



Journal of Health Organization and Management

Patterns of public participation: Opportunity structures and mobilization from a cross-national perspective

Jean Slutsky Emma Tumilty Catherine Max Lanting Lu Sripem Tantivess Renata Curi Hauegen
Jennifer A Whitty Albert Weale Steven D Pearson Aviva Tugendhaft Hufeng Wang Sophie
Staniszewska Krisantha Weerasuriya Jeonghoon Ahn Leonardo Cubillos

Article information:

To cite this document:

Jean Slutsky Emma Tumilty Catherine Max Lanting Lu Sripem Tantivess Renata Curi Hauegen
Jennifer A Whitty Albert Weale Steven D Pearson Aviva Tugendhaft Hufeng Wang Sophie
Staniszewska Krisantha Weerasuriya Jeonghoon Ahn Leonardo Cubillos, (2016), "Patterns of public
participation", Journal of Health Organization and Management, Vol. 30 Iss 5 pp. 751 - 768

Permanent link to this document:

<http://dx.doi.org/10.1108/JHOM-03-2016-0037>

Downloaded on: 03 November 2016, At: 07:42 (PT)

References: this document contains references to 56 other documents.

To copy this document: permissions@emeraldinsight.com

The fulltext of this document has been downloaded 120 times since 2016*

Users who downloaded this article also downloaded:

(2016), "Introduction: priority setting, equitable access and public involvement in health care",
Journal of Health Organization and Management, Vol. 30 Iss 5 pp. 736-750 <http://dx.doi.org/10.1108/JHOM-03-2016-0036>

(2016), "Public involvement in health priority setting: future challenges for policy, research and
society", Journal of Health Organization and Management, Vol. 30 Iss 5 pp. 796-808 <http://dx.doi.org/10.1108/JHOM-04-2016-0057>

Access to this document was granted through an Emerald subscription provided by emerald-srm:559163 []

For Authors

If you would like to write for this, or any other Emerald publication, then please use our Emerald for Authors service information about how to choose which publication to write for and submission guidelines are available for all. Please visit www.emeraldinsight.com/authors for more information.

About Emerald www.emeraldinsight.com

Emerald is a global publisher linking research and practice to the benefit of society. The company manages a portfolio of more than 290 journals and over 2,350 books and book series volumes, as well as providing an extensive range of online products and additional customer resources and services.

Emerald is both COUNTER 4 and TRANSFER compliant. The organization is a partner of the Committee on Publication Ethics (COPE) and also works with Portico and the LOCKSS initiative for digital archive preservation.

*Related content and download information correct at time of download.

Patterns of public participation

Opportunity structures and mobilization from a cross-national perspective

Patterns
of public
participation

751

Jean Slutsky, Emma Tumilty, Catherine Max, Lanting Lu,
Sripen Tantivess, Renata Curi Hauegen, Jennifer A. Whitty,
Albert Weale, Steven D. Pearson, Aviva Tugendhaft,
Hufeng Wang, Sophie Staniszewska, Krisantha Weerasuriya,
Jeonghoon Ahn and Leonardo Cubillos
(*Information about the authors can be found at the end of this article.*)

Received 6 March 2016
Revised 28 April 2016
Accepted 3 May 2016

Abstract

Purpose – The paper summarizes data from 12 countries, chosen to exhibit wide variation, on the role and place of public participation in the setting of priorities. The purpose of this paper is to exhibit cross-national patterns in respect of public participation, linking those differences to institutional features of the countries concerned.

Design/methodology/approach – The approach is an example of case-orientated qualitative assessment of participation practices. It derives its data from the presentation of country case studies by experts on each system. The country cases are located within the historical development of democracy in each country.

Findings – Patterns of participation are widely variable. Participation that is effective through routinized institutional processes appears to be inversely related to contestatory participation that uses political mobilization to challenge the legitimacy of the priority setting process. No system has resolved the conceptual ambiguities that are implicit in the idea of public participation.

Originality/value – The paper draws on a unique collection of country case studies in participatory practice in prioritization, supplementing existing published sources. In showing that contestatory participation plays an important role in a sub-set of these countries it makes an important contribution to the field because it broadens the debate about public participation in priority setting beyond the use of minipublics and the observation of public representatives on decision-making bodies.

