universal health coverage (UHC) lies through government spending (Kurowski et al. 2022; Kutzin 2013). No country can make meaningful progress towards UHC without predominant reliance on government health spending, defined as spending derived from general government funds and from obligatory health insurance contributions. Government revenues come from taxes and charges of various types and may be collected at the various levels of government in a country, and in some countries from on-budget external financing. Government funding can also come from borrowing, something that was widely seen during the COVID-19 pandemic (Kurowski et al. 2021; International Monetary Fund 2021).

The first type of health financing decision with implications for substantive fairness concerns changes to sources of government revenue, most frequently made in the search for increased revenue. This can come from introducing new taxes or charges; increasing contribution rates for taxes, charges, or obligatory health insurance; or expanding the range of people or firms who should make financial contributions. These decisions modify the distribution of financial contributions to the system across people and groups, and they include but are not limited to health per se.

Some sources of revenue – e.g., income taxes – lend themselves to making contributions progressive (where the proportion of income that people contribute increases with their income). However, in countries with large informal sectors, income taxes are difficult to levy, and those on the formal sector raise relatively little. These countries therefore often rely on tax sources such as value-added taxes that may be easier to administer but tend to be less progressive (Jouini et al. 2018; Younger 2018; Thomas 2020).

Overall fiscal fairness is, however, judged not solely in terms of the financial contributions to the system, but in terms of the distribution of net contributions – i.e., payments minus transfers back in cash or kind (Inchauste and Lustig 2017). Particularly in circumstances where taxes are not sufficiently progressive, governments can compensate people for inequities in contributions by targeting transfers from government revenues to the poor. Accordingly, decisions that change the distribution of financial contributions, or the distribution of transfers from these revenues, both influence substantive fairness (Inchauste and Lustig 2017).

A third type of revenue mobilization decision influencing equity concerns allocations from general government funds to health, at all levels of government. The level of general government expenditure sets the size of the overall

Table 1. Revenue mobilization decision types and equity implications

Revenue mobilization decision type	Equity implication
Changes to the types of taxes, contribution rates, and who should pay.	Differences across people and groups in net contributions to the public finance system.
Who is eligible to receive public/state transfers in cash or kind and the size of these payments.	Differences across people and groups in net contributions to the public finance system.
Changes to the allocations from general government funds to health at all levels of government, and by central government to lower levels.	Differences across people or groups in the availability of health services, quality, or level of financial protection.

government spending envelope. Government health spending is then determined by the decision about how much of this is allocated to health - taking into account budget allocations from general government funds and any earmarked revenue, such as social health insurance and health taxes. External financing is often channeled through government, as well, either earmarked for health or able to be allocated as part of the usual budget process. These decisions jointly determine how much is available to spend on health.

From the perspective of a sub-national unit, the revenue mobilization function covers not just transfers from the central level, but also how much funding can be raised locally and how much is allocated to health. Inter-regional inequities in health spending reflect, therefore, decisions made at the central level about transfers to each sub-national unit, the capacity of different local governments to raise revenue, and how much local governments allocate to health.

The three types of revenue mobilization decisions which impact on substantive equity are summarized in [Table 1](#).

An example of the first decision type comes from Norway. In 2022, Norway increased its wealth tax, which is assessed on the basis of net wealth, from 0.85 percent to 1.1 percent at the top tier (The Norwegian Tax Administration 2022). The wealth tax on its own does not generate substantial revenue (Thoresen et al. 2021), limiting its impact on the overall level of government revenues and its capacity to increase transfers to the poor. However, the revenue collected comes from people who are in the upper income group; thus, together with the personal income tax, the decision to increase the wealth tax enhances overall tax progressivity in Norway (Thoresen et al. 2021).

Who is eligible to receive public or state transfers in cash or kind and the size of these payments is the second feature determining the distribution of net payments into the sys-

tem. For example, in Tanzania, according to one analysis, electricity subsidies are considered to be regressive despite attempts to make them more pro-poor, while the country's direct and indirect taxes are largely progressive (Younger, Myamba, and Mdadila 2016). In Indonesia, energy subsidies are also considered regressive, disproportionately benefiting higher-income groups (Lontoh, Beaton, and Clarke 2015). They also represent a significant fiscal burden on the government and use up resources which could be spent on health.

Allocation from central government to sub-national units (e.g., regions or states) is an important decision in health financing, determining equity of resource distribution across sub-national units. In Malawi, the allocation of the operational budget for health across districts was long based on historical allocation—that is, based on last year's allocation with some incremental change (Twea, Manthalu, and Mohan 2020). After district assemblies recognized inequities in existing resource allocation, the National Local Government Finance Committee (NLGFC)—the central decision-making body responsible for resource allocations to local government—developed a new resource allocation formula linked to key drivers of service delivery costs and tied explicitly to the costs of delivering the Health Benefit Package (Twea, Manthalu, and Mohan 2020).

2.2 Pooling

Pooling is defined as the accumulation and management of prepaid financial resources—meaning resources contributed before an episode of illness—with the purpose of spreading the financial risk of health care expenses from individuals who fall ill to all members of the pool (World Health Organization 2010b). Pooling facilitates the capacity to use health services in the first place, as people are confident that they will not be faced with costly out-of-pocket payments (OOPs) for the services they receive. The most effective way to protect against the financial risk is to share it, “and the more people who share, the better the protec-

Table 2. Pooling decision types and equity implications

Pooling decision type	Equity implication
Changes in who is covered from pooled funds or how entitlements are activated for a guaranteed package.	Differences between people or groups in service coverage or the distribution of the financial burden associated with access to a set of guaranteed services.
Changes to laws or regulations regarding out-of-pocket payments for services in a guaranteed set.	Differences across people or groups in the extent of financial protection related to the guaranteed set of services.
Where multiple pools exist, changes that modify differences across pools.	Differences across people or groups in quality and/or scope of services, and/or in the extent of financial protection related to the guaranteed set of services.
Decisions to develop a new pool(s) alongside existing pool(s), where the new pool has different benefits or contributions compared to existing pool(s).	Differences across people or groups in quality and/or scope of services, and/or in the extent of financial protection related to the guaranteed set of services.

tion” (World Health Organization 2010b, 47). To promote equity, pooling requires subsidies from the healthy to the sick and from the rich to the poor, and contributions need to be obligatory. General government funds that finance national health systems are one form of obligatory prepayment and pooling. Obligatory health insurance contributions are another, although in reality the distinction is often blurred – most systems where pooling is based on obligatory health insurance contributions have their revenues supplemented from general government funds (Levy 2019; World Bank 2019; Giuffrida, Jakab, and Dale 2013; Sakamoto et al. 2018).

A first pooling decision type with equity implications relates to who is covered from pooled funds for a guaranteed package, including decisions to increase the size of the pool. In many low- and middle-income countries, increasing the size of the pool to include the informal sector or the poor has been extremely challenging, contributing to inequitable service coverage and financial protection (Kutzin, Yip, and Cashin 2016; Kwarteng et al. 2019). This decision type also includes rules on how entitlements are activated, e.g., whether one needs to have special documentation, which at times may be difficult to obtain, and actively enroll with a health insurance provider instead of being automatically included based on a national identification number. Making complicated rules on activating one’s entitlements can contribute to some people “falling through the cracks” in the system and not having access to health services when they need them (Kwarteng et al. 2019).

A second decision type important for equity concerns changes to laws or regulations about out-of-pocket payments for services in a guaranteed set. Increasing or introducing OOPs for a guaranteed set of services, without

at least ensuring that effective exemption mechanisms exist to protect the poorest population groups, will undermine equity (World Health Organization 2014). The Lancet Global Commission on Financing PHC noted that, regardless of the level of total health spending, a shift from OOP spending towards pooled arrangements would have a significant positive impact on the equity and efficiency of health financing (Hanson et al. 2022).

Where multiple pools exist, changes that modify differences across pools constitute a third type of pooling decision with important equity implications. Frequently, the people in some pools are “better” protected than others – they obtain more or higher-quality health services, with more financial protection. This is inherently unfair, and many governments have modified the subsidies they give to the different pools in response or introduced risk equalization procedures, whereby funds from one pool are transferred to others. Harmonization of benefits is another policy that seeks to equalize benefits across pools. This decision type also includes rules on whether and how people can opt out of obligatory health insurance.

Decisions to develop a new pool(s) alongside existing pool(s), where the new pool has different benefits or contributions compared to existing pool(s), can contribute to fragmentation but can also improve equity in service coverage and financial protection. In many low- and middle-income countries, it has been challenging to expand the existing generous health insurance programs for formal sector workers to the poor and the informal sector. In this context, creating a new program that is not based on contributions and provides coverage for those previously not included in other programs is seen as a positive step towards fair access to health services, even if

in the early stages the benefits are not as extensive as those of the existing schemes (Tangcharoensathien et al. 2020).

The four groups of pooling decisions that can have important equity implications are summarized in [Table 2](#).

Some examples of these decisions follow. Tanzania recently sought to reduce differences across its population in the range of health services available and the extent of financial protection through the introduction of the improved Community Health Funds (iCHF) (Lee, Tarimo, and Dutta 2018). While the implementation of the iCHF has not unfolded as expected (Mselle et al. 2022), the increase of the size of the pool from district to regional level is an important step in reducing fragmentation and reducing differences across communities when it comes to access to health services.

An example of the second type of decision in [Table 2](#) comes from pre-war Ukraine. The purchase of medicines was a key driver of OOPs in the country, disproportionately affecting lower-income groups and patients with chronic illnesses (Goroshko, Shapoval, and Lai 2018). To address this, in 2017, the government introduced the Affordable Medicines Programme (AMP). Initially, the AMP covered three selected conditions: cardiovascular diseases (CVDs), bronchial asthma (BA), and type 2 diabetes (DM-2). The program was then expanded, so that by 2021, it included 27 international nonproprietary names (INNs) and 297 medicines, including additional INNs for mental and neurological disorders (Bredenkamp et al. 2022). Moreover, the number of contracted pharmacies also increased steadily. To the extent possible, AMP has continued to function despite the war, reducing OOPs through increased pooling.

An example of the fourth type of equity-relevant pooling decision is a policy decision to establish budget-funded, explicit coverage programs for persons not covered by existing social security health insurance schemes for the formal sector. This can promote equity, if the new programs are adequately funded (Kutzin, Yip, and Cashin 2016; Tangcharoensathien et al. 2013; Knaul et al. 2012). Thus, in Mexico until 2020,⁵ additional public resources for health coverage were mainly allocated to Seguro Popular (Popular Health Insurance), a publicly funded program providing access to health services without co-pays to individuals with no employment-based health insurance (Reich 2020). Additional resources were channeled to Seguro Popular in preference to the social security schemes covering the country's formal sector. At the beginning of Seguro Popular, in 2000, public spending per capita for people covered by the social security schemes (generally, Mexico's better-off citizens) was 2.1 times the public spending per capita for the rest of the population. However, by

2010, this ratio had fallen to only 1.2 time more, a substantial gain for equity (Knaul et al. 2012).

2.3 Purchasing

Purchasing involves the allocation of funds to obtain the guaranteed set of services. In national health services, purchasing traditionally has involved buying the inputs to make health services, such as health workers, medicines, and medical equipment. In insurance-based systems, purchasing generally involves buying the health services. Purchasing decisions can be divided into what to purchase, who to purchase from, and how to pay for the inputs or services. Decisions in purchasing can contribute to equitable delivery of the set of quality services while keeping costs under control (World Bank 2019).

Decisions on what personal services are guaranteed and delivered, including conditions of access, are probably one of the most widely examined decision types in the health financing literature from an equity perspective (Norheim 2015, 2016). These decisions can increase or reduce differences across people or groups in coverage with personal health services. Covering expensive high-technology services for a small group of the population while the majority lacks access to basic health services is recognized as extremely inequitable (Ottersen and Norheim 2014; World Bank 2018; World Health Organization 2010a).

What to purchase also includes questions about the range of public-health services to provide, including population-based prevention such as screening and public-health functions such as surveillance for epidemic preparedness and response. This is the second type of decision in purchasing which is considered important from an equity perspective. Differences across people or groups in their capacity to maintain or protect their health can be reduced through decisions modifying the range, location, or quality of public-health services.

Lastly, equity can be improved or undermined through contracting, monitoring, and paying providers. Provider payment mechanisms create incentives for providers that can contribute to differences across people or groups in effective coverage with personal health services, including by type of condition or disease. An example is a situation in which providers are compensated on a fee-for-service basis for certain types of patients, e.g., those enrolled in a social insurance scheme, while for other patients providers receive per capita payment. This is likely to result in insured patients enjoying priority and better care or at least more services (Barasa et al. 2021).

⁵ In 2020, Seguro Popular was replaced by a new system under the Instituto de Salud para el Bienestar.

Table 3. Purchasing decision types and equity implications

Purchasing decision type	Equity implication
Decisions on what personal services are specified and delivered under the guaranteed set. ⁶	Differences across people or groups in coverage or effective coverage with personal health services, including by type of condition or disease.
Decisions modifying the range, location, or quality of essential public-health services.	Differences across people or groups in their capacity to maintain or protect their own health; differences in the effective operation of the health system with consequences for population health.
Decisions modifying contracting and provider-payment methods and rates.	Differences in coverage or effective coverage with personal health services, including the quality of services for different people or groups.

Monitoring instruments can help counterbalance or reinforce the incentives created through different payment methods. Thus, three types of purchasing decisions can be identified that have clear implications for equity (Table 3).

Recent country experience illustrates some of these purchasing choices. In Tanzania, services included in the guaranteed set for those enrolled in the Community Health Insurance Fund (CHF) were very limited. In most districts, CHF membership only covered preventive and curative services at the primary health care level (dispensaries and health centers), with very limited portability, which meant that beneficiaries had access to services only in the facility where they were registered (Wang and Rosemberg 2018). Moreover, benefits and conditions for accessing various services differed by district, even within the same region. Under the new improved CHF (iCHF) program described earlier, services were expanded whereby beneficiaries became entitled to services available up to the regional hospital level, subject to an exclusion list comprised predominantly of specialized procedures and medicines (Lee, Tarimo, and Dutta 2018). While the equity impact of the iCHF may so far have been limited due to the slow scale-up of the program (Mselle et al. 2022), the decision to harmonize and expand benefits at regional level is aimed at reducing differences across people in coverage with personal health services.

Decisions modifying the range, location, or quality of essential public-health services are not always made explicitly, but may be a result of reduced central funding, as was documented following the 2013 public-health reforms in England (Buck 2020). As a result of reform, which shifted responsibility for funding public-health services to local level with significant reduction in central funding, areas with higher revenue-raising capacity at the local level, or which assigned higher priority to public health, were able to maintain more

services for their communities, while other jurisdictions did not (Buck 2020).

An example of how provider-payment methods can improve equity can be found in the Kyrgyz Republic. Starting with the establishment of a purchasing agency in the late 1990s, the Kyrgyz Republic gradually moved from input-based payments financing buildings and doctors to more output-oriented provider-payment methods, improving equity in access and quality of care across geographical areas (Kutzin et al. 2010). Specifically, from 2001 to 2004, the total number of buildings decreased by 47 percent and floor space decreased by 40 percent, with the savings re-allocated to direct patient care, accompanied by a shift in spending from hospital to primary health care (Fuenzalida-Puelma et al. 2010). Investments in PHC are critical to ensuring that all people receive the health services they need without suffering financial hardship, and generally such investments are considered to promote equity (Hanson et al. 2022). Shifting spending away from large hospitals also improved geographic equity in per capita public spending on health.



This chapter has identified key decisions across the three core health financing domains that impact substantive fairness. The purpose at this stage was not to debate which policy options lead to fairer outcomes, but to identify the key decisions under each health financing function so that the principles and criteria of fair process can be applied to them. But what actually is a fair process, and how can policy makers and stakeholders be confident that health financing choices are being reached fairly? Chapter 3 examines these fundamental questions. Chapter 4 will then look at policy instruments to advance fair processes in health financing and country experiences in using them.

⁶ Importantly, purchasing includes acquiring inputs to produce health services, as well as purchasing the services themselves.

3

What is a fair process?

Consider the following stylized case, based on a real-world example. In late spring 2010, the reform-oriented leadership of the ministry of health of a lower-middle-income country is uncertain if it will stay in power beyond a few more months, due to upcoming parliamentary elections. However, health leaders are determined to tackle longstanding structural problems in the country's health financing system. Important decisions have already been made through a fast-paced reform based on good global and country evidence, driven largely by technical experts, though with little involvement of the public. Now, the leadership determines to move even faster and make important decisions on the next reform phase. Leaders perceive seizing the political window of opportunity and accelerating decision-making and implementation as more important than inclusivity, transparency, and extensive justification of policy choices to those affected by the decisions. The goal is to bring reforms to a point where a new government cannot easily reverse the choices made.

The decisions taken through the subsequent months are technically sound and in line with UHC principles and lessons from other countries. Yet the lack of transparency and inclusiveness in the process leaves these advances politically vulnerable. Decisions are not fully understood or accepted by many of those affected by them and become subject to widespread criticism, including on the grounds of an unfair process. In an environment where trust in the government was already low, this weakens the legitimacy of the reform decisions. Paradoxically, the evidence-based health financing reforms likely to benefit the large majority of citizens spur broad resentment and inflict political costs.

This example from recent country experience illustrates the relevance of fair process to improving results in health financing. While a fair process does not guarantee that painful decisions creating winners and losers will be accepted by all, meeting principles and criteria for procedural fairness can increase the likelihood of broad acceptance (newDemocracy Foundation and The United Nations Democracy Fund 2019; OECD 2017). Meaningful

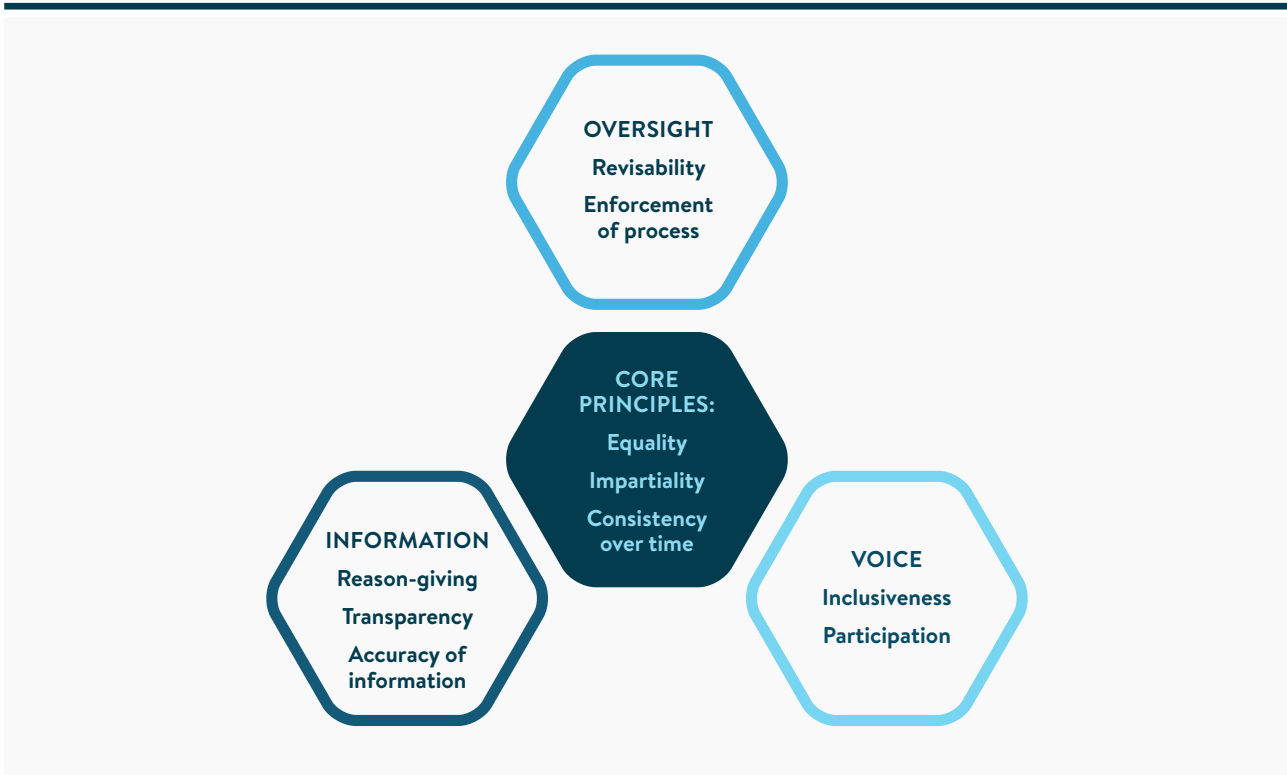
engagement with affected stakeholders and giving those who may oppose certain policies a chance to express their views sends the message that the solutions to public issues do not belong exclusively to a narrow “insider” group. This can ultimately build greater trust in the decision made (Matasick 2017). The question is, then, what does it mean to have a fair process? Are there principles and criteria by which policy makers can judge whether their decisions are fair from a procedural point of view and that can support them in improving current decision-making processes?

