



# Justice and public participation in universal health coverage: when is tiered coverage unfair and who should decide?

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## Abstract

Universal health coverage is often implemented within countries through several national insurance schemes that collectively cover their populations. Yet the extent of services and benefits available can vary substantially between different schemes. This paper argues that these variations in coverage comprise tiering and then reviews different accounts of health and social justice that consider whether and when a tiered health system is fair. Using these accounts, it shows that the fairness of tiering can be determined by assessing whether differences in coverage mean enrollees under some national insurance schemes do not achieve sufficient health or normal functioning and/or feel inferior relative to those belonging to other national insurance schemes. The paper further contends that these determinations of fairness should involve the people covered by different insurance schemes. Key universal health coverage questions to involve the public in answering are: *Do the sum of differences between the schemes in your country generate feelings of unequal moral worth and/or mean enrollees struggle to achieve sufficient health or normal functioning? Which specific differences between health insurance schemes generate the greatest feelings of unequal moral worth in individuals? Which specific differences generate the greatest barriers to individuals achieving sufficient health or normal functioning?* Rather than identifying which services to extend coverage to first, answering these questions will identify which disparities in services and benefits are the most morally urgent to address. Finally, some initial thoughts are offered on who from the public should be involved in making these decisions and how they might be involved as a matter of justice.

**Keywords** Universal health coverage · Participation · Ethics · Justice · Decision-making · Tiered system

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## Introduction

Universal health coverage (UHC) means that everyone in a society can access quality health services that meet their needs without being exposed to financial hardship in paying for them. Given resource constraints, this does not entail access to all possible services but a comprehensive range of key services that is well aligned with other social goals (WHO 2014). UHC was firmly endorsed by the World Health Assembly in 2005 and further supported in the World Health Report 2010 (WHO 2014). In 2015, it was included as a target in the Sustainable Development Goals: to ‘achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all’ (UNDP 2018).

The past 15 years has seen substantial growth in the UHC movement worldwide. Many countries have adopted UHC as an aspiration for their national policy such as Bangladesh, Brazil, China, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam (Reich et al. 2016; Qingyue and Shenglan 2013). Their governments implemented reforms designed to achieve UHC for their populations.

The values underlying UHC have clear implications for what its implementation looks like—namely, who is covered by the system, whether and when tiers are established, what services are covered, and how they are financed. The values that are implied by UHC support choices about how health systems are governed and how their organisations are managed (Fattore and Tedioso 2013). *Justice* is a core moral value underlying public health and UHC (Frenz and Vega 2010; Ho 2013; WHO 2014; WHO 2008; Powers and Faden 2006). What is required for UHC implementation to advance justice is beginning to be explored by ethics scholars (WHO 2014; Norheim 2016), though many questions remain for them to investigate. Different accounts of justice take different positions on the currency of justice (e.g. needs, capabilities, functionings), the threshold level to which it is owed (e.g. basic, sufficient, or optimal health), and the scope of justice (e.g. domestic or global, intragenerational or intergenerational). These accounts may support varying positions on who should be covered by UHC, whether and when tiers should be established, what services should be covered, and how they should be financed.

This paper focuses on the question of whether and when tiering is permissible as a matter of justice. Many countries have sought to achieve UHC for their citizens and residents by establishing a set of national insurance schemes that collectively cover everyone. Yet the extent of services and benefits often varies between the different schemes, so some groups can access more and/or better quality health care and services than others. The paper first describes what this approach looks like by providing the real-world examples of the Thai and Chinese health systems and argues that differences in services and benefits between national insurance schemes comprise a tiered system. It then reviews different accounts of health and social justice that consider whether and when a tiered health system is fair. Using these accounts, the paper shows that the fairness of tiering can be determined by assessing whether differences in services and benefits mean individuals under some insurance plans do not achieve a sufficient level of health and/or feel inferior compared to those belonging to other insurance plans.