Keywords Resource allocation, Priority setting, Contestatory participation, Public participation, Cross-national comparisons

Paper type General review

Introduction

The purpose of this special issue of the *Journal of Health Organization and Management* is to examine the role that public participation plays in the setting of health care priorities. Our concern is to map the various forms that public participation takes and to evaluate its role in priority setting in respect of important social values, including legitimacy and accountability. As we highlighted in the introductory paper, our focus is on public participation understood in its relation to public policy. We examine participation that is collective rather than individual, excluding consideration of the role of patients in the determination of their individual care. We also focus on participation that is about priorities as a matter of policy in general, even if the participation is triggered by a particular case, for example with an appeal to an administrative body by an individual about a denial of treatment. Because participation must be relevant to the making or changing of policy, participation in pure research on public attitudes, for example replies to questionnaires, is excluded in our analysis, although participation in



research that is an element of the policy process, for example patient feed-back responses, is a form of participation.

Even with these exclusions, public participation takes a wide variety of forms and terminology varies sometimes extending to involvement and representation (Arnstein, 1969; Conklin *et al.*, 2015, pp. 158-159; Gauvin *et al.*, 2010; Greer *et al.*, 2016, pp. 35-36; Mitton *et al.*, 2009, p. 223; Rowe and Frewer, 2005; Tritter and McCallum, 2006). In the present context, participation includes public representatives sitting on decision-making bodies, either as elected representatives or as appointed ones. It covers institutionalized relationships of consultation and discussion between policy makers and patient groups or other stakeholders, including stakeholder forums, consultations, partnerships and advisory committees. It may involve the use of minipublics established by policy making bodies or forms of participatory budgeting. Importantly, for our purposes, it also includes what in the Introduction was called 'contestatory participation' in the form of court challenges, demonstrations, protests, sit-ins and the like.

What is the relationship between the way in which priority setting is institutionalized, patterns of public participation and the mobilization of the public in decisions on priorities? In this paper, we suggest that there may be an inverse relationship between representational participation that is participation initiated and organized by policy making institutions, which may be thought of as engineered participation (Blaug, 2002), and contestatory participation on the other hand, which is outside the scope of the processes and initiatives defined by policy makers. This distinction can be regarded as an extended version of Stewart's (2016, pp. 13-14, pp. 127-8) 'invited' and 'uninvited' participation.

A key analytical concept in this context is that of political opportunity structures. This concept was developed in the context of explaining cross-national patterns of anti-nuclear protests in the 1980s (Kitschelt, 1986). The concept highlights the extent to which different types of institutions and processes create different opportunities for political participation. To the extent to which a relationship between institutions and opportunity structures holds, patterns of public participation will depend upon the form of health care organization that a country possesses, as well as general features of the political and cultural context. For example, in social insurance systems there is an institutional distinction between local and central government on the one hand and the social insurance agency on the other. In a tax-funded system, where local government structures are used to deliver health care, there may be an opportunity for participation through the electoral process that does not exist in a social insurance system. Institutions distribute political opportunities.

Public involvement and participation is also likely to be influenced by the more general institutional arrangements that are found in different countries. Federal political systems will induce different forms of organization from unitary systems. The age and extent of democracy within a country is also likely to have an effect, both through setting the formal constitutional context within which health care is provided, for example whether the constitution guarantees a right to health, as well as the patterns of political attitudes and culture that generally inform behavior within a country. Relationships between health care participation and these broader contextual variables are neither simple nor straightforward. The vibrancy of political mobilization in new democracies may be off-set by the weakness of state institutions in those same societies, resulting in a situation in which active mobilization encounters ineffective state structure. By contrast, in older democracies, the social contracts embodied in the relationships between the state and health care professionals, health care industries

and sub-national political actors as part of the process of introducing universal health care may well substantially constrain the scope and effectiveness of public participation in the making of policy (compare Marmor and Klein, 2012, p. 416).

The paper proceeds as follows: the next section outlines the methods and data for our study before going on to look in a subsequent section at the health policy contexts for the 12 countries; the following section describes the political opportunity structures that might support public participation or mobilization aimed at influencing the distribution of power in priority setting; a subsequent section proposes that there is an inverse relationship between routinized or institutionalized participation on the one hand and contestatory participation, on the other. We conclude by showing how our empirical analysis addresses some long-standing conceptual ambiguities in the idea and practice of public participation.