This chapter takes up these questions. It proceeds in three steps. First, based on a review of learning and practice in multiple fields, it proposes three core principles of fairness and seven criteria that actors can use to determine whether important decisions are being made in a way that is genuinely fair. Second, it discusses how leaders and stakeholders can advance fairness in health financing in real-world policy contexts, amid asymmetrical power relationships. Finally, it draws a distinction between directional and technical decisions in health financing, clarifying the practical implications of this difference for advancing fairness in health financing policy.

3.1 Principles and criteria for fair processes in financing UHC

An extensive literature spanning different disciplines — political theory and public administration (including deliberative democracy), public finance, environmental management, psychology, and health financing — has informed this report's characterization of key principles and criteria guiding procedural fairness (Dale et al. forthcoming). These principles and criteria have appeal across a diverse range of settings, and an extensive and interdisciplinary literature demonstrates their use (He and Warren 2011; Byskov et al. 2014; Leventhal, Karuza, and Fry 1980; Bachtiger et al. 2018; Daniels and Sabin 1997; Murphy 2005; P. Smith and McDonough 2001; Gutmann and Thompson 1995). However, this report recognizes

Figure 1. Principles and criteria for procedural fairness



that these concepts do not represent universally agreed features of a policy making process, and that the concepts are likely to be valued differently depending on a country's dominant value system, political regime, and social factors.

The report proposes to distinguish between core guiding principles and more practically oriented criteria for procedural fairness (Figure 2). The three core principles of equality, impartiality, and consistency over time form the foundations of a fair process. To allow them to be operationalized in practice, seven criteria are derived from them, organized in three domains; information, voice, and oversight. The criteria can inform the design and assessment of decision-making processes.

Three principles inform all aspects of a fair process

Equality has multiple dimensions (Bachtiger et al. 2018). First, equality implies that we pay particular attention to groups that empirically tend to face social, economic, and political barriers to participating, deliberating, and expressing their views (Mansbridge et al. 2012; Beauvais 2018). To this extent, the principle of equality may imply a clear pro-poor orientation and special emphasis on how disadvantaged and marginalized groups are treated in the decision-making process. Second, equality involves mutual respect, which means that participants in a decision-making process, whether they are policy makers, scientific

advisors, or members of the public, appreciate each other's moral and social worth and uphold a favorable attitude towards each other, even if they disagree among themselves about substantive matters (Beauvais 2018; Gutmann and Thompson 1990). It implies creating conditions for anyone, regardless of their social status and power, to bring forward relevant considerations, with the expectation that these will be heard, discussed, and addressed (Beauvais 2018; Gutmann and Thompson 1990).

Impartiality implies that the vested interests of decision-makers should not influence the outcomes of decision-making processes, and that prior beliefs should not prevent different views from getting equal and objective consideration (Leventhal 1980). Likewise, the vested interests of, for example, commercial and corporate actors, must be managed so as not to unduly influence decision outcomes (de Lacy-Vawdon and Livingstone 2020). Following the principle of impartiality, conflicts of interest must be addressed, and those making decisions should not hide or distort evidence in pursuit of self-serving goals. The concern for impartiality should, however, not lead to the exclusion of relevant voices. In health financing, the extent to which patients should be represented when determining the services to include in a health insurance scheme is heavily debated, especially since many patient organizations receive industry funding that can bias their views

Table 4. Principles for fair processes

Principle	Short explanation
Equality	Equality involves mutual respect and requires that people have equal opportunity to access information and articulate their views during a decision-making process, regardless of social status, gender, ethnicity, religion, or power.
Impartiality	Impartiality requires decision-makers to be unbiased and stipulates that their decisions not be driven by self-interest or unduly influenced by stakeholders with vested interests in the outcome.
Consistency over time	Consistency over time requires procedures for decision-making to be stable and predictable, and that changes to decision-making procedures are explained and justified.

(Fabbri et al. 2020; Mandeville et al. 2019). However, for equity reasons it can be important to pay attention to the values, needs, and preferences of patient populations that are marginalized for economic, social, or political reasons. A strict interpretation of conflicts of interest to secure impartial decision-making can risk excluding such relevant voices.

Consistency over time is about requiring decision-making processes to be stable and predictable, i.e., based on rules which are not altered too frequently or on an ad hoc basis (Leventhal, Karuza, and Fry 1980). Sudden and poorly explained changes can be perceived as unfair (van de Graaf 2021). If changes must be made to decision-making procedures, they should be thoroughly justified and involve the wider public (Gutmann and Thompson 2004). Consistency should be applied in how participation and representation are secured, how evidence is used, how information about the process is disclosed, the use of mechanisms for revisability, and the enforcement of similar processes across similar kinds of decisions (Hasman and Holm 2005; Ford 2015). Consistency is a fundamental criterion across different policy making domains. For legal systems, consistency has been shown to play a significant role in shaping people’s perception of fairness. In priority-setting processes that involve the use of health technology assessment (HTA), consistency brings structure to the process, both with respect to how information is presented and how it is used. For these decisions, definitive and consistently used procedures and structures have been emphasized by decision-makers as forming a key feature of a fair process (Kapiriri, Norheim, and Martin 2009).

The three core fair-process principles are summarized in [Table 4](#).

Fair-process criteria help translate principles into practice

The seven criteria for procedural fairness are reason-giving, transparency, accuracy of information, inclusiveness, public participation, revisability, and enforcement, summarized in [Table 5](#). These criteria should not be seen as binary; meaning that they are not either completely fulfilled or completely absent from most decision-making processes. Rather, they are often present in partial or evolving forms that provide some benefits yet leave scope for further development. Each of these criteria has different mechanisms that can support its implementation, and sometimes a single mechanism can support the implementation of multiple criteria. For example, a well-designed citizens’ panel can promote both participation and inclusiveness. This report groups the criteria into three domains: information, voice, and oversight.

Information: a requirement for reasoned debate

The first domain, information, covers reason-giving, transparency, and accuracy of information, which is concerned with the content and presentation of information.

Reason-giving requires that those promoting a policy or legislation justify it to others, including government institutions, the public, and other stakeholders (Gutmann and Thompson 2004). This should be done through a process with mutual exchange of reasons and explanations. Reason-giving encompasses respect, a fundamental value for a fair process from the perspective of theories of deliberative democracy, because only with respect does one listen actively, try to understand the meaning of a speaker’s statements, and value these views. Reason-giving is also verifiable: for example, a budgetary document can be checked for explanations that justify proposed changes in the health budget. This can prevent such changes from being perceived as arbitrary (Lakin 2018).

Table 5. Criteria for fair processes

Domain	Criterion	Short explanation
Information	Reason-giving	Reason-giving involves decision-makers' justifying decisions to those affected by them. It requires that disagreements be resolved by reasons being exchanged, listened to, and accepted or rejected by free and equal persons.
	Transparency	Transparency is about making information accessible, including information on the decision-making process (e.g., steps in the budget cycle); justifications during deliberations on the issue at hand (e.g., reasons for a proposed budget, any alternatives, and discussions around these); and reasoning on the decisions taken (e.g., why this particular budget is adopted), as well as the output of the decision itself (e.g., a budgetary document with actual figures in it).
	Accuracy of information	Accuracy of information is about decisions' being based on a comprehensive array of information sources, encompassing a diverse spectrum of evidence, perspectives, and views.
Voice	Public participation	Public participation is about enabling members of the public to access information, express their opinions, and directly engage in the decision-making process.
	Inclusiveness	Inclusiveness entails considering a broad range of views and concerns, necessitating mechanisms to involve individuals who typically do not contribute to public policy and decision-making and ensuring the inclusion of diverse perspectives and arguments, even in cases where stakeholders are unable to directly participate.
Oversight	Revisability	Revisability means accepting that new reasons—such as new evidence and new understandings of the issue at hand—can be given greater weight in the future, and therefore justify revised decisions. Mechanisms must therefore exist for those who disagree with the decision to challenge it and for decision-makers to respond to reasons and to consider revising the original decision.
	Enforcement	Enforcement has two aspects. One aspect concerns the presence of mechanisms to ensure that the criteria for procedural fairness are upheld. The second aspect pertains to the outcomes of the decision-making process and having laws, regulations, and oversight mechanisms to ensure that outcomes are implemented.

Transparency is about disclosing timely and clear information about the decision to everyone affected by it. It involves being open about the evidence base informing decisions, how the evidence has been generated, and how it will be used. Transparency is crucial to fulfilling reason-giving: information used to justify decisions must be accessible so that people can assess whether the information provided is sufficient and challenge the reasoning when required. Moreover, the transparency of a process allows the public to judge whether procedures for decision-making are working according to stated intentions: for example, publication of minutes of a discussion can show that people with a conflict of interest withdrew from participation. If persons with conflicts of interest did participate, making that information accessible can enable people to object to the process.

However, the positive influence of transparency on reason-giving depends on the decision situation, and there may be justified limits placed on transparency during a decision-making process. For example, the UK's Joint Committee on Vaccination and Immunisation (JCVI), an independent vaccine advisory committee that advises the UK government about the prioritization and introduction of vaccines in the immunization program, has a code of prac-

tice that stipulates the importance of making its work open to public scrutiny (JCVI 2013). At the same time, members of JCVI usually meet in a closed session to enable the free exchange of opinions and a sound deliberative process prior to reaching conclusions (JCVI 2013). Transparency is therefore primarily implemented in terms of providing full justification through a public statement once a decision has been reached. Moreover, since JCVI subsequently releases the minutes of its deliberations, the public can gain insight into the reasoning process that led to the committee's conclusions, including points of disagreement and the participation or otherwise of members with a conflict of interest.

Accuracy of information requires decision-making processes to be informed by a comprehensive array of information sources, encompassing a diverse spectrum of evidence, perspectives, and views. Sources should be trustworthy and contribute to an informed opinion. For example, when deciding on sound measures to combat the COVID-19 pandemic, governments were expected to provide their reasoning to the public, based on accurate information collected from diverse scientific sources (Eriksen 2022a). Reasons based on biased or inaccurate information can mislead participants and unsettle the deliberative process.

Voice: Mitigating power imbalances to achieve inclusion

The second domain covers participation and inclusiveness and is about creating opportunities for voice. Public participation implies creating opportunities for the public to directly participate in the decision-making process and influence the outcome (P. Smith and McDonough 2001; Weale et al. 2016). Meaningful engagement between decision-makers and the public requires forums that secure mutual respect and provide space for the public to express views, share evidence, and challenge official positions and for those making decisions to defend their arguments, respond to objections, and, if necessary, revise their decisions (Eriksen 2022b). Power imbalances between participants, shaped by social, political, and economic factors in society, must be mitigated to create a supportive environment for respectful deliberation (Gutmann and Thompson 2004; Masefield, Msosa, and Grugel 2020; Razavi et al. 2019). For example, direct representation of community members through mechanisms such as Brazil's health management councils enables citizens' voice and has potential for promoting fairer decision-making processes (Barnes and Coelho 2009, 230).

Inclusiveness is about securing the representation, directly or indirectly, of all relevant voices and interests that are affected by the decision (Baber and Bartlett 2018; Bohman 2012). Promoting inclusiveness involves ensuring that the diversity of views expressed in the public sphere is channeled to formally organized institutions that have decision-making power, like parliamentary assemblies and government departments (Dryzek 2009). It requires mechanisms—tailored to the needs of the specific decision and the affected audience—for bringing in voices that typically would not contribute to public policy and decision-making unless barriers to their participation are removed and their views and experiences are actively sought (Razavi et al. 2020). Special attention is therefore given to securing the views and perspectives of disadvantaged populations. However, achieving this goal requires attention to financial, social, and cultural sources of power differences that constrain or prevent inclusive processes (Razavi et al. 2020; World Health Organization 2019; Mulvale et al. 2019). Moreover, inclusiveness goes beyond a single-minded focus on the numerical representation of different groups, i.e., simply counting who and how many are directly present in participatory and decision-making forums. Inclusiveness requires ensuring that diverse perspectives, experiences, and underlying discourses are reflected, even when stakeholders are unable to directly participate in the process (Milewa 2008; Dryzek and Niemeyer 2008; Rajan et al. 2019).

Oversight: Securing fair process in the real world

The third domain, comprising revisability and enforcement, is about oversight of the process. Revisability means that new reasons — such as new evidence about the benefits and harms of a policy and new understandings of the issue at hand — can be given greater weight in the future and so justify revised decisions (Gutmann and Thompson 2004; Leventhal, Karuza, and Fry 1980). Mechanisms for revising decisions will vary depending on the decision type as well as a country's legal and political system. However, in all cases, mechanisms must exist for those who disagree with the decision to challenge it and bring updated evidence and reasons to bear on the issue, and for decision-makers to respond to these reasons and consider revising the original decision (Maluka, Kamuzora, San Sebastian, Byskov, Ndawi, et al. 2010; Gibson, Martin, and Singer 2004; Barasa et al. 2017). Equality implies that mechanisms for challenging and revising decisions must be accessible to all. Promoting impartiality requires special attention to ensuring that mechanisms for revision are not misused to counter the public interest. Finally, consistency prescribes that procedures for evaluating new arguments should be predictable.

Finally, whether fairer processes can be achieved is determined to a large extent by enforcement with respect to processes and outcomes. Without enforcement, none of the principles and criteria can be expected to achieve their stated intentions, ultimately undermining fairness. Legislation is a key tool for securing enforcement of fair processes. For example, consistency over time can be partially enforced through primary legislation regulating a process for adopting new taxes. However, if the legislation has many loopholes that result in frequent changes to the rules on how new taxes are adopted, then consistency over time is difficult to achieve. With respect to outcomes, the literature on deliberative democracy and participatory budgeting emphasizes the critical role that enforcement plays in securing respect for the binding nature of decisions (Gutmann and Thompson 2004). For example, officials who make decisions on behalf of other people have responsibility to ensure that these decisions are implemented.

3.2 Policy context

Crucial to the application of the fair-process concepts is a thorough consideration of the political culture in which they are applied and embedded (Sparkes et al. 2019; Reich 2002). Critical factors to consider include the distribution and exercise of power when policies are discussed and formed (Gore and Parker 2019; Sparkes et al. 2019;

Box 1. In focus: Public participation and inclusiveness

Not all forms of public participation meet the standards for procedural fairness proposed by this report. In fact, there is a vast literature showing that mechanisms for public participation can actually be used to exclude certain groups or to rubber stamp decisions (Williamson and Scicchitano 2014; Wilkinson et al. 2019). Too frequently, public participation becomes equated with engagement of interest groups and people with a specific agenda, rather than citizens overall (Chwalisz and Česnulaitytė 2020). A recent OECD policy paper on deliberative democracy therefore calls for “representative public deliberation” where “deliberative bodies like citizens’ assemblies create the democratic spaces for broadly representative groups of people to learn together, grapple with complexity, listen to one another, and find common ground on solutions” (OECD 2021, 5).

Different methods for public participation exist, and what is most appropriate in each case will depend on the issue or type of policy decision, its complexity, time constraints, and the availability of resources for implementing the meth-

od. Citizens’ juries, which have been used in health (Moretto et al. 2014; Street et al. 2014), are seen as ideal for developing well-informed citizen recommendations on complex policy questions, but they require significant resources to implement. The OECD recommends on average a minimum of four days, and often longer, to allow citizens participating in such a body adequate time to develop considered and detailed collective recommendations (Česnulaitytė 2020).

An important aspect of representative deliberative bodies is that self-selection should not drive who participates. Many health financing decisions involve mechanisms for public participation, like public hearings or consultations, organized within legislative processes. However, a key objection to these mechanisms is that they typically involve self-selection of stakeholders and insufficient facilitation of discussions; for this reason, they tend to fall short of mitigating power differences and securing meaningful engagement (Chwalisz and Česnulaitytė 2020; Guttman et al. 2008; Marais, Quayle, and Petersen 2020).

To ensure inclusiveness in these participatory mechanisms, it is recommended to use strategies for random recruitment of citizens. This can achieve representativeness of the group with respect to defined socioeconomic characteristics (e.g., level of income, ethnicity, rural/urban) and demographic traits (e.g., age, gender). Removing participation barriers such as cost of child-care or transportation is also a means of ensuring that participatory mechanisms are not dominated by the affluent (Česnulaitytė 2020). Facilitators must ensure that vested interests do not dominate the deliberations, and procedures for enabling participation and resolving disagreements should be consistently applied (Mansbridge et al. 2011; Curato et al. 2017). However, there may be significant challenges in implementing these methods, especially in low-income settings.

Hayward 2021); the supportive environment for and the strength of civil society (Francés and Parra-Casado 2019); and the specific political regime, including the state of open political discussion and good governance in the country (N. Smith et al. 2014; Herrera et al. 2017).

Fair process takes power relations seriously

The exercise of power and the power relations that operate at different levels lie at the heart of policy making (Gore and Parker 2019; Sriram et al. 2018; G. Sen et al. 2020). The design of fair processes cannot be separated from the role of power within political institutions or the imbalance of power among those who participate in decision-making processes (Abelson et al. 2003; Rohrer-Herold, Rajan, and Koch 2021). Financial or political power can be concentrated among elite groups in the population who can have greater ability to shape health financing policy at the expense of the interests of other stakeholders (Chemouni

2018). Specific stakeholders in health financing also wield greater power than others. In revenue mobilization decisions, some of the most powerful stakeholders are various industry representatives. For example, in several countries working to address the burden of non-communicable diseases and raise revenues for health, recent analyses identified the sugar-sweetened beverage (SSB) industry as a powerful policy actor, given its significant resources as well as the industry’s positioning as a contributor to economic growth and employment in some contexts (Thow et al. 2021). In pooling decisions, particularly in low- and middle-income countries, organized and better-resourced groups can resist the creation of a single pool if that means less generous benefits for them (Kutzin 2012; Savedoff 2004). In other settings, health insurance companies wield considerable financial, informational, and lobbying power and have vested interests in maintaining health insurance arrangements that promote their market share and profits,

even if these are not the most efficient and equitable for populations (Crancryn 2019; The Center for Public Integrity 1995).