Making such determinations requires obtaining the perspectives of those enrolled in the various national insurance plans in a given country. The paper proposes that key

UHC decisions to involve the public in making are, thus, whether the differences in services and benefits between insurance plans in their country are unfair and, if so, which are morally urgent to reduce or eliminate as a matter of justice. Rather than identifying which services to extend coverage to first, making these decisions will identify which *disparities* in services and benefits are a priority to address. Finally, some initial thoughts are offered on who from the public should be involved in making these decisions and how they might be involved. Here, the examples of the Thai and Chinese health systems are revisited to illustrate what the normative arguments might demand in decision-making practice.<sup>1</sup>

## The context

### A UHC model

A UHC model that has been implemented by many countries consists of having separate insurance plans for different segments of the population; collectively, the schemes cover countries' entire populations. Two examples are China and Thailand's health systems. In China, three national health insurance schemes exist for the population. The Urban Employee Basic Medical Insurance (UEBMI) was established in the early 1990s and covers urban employees, including the formally employed, informally employed, and migrant workers. The Urban Resident Basic Medical Insurance (URBMI) was established in 2007. It covers urban residents who are not covered by the UEBMI such as the self-employed, unemployed, elderly, children, and students. The New Rural Cooperative Medical Insurance (NRCMI) was established in 2003 and covers rural residents (Shan et al. 2017; World Bank 2010).

In Thailand, three national health insurance schemes also comprise UHC for the population. The Civil Servant Medical Benefit Scheme was established in 1980 for government employees and their dependents (parents, spouses, and children under 18). The Social Health Insurance Scheme was established in 1990 and covers private sector employees. The Universal Health Coverage Scheme was established in 2002 and covers the poor, vulnerable groups, and individuals working in the informal sector.

### Inequalities in UHC implementation

Despite multiple national health insurance plans in principle comprising UHC, in practice, differences often exist in service coverage and financing between schemes. This introduces inequalities in the services people access, in how much people pay for services, and in quality of the services they receive. Returning to the example of the Chinese health system, studies have demonstrated that significant entitlement disparities exist amongst the three Chinese schemes. UEBMI members enjoy the highest level

<sup>1</sup> The paper does not evaluate whether the Thai and Chinese health systems' tiered coverage is fair or whether existing forms of public participation in UHC decision-making in Thailand and China meet the demands of justice, i.e. in terms of who is involved and how they are involved.

of entitlements compared to members of the other two schemes. These include larger available funds, a broader scope of services covered, and higher compensation rates (Shan et al. 2017). The World Bank (2010) reported an almost a fivefold difference between financing for UEBMI beneficiaries (RMB 1100 per enrollee) and URBMI beneficiaries (RMB 236 per enrollee). Average financing in the NRCMI scheme was even lower (RMB 130 per enrollee).

In the Thai health system, the civil service scheme covers 7% of Thai citizens and receives 71 billion baht, the social security scheme covers 17% of Thai citizens and receives 37.7 billion baht, and the UHC scheme covers 76% of Thai citizens and receives 109 billion baht (Tangcharoensathien et al. 2018). Expenditure for the UHC scheme, which covers the poor, vulnerable groups, and informal workers, is very low relative to expenditure for the civil service scheme. Beneficiaries of the civil service scheme received up to 12,589 baht per head in 2013, compared to 2509 baht per head for social security scheme beneficiaries, and 2245 baht per head for UHC scheme beneficiaries. Disparities exist between schemes in terms of the services and benefits accessible to their enrollees, with members of the civil service scheme having access to better medical care (Muangpin and Ruji 2015).

### **Tiered systems or not?**

Where clear differences in coverage exist between national health insurance plans in terms of the services and benefits accessible to enrollees, this raises the question: do tiered systems exist in the countries implementing them? A tiered health system has been defined as having a first tier that usually relies on public insurance, providing guaranteed access to what is often referred to as ‘basic’ or ‘essential’ medical care. It also has a second tier that comprises voluntary insurance schemes for other health needs (Fourie 2017; Ruger 2010; Beauchamp and Childress 1994).