Methods and data

Our primary units of comparison are the national health care systems of countries, which include Australia, Brazil, China, Colombia, England, Germany, New Zealand, South Africa, South Korea, Sri Lanka, Thailand, and the USA. The USA is a special case, however. Although the various institutions of medical care finance (the Veterans Administration, Medicare, Medicaid and the private insurers) make decisions on priorities, there is no one national body that evaluates interventions for their value. However, there are two distinct bodies, the work of which is related to priority setting. One is the Institute for Clinical and Economic Review (ICER), an independent non-profit body that conducts health technology assessment. The other is the Patient-Centered Outcomes Research Institute (PCORI), mandated by Congress to gather research to improve the quality of evidence on the clinical effectiveness of health care interventions. These two bodies are included, alongside the country cases, in our analysis.

Data on the cases comes from reports presented by country experts at the workshop held in the Brocher Foundation in November 2015 (Weale *et al.*, 2016). Slides in PDF form giving details of those reports are available at: www.ucl.ac.uk/socialvalues. These country reports have been supplemented by information derived from secondary literature and data sources cited in relation to Table I.

Although the sample of countries omits some potentially important cases, with no country from the former Soviet bloc or Arab world included, it does represent a wide range in terms of geography as well as social and political structure. The countries have not been selected because they show evidence of public participation initiatives. That is to say, they have not been selected on the variable of interest (King *et al.*, 1994, pp. 139-149; Landman, 2000, pp. 44-45). Looking simply at systems chosen for positive public participation risks observation bias and false inference, particularly in respect of the effects of participation. As Berry *et al.* (1993, pp. 73-81) showed when looking at measures to increase public participation in US cities, seemingly positive results disappeared when compared to a control sample in which there were no such measures. More generally, surveys of participation initiatives are largely restricted to well-established democracies (Conklin *et al.*, 2015; Mitton *et al.*, 2009), which are likely to have their own distinctive dynamics and patterns of participation and political mobilization. By including countries outside the group of well-established democracies, we avoid these sources of potential observation bias.

A similar bias in many studies is towards participation that is initiated by administrative actors, either as part of their mandate or as an attempt to reach out to new forms of public engagement. The effect is to neglect the importance of non-invited

Table I.
Financing, HTA
and forms of public
participation:
key data

Country	Predominant basis of universal coverage	National HTA Agency with a key national priority-setting function	Forms of public representation
Australia	Medicare scheme funded predominantly from taxation	Pharmaceutical Benefits Advisory Committee (PBAC) for pharmaceuticals Medical Services Advisory Committee (MSAC) for medical devices National Committee for Technology Incorporation (CONITEC)	Consumer representative member on committee Stakeholder input (including patient and public engagement) invited for individual technology assessments
Brazil	National Health System predominantly funded from taxation	Participatory Health Councils at local, federal and state level with a mandate for equitable access to healthcare, social participation and social mobilization	Expert panels are formed to participate in the process to determine drug reimbursement list There is process by which the drug reimbursement list open to consultation, although it is mainly professionally dominated
China	Basic social medical insurance for employees Rural cooperative medical insurance for rural residents Basic social medical insurance for urban residents	None There are some academic HTA groups/institutions across China	User Associations to monitor health service quality and mediate between insurers/providers/service users Customer Service Offices to protect and promote quality improvements
Colombia	Universal Social Health Insurance funded through payroll taxes and general taxation. All citizens have access to the same basket of services	The Institute for Health Technology Assessment (IETS)	Patient representatives on appraisal and guidance committees Citizens Council minipublic, selected on a purposive basis, to advise on general issues
England	National Health Service predominantly funded through general taxation	National Institute for Health and Care Excellence (NICE)	IQWiG working groups allow patient groups to address items on the agenda Patient representatives on the FJC but without voting rights In the process of setting up a Citizen Committee for Participation to incorporate social value judgements in priority setting is in discussion
Germany	Social insurance	Institute for Quality and Efficiency in Health Care (IQWiG) and the Federal Joint Committee (FJC) National Evidence-based Healthcare Collaborating Agency (NECA) Health Insurance Review and Assessment Service (HIRA)	Consumer Advisory Committee advises on policies, optimal medicine use and funding issues
South Korea	Social insurance	Pharmaceutical Management Agency (PHARMAC)	
New Zealand	General taxation		