The principles and criteria for fair processes fulfill a key function in creating checks and balances and addressing these power differences. For example, transparency can contribute to levelling the playing field by ensuring that stakeholders have access to the same information and by revealing biases or conflicts of interests among decision-makers. Participation and inclusiveness can ensure that a diverse range of stakeholders are able to express views; challenge the reasoning of decision-makers; and create conditions such that a fair and objective evaluation of reasons and evidence, rather than the interests of powerful stakeholders, drive decisions.

Civil society plays a critical role in realizing fair-process principles and criteria

The strength of civil society — understood here as the various ways people’s interests are organized and represented — is vital for realizing fair-process principles and criteria. By advancing the voice and interests of marginalized communities (Okonjo-Iweala and Osafo- Kwaako 2007; De Vos et al. 2009; Daniels et al. 2000), civil society can promote equality, participation, and inclusiveness. Civil society in many settings presses for transparency, relays the views of members of the public in mutual exchange with decision-making authorities, and demands justification for decisions (Levine, Fischer, and Kumar 2021). With respect to impartiality and consistency over time, civil society exercises an important monitoring function in uncovering the influence of vested interests and advocating for equal treatment. Finally, the revisability criterion is meant to facilitate opportunities for civil society to challenge, shed new light on, and revise decisions when people’s interests are affected. In most settings, civil society plays an important monitoring role to ensure enforcement of principles of procedural fairness in decisions. In the absence of strong civil society movements, the value and implementation of fair-process criteria are greatly diminished.

Some features of fair process can operate in settings where democratic governance falls short

While open political discussions and good governance are central prerequisites, there is growing evidence demonstrating that at least certain elements of a fair process can be present in settings which do not meet traditional standards of democratic governance (Sass 2018; Kaufman and Kraay 2021). In these contexts, the domain and scope of issues put forward for deliberation are typically carefully determined by the authorities, which can lead to weakening of the quality of participation and its claims to be truly deliberative (Stokes 2006, 61). However, once parameters, such as the scope of questions to be deliberated, are

defined, there is empirical evidence that processes that partially meet key criteria for a fair process, for example inclusive public participation, reason-giving, and transparency, can be implemented in these jurisdictions. For example, in China, public hearings are required for new legislation, including on income taxes (He and Warren 2011). Another example from China concerns the country’s 2006-2009 health care reforms (Korolev 2014). The Reform Commission overseeing that process created a special internet-based platform for soliciting critical inputs during the reform discussion and received thousands of comments and suggestions (Korolev 2014). In Iran, the High Council for Health Insurance, a body within the Ministry of Health that has responsibility for health insurance benefits, has used working groups that foster deliberation among technical experts, medical professionals, patients, scientists, and insurance company representatives when selecting services for evaluation and appraising the evidence for recommendations on the selection of health benefits (Nouhi et al. 2022).

While establishing legal requirements for public participation is a good first step, a large body of evidence shows that in some cases, such participation becomes a tokenistic exercise (Lakin and Nyagaka 2016; Glimmerveen, Ybema, and Nies 2022). Nominal participation may even be deliberately instrumentalized to exclude certain groups (Glimmerveen, Ybema, and Nies 2022) or to create a safety valve to preempt social unrest and avoid addressing larger issues (Leib and He 2006, 7). Thus, “participation” is not a panacea, and what it signifies must be scrutinized in each case.

3.3 Implementing participation and inclusiveness: differentiating between directional and technical decisions

Not all health financing decisions demand the same level of public participation to yield a process that most citizens will accept as fair. Empirical examples suggest that many countries enable greater public participation, usually through mechanisms within their legislative processes, in decisions that set the key directions for health financing (Agyepong and Adjei 2008; Kim and Lee 2022; Mayka 2019). In contrast, countries may delegate decisions that are more technical in nature to government officials and technical bodies.

Directional versus technical decisions: country examples clarify the distinction

Decisions that span the gamut from directional to technical exist across all three key health financing domains described in Chapter 2. Examples from countries at different income levels underscore the distinction between these types and indicate that the principles and criteria

for fair process are likely to be reflected in varying ways, depending on context.

In Estonia, the Estonian Health Insurance Fund (EHIF) Act replaced regional health insurance funds and established the EHIF as the independent public body responsible for purchasing health services using a combination of earmarked payroll contributions and general taxes (Habicht, Habicht, and van Ginneken 2015; Jesse 2008). In the Estonian legal context, these types of acts are the second-highest level of legal documents after the Constitution. All such acts are adopted by the parliament only after public consultations with all related ministries and stakeholders, as well as three readings in parliament, reflecting these laws' direction-setting character. In contrast, the pricing methodology that serves as the basis for setting provider payment rates in Estonia represents a technical exercise defined by the Ministry of Social Affairs. Similarly, the Health Service List which sets provider payment methods and rates is a government-level act which is mainly driven by the EHIF staff, although the proposals are reviewed by the supervisory board of the Fund, consisting of state, employer, and employee representatives (Lai et al. 2013).

Ethiopia provides another example of the two different types of decisions. The most recent revision of the Ethiopian essential health services package was characterized by broad stakeholder participation, taking approximately 18 months, with active engagement of a wide range of stakeholders, including government representatives at various levels, experts, and members of the public. Thirty-five consultative workshops were convened to define the scope of the revision, select health interventions for review, agree on the prioritization criteria, gather evidence on the performance of the selected interventions on the agreed criteria, and compare health interventions (Joint Learning Network for Universal Health Coverage 2022). In comparison, provider payment methods and rates are seen as a largely technical exercise and are set through a routine process that includes health facilities and finance offices/bureaus without involvement of the public and civil society (SPARC 2022).

Another example of a directional decision comes from Peru, where in 2002 the National Accord (Acuerdo Nacional) was signed by representatives of religious and civil society organizations, political parties, and the government. The agreement affirmed the goal of ensuring universal access to health care services and social security (Seinfeld, Montanez, and Besich 2013). This was a milestone in developing the country's Comprehensive Health Insurance (SIS), which was based on consolidation of two existing schemes—the mother-child insurance and school

insurance programs. In comparison, the decisions on design and allocation of funding to various budgetary programs (e.g. nutrition, maternal and neonatal health, cancer prevention and control), as part of the budgeting for results process (referred to as “Presupuesto por Resultados”), is a highly technical exercise, driven by experts and government officials (Dale et al. 2020).

In health financing, the establishment of independent purchasers stands out as an example where countries tend to strive for the separation of technical decisions from broader political processes. These institutions are usually set up to make technical decisions, in some cases with the involvement of civil society, but at arm's-length from the day-to-day political process. As described in a recent UK government review of these types of bodies (Comptroller and Auditor General 2021), they are established when it is appropriate for the body to be distanced from government and seek input from external technical expertise. The National Health Service of Ukraine (NHSU) provides a good example of such a body. The NHSU was established as a Central Executive Agency with autonomy in technical and operational matters, including specification of services within the overall Program of Medical Guarantees, selection of providers, and developing payment methods and rates. During the formulation of policy options and decision-making by an arm's-length body or similar kinds of expert-driven institutions, the scope for direct public participation and representation tends to be limited. Accordingly, the legitimacy of such bodies depends heavily on the quality of public reasoning, which refers to their capacity to justify publicly the reasons for their decisions and the public's acceptance of this justification (Eriksen 2022b).

Practical implications for operationalizing the fair process criteria

The distinction between directional and technical health financing decisions is not always clear cut, and the way it is interpreted across countries will vary according to their political and legal systems. Broadly, however, distinguishing among different degrees of directional and technical decisions provides valuable insights for the practical application of fair-process criteria, especially when assessing the appropriate level of public participation in health financing decisions and determining the extent to which expert-led processes should be the main driver of these decisions.

Ambitious methods like citizens' panels and other approaches to implementing representative deliberative processes are well suited to address direction-setting questions, particularly those that may be divisive and are subject to conflicting public values; that involve trade-offs

marked by uncertainty, with no evidently “right” answer for achieving resolution; and that represent long-term issues that go beyond the short-lived incentives of electoral cycles (OECD 2020; Solomon and Abelson 2012; Abelson et al. 2013; Raisio 2009; Degeling, Carter, and Rychetnik 2015). Such a level of participation is deemed particularly useful in situations where there is a need to make hard choices that may yield potentially unpopular decisions (Abelson et al. 2003). In these cases, if a representative group of people is given the time and resources to learn, deliberate, find common ground, and collectively develop considered recommendations, politicians will have greater legitimacy to overcome political deadlock (OECD 2020; Raisio 2009).

Of practical importance is evidence suggesting that the public may not be willing to participate in time-consuming, face-to-face deliberative processes, unless their immediate interests are directly affected or they are afraid of losing something tangible, like their local hospital (Abelson et al. 2003; Abelson 2001). In cases where more limited public participation is deemed justified, the criteria of the information domain — reason-giving, transparency, and

accuracy of information — become key drivers of people’s perceptions of procedural fairness (Eriksen 2022b).



This chapter has described what a fair process is, based on a wide review of learning and practice from multiple fields. It has identified three core principles of fairness and seven criteria that actors can use to determine whether important decisions are being made in a way that is consistent with these principles, so is genuinely fair. It has explored how fair decision-making processes in health financing can work within the constraints of real-world policy contexts. And it has drawn an operationally important distinction between directional and technical decisions in health financing, clarifying the implications for advancing fairness in health financing. The analysis throughout has shown that applying fair-process criteria in the complex political give-and-take of health financing decisions is not easy. Yet an impressive number of countries are already doing so. Chapter 4 now explores policy instruments that countries can use to advance procedural fairness across the core domains of revenue mobilization, pooling, and purchasing.

4

Principles and criteria in practice: Examples from country experience

Valuable practical insights can be gained from the actions taken by various countries to strengthen procedural fairness across the core health financing functions of revenue mobilization, pooling, and purchasing. This chapter presents examples of such operational experiences in countries. The examples are organized according to four broad types of policy instruments that countries have used to advance procedural fairness: legislative and regulatory instruments; organizational arrangements; financing and capacity-strengthening measures; and tools related to information management and monitoring (*Table 6*).

In exploring how countries have used these instruments, this chapter does not try to assess whether the final de-

isions themselves improve substantive fairness. Rather, the primary focus of the chapter is to explore how these instruments can contribute to procedural fairness. This chapter is also not intended to provide a complete list of how every policy instrument has been utilized across every health financing function. Instead, it describes a diverse selection of instruments that can be used to advance one or more principle and criteria. For example, robust freedom of information laws promote transparency and reasoning by making information that has informed policy decisions accessible.

The chapter is organized by type of instrument and not by health financing function because many of these instru-

Table 6. Policy instruments for promoting procedural fairness

Type of instrument	Description
Legislative and regulatory	Legislative and regulatory instruments refer to legally binding provisions, such as laws and acts, enacted by legislative bodies to enforce criteria for procedural fairness, along with their detailed implementation instructions, such as directives. This category includes court rulings that interpret and apply the legislative instruments.
Organizational arrangements	Organizational arrangements involve changes to existing decision-making processes, changes in functions or scope of work, or the creation of new processes or organizational entities. Examples include the establishment of government working groups, citizens' juries, or organizational bodies responsible for health technology assessments. In addition, this category includes different types of auditing functions that ensure adherence to policies and procedures, measure performance against predetermined criteria, and convey results to interested users.
Financing and capacity-strengthening	Financing and capacity-strengthening instruments include adequate and stable budgets, which are necessary for developing and implementing other instruments promoting procedural fairness. Budgets need to cover costs for citizen engagement or maintaining free public access to legislative and regulatory documents. This category also includes building knowledge and skills in key areas, including health economics and methods for citizen engagement.
Information management and monitoring	Information management and monitoring encompasses tools for collecting and systematizing information, such as digital platforms for information sharing and soliciting public inputs, databases, data visualization tools for assessing public sector performance on procedural fairness criteria, and instruments for tracking public opinion and progress in policy implementation.

ments are cross-cutting, i.e., they can be used to advance procedural fairness in revenue mobilization decisions as well as pooling and purchasing. For example, different methods for citizen engagement, such as citizens' juries or public hearings, have been used for questions related to taxes as well as for determining which services to include in a health benefit package. While the focus here is on instruments that countries have used domestically in the pursuit of procedural fairness, the latter sections of the chapter also describe ways the international community has supported procedural fairness at country level by developing global instruments, providing funding, and through capacity-strengthening.

4.1 Legislative and regulatory instruments

A country's constitution serves as its fundamental legal framework, and constitutional provisions can promote procedural fairness in health financing. An example from South Africa shows how adherence to constitutional rules can shape revenue mobilization decision-making in a manner that strengthens procedural fairness. Section 77 of the South African Constitution defines "Money Bills," which are any laws that involve the allocation of public funds for a specific purpose or the imposition of taxes, levies, and duties (Parliament of the Republic of South Africa 2023; Government of South Africa 1996). The Constitution mandates a process with public involvement in the preparation of "Money Bills." Based on this mandate, before the introduction of such a bill in Parliament, the South African National Treasury publishes a discussion document or a draft bill and invites public comments. It is customary to host public consultations with stakeholders to engage with the comments and to redraft the bill (Kruger et al. forthcoming).

A recent illustration is the case of the Health Promotion Levy (HPL) on sugar-sweetened beverages (SSBs) (Hofman et al. 2021). The draft bill and key discussion documents were publicly released by the National Treasury, enabling public scrutiny of the justification and supporting scientific evidence (National Treasury of South Africa 2016). Four public hearings were conducted, with two taking place before the drafting of the bill (Finance Standing Committee 2017b, 2017a). This approach fostered participation and inclusivity by enabling a broad range of stakeholders to engage in the process. During these sessions, representatives from the National Treasury had to explain the rationale behind the proposed new tax, thereby promoting reason-giving. Finally, the National Treasury substantiated its consideration of all inputs by offering a written, point-by-point response in a final response document justifying the choices made (National Treasury of South Africa 2017).

Legal frameworks governing the public sector can play an important role in promoting procedural fairness. For example, Freedom of Information Laws exist in a majority of countries worldwide and are key in promoting transparency and public reasoning for all types of health financing decisions (World Bank 2020). For example, Ukraine's law "On Access to Public Information" (2011) was pivotal in promoting transparency and public participation when the subsequent law on "Government Financial Guarantees of Health Care Services" (Law 2168) was drafted, leading to the creation of a single pool to finance the benefits package provided by the National Health Service of Ukraine. Although there are gaps in compliance, the public information law is considered to have a powerful impact on strengthening transparency in Ukraine (Dzhygyr et al. forthcoming; Oleksiyuk 2018). It mandates that public authorities, as well as publicly owned or publicly funded organizations, regularly disclose information about their operations, activity plans, decisions, reports, and service provision rules online and in print. In addition, any citizen or organization can request additional information, which needs to be provided within five days.

In many settings, specific legislation governs and sets the legal framework for budgeting processes, providing rules and regulations that promote transparency, participation, and enforcement. Laws pertaining to national budget systems promote transparency in revenue mobilization decisions by specifying the schedule and procedures by which a country's budget should be prepared, approved, executed, accounted for, and when final accounts should be submitted for approval (de Renzio and Kroth 2011; Santiso 2004; Lienert and Fainboim 2010). These laws can also serve as a tool for promoting inclusiveness and participation by prescribing what types of stakeholders must participate in various stages of the budgetary process. For example, in the Kyrgyz Republic, the Budget Code is a key document describing the roles and responsibilities of the Ministry of Finance as well as line ministries and the parliament, and key steps in the preparation of the budget, as well as its approval, execution, and the auditing of expenditure (President of the Kyrgyz Republic 2016). The Budget Code also regulates civil society involvement, public hearings, and publication of budgetary documents.

Health sector legislation can incorporate provisions that mandate the use of specific instruments that promote procedural fairness. In Thailand, the National Health Security Act of 2002, which established the country's Universal Coverage Scheme (UCS), includes provisions that mandate citizen representation in governing bodies and the implementation of public participation processes (Kantamaturapoj, Kulthanasorn, et al. 2020; Marshall et al. 2021). For example, the National Health Security Board, the governing body of the UCS, consists of 30 members, with five seats reserved for citizens selected from civil society organizations related

to specific health constituencies. Citizens' participation on the board empowers them to influence decisions and ensure representation of their diverse interests and needs related to the standards and scope of health services provided, administrative policies, budgeting, and other governance matters. The National Health Security Act's legislative provisions also mandate public disclosure of information pertaining to the financial, operational, and performance aspects of the scheme; annual public hearings to gather experiences and opinions from citizens; and mechanisms for handling and responding to citizen complaints (Kantamaturapoj, Kulth-anmanusorn, et al. 2020; Kantamaturapoj, Marshall, et al. 2020; Marshall et al. 2021).

Finally, court rulings can contribute to promoting a fair process by interpreting and enforcing the laws and regulations described above. For example, as discussed in Chapter 1, in 2008, the Constitutional Court of Colombia ordered the unification of benefits plans for the country's contributory and subsidized health insurance schemes (Arrieta-Gomez 2018; Yamin and Parra-Vera 2009). The court justified its decision on the grounds that the existing two-tiered system, where the subsidized scheme offered access to less than half the entitlements available under the contributory scheme, violated principles of equality and non-discrimination enshrined in the Constitution. The Constitutional Court underscored procedural fairness by calling for transparency and participation in determining benefits, the robust use of evidence to inform such decisions, and the oversight of provider performance and health insurance entities through audits (Yamin and Parra-Vera 2009).

4.2 Organizational arrangements

Organizational arrangements can range from temporary structures with limited scope and participation (e.g., health financing working groups) to creating new bodies (e.g., a Supreme Audit Institution or a separate health technology assessment body) to broader participatory processes (e.g., national dialogues such as the Societal Dialogue for Health in Tunisia). This section first presents more traditional and less resource-intensive approaches, which often involve limited participation outside of government. It next describes experiences with establishing new bodies or expanding the functions of existing ones to promote procedural fairness principles and criteria. Finally, the section highlights experiences with more ambitious ways of engaging citizens that can be organized as one-off events or established as more permanent structures.

To inform health financing decisions, it is common practice to set up time-limited task forces, working groups, and similar organizational structures during the early phase of

the policy process. The composition of these groups is key for inclusivity. In Tanzania, for example, the Ministry of Health led the development of the improved Community Health Fund (iCHF) by establishing a task force that included government agencies, development partners, and some of the private organizations supporting the implementation of CHF schemes. However, this structure provided few openings for community voice (Binyaruka et al. forthcoming). Reports suggest that limited inclusivity and transparency in launching the iCHF and communicating its benefits have led to misunderstanding and mistrust among community members regarding key aspects of the scheme (Afriyie et al. 2021).