Health systems with several national health insurance plans may not constitute a ‘tiered’ system under that traditional definition. However, Norman Daniels et al. (2000) affirms that inequalities in services and quality of care comprise tiering and reduce the fairness of health systems. Such differences in coverage happen when individuals who can access voluntary insurance have better coverage than individuals who can only access public insurance. They also happen when disparities exist between the various ‘first tier’ insurance plans in terms of access to services and benefits. Where national health insurance plans are roughly equivalent in terms of services covered, quality of services, and benefits, having multiple plans does not create tiers.

### **The value of justice**

The question of whether or when a tiered health system is fair has been considered by philosophers using accounts of health and social justice. Those accounts do not define justice in the same way. (As previously noted, different accounts of justice take different positions on, for example, the currency of justice, the threshold level to which it is owed, and the scope of justice.) Each account’s position on tiered systems will be described and the implications for UHC implementation discussed.

## Justice and tiered health systems

Jennifer Ruger's health capability paradigm establishes a universal obligation to efficiently reduce shortfall inequalities in individuals' health capabilities. The aim is for societies to achieve *optimal* levels of health for their members (Ruger 2010). To ensure individuals' health capabilities, certain entitlements must be provided, including public health and health care interventions and services as well as the institutional structures and norms that facilitate access to them. A just health system has two main features: (1) equal access to goods and services and (2) equitable health financing (Ruger 2010). Equal access means access to high-quality care, not a 'decent minimum', 'adequate care', or 'tiered health care' (Ruger 2010, p. 8). Under this account of equal access, differences in health care quality are morally troubling and unjust because lower-quality care undermines individuals' capability for health functioning. Two people with the same health condition experience different health functionings if one has access to high-quality health care and the other does not (Ruger 2010). Thus, a two-tiered health system is unjust according to the health capability paradigm.

In contrast, Carina Fourie (2017) argues that accounts calling for a *sufficiency* of capabilities or functionings provide a limited justification for certain kinds of two-tiered health systems. This would include accounts such as: Madison Powers and Ruth Faden's sufficiency of well-being approach, Efrat Ram-Tiktin's sufficiency of basic human functional capabilities approach, and Andrew Allen Alvarez's sufficiency of vital capacities approach (Powers and Faden 2006; Alvarez 2007; Ram-Tiktin 2011; Ram-Tiktin 2012). Sufficiency justice requires that individuals achieve a sufficient level of health and other dimensions of wellbeing; this could mean having a decent life over a 'sufficient' life span (such as 75 years) (Powers and Faden 2006, p. 62). It could be achieved under certain kinds of two-tiered health systems. In such systems, the first tier would offer comprehensive basic care because it is necessary to provide a sufficiency of capabilities. Excluding entire types of preventative interventions and treatments (e.g. dental, prescription drugs) would be impermissible. The second tier would, therefore, be limited in terms of the types of preventative interventions and treatments offered exclusively to its users (Fourie 2017).

Similarly, Norman Daniels' extension of Rawlsian justice to health purports that ensuring a fair equality of opportunity demands universal coverage of 'decent' or 'adequate' services as part of the basic or first tier. The theory rules out the exclusion of whole categories of preventative interventions and treatments that are necessary for individuals to achieve normal functioning (Daniels 2008, p. 143). Normal functioning is defined as an absence of pathology (Daniels 2001). Without normal functioning, humans do not have the same opportunity range because disease restricts them from being and doing things that healthy individuals can be and do.

