

Editorial

Stakeholder participation on the path to universal health coverage: the use of evidence-informed deliberative processes

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Introduction

Countries around the world strive to achieve universal health coverage (UHC), but face major challenges in the functioning of their health systems [1, 2]. Health systems are complex, not only in the types of policy choices needed to achieve UHC, but also in the range of stakeholders that need to be involved in their design and implementation. Stakeholders refer to organisations or groups of individuals who have an interest in the policy choice in question, such as government ministries (in health, but also beyond e.g. in finance or agriculture), patient groups, providers, manufacturers, or citizens in general.

Stakeholders often have different interests by which they value and prioritise policy choices. We argue that the fairness of a decision-making processes, i.e. how stakeholder interests are taken into account, is critical for both the legitimacy and the feasibility of strategies to achieve UHC. For these reasons, policy makers should take pro-active efforts to consider the different interests of stakeholders in their decision-making process.

We spell out how methods and experiences from the field of health technology assessment (HTA), and more specifically evidence-informed deliberative processes (EDPs), can be useful to promote stakeholder participation in policy choices around UHC.

Health system challenges

The efforts to deliver UHC are confronted by a number of health system challenges, in three dimensions (Figure 1) [3]. First, policy makers need to make important choices as to *which interventions* they fund. This may involve decisions on the public funding of, for example,

expensive drugs for third-line antiretroviral therapy (ART). Such decisions should consider the interests of the relevant stakeholders, including HIV patients (wanting to get the best treatment), other patients (whose treatment may be displaced in case ART is funded), or tax payers (wanting to minimize public expenditure on health). The provision of third-line ART may also involve other policy choices, such as the mode and level of provider payment. With regard to these choices, individual specialists may find it reasonable to charge high prices in case third-line ART demands extra attention. At the same time, hospitals may want to restrict expensive therapies, especially if they have a large budget impact.

Second, policy makers need to make choices regarding the *geographic coverage* of their interventions. For example, they may want to increase the coverage of skilled birth attendance by training and employing midwives in rural populations. Again, this choice would need to reflect underlying stakeholders' views on equity, e.g. the preferences of the public regarding service provision to rural versus urban populations.

Third, policy makers need to make choices on the *level of private payments* when individuals use health services. These choices relate to stakeholders' perspectives as to whether people should be able to access care irrespective of their ability to pay. The broad public and especially low-income groups may have different interests, tracing back to sometimes conflicting principles of solidarity and own-responsibility.

Stakeholder involvement and legitimacy

The above examples demonstrate that society is composed of a variety of stakeholders who hold a wide range of perceptions of what makes policy decisions legitimate

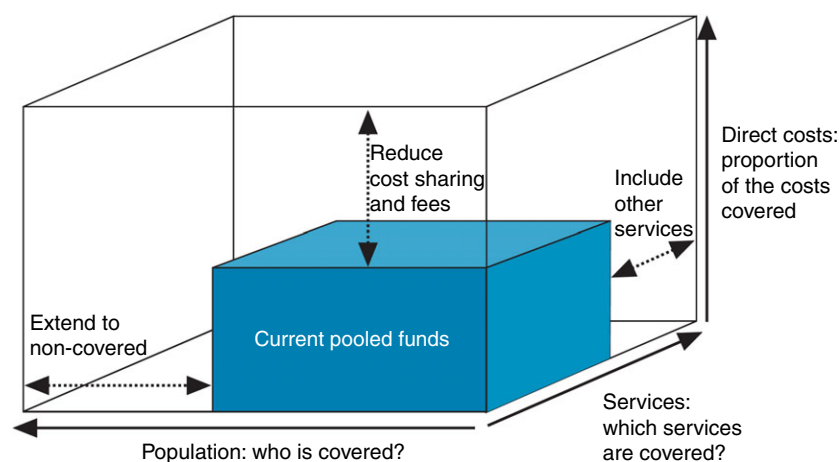


Figure 1 Three dimensions to consider when moving to universal health coverage. [Colour figure can be viewed at wileyonlinelibrary.com].