(continued)

Country	Predominant basis of universal coverage	National HTA Agency with a key national priority-setting function	Forms of public representation
South Africa	General taxation for a government provided service used by 68% of the population. 16% of the population use private insurance 16% of expenditure from out-of-pocket Moving towards a National Health Insurance (White Paper on NHI released in 2016)	None, but attempts to create one	Supported and specified in official policy Some formal structures in place but limited role in decision making advocacy. Litigation and protest more of an impact on priority setting
Sri Lanka	General taxation	None, but has a rapid assessment technique for health care service evaluations	None
Thailand	Three tax-based schemes: the Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS) and Universal Coverage Scheme (UCS). The last covers essential care for 75% of the population	Health Intervention and Technology Assessment Programme (HITAP)	Representatives of patients associations, people networks and civil society organizations alongside academics, health professionals, MOH departments and health product industries are involved in different stages of benefit package development including HTA
USA	Highly pluralistic, including Medicare, Medicaid, Veterans' Administration and mandated private insurance	None. Patient-Centered Outcome Research Institute (PCORI) and Institute for Clinical and Economic Review (ICER) conduct relevant research	PCORI have public comment periods/ an Engagement Plan to shape the nature of research ICER has 3 Advisory Boards, one for each of its public deliberation programs: New England Comparative Effectiveness Public Advisory Council (CEPAC); Midwest CEPAC; and the California Technology Assessment Forum (CTAF). Advisory Boards guide topic selection and provide advice on methods to enhance uptake and application of evidence reports to clinical practice and insurance coverage

Sources: Case studies presented at Brocher Foundation Workshop, November 9-13, 2015. Barnes and Coelho(2009), Blechler *et al.* (2008), Center for Health Market Innovations (2016), Center Intelligence Agency (2014), Class *et al.* (2014), Cornwall and Coelho (2007), De Vorteri (2014), Health Insurance Review & Assessment Service (2007), Jones (2010), Kahandaiyanage (2003), Kuchenbecker and Polanczyk (2012), Marshall and Gurr (2014), McIntyre *et al.* (2008), Mosquera *et al.* (2001), Mossialos *et al.* (2015), National Health Commission of Thailand (2006), OECD (2014, 2016), Oh *et al.* (2015), Petramale (2016), Rasanathan *et al.* (2012), Robertson *et al.* (2014), Sanchez (2016), Vargas-Zea *et al.* (2012), Wilsdon *et al.* (2014), Wing (2016), World Health Organisation (2015a, b)

forms of participation, forms that may be as important, if not more important, than invited forms (compare Stewart, 2016, p. 14). By making the unit of selection the country case, we open our analysis out to the contestatory forms of participation.

Country contexts

The 12 countries include a range of political experience, and exemplify the three waves of democracy (Huntington, 1996). Following the Polity IV data-set we can classify them as follows (see: www.systemicpeace.org/polity/polity4.htm). Four (Australia, England, New Zealand and the USA) are Anglophone first-wave democracies, which achieved substantial mass enfranchisement by the first part of the twentieth century, building on the beginnings of democratization from the early part of the nineteenth centuries. Of course, even in these cases, major developments were needed for the country fully to meet conditions of democracy, for example in the southern states of the USA before the 1965 Voting Rights Act. Alongside these four first-wave democracies, there are three second-wave democracies (Colombia, Germany and Sri Lanka) each with a history of continuous democracy, to varying degrees, from the middle of the twentieth century to the present. Although Sri Lanka had universal franchise since the 1930s, it counts as second wave since until 1948 it was a UK colony. In the case of both Colombia and Sri Lanka their history of democracy is also marked by extensive civil violence. There are three third-wave democracies (Brazil, South Korea and South Africa) and two countries without an extended history of democracy, including Thailand, in which there have been significant periods of military rule, and China, which is a one-party system.

These differences in democratic experience do not correlate in any simple way with the institutionalization of universal health care. Germany was the first country in the world to institutionalize a form of collectivized provision for health care in 1883 in the Wilhelmine Empire under Bismarck. Sri Lanka had tax-funded universal health care in the 1930s while it was still a British colony. The South Korean health insurance scheme was first introduced in 1977 when the country was under military rule and achieved universal health care in 1988 under the last president from a military background. By contrast, the USA did not achieve anything like universal health care until the 2010 Affordable Care Act. These complex patterns suggest important issues in the dynamics of political legitimacy. One obvious hypothesis is:

H1. sometimes authoritarian systems seek to enhance a potentially vulnerable legitimacy through social reforms, including the extension of health care provision.