Sufficiency and Rawlsian justice would also allow for differences in the way services are delivered between the first and second tier. There are a wide range of ways in which services can be delivered that would not compromise achieving normal functioning or sufficient health, so there is scope for services to differ between tiers (Fourie 2017; Daniels 2008). Where services do impact sufficiency or normal functioning (e.g. choice of surgeon or hospital makes a substantial difference in whether an operation will succeed) then the relevant services should be part of the basic package. Where services do not make difference to sufficiency or normal functioning

(e.g. privacy, quality of food, comfort of hospital room, rapid access to services rationed by queuing) then they can be made exclusively available to second tier users (Fourie 2017; Daniels 1998). Finally, sufficientarian and Rawlsian justice would rule out tiered health systems where the first tier is undermined by the second tier because such systems would obstruct achievement of normal functioning or a sufficiency of capabilities for individuals who only receive care under the first tier (Fourie 2017; Daniels 1998). For instance, a parallel substitution system that allows people to opt out of the first tier and threatens its funding would be impermissible (Fourie 2017).

Fourie (2017) further contends that social egalitarian accounts of justice would provide a limited justification for certain kinds of two-tiered health systems. This would include Iris Marion Young's relational egalitarian approach and Elizabeth Anderson's democratic equality approach (Anderson 1999; Young 1990; Young 2000). Social equality focuses on what it means for people to stand in relations of equality: to be treated as equals and feel that they are equals. Where societies do not create conditions of social equality, respect for persons is violated, which negatively affects individuals' well-being in terms of respect for the self and by others. Social cohesion, civic friendship, and trust are also damaged at a population level. This is exacerbated in hierarchical societies, where the same people or groups are frequently at the bottom of a variety of social hierarchies (Fourie 2017).

According to social egalitarian accounts, the way social institutions are set up and social goods like medical care are distributed should not create or reinforce (even unintentionally) certain kinds of unequal relationships that imply some people have lower social status or moral worth than others (Fourie 2017). Two-tier health systems have the potential to violate social equality when a large range of services on the second tier are not available on the first tier. Such differences make those receiving coverage only via the first tier feel inferior, damaging their self-worth (Fourie 2017). Like sufficientarian justice, social egalitarian accounts rule out parallel substitution systems, though for a different reason. According to social egalitarians, parallel substitution systems are morally bad because people are no longer in same boat; they live in different health care worlds, resulting in the breakdown of bonds and social cohesion between members of society (Fourie 2017).

### **Implications for UHC implementation**

Fourie, Daniels, and Ruger's work highlights that relying on alternative conceptions of justice may endorse different types of UHC systems. It demonstrates that accounts of justice take somewhat different positions on the matter of whether and when tiered health systems are permissible. The health capability paradigm rejects tiered systems because they create differences in quality of care.

Sufficientarian justice, Rawlsian justice, and social egalitarianism provide a limited justification for certain kinds of two-tiered health systems. Sufficientarian and Rawlsian justice consider the impact of tiered systems on individuals' health status whereas social egalitarians are concerned with their impact on respect at the individual level and social cohesion at a population level. As a result, while all three accounts reject parallel substitution systems, they do so for different reasons. Sufficientarian and Rawlsian justice may also permit greater differences in service delivery between the first and second tiers of a health system than social egalitarianism would. This is because some differences in

service delivery that make individuals feel treated as having less moral worth may have little or no impact on whether they achieve sufficient health or normal functioning.

Where the value of justice as equity underlying UHC is interpreted as sufficiency, normal functioning, and/or social equality, a single insurance plan is not necessarily required for countries' populations as a matter of justice. The fairness of tiering can be assessed by considering whether differences in coverage mean individuals under some national insurance plans do not achieve a sufficient level of health or normal functioning and/or feel inferior compared to those belonging to other national insurance plans. Such conditions likely occur in UHC systems where large disparities exist between different national insurance plans in terms of benefits and services. These differences would likely mean individuals covered under some insurance plans do not achieve normal functioning or a sufficient level of health and feel inferior compared to others belonging to insurance plans with greater benefits, more services, better service quality, and/or better service delivery. To advance justice, such differences between plans need to be reduced (Daniels et al. 2000). (This is also consistent with the health capability paradigm.) Diminishing differences in benefits and services should be a key aim of subsequent UHC reforms in countries with large disparities between national health insurance plans.