New permanent bodies can be established to strengthen information, voice, and/or oversight. To set priorities in the design of benefits packages, numerous countries in every region have now established bodies responsible for health technology assessments (HTA) (Bertram, Dhaene, and Tan-Torres Edejer 2021). Examples from different regions include the National Institute for Health and Care Excellence (NICE) in the United Kingdom (UK) (Cowles et al. 2017), the Health Intervention and Technology Assessment Program (HITAP) in Thailand (Tantivess, Teerawattananon, and Mills 2009), the National Authority for Assessment and Accreditation in Healthcare in Tunisia (Fasseeh et al. 2020), the Pharmaceutical Benefits Advisory Committee (PBAC) in Australia (Kim, Byrnes, and Goodall 2021), and the National Center for Health Technology Excellence in Mexico (Gómez-Dantés and Frenk 2009). Considerable variation exists in these institutions' legal foundations, design, relationship to the ministry of health, decision processes, and whether their recommendations are binding. However, they strive for transparency and the inclusive involvement of stakeholders, and a broad and robust evidence base when making decisions. They typically offer affected parties opportunities for revisions and appeal, although the effectiveness of these mechanisms varies (Bertram, Dhaene, and Tan-Torres Edejer 2021).

An organizational feature adopted specifically to strengthen participation and inclusiveness in purchasing decisions has been the direct representation of civil society members in purchasers' supervisory boards. Thailand has a well-established practice of civil society participation (Marshall et al. 2021), while the Kyrgyz Republic (Habicht et al. 2020) and Ukraine (World Health Organization and World Bank 2019) have introduced these features more recently.

Earlier chapters made a distinction between directional and technical decisions in health financing: countries typically ensure more participation in the former than in the latter, where technical committees often draw on subject matter experts to analyze and interpret complex technical issues and data (Eriksen 2022a). A prime example is National Immunization Technical Advisory Groups (NITAGS),

used in many countries to assess the cost-effectiveness of new vaccines prior to a decision about whether they should be publicly financed (Donadel et al. 2021). For these types of committees, organizational rules of procedure can be an instrument that promotes other criteria of procedural fairness. For example, the UK JCVI's Code of Practice specifies management of conflicts of interest to ensure impartiality, transparent appraisal of the evidence base, and publicly releasing the reasoning underpinning Committee decisions, including points of disagreement (JCVI 2013).

Supreme Audit Institutions (SAIs) play an important role in promoting transparency, citizen participation, inclusivity, and enforcement by providing objective, unbiased, and accessible information on how public funds are managed (Castro 2022). Audit reports inform the public as well as the country's legislature about how governments use public funds and the results they achieve. For example, during the Ebola outbreak in 2014-15, the SAIs of Liberia and Sierra Leone conducted real-time audits as well as retrospective analyses in the aftermath of the outbreak (INTOSAI Development Initiative et al. 2020), yielding findings that have proved relevant for managing the COVID-19 pandemic.

SAIs can incorporate civil society priorities by aligning future audits with areas of concern identified by citizens and integrating civil society feedback to shape the scope of audit processes. A notable example is Argentina's SAI, which has held annual meetings with diverse civil society organizations since 2004, allowing these groups to propose audit topics for inclusion in the subsequent year's action plan (Open Government Partnership 2020).

In many contexts, legislative processes for policy proposals incorporate public hearings (Mikuli and Kuca 2016; Parliament of the Republic of South Africa n.d.). These can provide a platform for stakeholders to give input on financing choices influencing the expansion of health care coverage toward UHC. As mentioned above, to fulfil the legislative requirements under Thailand's National Health Security Act, annual public hearings have been implemented to gather input from citizens on priorities for new benefits within the Universal Coverage Scheme (UCS) (Viriyathorn et al. forthcoming). Through the annual public hearings, important changes to UCS benefits have been initiated, such as the harmonization of access to emergency services and the removal of the two-child limit on covered birth deliveries (Kantamaturapoj, Kulthanmanusorn, et al. 2020).

Citizens' juries and other processes based on random selection of participants are increasingly being used to involve members of the public in decision-making. Under these models, a group of randomly chosen citizens have the

opportunity to deliberate on a particular issue and provide recommendations to decision-makers (Street et al. 2014; Reckers-Droog et al. 2020). Random selection enables inclusiveness and favors a diverse range of perspectives representative of the population at large. This can help strengthen legitimacy and reinforce trust in the decision process. In Brisbane, Australia, for example, a citizens' jury was convened to deliberate on the proposal to increase taxes on SSBs (Moretto et al. 2014). The jury was tasked to evaluate the acceptability of using taxation to influence the consumption of unhealthy drinks and curb the prevalence of childhood obesity.

A related instrument used to understand how the deliberative process influences participants' views is deliberative polling. It involves a representative sample of citizens who are surveyed before engaging in structured discussions and deliberations and who then complete a post-deliberation survey to measure changes in their opinions. In Chile in 2020, a multi-stakeholder partnership involving the Tribu Foundation, academic institutions, and the Chilean senate implemented deliberative polling with a random sample of 514 citizens (Sartor and CDD 2022). The goal was to discuss pension and health financing reform proposals, including an increase in taxes or insurance premiums to finance treatment for rare diseases, as well as implementing a single insurer for everyone. The Chilean example demonstrated a crucial lesson from deliberative polling: through the process, citizens adjusted their views on policy proposals in light of new information and moderated discussion, with participants in some cases becoming less favorable toward the proposals under consideration. Results underscore the importance of engaging citizens in informed, deliberative discussions and using these processes to ensure that public values and preferences are reflected in health financing reforms.

Some countries have adopted ambitious, broad-based instruments to promote public participation and strengthen transparency and other procedural fairness criteria. One model is often referred to as a "societal" or "national" policy dialogue. Two examples show how this approach has been used to promote participation and inclusiveness when exploring critical questions related to health financing. One is from Tunisia, which initiated a "Societal Dialogue for Health" in 2012 as part of its post-revolution political reforms (Ben Mesmia, Chtioui, and Ben Rejeb 2020). The objective was to facilitate a transparent and participatory approach in exploring critical decisions that would shape the country's health financing system and set its long-term directions. This involved working closely with civil society groups under the Societal Dialogue for Health and establishing a Citizen Participation Unit in the Ministry of Health to mainstream participation and inclusiveness in future decision-making. Morocco adopted a similar mech-

anism in the development of its health financing strategy. The Moroccan model brought together government officials, civil society groups, private sector representatives, and parliamentarians, with a focus on reducing fragmentation between existing health insurance schemes (Akhnif et al. 2020).

Participatory budgeting is a broad-based instrument applied specifically to the budgeting process. It has been implemented across a wide range of settings (Bartocci et al. 2022). It enhances public participation in budget decisions; increases the likelihood that public preferences and needs will be considered; boosts transparency by sharing information on the allocation and use of public funds; and enhances reason-giving by requiring clear justifications from decision-makers. However, evidence from a range of settings suggests that realizing the potential of participatory budgeting requires strategies for securing diverse and representative groups of participants and addressing power imbalances among participants (Bartocci et al. 2022; Calisto Friant 2019; Sintomer, Herzberg, and Röcke 2008).

While much of the empirical evidence on the use of participatory budgeting comes from the local level, the Republic of Korea offers an instructive case of its application to national budget decisions (Yoon 2021). Following the establishment of a dedicated division for the purpose within the Ministry of Economy and Finance, opportunities for participation have been created by implementing a dedicated online platform where participants can rate existing budget proposals and make their own suggestions. Reason-giving is improved when government officials responsible for budget decisions are expected to consider citizen preferences and priorities expressed via the participatory platform and explain the ultimate allocation of budget resources in light of citizen input.

4.3 Financing and capacity strengthening

Instruments in this category include dedicated budgets to cover implementation costs; building administrative capacity to manage organizational arrangements; financial incentives and skill-building to empower the public to participate; and building technical capacity on health financing in the ministry of health.

Experience across different contexts demonstrates the importance of having dedicated budgets to cover the costs of instruments that promote procedural fairness in decision-making processes. For example, the government

of the Republic of Korea has set aside the equivalent of GBP 1.2 million to fund the national participatory budgeting group, conduct surveys, raise public awareness, and support the facilitation of participatory budgeting at the national level.⁷

Implementing and managing instruments like public hearings, citizens' panels, and deliberative polling requires building administrative capacity to ensure that deliberations are well structured and facilitated, and that all participants have equal opportunities to express their opinions. This includes dedicating staff to manage the process, training and incentivizing participants, and allowing the public adequate time to develop considered collective recommendations (Abelson, Warren, and Forest 2012; Calisto Friant 2019; Sintomer, Herzberg, and Röcke 2008). Thailand's experience with conducting annual public hearings highlights the critical importance of skilled professional facilitation to ensure meaningful public engagement and uphold the principle of equality (Kantamaturapoj, Marshall, et al. 2020).

Examples from Tanzania and The Gambia highlight how the lack of adequate financing and administrative capacity can limit the effectiveness of mechanisms aiming to increase transparency and participation. Tanzania's Council Health Services Boards (CHSB), the entities responsible for reviewing local health plans and budgets, did not have funds to organize regular meetings and appropriate training for members representing the community, who were expected to contribute to priority-setting in their districts (Maluka et al. 2010). A lack of clearly defined budget for these activities hampered the effectiveness of the CHSB. In The Gambia, during discussion of the National Health Insurance Scheme (NHIS) bill in the National Assembly, the government faced time and resource constraints that prevented officials from organizing public consultations through "Citizen Bantabas" – a traditional practice where community members gather to discuss critical societal issues and that might have boosted public understanding and trust in the decision process (Njie, Dale, and Gopinathan forthcoming).

Financial incentives can be essential to removing economic barriers that prevent disadvantaged populations from participating in activities like public hearings, citizens' panels, and participatory budgeting. Without adequate resources, individuals from low-income backgrounds may find it difficult to take part in these initiatives, which can further deepen inequality and exclusion. For example, to strengthen inclusiveness when the citizens' panel was implemented in Brisbane to deliberate on taxation of SSBs, participants were offered a stipend of \$A 200 and vouchers

⁷ <https://participedia.net/case/7431>

to assist with their transportation and accommodation needs (Moretto et al. 2014). Similarly, to strengthen representation during annual public hearings in Thailand, expenses such as transportation costs for all attendees are included in the budget of the National Health Security Office (Kantamaturapoj, Marshall, et al. 2020). However, achieving greater inclusiveness requires more than just financial incentives; it also depends on investing resources to strengthen knowledge among marginalized and vulnerable populations. Developing critical thinking, communication, research, and analytical skills among these groups can enable them to more effectively engage in decision-making processes (Snow, Tweedie, and Pederson 2018; Montesanti et al. 2017).

Building technical capacity in health economics and financing policy within the ministry of health itself is considered a key instrument for promoting use of evidence in health financing decisions for UHC. Ethiopia provides a valuable example of how civil servant training can build capacity for accuracy of information. Policy makers at the Federal Ministry of Health and researchers at academic institutions have received PhD-level training in ethics, health economics, and priority setting, partly enabled through a long-term international partnership with academic institutions. This capacity was foundational to the revision of the country's essential health services package (Eregata et al. 2020). The revision process involved extensive consultations with technical experts and members of the public and relied on evidence concerning seven prioritization criteria, including cost-effectiveness, equity impacts, and financial risk protection (Eregata et al. 2020; Hailu et al. 2021; Verguet et al. 2021).

In Thailand, a capacity-strengthening instrument for promoting accuracy of information has been the International Health Policy Program (IHPP), a unit within Thailand's Ministry of Public Health. The IHPP was established to build national capacity for generating research and evidence, including by supporting training in academic institutions abroad (Pitayarangsarit and Tangcharoensathien 2009). The unit has been instrumental in enhancing capacity to produce HTAs and other sources of information needed to inform the inclusion of new benefits and the overall design and development of Thailand's tax-financed universal coverage scheme (Tangcharoensathien et al. 2013; Tangcharoensathien, Wibulpholprasert, and Nitayaramphong 2004). Thailand's capacity-strengthening efforts have also focused on the contributions of civil society organizations and community members, in addition to policy makers, politicians, local administrative organizations, government services, academia, think tanks, and research institutions. This collaborative "triangle that moves the mountain" approach has been pivotal in informing health financing decisions and accelerating

Thailand's progress towards UHC (Tangcharoensathien et al. 2021).

4.4 Information management and monitoring

Information management and monitoring instruments play a key role in promoting transparency, accuracy of information, public participation, and enforcement. They are also important for measuring performance with respect to the different criteria for procedural fairness.

Some well-recognized tools for monitoring and assessing budget transparency, public participation, and reason-giving practices have been developed and led by global or regional initiatives and are described in the next section. Others, such as Kenya's County Budget Transparency Survey (CBTS), are developed and led locally, though they originated from the Open Budget Survey (OBS), a global assessment of budget transparency, participation, and oversight conducted by the International Budget Partnership (IBP). Kenya's survey, most recently published in 2023, has been used to assess transparency and public participation practices among the 47 county governments (IBP Kenya, 2023). The survey measures county governments' compliance with the national legal and regulatory framework on budget transparency and participation, including the Constitution, the Public Finance Management Act, and other relevant laws and regulations. By providing a transparency scorecard for each county government and highlighting areas for improvement, the CBTS empowers civil society organizations, policy makers, and citizens to advocate for more effective and inclusive budget processes.

An increasingly used tool is a citizens' budget, which is an easy-to-understand document that summarizes and explains to the public the main features of the annual budget of a country or subnational jurisdiction (Petrie and Shields 2010; IBP 2015). Transparency is promoted by governments' publishing critical budget information in a manner that is readily accessible to the public. Such access is also a prerequisite for participation and reason-giving in the budgetary process, since it enables people to ask questions and request explanations for the choices made. For example, as part of its democratic transition, The Gambia is piloting citizens' budgets to provide clear, simplified summaries of the government's revenue and expenditure plans, thereby enabling citizens to have a better understanding of how public funds are allocated (Lizundia 2020).

Certain participation tools also offer opportunities for monitoring by citizens. One instrument is the use of citi-

zen or community scorecards in the health sector to monitor provider performance and the quality of health services and thereby strengthen transparency and enforcement (Björkman and Svensson 2009). These scorecards, which have been trialed in Afghanistan, the Democratic Republic of Congo, Ghana, Malawi, and Uganda, are based on surveys among health service users regarding their experiences with health service providers (Björkman and Svensson 2009; Kiracho et al. 2021). They typically encompass questions on multiple facets of health service delivery, including access, quality, medicine availability, and provider responsiveness. Shared with providers and policy makers, these scorecards can trigger plans to address citizen concerns. However, they are often implemented with external support and not routinely as part of regular public sector processes. To overcome this problem, in Uganda, ongoing discussions led by the government, with support from local and international research institutions, are focusing on the implementation of community score cards on a routine basis, with the aim of linking them to decision-making processes (Kiracho et al. 2021).

Information management tools can reinforce monitoring of the key procedural fairness criteria. Online platforms and other e-government solutions are increasingly recognized as tools for improving public access to information, including detailed information on policy implementation and performance, and enabling the public to monitor public institutions. For example, in Chile, the Council for Transparency developed an online platform to give access to data on public officials' hearings and meetings. All the information can be searched and filtered by policy maker, participating stakeholders, or dates, and the Council's datasets can be downloaded for further analysis and/or reuse. Moreover, the online tool allows users to visualize time trends, compare information across ministries, and see infographics on companies, types of interests represented, and other variables.

Databases that compile quality-assured cost data are important for purchasing decisions in health. In India, the Indian National Cost Database, set up in 2015, seeks to fill a gap in the availability of transparent, accurate, and up-to-date information around provider-payment rates. In 2016, data on the unit costs of health services from 167 public health facilities (district-level and below) located in six different states across India were collected and made available in the database. New waves of data collection followed. The collected cost data were among the sources used to inform reimbursement rates for AB-PMJAY, India's publicly funded health insurance scheme covering approximately 10 million families, as well as for the costing

of PMJAY COVID-19 Health Benefit Packages (Guinness et al. 2020; Prinja et al. 2020).

4.5 Global initiatives and external support

Open and inclusive processes in health financing can only gain lasting traction at national level if they are country owned and led. However, regional and global organizations can play an important facilitating role in certain contexts, for instance by providing funding, strengthening country capacities, or developing global or regional tools that supplement domestic strategies and instruments.

International seed funding and technical support served as a catalyst for Tunisia's Societal Dialogue for Health, described above. In Turkey, the integration of Green Card holders⁸ into the General Health Insurance System was based on a thorough technical analysis and evidence produced by a team of both local and international experts. To access the necessary expertise, the Ministry of Health commissioned multiple technical reports and received external funding from institutions like the World Bank (Atun et al. 2013). Similarly, health financing decisions in Ethiopia and Ukraine, described above, benefited from targeted technical assistance and capacity-strengthening supported by external partners.

Examples of globally developed tools that countries can draw on in revenue mobilization include the IBP's Open Budget Survey (OBS), previously cited, and the Public Expenditure and Financial Accountability (PEFA) approach. The OBS regularly publishes country rankings as well as more detailed reports on public participation, transparency, and oversight around public budgets, encouraging countries to consider their performance on procedural fairness (IBP 2022). The PEFA framework is another global monitoring instrument. It provides countries with a standardized assessment of how well they fare on key criteria of procedural fairness, including transparency, reason-giving, and enforcement (PEFA 2022). Transparency and reason-giving are covered by PEFA indicators on public access to information, good budget documentation, and alignment of strategic plans and medium-term budgets, while enforcement of decisions is captured by indicators for budget reliability and oversight (PEFA 2019).

In purchasing, tools are available to facilitate a systematic approach to setting health priorities, particularly in low- and lower-middle-income settings. The Disease Control

⁸ These were members of a separate non-contributory government-funded health insurance scheme for the poor.

⁹ <https://www.uib.no/en/bceps/130756/fairchoices-dcp-analytics-tool>.

Priorities (DCP) publications, for example, promote the use of evidence-based decision-making in setting health priorities. The fourth edition of DCP (DCP4), expected in 2025, will suggest updated essential UHC packages and intersectoral policies using new evidence. It will be accompanied by new tools, like the FairChoices-DCP Analytics Tool,⁹ to support countries in their revision of essential health care packages using evidence-based evaluations to assess impact on health, equity, and financial risk protection.

4.6 General observations from country experience

The country examples showcased in this chapter highlight the range of tools that countries have used to promote procedural fairness in health financing for UHC, across settings with diverse income levels and political systems. The instruments described cut across all three health financing functions. This chapter has not attempted to critically analyze the impact of each tool separately or in combination. Its objective has been to indicate the diversity and potential complementarity of instruments that countries can draw on and adapt to their own circumstances. Countries' use of these instruments enables several general observations, of which we emphasize four.

First, in many countries examined in this report, including in South Africa, Thailand, and Ukraine, legislative and regulatory instruments provide an important basis for procedural fairness. Often, these take the form of broad laws governing the public sector, such as Freedom of Information Laws. In a few cases, health-specific legislation builds upon these laws, further strengthen-

ing conditions that promote criteria such as transparency, participation, and inclusiveness.

Second, the country examples suggest that countries use a combination of instruments to promote procedural fairness. Reports from Ethiopia and Thailand highlight how these countries aligned organizational instruments for public participation and transparency with capacity-strengthening instruments like civil servant training for managing participatory processes and generating and using evidence. This appears to have contributed to a stronger foundation for fairer processes for health financing decisions in these settings. In other cases, such as Tanzania and The Gambia, the effectiveness of organizational instruments has been undermined by a lack of financing and administrative capacity to organize regular meetings at subnational level.

Third, as was also noted in Chapter 3, for some decisions countries draw to a greater extent on technical experts, with limited public participation for those specific decisions. Greater public participation is often elicited for higher-level policy decisions that set overall directions for health financing. In the case of decisions largely driven by expert committees, such as the UK's JCVI for vaccine decisions, instruments like organizational rules of procedure can improve procedural fairness by promoting accuracy of information, transparency, and reason-giving.