[4]. Based on these perceptions they value specific policy choices more than others. The more pluralist a society is, the greater the likelihood of disagreement among stakeholders which policy options should be pursued [5]. If ignored, such discordance risks to compromise the legitimacy of decisions. Legitimacy refers to the fairness of a decision-making process as perceived by stakeholders, which is an important prerequisite for broad societal support for decisions [5].

The explicit involvement of stakeholders in decision-making is an important element to address the issue of legitimacy, for three reasons. First, stakeholder involvement serves to identify the full range of interests that society has in relation to a particular decision. Second, it can improve the understanding among stakeholders of each other's interests [6]. Third, stakeholder involvement can contribute to better quality policy decisions, as stakeholders contribute knowledge about the local context. Policy makers usually do not oversee the whole spectrum of societal interests and perceptions how health systems challenges can best be tackled [7].

At the same time, stakeholder involvement is also an important safeguard to ensure the feasibility of policy strategies. Stakeholders bring in local knowledge about barriers to implementation. If policy makers ignore this knowledge, they risk to choose policy strategies that may not be feasible to implement. For example, the current evidence base for prioritizing ART scale-up strategies results in recommendations that are theoretically optimal but practically infeasible to implement due to, among other reasons, health workforce limitations [8].

It is important to realise that stakeholder *consensus* is not essential. It may be sufficient to ensure an optimal level of understanding of why a particular decision was

taken. Policy makers hold the final authority, and are accountable for their final decisions to society.

Taking into account stakeholder interests

Presently, policy makers employ a range of mechanisms to respond to health system challenges. For example, sector-wide plans describe a governmental health strategy for, typically, a five-year period. At the programme level, managers design optimal disease control strategies. To our knowledge, these mechanisms only implicitly consider stakeholder interests [9]. A resulting vexing question is how policy makers can make these stakeholder interests explicit and take these into account when making decisions?

We consider the field of HTA as instrumental in this context. HTA is defined as “a multidisciplinary field of policy analysis, studying the medical, economic, social and ethical implications of development, diffusion and use of health technology” [10]. Recent methodological developments in HTA are oriented towards stakeholder involvement as a way to identify and consider their perspectives. Here, we concentrate on one specific approach in HTA, evidence-informed deliberative processes (EDPs). EDPs provide a structured process for making choices and trade-offs between different policy choices, so as to reflect stakeholders' different perspectives [11].

Evidence-informed deliberative processes are, on the one hand, characterised by deliberation between stakeholders to identify, reflect and learn about the meaning and importance of each other's perspective. On the other hand, they involve structured and evidence-informed evaluation of the identified decision criteria where possible. Evidence-informed evaluation allows contributions from stakeholders in terms of their (clinical) experience and

their judgments when stronger evidence is unavailable [12].

Evidence-informed deliberative processes include five steps (Figure 2). In the first step, an appraisal committee is established, involving relevant stakeholders e.g. patients, informal carers, health professionals. In the second step (*scoping*), this committee systematically explores the relevant aspects of a specific problem area from the various stakeholder perspectives. This step may concern the nomination of interventions for assessment, and the choice of relevant criteria to consider in the assessment. Here, stakeholder interests are operationalised in criteria – e.g. the value ‘maximising health for a given budget’ can be operationalised in the criterion ‘cost-effectiveness’. In the third step (*assessment*), the committee organises evidence collection on these criteria. In the fourth step (*appraisal*), members of the appraisal committee scrutinize and deliberate to interpret the evidence in conjunction with other stakeholder interests. In the fifth step (*communication and appeal*), agencies publish their argumentation, install options for appeal (e.g. request a re-consideration of the evidence), and organize monitoring and evaluation following implementation of their recommendations. These steps are described in detail elsewhere [13].