### **Public participation in deciding when tiered coverage is unfair**

Public participation is a core feature of people-centred health care and systems. People should be agents that actively shape the health system, including how services are financed and delivered (WHO 2015). Calls for public participation in UHC decision-making have been made and rationales for doing so provided (WHO 2014).

It has been suggested that the public should be involved in making the following critical choices on the path to UHC: which services to expand coverage to first, which individuals or groups to extend coverage to first, and how to reduce out-of-pocket payments to finance health services (WHO 2014). In practice, public participation in deliberative events is an increasingly prominent feature of health priority-setting and resource allocation and generally focuses on decisions related to service selection (Mitton et al. 2009; Degeling et al. 2015). These decisions include:

- Defining the basic package of services to include in health insurance plans (Goold et al. 2005; Ginsburg et al. 2006),
- Determining whether to add new (high-cost) treatments into the basic package of services covered by existing health insurance plans, often as part of health technology assessments (Abelson et al. 2007; Kieslich et al. 2016; Oh et al. 2015; Degeling et al. 2017),
- Selecting the values and principles to guide the choice of services to include in the basic package (Menon and Stafinski 2008; Lenaghan 1999), and
- Identifying local and national priorities for health services, programmes, and reforms and ranking them (Degeling et al. 2017).

To a lesser extent, public participation occurs in making health financing decisions. For example, it has been part of setting health insurance premium levels (Oh et al. 2015; Deng and Wu 2010).

As a matter of justice, an aim of UHC implementation is arguably to reduce unfair disparities in the benefits and services covered by different national health insurance plans. Rather than identifying which services to extend coverage to first, this demands determining whether disparities in coverage are unfair and identifying which unfair disparities ought to be addressed first. Making such determinations requires the assessment of national insurance schemes from the perspectives of their enrollees. Those covered by the schemes can provide important insights about whether they can achieve sufficient health and whether their self-worth is being damaged. Key UHC questions to involve the public in making answering are then: *Do the sum of differences between schemes in your country generate feelings of unequal moral worth and/or mean enrollees struggle to achieve sufficient health or normal functioning? Which specific differences between health insurance plans generate the greatest feelings of unequal moral worth in individuals (i.e. make individuals feel inferior or damage feelings of shared experience with others)? Which specific differences generate the greatest barriers to individuals achieving sufficient health or normal functioning?* Here, differences encompass what services are covered, how services are delivered, and how services are financed, e.g. differences in co-pays, deductibles, and payment methods.

Answering the questions would entail considering what differences exist between insurance plans, whether the totality of those differences is unfair, and identifying which (if any) of them are most morally urgent to reduce or eliminate as a matter of justice. Sufficientarian justice, Rawlsian justice, and social egalitarianism suggest the main focus of reforms to reduce tiering should be on differences that generate feelings of social inequality and/or prevent the achievement of health sufficiency or normal functioning (Fourie 2017). Those differences that are ranked as generating the greatest feelings of inferiority and/or the biggest obstacles to health sufficiency or normal functioning by the public would then be ‘morally urgent’ or priority areas upon which to focus reforms.

## Making the decisions

The paper has proposed that the public should be involved in decision-making about reducing disparities in UHC implementation. A next step is to consider who from the public should be represented in making this type of decision and how they should be involved in making it.