Finally, the range of instruments available, their applicability to all parts of health financing, and the diversity of countries in which they have been used suggest that all countries can make progress towards fairer decisions for UHC – with the goals of improving participation, inclusiveness, transparency, and accuracy of information in health financing decisions.

5

The way forward: Working together for fairer decisions on the path to UHC

Building on a clear understanding of the types of health financing decisions that can affect the substantive equity of coverage outcomes, including who accesses health services and who suffers severe financial hardship from paying out-of-pocket for them, this report has made the case that fair processes to reach decisions in these areas have numerous benefits. Procedural fairness can contribute to more equitable outcomes, strengthen the legitimacy of the process, foster trust in public institutions, and increase the sustainability of health financing decisions.

The foundations of fairer processes in health financing are the core principles of equality, impartiality, and consistency over time. Procedural fairness requires that health financing decisions be guided by these principles. Translating principles into practice involves implementing seven criteria, spanning three domains. The first domain, information, incorporates reason-giving, transparency, and accuracy of information. The second, voice, involves applying instruments to enable public participation and securing inclusive representation in these mechanisms. The third domain, which includes revisability and enforcement, is about process oversight.

Governments, civil society, international partners, and scholars can work in complementary ways to apply these principles and criteria and improve procedural fairness in countries.

This report has described a range of policy instruments that governments are using and adapting to promote procedural fairness in health financing decisions. These include legislative and regulatory tools, organizational arrangements, financing and capacity-strengthening measures, and tools related to information management and monitoring. As they apply these instruments, governments can use the fair-process principles and criteria to systematically examine their decision-making processes and address gaps. For

example, where appropriate laws and regulations are in place, governments can assess how effectively they are implemented and whether practice is consistent with intent.

While oversight functions rest with governments, civil society actors can play a key role in enforcing oversight and propelling change. Civil society actors can use the report's principles and criteria to monitor procedural fairness in health financing and hold governments accountable for implementing laws and regulations. They can also work with governments to engage the public more actively and directly in decisions requiring wider participation.

International partners can use the criteria to examine their own decision-making processes, as well as the decisions that are made at country level in programs they support. They can also provide technical and financial resources to enable countries to strengthen their regulatory frameworks and data collection and assessment systems and establish robust institutional mechanisms to meet procedural fairness criteria.

Scholars from different fields can use this report to pursue an interdisciplinary research agenda on procedural fairness in health financing. Future research can help generate deeper understanding of how the principles and criteria proposed in this report can support fairer policies and outcomes; how they can be applied in different settings in a feasible and sustainable way; and how to improve them over time.

Countries face practical constraints in implementing the principles and criteria, and it is not feasible or desirable to apply them uniformly across all health financing decisions. A practical approach to procedural fairness depends on many factors, with country capacities and specific contextual circumstances being of primary importance. For example, while most countries encourage some form of

public participation in policy development, there might be reasonable limits to public participation in technical discussions that require specialized expertise. There are also trade-offs in terms of the urgency of decision-making, since implementing instruments promoting procedural fairness is likely to take more time than a less open and inclusive approach. Investing in such efforts may result in a longer timeline for developing health financing strategies or enacting new tax laws. However, this investment increases opportunities to unlock the benefits associated with fair-process principles and criteria.

This report has confirmed that, even with limited resources, a growing number of countries are taking steps towards a fairer process for decisions in health financing. These countries have recognized that concerns for a fair process are not secondary or optional complements to core health financing goals. Translating fair-process principles and criteria into practice can improve countries' UHC results. By integrating fairer processes into health financing, more equitable outcomes can be promoted, while enhancing legitimacy, trust, and the long-term sustainability of reforms.

References

- Abelson**, Julia, P. G. Forest, J. Eyles, P. Smith, E. Martin, and F. P. Gauvin. 2003. "Deliberations about deliberative methods: issues in the design and evaluation of public participation processes." *Social Science & Medicine* 57 (2): 239-51. [https://doi.org/10.1016/s0277-9536\(02\)00343-x](https://doi.org/10.1016/s0277-9536(02)00343-x)
- Abelson**, Julia. 2001. "Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada." *Social Science & Medicine* 53 (6): 777-793. [https://doi.org/10.1016/s0277-9536\(00\)00386-5](https://doi.org/10.1016/s0277-9536(00)00386-5)
- Abelson**, Julia, Erika A. Blacksher, Kathy K. Li, Sarah E. Boesveld, and Susan D. Goold. 2013. "Public deliberation in health policy and bioethics: mapping an emerging, interdisciplinary field." *Journal of Deliberative Democracy* 9 (1).
- Abelson**, Julia, Mark E. Warren, and Pierre-Gerlier Forest. 2012. "The future of public deliberation on health issues." *The Hastings Center Report* 42 (2): 27.
- Afriyie**, Doris Osei, Brady Hooley, Grace Mhalu, Fabrizio Tediosi, and Sally M. Mtenga. 2021. "Governance factors that affect the implementation of health financing reforms in Tanzania: an exploratory study of stakeholders' perspectives." *BMJ Global Health* 6 (8): e005964.
- Agyepong**, Irene Akua, and Sam Adjei. 2008. "Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme." *Health Policy and Planning* 23 (2): 150-160.
- Akhnif**, El Houcine, Hafid Hachri, Abdelouahab Belmadani, Awad Mataria, and Maryam Bigdeli. 2020. "Policy dialogue and participation: a new way of crafting a national health financing strategy in Morocco." *Health Research Policy and Systems* 18: 1-12.
- Andia**, Tatiana S., and Everaldo Lamprea. 2019. "Is the judicialization of health care bad for equity? A scoping review." *International Journal for Equity in Health* 18 (1): 1-12.
- Arrieta-Gómez**, A. I. 2018. "Realizing the Fundamental Right to Health through Litigation: The Colombian Case." *Health and Human Rights* 20 (1): 133-145.
- Atun**, Rifat, Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, Ipek Gürol, Serpil Nazlıoğlu, Şenay Özgülcü, Ülger Aydoğan, and Banu Ayar. 2013. "Universal health coverage in Turkey: enhancement of equity." *The Lancet* 382 (9886): 65-99.
- Ayala**, Ricardo, and Bernardo Alarcon. 2020. "The social contract and health care in Chile." *The Lancet* 396 (10255): 882-883. [https://doi.org/10.1016/S0140-6736\(20\)31969-3](https://doi.org/10.1016/S0140-6736(20)31969-3)
- Baber**, Walter, and Robert Bartlett. 2018. "Deliberative Democracy and the Environment." In *The Oxford Handbook of Deliberative Democracy*, edited by Andre Bachtiger, John S. Dryzek, Jane Mansbridge, and Mark Warren. Oxford, UK: Oxford University Press.
- Bachtiger**, Andre, John S. Dryzek, Jane Mansbridge, and Mark Warren. 2018. "Deliberative Democracy: An Introduction." In *The Oxford Handbook of Deliberative Democracy*, edited by Andre Bachtiger, John S. Dryzek, Jane Mansbridge, and Mark Warren. Oxford, UK: Oxford University Press.
- Barasa**, Edwine W., I. Mathauer, E. Kabia, N. Ezumah, R. Mbau, A. Honda, F. Dkhimi, O. Onwujekwe, H. T. Phuong, and K. Hanson. 2021. "How do healthcare providers respond to multiple funding flows? A conceptual framework and options to align them." *Health Policy and Planning* 36 (6): 861-868. <https://doi.org/10.1093/heapol/czab003>

- Barasa**, Edwine W., S. Cleary, S. Molyneux, and M. English. 2017. "Setting healthcare priorities: a description and evaluation of the budgeting and planning process in county hospitals in Kenya." *Health Policy & Planning* 32 (3): 329-337. <https://doi.org/10.1093/heapol/czw132>
- Barasa**, Edwine W., Thomas Maina, and Nirmala Ravishankar. 2017. "Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya." *International Journal for Equity in Health* 16 (1). <https://doi.org/10.1186/s12939-017-0526-x>
- Barnes**, Marian, and Vera Schattan Coelho. 2009. "Social participation in health in Brazil and England: inclusion, representation and authority." *Health Expectations* 12 (3): 226-236.
- Bartocci**, Luca, Giuseppe Grossi, Sara Giovanna Mauro, and Carol Ebdon. 2022. "The journey of participatory budgeting: a systematic literature review and future research directions." *International Review of Administrative Sciences*. <https://doi.org/10.1177/00208523221078938>
- Beauvais**, Edana. 2018. "Deliberation and Equality." In *The Oxford Handbook of Deliberative Democracy*, edited by Andre Bachtiger, John S. Dryzek, Jane Mansbridge, and Mark Warren. Oxford, UK: Oxford University Press.
- Ben Mesmia**, H., R. Chtioui, and M. Ben Rejeb. 2020. "The Tunisian societal dialogue for health reform (a qualitative study)." *European Journal of Public Health* 30 (Supplement_5): ckaa166. 1393.
- Bertram**, M., G. Dhaene, and T. Tan-Torres Edejer. 2021. Institutionalizing health technology assessment mechanisms: a how-to guide. Geneva: World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/340722/9789240020665-eng.pdf?sequence=1&isAllowed=y>
- Binyaruka**, Peter, Gemini Mtei, John Maiba, Unni Gopinathan, and Elina Dale. Forthcoming. "Fair process for financing universal health coverage: improved community health fund (iCHF) in Tanzania." *Health Policy and Planning* (supplement scheduled for 2023).
- Björkman**, Martina, and Jakob Svensson. 2009. "Power to the people: evidence from a randomized field experiment on community-based monitoring in Uganda." *The Quarterly Journal of Economics* 124 (2): 735-769.
- Bohman**, J. 2012. "Representation in the deliberative system." In *Deliberative Systems: Deliberative Democracy at the Large Scale*, edited by J. Parkinson & J. Mansbridge, 72-94. Cambridge: Cambridge University Press. <https://doi.org/10.1017/CBO9781139178914.005>
- Bollyky**, Thomas J., Tara Templin, Matthew Cohen, Diana Schoder, Joseph L. Dieleman, and Simon Wigley. 2019. "The relationships between democratic experience, adult health, and cause-specific mortality in 170 countries between 1980 and 2016: an observational analysis." *The Lancet* 393 (10181): 1628-1640. [https://doi.org/10.1016/S0140-6736\(19\)30235-1](https://doi.org/10.1016/S0140-6736(19)30235-1)
- Bollyky**, Thomas J., Erin N. Hulland, Ryan M. Barber, James K. Collins, Samantha Kiernan, Mark Moses, David M. Pigott, Robert C. Reiner Jr, Reed J. D. Sorensen, and Cristiana Abbafati. 2022. "Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021." *The Lancet* 399 (10334): 1489-151. [https://doi.org/10.1016/S0140-6736\(22\)00172-6](https://doi.org/10.1016/S0140-6736(22)00172-6)
- Bossert**, Thomas J., and Pablo Villalobos Dintrans. 2020. "Health Reform in the Midst of a Social and Political Crisis in Chile, 2019-2020." *Health Systems & Reform* 6 (1): e1789031. <https://doi.org/10.1080/23288604.2020.1789031>
- Bowlsby**, Scott Fletcher, Lucy J. Parry, and Czimmerman. 2019. "Public Hearing." *Participedia*. Accessed 02.06.2023. <https://participedia.net/method/162>
- Bredenkamp**, Caryn, Elina Dale, Olena Doroshenko, Yuriy Dzhgyr, Jarno Habicht, Loraine Hawkins, Alexandr Katsaga, Kateryna Maynzyuk, Khrystyna Pak, and Olga Zues. 2022. *Health Financing Reform in Ukraine: Progress and Future Directions*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/37585>

- Brendbekken**, Audun, Bjarne Robberstad, and Ole F. Norheim. 2022. "Public participation: healthcare rationing in the newspaper media." *BMC Health Services Research* 22 (1): 407. <https://doi.org/10.1186/s12913-022-07786-w>
- Brown**, Sophie. 2016. "'Everyone sees everything': Overhauling Ukraine's corrupt contracting sector." *Open Contracting Partnership*. <https://medium.com/open-contracting-stories/everyone-sees-everything-fa6df0d00335>
- Buck**, David. 2020. *The English local government public health reforms: An independent assessment*. London, UK: The King's Fund. <https://www.kingsfund.org.uk/sites/default/files/2020-01/LGA%20PH%20reforms%20-%20final.pdf>
- Byсков**, J., B. Marchal, S. Maluka, J. M. Zulu, S. A. Bukachi, A. K. Hurtig, A. Blystad, P. Kamuzora, C. Michelo, L. N. Nyandieka, B. Ndawi, P. Bloch, O. E. Olsen, and React Consortium. 2014. "The accountability for reasonableness approach to guide priority setting in health systems within limited resources--findings from action research at district level in Kenya, Tanzania, and Zambia." *Health Research Policy & Systems* 12: 49. <https://doi.org/10.1186/1478-4505-12-49>
- Calisto** Friant, M. 2019. "Deliberating for sustainability: lessons from the Porto Alegre experiment with participatory budgeting." *International Journal of Urban Sustainable Development* 11 (1): 81-99. <https://doi.org/10.1080/19463138.2019.1570219>
- Castro**, Benjamin Fuentes. 2022. *Supreme Audit Institutions: Natural Allies to Open Government*. *Open Government Partnership*. <https://www.opengovpartnership.org/stories/supreme-audit-institutions-natural-allies-to-open-government/>
- CESCR** (United Nations Committee on Economic, Social and Cultural Rights). 2000. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). In Doc. E/C.12/2000/4. Geneva, Switzerland: United Nations Human Rights Office of the High Commissioner.
- Česnulaitytė**, Ieva. 2020. "Models of representative deliberative processes." In *Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave*, edited by the Organisation for Economic Co-operation and Development (OECD). Paris, France: OECD Publishing.
- Chambers**, Simone. 2018. "Jürgen Habermas, Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy." In *The Oxford Handbook of Classics in Contemporary Political Theory*, edited by Jacob T. Levy. Oxford, UK: Oxford University Press.
- Chemouni**, Benjamin. 2018. "The political path to universal health coverage: power, ideas and community-based health insurance in Rwanda." *World Development* 106: 87-98.
- Chwalisz**, Claudia. 2020. "Introduction: Deliberation and new forms of government." In *Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave*, edited by the Organisation for Economic Co-operation and Development (OECD), 19-32. Paris, France: OECD Publishing.
- Chwalisz**, Claudia, and Ieva Česnulaitytė. 2020. "What is a 'successful' representative deliberative process for public decision making? Assessing the evidence." In *Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave*, edited by the Organisation for Economic Co-operation and Development (OECD), 80-114. Paris, France: OECD Publishing.
- Comptroller and Auditor General**. 2021. "Central oversight of arm's-length bodies." London, UK: National Audit Office of the United Kingdom.
- Cowles**, Emma, Grace Marsden, Amanda Cole, and Nancy Devlin. 2017. "A review of NICE methods and processes across health technology assessment programmes: why the differences and what is the impact?" *Applied Health Economics and Health Policy* 15: 469-477.
- Crancryn**, A. 2019. "The Army Built to Fight 'Medicare for All!'" *Politico*. November 25, 2019. <https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-lobbying-072110>

- Curato**, Nicole, John S. Dryzek, Selen A. Ercan, Carolyn M. Hendriks, and Simon Niemeyer. 2017. "Twelve key findings in deliberative democracy research." *Daedalus* 146 (3): 28-38.
- Dale**, Emma, Grace Marsden, Amanda Cole, and Nancy Devlin. 2017. "A review of NICE methods and processes across health technology assessment programmes: why the differences and what is the impact?" *Applied Health Economics and Health Policy* 15: 469-477.
- Dale**, Elina, Elizabeth Peacocke, Espen Movik, Alex Voorhoeve, Trygve Ottersen, Christoph Kurowski, David Evans, Ole Frithjof Norheim, and Unni Gopinathan. Forthcoming. "Criteria for the procedural fairness of health financing decisions: a scoping review" *Health Policy and Planning* (supplement scheduled for 2023).
- Daniels**, N. 2008a. "Accountability for Reasonableness in Developing Countries: Two Applications." In *Just Health: Meeting Health Needs Fairly*, edited by N. Daniels, 274-296. New York, NY: Cambridge University Press.
- Daniels**, N. 2008b. "How Can We Meet Health Needs Fairly When We Can't Meet Them All? Accountability for Reasonable Resource Allocation." In *Just Health: Meeting Health Needs Fairly*, edited by N. Daniels. New York, NY: Cambridge University Press.
- Daniels**, N. 2008c. *Just Health: Meeting Health Needs Fairly*. New York, NY: Cambridge University Press.
- Daniels**, N., J. Bryant, R. A. Castano, O. G. Dantes, K. S. Khan, and S. Pannarunothai. 2000. "Benchmarks of fairness for health care reform: a policy tool for developing countries." *Bulletin of the World Health Organization* 78 (6): 740-750. <https://pubmed.ncbi.nlm.nih.gov/10916911>
- Daniels**, Norman, and James Sabin. 2008. "Accountability for reasonableness: an update." *British Medical Journal* 337: a1850. <https://doi.org/10.1136/bmj.a1850>
- Daniels**, Norman, and James Sabin. 1997. "Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers." *Philosophy and Public Affairs* 26 (4): 303-350. <https://doi.org/10.1111/j.1088-4963.1997.tb00082.x>
- Das**, Pamela, and Udani Samarasekera. 2011. "The Commission on Macroeconomics and Health: 10 years on." *The Lancet* 378 (9807): 1907-1908. [https://doi.org/10.1016/S0140-6736\(11\)61828-X](https://doi.org/10.1016/S0140-6736(11)61828-X)
- de Lacy-Vawdon**, Cassandra, and Charles Livingstone. 2020. "Defining the commercial determinants of health: a systematic review." *BMC Public Health* 20 (1): 1-16.
- de Renzio**, P., and V. Kroth. 2011. *Transparency and Participation in Public Financial Management: What Do Budget Laws Say?* International Budget Partnership. <https://internationalbudget.org/wp-content/uploads/Research-Note-1-Transparency-in-Public-Finance-Laws1.pdf>.
- De Vos**, P., W. De Ceukelaire, G. Malaise, D. Pérez, P. Lefèvre, and P. Van der Stuyft. 2009. "Health through people's empowerment: a rights-based approach to participation." *Health and Human Rights* 11 (1): 23-35.
- Degeling**, Chris, Stacy M. Carter, and Lucie Rychetnik. 2015. "Which public and why deliberate?—A scoping review of public deliberation in public health and health policy research." *Social Science & Medicine* 131: 114-121.
- Donadel**, Morgane, Maria Susana Panero, Lynnette Ametewee, and Abigail M. Shefer. 2021. "National decision-making for the introduction of new vaccines: A systematic review, 2010–2020." *Vaccine* 39 (14): 1897-1909.
- Dryzek**, John S. 2009. "Democratization as Deliberative Capacity Building." *Comparative Political Studies* 42 (11): 1379-1402. <https://doi.org/10.1177/0010414009332129>
- Dryzek**, John S., and Simon Niemeyer. 2008. "Discursive representation." *American Political Science Review* 102 (4): 481-493.