Conversely, democratic systems, in which there is the freedom of groups and interests to mobilize may create the conditions in which health care reform can be blocked by political mobilization, of which the USA is the most obvious example (Marmor and Oberlander, 2011).

The familiar distinction between Bismarck and Beveridge systems of health care financing is increasingly coming under strain, in part from the influx of tax support in social insurance systems and in part from moves to provider competition in social insurance markets under the influence of ideas from new public management (Greer *et al.*, 2016, pp. 7-8; Okma and de Roo, 2009). Nonetheless, in terms of governance, the relative autonomy of social insurance funds is still a relevant distinguishing institutional characteristic in classifying countries according to their predominant mode of financing in securing universal health care. Three of our 12 countries have collective provision that is based on social insurance systems (Colombia, Germany and South Korea).

All the other systems, with the exception of the USA, use revenue derived from taxation as the predominant instrument to extend coverage to the majority of those unable to pay for private insurance. The USA stands out as a highly pluralistic system, with private and occupational coverage, Medicare, Medicaid, the Veterans' Administration and, since the 2010 Affordable Care Act, mandated private insurance. Private insurance plays a significant role in all the countries, although to varying degrees. In some countries, for example South Korea, there is some public regulation of private insurance cover.

Eight of our 12 countries have formal institutions conducting HTA that have at least some part in priority setting, including the country with the oldest of such institutions, namely the Pharmaceutical Benefits Assessment Committee (PBAC) in Australia. China and Sri Lanka do not, and neither does South Africa although there are efforts underway to create one. Again, the USA is a special case. Formally, it does not have an HTA agency. However, PCORI conducts research on patient-oriented care and an independent body, ICER, undertakes work on cost-effectiveness. Nevertheless, the absence of a collectivized system of health service financing and payment means that there is no national agency equivalent to that found in other countries. Key elements of health care financing and the presence or otherwise of a HTA agency are summarized for these countries in Table I, together with information on forms of public participation.

Opportunity structures

Political opportunity structures are important in relation to the political involvement and mobilization of citizens on matters of public policy. The concept helps highlight the extent to which institutional structures are open or closed to public participation. For example, some administrative and constitutional processes permit a right of opposition at the agenda-setting or formation stage of policy, whereas in other political systems opposition is channelled into the implementation stage of policy. If we are interested in understanding the forms and effectiveness of public participation, it is always a pertinent question to ask where public movements may realistically seek to make their influence felt.

A number of countries in our sample include provision for the representation of patients, the public or consumers in the governance of health care, either as part of an HTA process or as part of the resource allocation process more generally. (For the sake of brevity we shall speak of "public" representation in the bulk of the paper, returning at the end to the conceptual complexities implicit in the notion.) In terms of governance, Brazil and Colombia provide for public representatives on decision-making bodies at various levels of government, Brazil within the different levels of its federal system (federal, state and local) and Colombia in its decentralized system. In Brazil, public representatives on the Health Councils, which make decisions on resource allocation and service provision, are thought of as citizen representatives, sitting alongside representatives of the government, providers and health professionals to formulate policy. In England there is a place reserved for lay representatives in the Clinical Commissioning Groups who have responsibility for commissioning according to population needs and are responsible for the finance of much of the care that is provided, as well as NHS England at various locations in the decision-making structures. In South Africa, the Community Health Committees are supposed to provide a public voice in relation to the work of the tier of local government (metropolitan, district or local) that has the responsibility for providing health services in a locality. By contrast two of the sample, China and Sri Lanka, have systems of general decision-making that are professionally dominated, with little or no effective role for organized groups to contribute to governance.