It has been suggested that Accountability for Reasonableness (A4R) should serve as the ethical framework to guide public participation in UHC decision-making (WHO 2014). While not disputing that the four A4R conditions can usefully be applied to help ensure fair UHC decision-making, the framework does not offer adequate guidance to address matters of inclusion. A4R requires that a wide range of stakeholders be involved in decision-making (Gruskin and Daniels 2008), but it largely does not account for power differences in decision-making contexts (Gibson et al. 2005). Certain countries’ experiences implementing A4R suggest that meeting its standard of inclusion is not sufficient in contexts where social and economic disparities are rife. For example, Shayo et al. (2012) found that even where health priority-setting processes included men and women representing a diverse array of income-levels, education levels, and ethnicities, being male, having a higher income or education level, and/or



being from the main ethnic group in the district-under-study meant that a person was listened to more seriously and had greater influence on the outcome. Simply including a wide range of stakeholders does not ensure those considered disadvantaged and marginalised can raise their voices and influence decision-making, which is a core requirement of justice as equity (Young 1990, 2000).

Given the limitations of A4R framework, some initial thoughts are provided on who to include when making decisions about the fairness of tiered coverage and how to include them by, instead, applying a recently proposed working model of deep inclusion to the UHC context (Pratt et al. 2016). Here, the examples of the Thai and Chinese health systems are revisited to illustrate what deep inclusion might demand in practice. A model of deep inclusion should be to guide decision-making when it is conducted in the context of power inequalities in order to help ensure processes do not exclude peoples' voices, especially those of marginalised groups (Pratt et al. 2016). The specific account of deep inclusion applied in this paper considers what inclusion means not only in health decision-making but also in order to advance the value of justice as equity. As such, the working model seemed particularly relevant to apply to the context of UHC decision-making.

The working model proposes deep inclusion has three dimensions: breadth, qualitative equality, and high-quality involvement of minority and disadvantaged groups, which Denis Goulet (1995, 2006) has termed 'non-elite participation' (Pratt et al. 2016). The dimension of breadth captures who is involved in the decision-making process while the latter two dimensions focus on how and when stakeholders participate. Strong performance on all three dimensions is necessary for health decision-making to generate outputs that advance health equity. Non-elite participation is particularly critical (Young 1990, 2000). To develop the model, concepts from deliberative democracy and development ethics literature were applied. In particular, the scholarship of Iris Marion Young, Henry S. Richardson, and Goulet were used. Philosophers Young and Richardson each consider inclusion in contexts of power disparities, while Goulet has explored the phenomenon of non-elite participation (Pratt et al. 2016).

## Who should participate

Inclusion has been broadly defined as ensuring that all those affected by a decision take part in the decision-making process (Young 2000; Gruskin and Daniels 2008). Where the decision being made is about reducing disparities between national health insurance plans, those affected would clearly include members of each of the various plans a country offers. In Thailand, for example, it would demand the participation of members of the civil service scheme, the social security scheme, and the UHC scheme.

Achieving breadth encompasses two main elements: range and mass. Range refers to ensuring that participants span a wide spectrum of relevant roles and demographics (Pratt et al. 2016). Relevant roles in the context of UHC insurance schemes would include the 'disinterested' citizen or general public, service-users/patients/consumers, and carers and families of patients. Each role is identified and described in general terms in the literature (Degeling et al. 2015; Pratt et al. 2016). Here, the 'disinterested' citizen would refer to insurance plan members who are enrolled but do not make frequent use of the health care system. They can educate policymakers on what they think is fair given the needs and interests of society (Degeling et al. 2015) and can

provide information as to which differences between insurance plans would likely make individuals feel most inferior. Patients, carers, and families have knowledge about being affected by illness and using the health system regularly (Degeling et al. 2015). They can likely provide information as to which differences between insurance plans' benefits and coverage of services for their illnesses make them feel most inferior and which differences most affect their ability to achieve sufficient health or normal functioning.

Beyond disinterested citizens, patients, carers, and family members from each insurance scheme, the participation of disadvantaged groups is key to achieving breadth (Pratt et al. 2016). Public participation in making the aforementioned UHC decision should include enrollees from disadvantaged and vulnerable groups from each insurance scheme. For example, in China, it would mean including migrant and informal workers from the UEBMIS, unemployed and elderly individuals from the URBMIS, and rural residents from the NRCMS as well as other disadvantaged groups within each scheme.