- Dzhygyr**, Yuriy, Elina Dale, Alex Voorhoeve, Unni Gopinathan, and Katya Maynzyuk. Forthcoming. "Procedural fairness and the resilience of health financing reforms in Ukraine." *Health Policy and Planning* (supplement scheduled for 2023).
- Engineer**, C. Y., E. Dale, A. Agarwal, O. Alonge, A. Edward, S. Gupta, H. B. Schuh, G. Burnham, and D. H. Peters. 2016. "Effectiveness of a pay-for-performance intervention to improve maternal and child health services in Afghanistan: a cluster-randomized trial." *Int J Epidemiol* 45 (2): 451-9. <https://doi.org/10.1093/ije/dyv362>
- Eregata**, G. T., A. Hailu, Z. A. Geletu, S. T. Memirie, K. A. Johansson, K. Stenberg, M. Y. Bertram, A. Aman, and O. F. Norheim. 2020. "Revision of the Ethiopian Essential Health Service Package: An Explication of the Process and Methods Used." *Health Systems & Reform* 6 (1): e1829313. <https://doi.org/10.1080/23288604.2020.1829313>
- Eriksen**, Erik O. 2022a. "Experts: from technocrats to representatives." In *The Accountability of Expertise: Making the Un-Elected Safe for Democracy*, edited by Erik O. Eriksen, 173-195. New York, NY: Routledge.
- Eriksen**, Erik O. 2022b. "Introduction: making the unelected safe for democracy." In *The Accountability of Expertise: Making the Un-Elected Safe for Democracy*, edited by Erik O. Eriksen, 1-13. New York, NY: Routledge.
- Fabbri**, Alice, Lisa Parker, Cinzia Colombo, Paola Mosconi, Giusy Barbara, Maria Pina Frattaruolo, Edith Lau, Cynthia M. Kroeger, Carole Lunny, and Douglas M. Salzwedel. 2020. "Industry funding of patient and health consumer organisations: systematic review with meta-analysis." *British Medical Journal* 368.
- Fasseeh**, Ahmad, Rita Karam, Mouna Jameleddine, Mohsen George, Finn Børllum Kristensen, Abeer A. Al-Rabayah, Abdulaziz H. Alsaggabi, Maha El Rabbat, Maryam S. Alowayesh, and Julia Chamova. 2020. "Implementation of health technology assessment in the Middle East and North Africa: comparison between the current and preferred status." *Frontiers in Pharmacology* 11: 15.
- Finance** Standing Committee. 2017a. Sugary Beverages Tax & Rates and Monetary Amounts Bill: public hearings. National Treasury, Government of South Africa.
- Ford**, A. 2015. "Accountability for reasonableness: the relevance, or not, of exceptionality in resource allocation." *Medicine, Health Care & Philosophy* 18 (2): 217-27. <https://doi.org/10.1007/s11019-014-9592-7>
- Francés**, Francisco, and Daniel Parra-Casado. 2019. Participation as a driver of health equity. Copenhagen, Denmark: WHO Regional Office for Europe. <https://apps.who.int/iris/bitstream/handle/10665/324909/9789289054126-eng.pdf>
- Freeman**, Samuel. 2003. "Introduction: John Rawls - An Overview." In *The Cambridge Companion to Rawls*, edited by Samuel Freeman, 1-61. New York: Cambridge University Press. Original edition, 2002.
- Friedman**, A. 2008. "Beyond accountability for reasonableness." *Bioethics* 22 (2): 101-12. <https://doi.org/10.1111/j.1467-8519.2007.00605.x>
- Fuenzalida-Puelma**, H. L. , S. O'Dougherty, T. Evetovits, C. Cashin, G. McEuen, and M. Kacevicius. 2010. "Purchasing of health care services." In *Implementing Health Financing Reform: Lessons from countries in transition*, edited by J. Kutzin, C. Cashin, and M. Jakab, 155-186. Copenhagen, Denmark: European Observatory on Health Systems and Policies.
- Gibson**, J. L., D. K. Martin, and P. A. Singer. 2004. "Setting priorities in health care organizations: criteria, processes, and parameters of success." *BMC Health Services Research* 4 (1): 25.
- Giuffrida**, Antonio, Melitta Jakab, and Elina Dale. 2013. *Toward Universal Coverage in Health : The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/13311>
- Glimmerveen**, Ludo, Sierk Ybema, and Henk Nies. 2022. "Who Participates in Public Participation? The Exclusionary Effects of Inclusionary Efforts." *Administration & Society* 54 (4): 543-574. <https://doi.org/10.1177/00953997211034137>
- Gómez-Dantés**, Octavio, and Julio Frenk. 2009. "Health technology assessment in Mexico." *International Journal of Technology Assessment in Health Care* 25 (S1): 270-275.

- Gonçalves**, Sónia. 2014. "The effects of participatory budgeting on municipal expenditures and infant mortality in Brazil." *World Development* 53: 94-110.
- Gore**, R., and R. Parker. 2019. "Analysing power and politics in health policies and systems." *Glob Public Health* 14 (4): 481-488. <https://doi.org/10.1080/17441692.2019.1575446>
- Goroshko**, Alona, Natalia Shapoval, and Taavi Lai. 2018. *Can people afford to pay for health care? New evidence on financial protection in Ukraine*. Copenhagen, Denmark: World Health Organization Regional Office for Europe. https://www.euro.who.int/__data/assets/pdf_file/0008/381590/ukraine-fp-eng.pdf
- Government of South Africa**. 1996. "Constitution of the Republic of South Africa, 1996: Chapter 4 - Parliament." <https://www.gov.za/documents/constitution-republic-south-africa-1996-chapter-4-parliament#77>
- Greer**, Scott L., Matthias Wismar, and Monika Kosinska. 2017. "What is civil society and what can it do for health?" *Civil Society and Health*: 1.
- Gutmann**, Amy, and Dennis F. Thompson. 1990. "Moral Conflict and Political Consensus." *Ethics* 101 (1): 64-88. <https://doi.org/10.1086/293260>
- Gutmann**, Amy, and Dennis F. Thompson. 1995. "Moral Disagreement in a Democracy." *Social Philosophy and Policy* 12 (1): 87-110. <https://doi.org/10.1017/S026505250000457X>
- Gutmann**, Amy, and Dennis F. Thompson. 1998. *Democracy and disagreement*. Cambridge, MA: Harvard University Press.
- Gutmann**, Amy, and Dennis F. Thompson. 2004. *Why Deliberative Democracy?* Princeton, NJ: Princeton University Press.
- Guttman**, N., C. Shalev, G. Kaplan, A. Abulafia, G. Bin-Nun, R. Goffer, R. Ben-Moshe, O. Tal, M. Shani, and B. Lev. 2008. "What should be given a priority - costly medications for relatively few people or inexpensive ones for many? The Health Parliament public consultation initiative in Israel." *Health Expectations* 11 (2): 177-88. <https://doi.org/10.1111/j.1369-7625.2007.00485.x>
- Habermas**, J. 1996. *Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy*. Translated by W. Rehg. Cambridge, MA: MIT Press.
- Habicht**, Jarno, Loraine Hawkins, Melitta Jakab, Andres Rannamae, and Aigul Sydakova. 2020. *Governance for strategic purchasing in Kyrgyzstan's health financing system*. Geneva, Switzerland: World Health Organization.
- Habicht**, T., J. Habicht, and E. van Ginneken. 2015. "Strategic purchasing reform in Estonia: Reducing inequalities in access while improving care concentration and quality." *Health Policy* 119 (8): 1011-6. <https://doi.org/10.1016/j.healthpol.2015.06.002>
- Hailu**, Alemayehu, Getachew Teshome Eregata, Amanuel Yigezu, Melanie Y. Bertram, Kjell Arne Johansson, and Ole F. Norheim. 2021. "Contextualization of cost-effectiveness evidence from literature for 382 health interventions for the Ethiopian essential health services package revision." *Cost Effectiveness and Resource Allocation* 19 (1): 1-10.
- Hanson**, Kara, Nouria Brikci, Darius Erlangga, Abebe Alebachew, Manuela De Allegri, Dina Balabanova, Mark Blecher, Cheryl Cashin, Alexo Esperato, David Hipgrave, Ina Kalisa, Christoph Kurowski, Qingyue Meng, David Morgan, Gemini Mtei, Ellen Nolte, Chima Onoka, Timothy Powell-Jackson, Martin Roland, Rajeev Sadanandan, Karin Stenberg, Jeanette Vega Morales, Hong Wang, and Haja Wurie. 2022. "The Lancet Global Health Commission on financing primary health care: putting people at the centre." *The Lancet Global Health* 10 (5): e715-e772. [https://doi.org/10.1016/S2214-109X\(22\)00005-5](https://doi.org/10.1016/S2214-109X(22)00005-5)
- Hasman**, A., and S. Holm. 2005. "Accountability for reasonableness: opening the black box of process." *Health Care Analysis* 13 (4): 261-73.

- Hayward**, Clarissa Rile. 2021. "Why does publicity matter? Power, not deliberation." *Journal of Political Power* 14 (1): 176-195. <https://doi.org/10.1080/2158379X.2021.1879571>
- He**, Baogang, and Mark E. Warren. 2011. "Authoritarian Deliberation: The Deliberative Turn in Chinese Political Development." *Perspectives on Politics* 9 (2): 269-289. <https://doi.org/10.1017/S1537592711000892>
- Herrera**, C. A., S. Lewin, E. Paulsen, A. Ciapponi, N. Opiyo, T. Pantoja, G. Rada, C. S. Wiysonge, G. Bastias, S. Garcia Marti, C. I. Okwundu, B. Peñaloza, and A. D. Oxman. 2017. "Governance arrangements for health systems in low-income countries: an overview of systematic reviews." *Cochrane Database Syst Rev* 9 (9): Cd011085. <https://doi.org/10.1002/14651858.CD011085.pub2>
- Hofman**, Karen J., Nicholas Stacey, Elizabeth C. Swart, Barry M. Popkin, and Shu Wen Ng. 2021. "South Africa's Health Promotion Levy: Excise tax findings and equity potential." *Obesity Reviews* 22 (9): e13301.
- Honda**, Ayako, and Amarech Obse. 2020. "Payment Arrangements for Private Healthcare Purchasing Under Publicly Funded Systems in Low- and Middle-Income Countries: Issues and Implications." *Applied Health Economics and Health Policy* 18 (6): 811-823. <https://doi.org/10.1007/s40258-019-00550-y>
- IBP** (International Budget Partnership). 2015. "Examples of Citizens Budgets." Washington, DC: International Budget Partnership. <https://internationalbudget.org/publications/examples-of-citizens-budgets/>
- IBP** (International Budget Partnership). 2022. Open Budget Survey 2021. Washington, DC: International Budget Partnership. <https://www.internationalbudget.org/open-budget-survey-2021/>
- IBP** (International Budget Partnership) Kenya. 2023. *Kenya's County Budget Transparency Survey 2022*. Nairobi: International Budget Partnership Kenya. <https://internationalbudget.org/wp-content/uploads/Kenya-County-Budget-Transparency-Survey-2022-web.pdf>
- Inchauste**, Gabriela, and Nora Lustig. 2017. *The Distributional Impact of Taxes and Transfers: Evidence From Eight Developing Countries*. Directions in Development—Poverty. Washington, DC: World Bank.
- International Monetary Fund**. 2018. *Assessing Fiscal Space: An Update and Stocktaking*. Washington, DC: International Monetary Fund. <https://www.imf.org/en/Publications/Policy-Papers/Issues/2018/06/15/pp041118assessing-fiscal-space>
- International Monetary Fund**. 2021. *World Economic Outlook: Recovery during a Pandemic - Health Concerns, Supply Disruptions, Price Pressures*. Washington, DC: International Monetary Fund. <https://www.imf.org/en/Publications/WEO/Issues/2021/10/12/world-economic-outlook-october-2021>
- INTOSAI** Development Initiative, African Organization of French-speaking Supreme Audit Institutions (CREFIAP), General Auditing Commission of Liberia (GAC), and Audit Service Sierra Leone (ASSL). 2020. *Accountability in a time of crisis: how Supreme Audit Institutions and development partners can learn from previous crises and ensure effective responses to Covid-19 in developing countries*. Oslo, Norway: INTOSAI Development Initiative. <https://intosaibc.wpengine.com/wp-content/uploads/2020/04/Accountability-in-a-time-of-crisis-Covid-related-paper-by-IDI-and-partners-210420.pdf>
- JCVI** (Joint Committee on Vaccination and Immunisation). 2013. "Joint Committee on Vaccination and Immunisation Code of Practice." London, UK: JCVI. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224864/JCVI_Code_of_Practice_revision_2013_-_final.pdf
- Jesse**, Maris. 2008. *Governance of the health system, health insurance fund and hospitals in Estonia: opportunities to improve performance*. Copenhagen, Denmark: WHO Regional Office for Europe. https://www.euro.who.int/__data/assets/pdf_file/0004/78979/E91376.pdf

Joint Learning Network for Universal Health Coverage. 2022. Making explicit choices on the path to UHC - the JLN Health Benefits Package Revision Guide. Washington, DC: Joint Learning Network for Universal Health Coverage, International Decision Support Initiative (iDSI), and The World Bank Group.
<https://www.jointlearningnetwork.org/wp-content/uploads/2022/12/Making-Explicit-choices.v4.pdf>

Jouini, Nizar, Nora Lustig, Ahmed Moummi, and Abebe Shimeles. 2018. "Tunisia: Fiscal Policy, Income Redistribution, and Poverty Reduction." In *Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty*, edited by Nora Lustig, 723-744. Washington, DC: CEQ Institute at Tulane University and Brookings Institution Press.

Kantamaturapoj, K., A. Kulthanmanusorn, W. Witthayapipopsakul, S. Viriyathorn, W. Patcharanarumol, C. Kanchanachitra, S. Wibulpolprasert, and V. Tangcharoensathien. 2020. "Legislating for public accountability in universal health coverage, Thailand." *Bulletin of the World Health Organization* 98 (2): 117-125. <https://doi.org/10.2471/BLT.19.239335>

Kantamaturapoj, K., A. I. Marshall, S. Chotchoungchatchai, K. Kiewnin, W. Patcharanarumol, and V. Tangcharoensathien. 2020. "Performance of Thailand's universal health coverage scheme: Evaluating the effectiveness of annual public hearings." *Health Expectations* 23 (6): 1594-1602. <https://doi.org/10.1111/hex.13142>

Kapiriri, L., O. F. Norheim, and D. K. Martin. 2009. "Fairness and accountability for reasonableness. Do the views of priority setting decision makers differ across health systems and levels of decision making?" *Social Science & Medicine* 68 (4): 766-73. <https://doi.org/10.1016/j.socscimed.2008.11.011>

Kaufman, D., and A. Kraay. 2021. *Worldwide Governance Indicators*. Washington, DC: World Bank.

Kim, Hansoo, Joshua Byrnes, and Stephen Goodall. 2021. "Health technology assessment in Australia: The pharmaceutical benefits advisory committee and medical services advisory committee." *Value in Health Regional Issues* 24: 6-11.

Kim, Seongjo, and Sun-Woo Lee. 2022. "Distorted policy transfer and institutional conflicts: the health insurance reform in South Korea." *Japanese Journal of Political Science* 23 (1): 18-33.

Kiracho, Elizabeth Ekirapa, Christine Anyu, Rebecca Racheal Apolot, Suzanne Namusoke Kiwanuka, and Ligia Paina. 2021. "Designing for Scale and taking scale to account: lessons from a community score card project in Uganda." *International Journal for Equity in Health* 20: 1-11.

Knaul, Felicia Marie, Eduardo González-Pier, Octavio Gómez-Dantés, David García-Junco, Héctor Arreola-Ornelas, Mariana Barraza-Lloréns, Rosa Sandoval, Francisco Caballero, Mauricio Hernández-Avila, and Mercedes Juan. 2012. "The quest for universal health coverage: achieving social protection for all in Mexico." *The Lancet* 380 (9849): 1259-1279.

Korolev, Alexander. 2014. "Deliberative Democracy Nationwide?—Evaluating Deliberativeness of Healthcare Reform in China." *Journal of Chinese Political Science* 19 (2): 151-172. <https://doi.org/10.1007/s11366-014-9287-1>

Kruger, Petronell, Susan Goldstein, and Karen Hofman. Forthcoming. "The Passage and Implementation of a Health Promotion Levy in South Africa as a Case Study of fair financing procedures." *Health Policy and Planning* (supplement scheduled for 2023).

Kurowski, Christoph, David B. Evans, Ajay Tandon, Patrick Hoang-Vu Eozenou, Martin Schmidt, Alec Irwin, Jewelwayne Salcedo Cain, Eko Setyo Pambudi, and Iryna Postolovska. 2021. *From Double Shock to Double Recovery: Implications and Options for Health Financing in the Time of COVID-19*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/35298>

Kurowski, Christoph, David B. Evans, Ajay Tandon, Patrick Hoang-Vu Eozenou, Martin Schmidt, Alec Irwin, Jewelwayne Salcedo Cain, Eko Setyo Pambudi, and Iryna Postolovska. 2022. *From Double Shock to Double Recovery: Implications and Options for Health Financing in the Time of COVID-19. Second Technical Update: Old Scars, New Wounds*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/35298>

- Kutzin**, Joseph. 2012. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 90 (11): 867-8. <https://doi.org/10.2471/blt.12.113654>
- Kutzin**, Joseph. 2013. "Health financing for universal coverage and health system performance: concepts and implications for policy." *Bulletin of the World Health Organization* 91 (8): 602-611. <https://doi.org/10.2471/BLT.12.113985>
- Kutzin**, Joseph, Sergey Shishkin, Lucie Bryndová, Pia Schneider, and Pavel Hrobon. 2010. "Reforms in the pooling of funds." In *Implementing Health Financing Reform. Lessons from Countries in Transition*, edited by Joseph Kutzin, Cheryl Cashin, and Melitta Jakab. Brussels: European Observatory on Health Systems and Policies.
- Kutzin**, Joseph, Winnie Yip, and Cheryl Cashin. 2016. "Alternative Financing Strategies for Universal Health Coverage." In *World Scientific Handbook of Global Health Economics and Public Policy*, edited by Richard M. Scheffler, 267-309. Singapore: World Scientific.
- Kwarteng**, Anthony, James Akazili, Paul Welaga, Philip Ayizem Dalinjong, Kwaku Poku Asante, Doris Sarpong, Samuelina Arthur, Martin Bangha, Jane Goudge, and Osman Sankoh. 2019. "The state of enrollment on the National Health Insurance Scheme in rural Ghana after eight years of implementation." *International Journal for Equity in Health* 19 (1): 4. <https://doi.org/10.1186/s12939-019-1113-0>
- Kwon**, Soonman, and Michael R. Reich. 2005. "The changing process and politics of health policy in Korea." *Journal of Health Politics, Policy and Law* 30 (6): 1003-1026.
- Lai**, T., T. Habicht, K. Kahur, M. Reinap, R. Kiivet, and E. van Ginneken. 2013. "Estonia: health system review." *Health Systems in Transition* 15 (6): 1-196.
- Lakin**, Jason. 2018. *Assessing the Quality of Reasons in Government Budget Documents*. Washington, DC: International Budget Partnership. <https://internationalbudget.org/wp-content/uploads/assessing-the-quality-of-reasons-in-government-budget-documents-ibp-2018.pdf>
- Lakin**, Jason, and Mokeira Nyagaka. 2016. *Deliberating Budgets: How Public Deliberation Can Move Us Beyond the Public Participation Rhetoric*. Nairobi, Kenya: International Budget Partnership. <https://internationalbudget.org/wp-content/uploads/ibp-paper-public-deliberation-in-kenya-2016.pdf>
- Langvatn**, Silje A. 2016. "Legitimate, but unjust; just, but illegitimate: Rawls on political legitimacy." *Philosophy & Social Criticism* 42 (2): 132-153.
- Lee**, B. K., K. Tarimo, and A. Dutta. 2018. *Tanzania's Improved Community Health Fund: An Analysis of Scale-Up Plans and Design*. Washington, DC: Palladium - Health Policy Plus. http://www.healthpolicyplus.com/ns/pubs/10259-10469_TanzaniaiCHFScaleUpbrief.pdf
- Leib**, Ethan J., and Baogang He. 2006. "Editors' Introduction." In *The Search For Deliberative Democracy in China*, edited by Ethan J. Leib and Baogang He, 1-19. New York, NY: Palgrave MacMillan.
- Leston-Bandeira**, Cristina, and Louise Thompson. 2017. "Integrating the view of the public into the formal legislative process: public reading stage in the UK House of Commons." *The Journal of Legislative Studies* 23 (4): 508-528.
- Leventhal**, Gerald S. 1980. "What Should Be Done with Equity Theory? New Approaches to the Study of Fairness in Social Relationships." In *Social Exchange: Advances in Theory and Research*, edited by Kenneth J. Gergen, Martin S. Greenberg, and Richard H. Willis, 27-55. Boston, MA: Springer.
- Leventhal**, Gerald S., Jurgis Karuza, and William Rick Fry. 1980. "Beyond Fairness: A Theory of Allocation Preferences." In *Justice and Social Interaction*, edited by Gerold Mikula. Bern, Switzerland: Hans Huber Publishers.