Although priority setting is implicit in any governance process, HTA agencies occupy a special place in relation to public involvement and participation. They provide a particular set of opportunity structures by reference to which participation can take place, both as focal points and as stimuli. They are focal points because their processes are a tangible point at which otherwise diffuse forms of resource allocation take place. They are stimuli, because the decisions that they make, in particular decisions to deny or delist treatments, provide the impetus for public engagement on the part of patient groups, industry and others. Moreover, independent or quasi-independent public agencies often have a sense that they are subject to a legitimacy deficit that can only be remedied through some form of patient or public involvement. HTA agencies may sometimes be established in the hope that, in rendering decisions on priorities through methods of technical assessment, they can thereby de-politicize priority-setting, as in the example of NICE (Klein, 2013, pp. 199-204). Ironically, however, such bodies often feel the need to secure public involvement in order to render their decision-making legitimate. For this reason, it is not simply a question of the supply of political participation from the side of the public; it is also a question of the demand for political participation on the part of administrative agencies.

It is well known that the “public” is defined in different ways both by analysts and by administrators and policy makers (Conklin *et al.*, 2015, p. 154; Mitton *et al.*, 2009, p. 223). It is no surprise, therefore, to see that different HTA agencies use different principles for public representation in their processes of decision-making. For example, in Australia the public representative on PBAC and the Medical Services Advisory Committee are thought of as consumer representatives. In New Zealand PHARMAC has a consumer advisory panel. In South Korea, in relation to the HTA agencies, the representatives are drawn from distinct social groups, including labour and consumer organizations. In Germany the representatives on the Federal Joint Committee, which receive information from the HTA body IQWiG, are patient representatives. In the USA PCORI has a governing board that aims to be representative of the community at large, and stakeholders propose topics for investigation. In Colombia, IETS uses open online consultations to reach out to the different stakeholders, patient organizations and the general public. In Brazil, Conitec provides different questionnaires for both the general public and health professionals through its official website in order to promote public consultation.

Participation can occur at various stages of the decision process for HTA agencies. For example, in Korea the National Evidence-based Healthcare Collaborating Agency has a topic solicitation process by which suggestions for research can be submitted by members of the public, as well as academia and policy makers. In Thailand, patient groups, lay people and civil society organizations play an important role in making suggestions to the National Health Security Office, the Universal Coverage Scheme managing authority, as to which technologies should be evaluated (Mohara *et al.*, 2012). The public can also be involved through representation on various bodies in HTA agencies, or through participation in advisory panels. By contrast, public participation in a body like NICE does not have an agenda-setting role in determining the interventions to be appraised. Those topics are initially determined by the government through the Department of Health.

Although a great deal of theoretical and research interest has been shown in minipublics, they do not feature prominently in the forms of public participation in most countries, either in relation to general governance or in relation to priority setting (Whitty, 2013). In terms of their role in the formal policy process, England

stands out in its use of minipublics, in particular the NICE Citizens Council, which comprises thirty members of the public selected to be broadly representative in demographic terms (Davies *et al.*, 2006; Littlejohns and Rawlins, 2009), and the NHS England Citizen Assembly. ICER and PCORI in the USA also use minipublic processes. For example, ICER has used public deliberation and voting to help determine value in relation to medicines, breaking up the country into a group for New England, one for the Mid-West and one for California. On these panels, two-thirds of the participants are physicians and the remainder are patient groups or public members. The South Korean health insurance agency has responded to the experimental use of a minipublic on the willingness to pay to expand the drug formulary and set up such a panel on a more permanent basis. By contrast, in most of our sample minipublics have been the preserve of researchers, interested in eliciting public preferences for example, or have been used relatively little, including in quite highly developed systems like Germany. One hypothesis is:

- H2.* These patterns reflect the balance between professional influence and power in a health care system (strong in Sri Lanka, China and Germany), as distinct from other groups, particularly politicians or managers, in other systems.

However, this hypothesis would require more evidence fully to test its plausibility.

From opportunities to mobilization

There is one particular reason why HTA agencies are likely to be a focal point of participation, namely their role in denying or limiting access to interventions that may be widely or intensely demanded by the public, particularly when those interventions are pharmaceutical products with strong industry backing. Considerations of cost-effectiveness, alongside other criteria, act as a hurdle to access and sometimes lead to a decision not to cover or include in the drug formulary medicines for which there is evidence for clinical effectiveness but not cost-effectiveness. These decisions therefore affect the extent to which the medical care provided by a system is comprehensive as well as equitable, presenting no financial barriers to access. Low cost access to an inadequate range of therapies will seem to the public to be a breach of the principle of universal health care. Moreover, the processes and chains of reasoning that HTA agencies use to assess cost-effectiveness are typically esoteric, drawing upon economic and statistical modeling, sampling assumptions and measures of outcome that only make sense within a particular policy paradigm. Members of the public, particularly patient groups, may also be sceptical of the feasibility constraints that cost-effectiveness analysis involves, holding in particular that costs are not a natural given but something that may be affected by policy decisions as well as accounting conventions. It is not, therefore, surprising that, in different countries, much participatory activity takes place around questions about access to pharmaceuticals, perhaps also symbolizing a broader range of concerns about access to care.