Evidence-informed deliberative processes have been used to support West Java provincial authorities in Indonesia in the development of their strategic plan on HIV/AIDS for 2014–18. A project team established an appraisal committee of 23 stakeholders including provincial governmental authorities, staff members from community organisations that represent people living with HIV/AIDS, programme managers from the provincial AIDS commission, and scientists. The panel identified 50 interventions and these were evaluated against

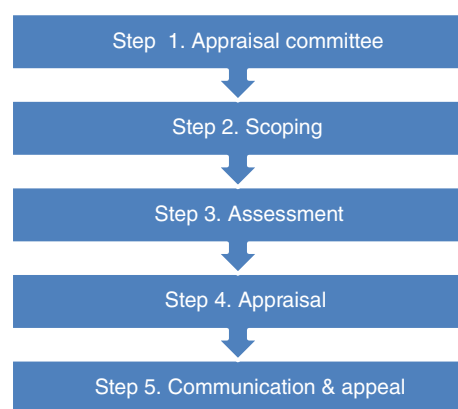


Figure 2 Five steps of evidence-informed deliberative processes. [Colour figure can be viewed at wileyonlinelibrary.com].

four criteria: impact on the epidemic, stigma reduction, cost-effectiveness and coverage. After a deliberative discussion, the committee prioritised a combination of several treatment, prevention and mitigation interventions, and identified the organisations to implement and fund the prioritised activities. This evidence-informed deliberative process improved both stakeholders’ involvement and the evidence base of the strategic planning process [14].

Conclusion

We call for a more systematic involvement of stakeholders in policy choices to achieve UHC, and propose the use of EDPs as an overarching framework. EDPs provide a procedural approach for building consensus towards feasible, and ultimately, the most legitimate strategies for achieving UHC. The way these EDP steps can be applied depends on the specific health system challenge(s) and the existing decision-making process.

References

1. World Health Report. Health systems: improving performance. World Health Organization: Geneva, 2013. (Available from: http://www.who.int/whr/2000/en/whr00_en.pdf) [cited 2016 Oct 24]. 2013.
2. Healthy systems for universal health coverage - a joint vision for healthy lives. World Health Organisation and International Bank for Reconstruction and Development/ The World Bank: Geneva, 2017.
3. World Health Organisation. World Health Report 2010. Health systems financing: the path to universal coverage. 2010.
4. Grin J, devan GH, Hoppe R. Technology assessment through interaction. A guide. Den Haag: SDU (working document Rathenau Institute, W57); 1997.
5. Daniels N. Accountability for reasonableness. *Br Med J* 2000; **321**: 1300–1301.
6. Richardson H. *Practical Reasoning About Final Ends*. Georgetown University: Cambridge University Press: Cambridge, 1997.
7. Stermann JD. *Systems Thinking and Modelling for a Complex World*. Irwin McGraw Hill: Boston, MA, 2000.
8. Mikkelsen E, Hontelez JAC, Jansen MPM *et al.* Evidence for scaling up HIV treatment in sub-Saharan Africa: a call for incorporating health system constraints. *PLoS Med* 2017; **14**: e1002240.
9. Bijlmakers L, Mueller D, Kahveci R, Chen YY, van der Wilt GJ. Integrate-Hta: a low- and middle-income country perspective. *Int J Technol Assess Health Care* 2017; **33**: 599–604.
10. INAHTA (International Network of Agencies for Health Technology Assessment) HTA Resources. (Available from: <http://www.inahta.org/HTA/>) 2009.

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11. Abelson J, Wagner F, DeJean D *et al.* Public and patient involvement in health technology assessment: a framework for action. *Int J Technol Assess Health Care* 2016; **32**: 256–264.
12. Slonim-Nevo INV. The myth of evidence-based practice: towards evidence-informed practice. *Br J Soc Work* 2011; **00**: 1–22.
13. Baltussen R, Mikkelsen E, Tromp N *et al.* Balancing efficiency, equity and feasibility of HIV treatment in South Africa – development of programmatic guidance. *Cost Eff Resour Alloc* 2013; **11**: 26.
14. Tromp N, Prawiranegara R, Siregar A *et al.* Translating international HIV treatment guidelines into local priorities in Indonesia. *Trop Med Int Health* 2018; **23**: 279–294.

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