- Levine, R., T. Fischer, and A. Kumar.** 2021. *Civil Society Engagement in Implementing Domestic Tax Policy*. Washington, DC: Transparency and Accountability Initiative and IDinsight. https://www.idinsight.org/wp-content/uploads/2021/06/CSO_Role_In_TaxAdmin_EvidenceReview_vf-Torben-Fischer.pdf
- Levy, Santiago.** 2019. "Social Insurance, Human Development and Social Cohesion." *Journal of Human Development and Capabilities* 20 (3): 280-296. <https://doi.org/10.1080/19452829.2019.1612548>
- Lienert, I., and I. Fainboim.** 2010. *Reforming Budget System Laws*. Washington, DC: International Monetary Fund. <https://www.imf.org/external/pubs/ft/tnm/2010/tnm1001.pdf>
- Lizundia, E.** 2020. "The Gambia: Improving Fiscal Transparency at a Critical Juncture." International Republican Institute. <https://www.iri.org/news/the-gambia-improving-fiscal-transparency-at-a-critical-juncture/>
- Lontoh, Lucky, Christopher Beaton, and Kieran Clarke.** 2015. *Indonesia Energy Subsidy Review: A biannual survey of energy subsidy policies*. Geneva, Switzerland: The International Institute for Sustainable Development. https://www.iisd.org/gsi/sites/default/files/ffs_indonesia_reviewi2v1_english.pdf
- Maluka, S., P. Kamuzora, M. San Sebastian, J. Byskov, B. Ndawi, and A. K. Hurtig.** 2010. "Improving district level health planning and priority setting in Tanzania through implementing accountability for reasonableness framework: Perceptions of stakeholders." *BMC Health Services Research* 10: 322. <https://doi.org/0.1186/1472-6963-10-322>
- Maluka, S., P. Kamuzora, M. San Sebastian, J. Byskov, O. E. Olsen, E. Shayo, B. Ndawi, and A. K. Hurtig.** 2010. "Decentralized health care priority-setting in Tanzania: evaluating against the accountability for reasonableness framework." *Social Science & Medicine* 71 (4): 751-9. <https://doi.org/10.1016/j.socscimed.2010.04.035>
- Mandeville, Kate L., Rosie Barker, Alice Packham, Charlotte Sowerby, Kielan Yarrow, and Hannah Patrick.** 2019. "Financial interests of patient organisations contributing to technology assessment at England's National Institute for Health and Care Excellence: policy review." *British Medical Journal* 364.
- Mansbridge, Jane, James Bohman, Simone Chambers, Thomas Christiano, Archon Fung, John Parkinson, Dennis F. Thompson, and Mark E. Warren.** 2012. "A systemic approach to deliberative democracy." In *Deliberative systems: Deliberative democracy at the large scale*, edited by J. Parkinson & J. Mansbridge, 1-26. Cambridge: Cambridge University Press.
- Mansbridge, Jane Jebb, James Bohman, Simone Chambers, David Estlund, Andreas Føllesdal, Archon Fung, Cristina Lafont, Bernard Manin, and José Luis Martí.** 2011. "The place of self-interest and the role of power in deliberative democracy." *Raisons politiques* 42 (2): 47-82.
- Marais, Debra Leigh, Michael Quayle, and Inge Petersen.** 2020. "Making consultation meaningful: Insights from a case study of the South African mental health policy consultation process." *PLoS One* 15 (1): e0228281.
- Marshall, Aniqah Islam, Kanang Kantamaturapoj, Kamonwan Kiewnin, Somtanuek Chotchongchatchai, Walai-porn Patcharanarumol, and Viroj Tangcharoensathien.** 2021b. "Participatory and responsive governance in universal health coverage: an analysis of legislative provisions in Thailand." *BMJ Global Health* 6 (2): e004117. <https://doi.org/10.1136/bmjgh-2020-004117>
- Masefield, S. C., A. Msosa, and J. Grugel.** 2020. "Challenges to effective governance in a low income health-care system: a qualitative study of stakeholder perceptions in Malawi." *BMC Health Services Research* 20 (1): 1142. <https://doi.org/10.1186/s12913-020-06002-x>
- Matasick, Craig.** 2017. "Open government: How transparency and inclusiveness can reshape public trust." In *Trust and Public Policy: How Better Governance Can Help Rebuild Public Trust*, edited by the Organisation for Economic Co-Operation and Development (OECD), 105-124. OECD Public Governance Reviews. Paris, France: OECD Publishing.

- Mayka**, Lindsay. 2019. "The origins of strong institutional design: Policy reform and participatory institutions in Brazil's health sector." *Comparative Politics* 51 (2): 275-294.
- McDevitt**, Andrew. 2022. "Open Contracting." In *The Skeptic's Guide to Open Government*, edited by Open Government Partnership. Washington, DC: Open Government Partnership.
- McIntyre**, Di, Michael K. Ranson, Bhupinder K. Aulakh, and Ayako Honda. 2013. "Promoting universal financial protection: evidence from seven low- and middle-income countries on factors facilitating or hindering progress." *Health Research Policy and Systems* 11 (1): 36. <https://doi.org/10.1186/1478-4505-11-36>
- Mikuli**, Piotr, and Grzegorz Kuca. 2016. "The public hearing and law-making procedures." *Liverpool Law Review* 37: 1-17.
- Milewa**, T. 2008. "Representation and legitimacy in health policy formulation at a national level: perspectives from a study of health technology eligibility procedures in the United Kingdom." *Health Policy* 85 (3): 356-62.
- Miller**, Arthur H., and Ola Listhaug. 1990. "Political Parties and Confidence in Government: A Comparison of Norway, Sweden and the United States." *British Journal of Political Science* 20 (3): 357-386. <http://www.jstor.org/stable/193915>
- Milne**, Vanessa, and Terrence Sullivan. 2014. "Controversy over closing rural hospitals." *Healthy Debate*, October 9, 2014. <https://healthydebate.ca/2014/10/topic/closing-rural-hospital/>
- Mitton**, C. R., M. McMahon, S. Morgan, and J. Gibson. 2006. "Centralized drug review processes: are they fair?" *Social Science & Medicine* 63 (1): 200-11.
- Montesanti**, Stephanie R., Julia Abelson, John N. Lavis, and James R. Dunn. 2017. "Enabling the participation of marginalized populations: case studies from a health service organization in Ontario, Canada." *Health Promotion International* 32 (4): 636-649.
- Moore**, A. 2009. "Sink or swim: how small hospitals survive competition." *Health Service Journal*. Accessed 1 August 2022.
- Moretto**, Nicole, Elizabeth Kendall, Jennifer Whitty, Joshua Byrnes, Andrew P. Hills, Louisa Gordon, Erika Turkstra, Paul Scuffham, and Tracy Comans. 2014. "Yes, the government should tax soft drinks: findings from a citizens' jury in Australia." *International Journal of Environmental Research and Public Health* 11 (3): 2456-2471.
- Mselle**, G., P. Nsanya, K. D. Konlan, Y. Lee, J. Ryu, and S. Kang. 2022. "Factors Associated with the Implementation of an Improved Community Health Fund in the Ubungo Municipality Area, Dar es Salaam Region, Tanzania." *International Journal of Environmental Research and Public Health* 19 (9). <https://doi.org/10.3390/ijerph19095606>
- Mulvale**, Gillian, Sandra Moll, Ashleigh Miatello, Glenn Robert, Michael Larkin, Victoria J. Palmer, Alicia Powell, Chelsea Gable, and Melissa Girling. 2019. "Codesigning health and other public services with vulnerable and disadvantaged populations: Insights from an international collaboration." *Health Expectations* 22 (3): 284-297.
- Murphy**, Kristina. 2005. *Regulating more effectively: The relationship between procedural justice, legitimacy and tax non-compliance*. Canberra, Australia: Center for Tax System Integrity in the Australian National University and Australian Taxation Office. <https://openresearch-repository.anu.edu.au/handle/1885/43082>
- Nakatani**, Miho. 2021. "How do political decision-making processes affect the acceptability of decisions? Results from a survey experiment." *International Political Science Review*: 0192512121998250. <https://doi.org/10.1177/0192512121998250>
- National Treasury** of South Africa. 2016. *Taxation of sugar sweetened beverages. Policy proposal*. <https://www.treasury.gov.za/public%20comments/sugar%20sweetened%20beverages/policy%20paper%20and%20proposals%20on%20the%20taxation%20of%20sugar%20sweetened%20beverages-8%20july%202016.pdf>
- National Treasury** of South Africa. 2017. Final Response Document on the 2017 Rates and Monetary Amounts and Amendment of Revenue Laws Bill - Health Promotion Levy, 2017.

newDemocracy Foundation and The United Nations Democracy Fund. 2019. "For Politicians - this helps leaders lead " In *Enabling National Initiatives to Take Democracy Beyond Elections*, 23-58. Sydney: newDemocracy Foundation.

Njie, H., E. Dale, and U. Gopinathan. Forthcoming. "Procedural Fairness in Decision- Making for Financing a National Health Insurance Scheme: A Case Study from The Gambia." *Health Policy and Planning* (supplement scheduled for 2023).

Norheim, Ole F. 2015. "Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage." *International Journal of Health Policy & Management* 4 (11): 711-4. <https://doi.org/10.15171/ijhpm.2015.184>

Norheim, Ole F. 2016. "Ethical priority setting for universal health coverage: challenges in deciding upon fair distribution of health services." *BMC Medicine* 14 (1): 75. <https://doi.org/10.1186/s12916-016-0624-4>

Norheim, Ole F., Joelle M. Abi-Rached, Liam Kofi Bright, Kristine Bærøe, Octávio L. M. Ferraz, Siri Gloppen, and Alex Voorhoeve. 2021. *Difficult trade-offs in response to COVID-19: the case for open and inclusive decision-making*. Bergen, Norway: University of Bergen.
https://www.who.int/docs/default-source/hgf/difficult-trade-offs-in-response-to-covid-19.pdf?sfvrsn=daa3b222_17

Nouhi, Mojtaba, Rob Baltussen, Seyed Sajad Razavi, Leon Bijlmakers, Mohammad Ali Sahraian, Zahra Goudarzi, Parisa Farokhian, Jamaledin Khedmati, Reza Jahangiri, and Alireza Olyaeemanesh. 2022. "The Use of Evidence-Informed Deliberative Processes for Health Insurance Benefit Package Revision in Iran." *International Journal of Health Policy and Management* 11 (11): 2719–2726. https://www.ijhpm.com/article_4219_02c15c1c9fdf9ae19301ec848669e028.pdf

Nygren-Krug, H. 2019. "The Right(s) Road to Universal Health Coverage." *Health and Human Rights Journal* 21 (2): 215 - 228. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2019/12/Nygren.pdf>

OECD (Organisation for Economic Co-operation and Development). 2017. *Trust and Public Policy: How Better Governance Can Help Rebuild Public Trust*. OECD Public Governance Reviews. Paris: OECD Publishing.

OECD (Organisation for Economic Co-operation and Development). 2020. *Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave*. Paris: OECD Publishing.

OECD (Organisation for Economic Co-operation and Development). 2021. "Eight ways to institutionalise deliberative democracy." Paris: OECD Publishing. <https://www.oecd-ilibrary.org/content/paper/4fcf1da5-en>

Okonjo-Iweala, N., and P. Osafo-Kwaako. 2007. *The Role of Civil Society Organizations in Supporting Fiscal Transparency in African Countries*. Washington, DC: Results for Development.
<https://r4d.org/resources/role-civil-society-organizations-supporting-fiscal-transparency-african-countries/>

Oleksiyuk, T. 2018. *Access to public information in Ukraine: achievements and challenges between adoption of the Law and present day*. Kyiv, Ukraine: United Nations Development Programme. https://www.undp.org/sites/g/files/zskgke326/files/migration/ua/ATI_En.pdf

Onwujekwe, Obinna, and Prince Agwu. 2022. "Can Strategic Health Purchasing Reduce Inefficiency and Corruption in the Health Sector? The Case of Nigeria." *Health Systems & Reform* 8 (2): e2057836.
<https://doi.org/10.1080/23288604.2022.2057836>

Open Government Partnership. 2020. "Promotion of Mechanisms to Engage Civil Society in the Audit Cycle (AR0058)." Open Government Partnership. <https://www.opengovpartnership.org/members/argentina/commitments/ar0058/>

Ottersen, Trygve, and Ole F. Norheim. 2014. "Making fair choices on the path to universal health coverage." *Bulletin of the World Health Organization* 92 (6): 389-389. <https://doi.org/10.2471/blt.14.139139>

Parliament of the Republic of South Africa. 2023. "How a law is made." <https://www.parliament.gov.za/how-law-made>

- Parliament of the Republic of South Africa.** n.d. "Submissions." <https://www.parliament.gov.za/submissions>
- Participedia.** 2021. "National Participatory Budgeting in South Korea." Participedia. Accessed 02.06.2023. <https://participedia.net/case/7431>
- PEFA.** 2019. *Framework for assessing public financial management*. Washington, DC: Public Expenditure and Financial Accountability Secretariat. https://www.pefa.org/sites/pefa/files/resources/downloads/PEFA%202016_latest%20version_with%20links%20%282%29.pdf
- PEFA.** 2022. "What is PEFA?" Washington, DC: Public Expenditure and Financial Accountability Secretariat. <https://www.pefa.org/about>
- Petrie, M., and J. Shields.** 2010. "Producing a Citizens' Guide to the Budget: Why, What and How?" *OECD Journal on Budgeting* 2010/2. <https://www.oecd.org/gov/budgeting/48170438.pdf>
- Pitayarangsarit, Siriwan, and Viroj Tangcharoensathien.** 2009. "Sustaining capacity in health policy and systems research in Thailand." *Bulletin of the World Health Organization* 87: 72-74.
- President of the Kyrgyz Republic.** 2016. Бюджетный кодекс Кыргызской Республики [The Budget Code of the Kyrgyz Republic]. Law No 59. Bishkek, Kyrgyz Republic: Ministry of Justice. Available at <http://cbd.minjust.gov.kg/act/view/ru-ru/111338?cl=ru-ru>
- Prichard, W., A. Custers, R. Dom, S. Davenport, and M. Roscitt.** 2019. *Innovations in Tax Compliance: Conceptual Framework*. Washington, DC: World Bank. <https://documents1.worldbank.org/curated/en/816431569957130111/pdf/Innovations-in-Tax-Compliance-Conceptual-Framework.pdf>
- Prinja, Shankar, Akashdeep Singh Chauhan, Kavitha Rajsekhar, Laura Downey, Pankaj Bahuguna, Oshima Sachin, and Lorna Guinness.** 2020. "Addressing the cost data gap for universal healthcare coverage in India: a call to action." *Value in Health Regional Issues* 21: 226-229.
- Raisio, Harri.** 2009. "Deliberating together: Public deliberation in the context of the Hungarian health insurance reform." *Society and Economy* 31 (2): 253-269.
- Rajan, D., N. Mathurapote, W. Putthasri, T. Posayanonda, P. Pinprateep, S. de Courcelles, R. Bichon, E. Ros, A. Delobre, and G. Schmets.** 2019. "Institutionalising participatory health governance: lessons from nine years of the National Health Assembly model in Thailand." *BMJ Global Health* 4 (Suppl 7): e001769. <https://doi.org/10.1136/bmjgh-2019-001769>
- Rawls, John.** 2005. *Political Liberalism: Expanded Edition*. Columbia Classics in Philosophy. New York, NY: Columbia University Press.
- Rawls, John.** 2012. "Political liberalism: reply to Habermas." In *Habermas and Rawls: Disputing the Political*, edited by J.G. Finlayson & F. Freyenhagen, 46 – 91. London: Routledge. <https://doi.org/10.4324/9780203723869>
- Razavi, S. D., L. Kapiriri, J. Abelson, and M. Wilson.** 2019. "Who is in and who is out? A qualitative analysis of stakeholder participation in priority setting for health in three districts in Uganda." *Health Policy & Planning* 34 (5): 358-369. <https://doi.org/10.1093/heapol/czz049>
- Razavi, S. D., L. Kapiriri, J. Abelson, and M. Wilson.** 2020. "Barriers to Equitable Public Participation in Health- System Priority Setting Within the Context of Decentralization: The Case of Vulnerable Women in a Ugandan District." *International Journal of Health Policy & Management* 26: 26. <https://doi.org/10.34172/ijhpm.2020.256>

Rechel, Bernd, Aleksandar Džakula, Antonio Duran, Giovanni Fattore, Nigel Edwards, Michel Grignon, Marion Haas, Triin Habicht, Gregory P. Marchildon, Antonio Moreno, Walter Ricciardi, Louella Vaughan, and Tina Anderson Smith. 2016. "Hospitals in rural or remote areas: An exploratory review of policies in 8 high-income countries." *Health Policy* 120 (7): 758-769. <https://www.sciencedirect.com/science/article/pii/S0168851016301270>

Reckers-Droog, Vivian, Maarten Jansen, Leon Bijlmakers, Rob Baltussen, Werner Brouwer, and Job van Exel. 2020. "How does participating in a deliberative citizens panel on healthcare priority setting influence the views of participants?" *Health Policy* 124 (2): 143-151.

Reich, Michael R. 2002. "The Politics of Reforming Health Policies." *Global Health Promotion* 9 (4): 138-142. <https://doi.org/10.1177/175797590200900401>

Reich, Michael R. 2020. "Restructuring Health Reform, Mexican Style." *Health Syst Reform* 6 (1): 1-11. <https://doi.org/10.1080/23288604.2020.1763114>

Rid, A. 2009. "Justice and procedure: how does 'accountability for reasonableness' result in fair limit-setting decisions?" *Journal of Medical Ethics* 35 (1): 12-16. <https://doi.org/10.1136/jme.2008.024430>

Rohrer-Herold, K., D. Rajan, and K. Koch. 2021. "An enabling environment for participation." In *Voice, agency, empowerment. Handbook on social participation for universal health coverage*, edited by World Health Organization, 41-57. Geneva, Switzerland: World Health Organization.