Public participants should also span a spectrum of relevant demographics for each role and disadvantaged group. Relevant demographics are individual characteristics likely to give rise to differential understandings of needs related to the health system (Pratt et al. 2016). For patients, for example, relevant demographics might include race, gender, income level, and having different types of illnesses. To some extent, however, having participants who are enrolled in the different national health insurance schemes should help achieve a spectrum of demographics. The Thai and Chinese schemes, for example, cover individuals working in different sectors (formal, informal) and locations (urban, rural).

Mass refers to the number of participants belonging to each category (in this case, each insurance scheme) and having the various roles and demographics. The aim is to make a best effort to achieve a critical mass of different perspectives, including those of disadvantaged groups, and to ensure that certain powerful roles or groups do not dominate the decision-making process by force of numbers (Pratt et al. 2016). In the context of the Chinese and Thai health systems, achieving mass would entail having similar numbers of participants from each insurance scheme or perhaps weighting the number of participants from each scheme by the proportion of the population belonging to them. The latter would likely privilege participation by more disadvantaged members of the Thai and Chinese populations because the insurance schemes with the greatest numbers are those covering the poor, the vulnerable, and the informal sector (Thailand) and rural residents (China). Even so, disadvantaged groups are enrolled in the two urban Chinese insurance schemes and it would be important to ensure sufficient numbers of such individuals participate as well.

### **How they should participate**

In terms of *how* members of the different insurance schemes should be involved in UHC decision-making, considerations relating to process, promoting qualitative equality, and achieving high-depth non-elite participation are pertinent. For participants to identify which differences between insurance schemes generate significant feelings of lesser worth or substantial barriers to achieving sufficient health or normal functioning, they *first* require an understanding of what is offered under other schemes, i.e. the schemes in which they are not enrolled. Such an understanding can be generated in

many ways. For example, it could consist of having a workshop directly prior to the decision-making process where participants undertake a mapping exercise to catalogue differences between their insurance schemes. This would allow the differences between schemes to be identified by the public, rather than by those engaging them in UHC decision-making. Next, a deliberative process could be undertaken to determine which differences generate the greatest feelings of inferiority and/or the greatest barriers to achieving sufficient health or normal functioning. Doing so would be consistent with the working model, which emphasises using deliberative processes<sup>2</sup> to reach decisions (Pratt et al. 2016). Deliberative processes involving the public have been used to inform institutional ethics policies on biobanking and benefit sharing. The deliberative methods applied in those studies may be a rich resource to draw upon to inform UHC decision-making. Key features included having a day of information provision and an introduction to deliberation prior to commencing deliberations, undertaking both small and large group deliberations, and having a ratification process that achieves closure but documents minority viewpoints (O’Doherty et al. 2012; Marsh et al. 2011; Njue et al. 2014).

During deliberative processes, it is important to ensure participants have an equal opportunity to raise their voices and to be heard (Richardson 2002; Crocker 2008; Cornwall 2011). Promoting qualitative equality entails identifying factors<sup>3</sup> that are likely to suppress people’s opportunity to participate equally and then structuring deliberative processes to minimise the impact of those factors (Pratt et al. 2016). This could involve ensuring that the methods of deliberation favour those with less power (e.g. through choice of venue, language, means of discussion). In the Thai context, for example, it would be important for deliberative methods to favour the poor, informal workers, and other disadvantaged groups relative to government and private sector employees.

Finally, the working model proposes that it is essential to achieve a *high-depth* of non-elite participation, which means that disadvantaged groups participate from the start of decision-making processes onwards and are involved as decision-makers rather than as consultants (Pratt et al. 2016). In China and Thailand, it would thus be important that migrants, rural residents, the unemployed, and informal workers (amongst others) participate both in mapping the differences between health insurance plans *and* then in determining which differences are the most urgent to address as a matter of justice. This contrasts with having a consultant role where, for instance, non-elites provide information on what differences between schemes make them feel

<sup>2</sup> Young (1990) and Richardson (2002) characterise deliberative decision-making as a process of discussing problems or claims of need through dialogue with others who test and challenge these proposals. The deliberative public rejects or refines proposals and collectively agrees on those proposals that are supported by the best reasons.

<sup>3</sup> Such factors could include institutional practices (formal rules and procedures) and norms. Where people’s identities consist of characteristics associated with lower status, it often results in their being listened to less in health decision-making (Shayo et al. 2012). Where local spaces are used for deliberations, they can carry traces of norms that disempower individuals with certain characteristics (Gaventa 2002). In LMICs, village-level decision-making structures may be fora in which minorities are simply informed and generally do not have a say. Thus, citizen consultations that use them will be characterised by members of minorities being present but rarely speaking (Mompoti and Prinsen 2011). Certain accents, word choices, and ways of speaking may also diminish individuals’ chances of being heard because they are given less value in particular societies (Cornwall 2004; Young 2000).

inferior and then that information is used by policymakers to rank differences as more or less urgent.

## Conclusions

UHC is often implemented within countries through several national health insurance schemes that collectively cover their populations. Yet the extent of coverage available can vary substantially amongst the different schemes within a country. This paper has argued that such differences in services and benefits comprise tiering and that their fairness can be determined by assessing whether they lead individuals under some insurance plans to fail to achieve sufficient health or normal functioning and/or to feel inferior relative to those belonging to other insurance plans.

Making determinations of whether differences in coverage between schemes are unfair and which are a priority to address demands public participation. Patients, carers, disinterested citizens, and members of disadvantaged groups from different UHC schemes within a given country should participate in making these decisions via a deliberative process that is structured to mitigate power disparities between them. Ideally, members of disadvantaged groups will be involved from the start of such processes and as decision-makers rather than as consultants.

Despite generating new ideas about the fairness of tiered coverage and the nature of public participation in UHC decision-making, the paper has some important limitations. First, it focuses on the value of justice—and a particular conception of justice (as equity)—and its implications for the decision of whether and when tiering is permissible. What values should underlie UHC—solidarity, equity, benefit maximisation, reciprocity—are still a matter of debate and have clear implications for what UHC looks like, namely, who is covered by the system, whether tiering is established, and what services are covered. The implications of different values for these choices are yet to be fully explored. Future work should, for example, apply values beyond justice to explore questions of tiering and UHC implementation. Tensions between what types of tiering different values support or permit should be investigated as part of that work.

Second, the paper focuses on the fairness of tiering in countries that have adopted multiple health insurance plans to achieve UHC. Many countries have not taken this path to UHC. For instance, the decision would not directly apply to South Korea, where a single national insurance plan has been adopted for the entire country. Nonetheless, disparities in coverage do occur where single national plans have been enacted. In such contexts, it would still be important to assess the fairness of these disparities and to ask the public which of those disparities are most urgent to address as a matter of justice in order to guide policymakers. The points made in this paper are thus potentially broadly relevant.

Finally, the paper applies a single account of deep inclusion to provide guidance on who should participate and how they should participate to make the identified UHC decisions. This account draws on literature from development studies and political philosophy. However, the literature on participation and inclusion in contexts of power disparities is broader than what has been used to develop the working model of deep inclusion. This broader literature can be used to explore the questions of who should participate and how they should participate in UHC decision-making.

Despite these limitations, the paper offers several initial ideas that can contribute to growing discussions on fairness in UHC implementation and public participation in UHC decision-making. It is hoped that these ideas will stimulate more debate and dialogue on these topics and further ethics scholarship on the relationship of UHC to justice and other values.

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### Compliance with ethical standards

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