Rumbold, B., A. Weale, A. Rid, J. Wilson, and P. Littlejohns. 2017. "Public Reasoning and Health-Care Priority Setting: The Case of NICE." *Kennedy Institute of Ethics Journal* 27 (1): 107-134. <https://doi.org/10.1353/ken.2017.0005>

Rumbold, Benedict, Rachel Baker, Octavio Ferraz, Sarah Hawkes, Carleigh Krubiner, Peter Littlejohns, Ole F. Norheim, Thomas Pegram, Annette Rid, and Sridhar Venkatapuram. 2017. "Universal health coverage, priority setting, and the human right to health." *The Lancet* 390 (10095): 712-714.

Sachs, Jeffrey D., Salim S. Abdool Karim, Lara Akinin, Joseph Allen, Kirsten Brosbøl, Francesca Colombo, Gabriela Cuevas Barron, María Fernanda Espinosa, Vitor Gaspar, Alejandro Gaviria, Andy Haines, Peter J. Hotez, Phoebe Koundouri, Felipe Larraín Bascuñán, Jong-Koo Lee, Muhammad Ali Pate, Gabriela Ramos, K. Srinath Reddy, Ismail Serageldin, John Thwaites, Vaira Vike-Freiberga, Chen Wang, Miriam Khamadi Were, Lan Xue, Chandrika Bahadur, Maria Elena Bottazzi, Chris Bullen, George Laryea-Adjei, Yanis Ben Amor, Ozge Karadag, Guillaume Lafortune, Emma Torres, Lauren Barredo, Juliana G. E. Bartels, Neena Joshi, Margaret Hellard, Uyen Kim Huynh, Shweta Khandelwal, Jeffrey V. Lazarus, and Susan Michie. 2022. "The Lancet Commission on lessons for the future from the COVID-19 pandemic." *The Lancet* 400 (10359): 1224-1280. [https://doi.org/10.1016/S0140-6736\(22\)01585-9](https://doi.org/10.1016/S0140-6736(22)01585-9)

Sakamoto, H., M. Rahman, S. Nomura, E. Okamoto, S. Koike, and H. Yasunaga. 2018. *Japan Health System Review*. New Delhi, India: World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/259941/9789290226260-eng.pdf>

Santiso, C. 2004. "Legislatures and Budget Oversight in Latin America: Strengthening Public Finance Accountability in Emerging Economies." *OECD Journal on Budgeting* 4 (2). <https://www.oecd.org/gov/budgeting/43488676.pdf>

Sartor, Nina, and CDD. 2022. "National Deliberative Poll In Chile." *Participedia*. Accessed 24.05.2023. <https://participedia.net/case/8458?lang=en>

Sass, Jensen. 2018. "Deliberative Ideals Across Diverse Cultures." In *The Oxford Handbook of Deliberative Democracy*, edited by Andre Bachtiger, John S. Dryzek, Jane Mansbridge, and Mark Warren. Oxford, UK: Oxford University Press.

Savedoff, W. D. 2004. "Is there a case for social insurance?" *Health Policy Plan* 19 (3): 183-4. <https://doi.org/10.1093/heapol/czh022>

- Seinfeld**, Janice, Vilma Montanez, and Nicolas Besich. 2013. *The Health Insurance System in Peru: Towards a Universal Health Insurance*. Washington, DC: Global Development Network.
https://www.academia.edu/33391064/The_Health_Insurance_System_in_Peru_Towards_a_Universal_Health_Insurance
- Sen**, Amartya. 2002. "Why health equity?" *Health Economics* 11 (8): 659-666. <https://doi.org/10.1002/hec.762>.
- Sen**, Gita, Aditi Iyer, Sreeparna Chattopadhyay, and Rajat Khosla. 2020. "When accountability meets power: realizing sexual and reproductive health and rights." *International Journal for Equity in Health* 19 (1): 111. <https://doi.org/10.1186/s12939-020-01221-4>
- Shiffman**, Jeremy. 2019. "Political Context and Health Financing Reform." *Health Systems & Reform* 5 (3): 257-259. <https://doi.org/10.1080/23288604.2019.1633894>
- Sintomer**, Y., C. Herzberg, and A. Röcke. 2008. "Participatory budgeting in Europe: Potentials and challenges." *International Journal of Urban and Regional Research* 32 (1): 164-178. <https://doi.org/10.1111/j.1468-2427.2008.00777.x>
- Smith**, Neale, Craig Mitton, Alan Davidson, and Iestyn Williams. 2014. "A politics of priority setting: Ideas, interests and institutions in healthcare resource allocation." *Public Policy and Administration* 29 (4): 331-347. <https://doi.org/10.1177/0952076714529141>
- Smith**, P. D., and M. H. McDonough. 2001. "Beyond public participation: Fairness in natural resource decision making." *Society and Natural Resources* 14 (3): 239-249. <https://doi.org/10.1080/089419201750111056>
- Snow**, M. Elizabeth, Katherine Tweedie, and Ann Pederson. 2018. "Heard and valued: the development of a model to meaningfully engage marginalized populations in health services planning." *BMC Health Services Research* 18 (1): 1-13.
- Solomon**, Stephanie, and Julia Abelson. 2012. "Why and when should we use public deliberation?" *The Hastings Center Report* 42 (2): 17.
- SPARC** (Strategic Purchasing Africa Resource Center). 2022. *Advancing Strategic Health Purchasing in Ethiopia*. Washington, DC: SPARC. <https://sparc.africa/download/advancing-strategic-health-purchasing-in-ethiopia/>
- Sparkes**, S. P., J. B. Bump, E. A. Özçelik, J. Kutzin, and M. R. Reich. 2019. "Political Economy Analysis for Health Financing Reform." *Health Syst Reform* 5 (3): 183-194. <https://doi.org/10.1080/23288604.2019.1633874>
- Sriram**, V., S. M. Topp, M. Schaaf, A. Mishra, W. Flores, S. R. Rajasulochana, and K. Scott. 2018. "10 best resources on power in health policy and systems in low- and middle-income countries." *Health Policy Plan* 33 (4): 611-621. <https://doi.org/10.1093/heapol/czy008>
- Stokes**, Geoffrey. 2006. "Critical Theories of Deliberative Democracy and The Problem of Citizenship." In *The Search For Deliberative Democracy in China*, edited by Ethan J. Leib and Baogang He, 53-73. New York, NY: Palgrave MacMillan.
- Street**, J., K. Duszynski, S. Krawczyk, and A. Braunack-Mayer. 2014. "The use of citizens' juries in health policy decision-making: A systematic review." *Social Science & Medicine* 109: 1-9. <https://doi.org/10.1016/j.socscimed.2014.03.005>
- Tangcharoensathien**, Viroj, S. Pitayarangarit, W. Patcharanarumol, P. Prakongsai, H. Sumalee, J. Tosanguan, and A. Mills. 2013. "Promoting universal financial protection: how the Thai universal coverage scheme was designed to ensure equity." *Health Research Policy & Systems* 11: 25. <https://doi.org/10.1186/1478-4505-11-25>
- Tangcharoensathien**, Viroj, Walaiporn Patcharanarumol, Waraporn Suwanwela, Somruethai Supangul, Warisa Panichkriangkrai, Hathairat Kosiyaporn, and Woranan Witthayapipopsakul. 2020. "Defining the Benefit Package of Thailand Universal Coverage Scheme: From Pragmatism to Sophistication." *International Journal of Health Policy and Management* 9 (4): 133-137. https://www.ijhpm.com/article_3685_35ff6b9aff1f920a2fe7551b024df789.pdf

Tangcharoensathien, Viroj, Supakit Sirilak, Piyamitr Sritara, Walaiporn Patcharanarumol, Angkana Lekagul, Wanrudee Isaranu-watchai, Woranan Wittayapipopsakul, and Orana Chandrasiri. 2021. "Co-production of evidence for policies in Thailand: from concept to action." *British Medical Journal* 372.

Tangcharoensathien, Viroj, Suwit Wibulpholprasert, and Sanguan Nitayaramphong. 2004. "Knowledge-based changes to health systems: the Thai experience in policy development." *Bulletin of the World Health Organization* 82 (10): 750-756.

Tantivess, Sripen, Yot Teerawattananon, and Anne Mills. 2009. "Strengthening cost-effectiveness analysis in Thailand through the establishment of the health intervention and technology assessment program." *Pharmacoeconomics* 27: 931-945.

The Center for Public Integrity. 1995. "Well-healed: inside lobbying for health care reform, Part II." *Int J Health Serv* 25 (4): 593-632. <https://doi.org/10.2190/0lp1-2eam-3qjm-r8dt>

The Norwegian Tax Administration. 2022. Wealth tax and valuation discounts. Oslo, Norway: Skatteetaten. Thomas, Alastair. 2020. "Reassessing the regressivity of the VAT." OECD Taxation Working Paper Number 59. Organisation for Economic Co-Operation and Development, Paris. <https://www.oecd-ilibrary.org/content/paper/b76ced82-en>

Thomson, Sarah, Jonathan Cylus, and Tamás Evetovits. 2019. Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: World Health Organization. <https://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>

Thomson, Sarah, Josep Figueras, Tamás Evetovits, Matthew Jowett, Philipa Mladovsky, Anna Maresso, and Hans Kluge. 2015. "The impact of the crisis on health systems and health: lessons for policy." In *Economic Crisis, Health Systems and Health in Europe: impact and implications for policy*, edited by Sarah Thomson, Joseph Figueras, Tamás Evetovits, Matthew Jowett, Philipa Mladovsky, Anna Maresso, Jonathan Cylus, Marina Karanikolos and Hans Kluge, 159 - 178. Berkshire, UK: McGraw-Hill Education Open University Press.

Thoresen, Thor O., Marius A. K. Ring, Odd E. Nygård, and Jon Epland. 2021. A wealth tax at work. Oslo, Norway: Statistics Norway. https://www.ssb.no/en/inntekt-og-forbruk/skatt-for-personer/artikler/a-wealth-tax-at-work/_web.pdf

Thow, Anne Marie, Safura Abdool Karim, Mulenga M. Mukanu, Gemma Ahaibwe, Milka Wanjohi, Lebogang Gaogane, Hans Justus Amukugo, Charles Mulindabigwi Ruhara, Twalib Ngoma, Gershim Asiki, Agnes Erzse, and Karen Hofman. 2021. "The political economy of sugar- sweetened beverage taxation: an analysis from seven countries in sub-Saharan Africa." *Global Health Action* 14 (1): 1909267. <https://doi.org/10.1080/16549716.2021.1909267>

Touhcton, Michael, and Brian Wampler. 2014. "Improving social well-being through new democratic institutions." *Comparative Political Studies* 47 (10): 1442-1469. <https://doi.org/10.1177/0010414013512601>

Twea, P., G. Manthalu, and S. Mohan. 2020. "Allocating resources to support universal health coverage: policy processes and implementation in Malawi." *BMJ Global Health* 5 (8): 08. <https://doi.org/10.1136/bmjgh-2020-002766>

Tyler, Tom R. 2000. "Social Justice: Outcome and Procedure." *International Journal of Psychology* 35 (2): 117-125. <https://onlinelibrary.wiley.com/doi/abs/10.1080/002075900399411>

UNHCR and WHO (United Nations High Commissioner for Human Rights and World Health Organization). 2008. The Right to Health. Fact Sheet No. 31. Office of the United Nations High Commissioner for Human Rights and the World Health Organizations. <https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf>

van de Graaf, Cathérine. 2021. "Procedural fairness: Between human rights law and social psychology." *Netherlands Quarterly of Human Rights* 39 (1): 11-29. <https://doi.org/10.1177/0924051921992749>

van Dijke, Marius, Lemessa Bayissa Gobena, and Peter Verboon. 2019. "Make Me Want to Pay. A Three-Way Interaction Between Procedural Justice, Distributive Justice, and Power on Voluntary Tax Compliance." *Frontiers in Psychology* 10: 1632-1632. <https://doi.org/10.3389/fpsyg.2019.01632>

- Vélez, M., M. G. Wilson, J. Abelson, J. N. Lavis, and G. Paraje.** 2020. "Understanding the Role of Values in Health Policy Decision-Making From the Perspective of Policy- Makers and Stakeholders: A Multiple-Case Embedded Study in Chile and Colombia." *Int J Health Policy Manag* 9 (5): 185-197. <https://doi.org/10.15171/ijhpm.2019.94>
- Verguet, Stéphane, Alemayehu Hailu, Getachew Teshome Eregata, Solomon Tessema Memirie, Kjell Arne Johansson, and Ole Frithjof Norheim.** 2021. "Toward universal health coverage in the post-COVID-19 era." *Nature Medicine* 27 (3): 380-387.
- Verkhovna Rada of Ukraine.** 2011. Закон України про доступ до публічної інформації [Law of Ukraine on Access to public information]. In 2939-VI. Kyiv, Ukraine: Верховна Рада України.
- Verkhovna Rada of Ukraine.** 2017. Про державні фінансові гарантії медичного обслуговування населення [Law on "Government Financial Guarantees of Health Care Services"]. In 2168-VIII. Kyiv, Ukraine: Верховна Рада України.
- Viriyathorn, Shaheda, Saranya Sachdev, Waraporn Suwanwela, Waritta Wangbanjongkun, Walaiporn Patcharanarumol, and Virroj Tangcharoensathien.** Forthcoming. "Procedural fairness in benefit package design: inclusion of pre-exposure prophylaxis of HIV in Universal Coverage Scheme in Thailand." *Health Policy and Planning* (supplement scheduled for 2023).
- Wagstaff, Adam, Gabriela Flores, Justine Hsu, Marc-François Smitz, Kateryna Chepynoga, Leander R. Buisman, Kim Van Wilgenburg, and Patrick Eozenou.** 2018. "Progress on catastrophic health spending in 133 countries: a retrospective observational study." *The Lancet Global Health* 6 (2): e169-e179. [https://doi.org/10.1016/s2214-109x\(17\)30429-1](https://doi.org/10.1016/s2214-109x(17)30429-1)
- Wang, H., and N. Rosemberg.** 2018. *Universal Health Coverage in Low-Income Countries: Tanzania's efforts to Overcome Barriers to Equitable Health Service Access.* Washington, DC: World Bank. <https://openknowledge.worldbank.org/bitstream/handle/10986/29174/122815-WP-RDC-Tanzania-pages-fixed-PUBLIC.pdf?sequence=1&isAllowed=y>
- Weale, A., K. Kieslich, P. Littlejohns, A. Tugendhaft, E. Tumilty, K. Weerasuriya, and J. A. Whitty.** 2016. "Introduction: priority setting, equitable access and public involvement in health care." *Journal of Health Organization & Management* 30 (5): 736-50. <https://doi.org/10.1108/JHOM-03-2016-0036>
- Wilkinson, C., J. Briggs, K. Salt, J. Vines, and E. Flynn.** 2019. "In participatory budgeting we trust? Fairness, tactics and (in) accessibility in participatory governance." *Local Government Studies* 45 (6): 1001-1020. <https://doi.org/10.1080/03003930.2019.1606798>
- Williams, Emyr, Emily St. Denny and Dan Bristow.** 2017. *Participatory Budgeting: An Evidence Review.*
- Public Policy Institute for Wales.** <https://www.oidp.net/docs/repo/doc215.pdf>
- Williamson, A. R., and M. J. Scicchitano.** 2014. "Dimensions of Public Meeting Participation: Evidence from Florida's Truth-in-Millage Act." *Urban Affairs Review* 50 (1): 134-146. <https://doi.org/10.1177/1078087413480463>
- Woolcock, Michael, and Christopher Gibson.** 2007. "Empowerment, Deliberative Development and Local Level Politics in Indonesia: Participatory Projects as a Source of Countervailing Power." *Brooks World Poverty Institute Working Paper Number 8.* Manchester, UK: SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1204708
- World Bank.** 2018. *Equity on the Path to UHC. Deliberate Decisions for Fair Financing. Background Report.* Washington, DC: World Bank. <https://pubdocs.worldbank.org/en/330861541427342391/Background-paper.pdf>
- World Bank.** 2019. *High-Performance Health Financing Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century.* Washington, DC: World Bank. <https://documents1.worldbank.org/curated/en/641451561043585615/pdf/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century.pdf>
- World Bank.** 2020a. *Freedom of Information Access : Key Challenges, Lessons Learned and Strategies for Effective Implementation.* Washington, DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/34155>

- World Bank.** 2020b. *Poverty and Shared Prosperity 2020: Reversals of Fortune*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/bitstream/handle/10986/34496/9781464816024.pdf>
- World Health Organization.** 2010a. *Health systems financing: The path to universal coverage*. Geneva, Switzerland: World Health Organization. <https://www.who.int/whr/2010/en/>
- World Health Organization.** 2010b. *Health systems financing: the path to universal coverage*. Geneva, Switzerland: World Health Organization. <https://www.who.int/publications/i/item/9789241564021>
- World Health Organization.** 2014. *Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage*. Geneva, Switzerland: World Health Organization. http://apps.who.int/iris/bitstream/handle/10665/112671/9789241507158_eng.pdf;jsessionid=57DE53D7EB4A9198B38159B0346E8DC4?sequence=1
- World Health Organization.** 2015. *Anchoring universal health coverage in the right to health: what difference would it make? Policy brief*. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/199548/9789241509770_eng.pdf?sequence=1&isAllowed=y
- World Health Organization.** 2019. "Participation as a driver of health equity." <https://apps.who.int/iris/bitstream/handle/10665/324909/9789289054126-eng.pdf?sequence=1&isAllowed=y>
- World Health Organization and World Bank.** 2019. *Ukraine Review of Health Financing Reforms 2016-2019*. Copenhagen, Denmark: World Health Organization. https://www.euro.who.int/__data/assets/pdf_file/0008/416681/WHO-WB-Joint-Report-Full-report_Web.pdf
- Xu, Ke, David B. Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus, and Christopher J. L. Murray.** 2003. "Household catastrophic health expenditure: a multicountry analysis." *The Lancet* 362 (9378): 111-117. [https://doi.org/10.1016/s0140-6736\(03\)13861-5](https://doi.org/10.1016/s0140-6736(03)13861-5)
- Yamin, A. E., and T. Boghosian.** 2020. "Democracy and Health: Situating Health Rights within a Republic of Reasons." *Yale Journal of Health Policy, Law, and Ethics* 19 (2): 96-145. <http://hdl.handle.net/20.500.13051/5961>
- Yamin, Alicia Ely, and Oscar Parra-Vera.** 2009. "How do courts set health policy? The case of the Colombian Constitutional Court." *PLoS Medicine* 6 (2): e1000032.
- Yamin, Alicia Ely, Andrés Pichon-Riviere, and Paola Bergallo.** 2019. "Unique challenges for health equity in Latin America: situating the roles of priority-setting and judicial enforcement." *International Journal for Equity in Health* 18 (1): 1-4.
- Yoon, J.** 2021. "National Participatory Budgeting in South Korea." *Participedia*. <https://participedia.net/case/7431>
- Younger, Stephen D.** 2018. "Ghana and Tanzania: The Impact of Reforming Energy Subsidies, Cash Transfers, and Taxes on Inequality and Poverty." In *Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty*, edited by Nora Lustig, 702-712. Washington, DC: CEQ Institute at Tulane University and Brookings Institution Press.
- Younger, Stephen D., Flora Myamba, and Kenneth Mdadila.** 2016. "Fiscal Incidence in Tanzania." *African Development Review* 28 (3): 264-276. <https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-8268.12204>