In England patient groups have mobilized around access to pharmaceuticals that NICE has judged cost ineffective, including Abiraterone and Herceptin. Herceptin has also been an issue in New Zealand and Australia. In South Korea, mobilization has occurred around several new drugs that were not being covered in the national formulary, as well as coverage in the regulated private insurance system used to cover out-of-pocket expenses, in particular for Xalkori for lung cancer in 2015, where eventually the mobilized groups pushed the financial authority to rule in their favor. In Brazil mobilization has taken place over Fingolimod, following the precedent of

mobilization in 1996, which led to free combination antiretroviral therapy being offered to all citizens with AIDS. However, although an HTA agency provides a focal point for mobilization, it is certainly not a necessary condition. In South Africa, without an HTA agency, patient groups, following the campaigns around AIDS medicines, have mobilized in the Treatment Action Campaign (TAC) on such matters as reduction in drug pricing and the development of needs-based budgeting. Even in the silent system of Sri Lanka, there has been a move to supply HPV vaccine, though this was professionally led.

In any system it is always possible that there will be contestatory participation taking the form of protests and campaigns against administrative decision-making. However, we can distinguish cases where such participation is occasional and supplementary to more routinized forms of participation from cases where contestatory participation is a major characteristic of the policy making process. How is the extent and seriousness of institutionalized participation related to the character of the public participation? Answering this question depends on making a distinction between public participation in formal decision-making that is consequential from participation where it is not.

There is no one test that can simply be applied to determine whether a system treats formal public participation seriously and one where it does not. However, as a first cut, one test is to distinguish those cases of public participation in which public representatives can influence policy agendas, as distinct from those cases where they cannot. Sometimes this can mean having formal or quasi-formal agenda-setting responsibilities; sometimes it is a matter of sitting as a full member on a decision-making body. For example, with the HITAP process in Thailand, the public representatives have a role in proposing or prioritizing topics for analysis. In Germany patient representatives sit on the high level body that makes a decision on the added benefit of pharmaceuticals that have been evaluated by IQWiG. In England, the emergent NHS Citizen invites and facilitates broad, deliberative input to board priorities via online and physical forums which are, in turn, mediated by a Citizens' Jury. By contrast, in other countries, participation appears to be token. The members of the Community Health Councils in South Africa generally fall into this category as do the patient representatives in South Korea. In South Africa, community participation is entrenched in various policy documents and formalised in the National Health Act which makes provision for the establishment of community health committees, hospital boards and local health councils. The members of these committees are supposed to ensure community participation in the governance of local clinics. While the political climate is in theory supportive of community participation, and while there are some Community Health Committees in existence with public representation, the role of these bodies is poorly defined, ultimately not functioning optimally with members having little input in decision making but rather playing the role of pseudo community health workers. Similarly, in Brazil and Colombia lay representation on Health Councils takes place at the different levels of political organization, but members are sometimes nominated rather than being independently selected.

In our sample, there are four countries where contestatory participation is routine: Brazil, Colombia, South Africa and South Korea. For example, in Colombia and Brazil, there is extensive use of the courts to challenge the denial of access as a violation of their right to health. In some cases, patients seek access to medicines to which they would be entitled to by policy, but that are denied them through failures of implementation. In other cases, patients seek access to medicines that have not been

included or have been explicitly deemed ineligible for coverage as a result of priority setting (Dittrich *et al.*, 2016). Every year thousands of patients use this contestatory participation path to highlight failures in the provision of services or to overturn results of HTA and benefit basket design. Judges usually rule in favor of the plaintiffs. This phenomenon has escalated to the higher courts that have, in some cases, mandated reforms be made in order to address the underlying roots of this avalanche of litigation.

The constitutional right to health has also been a focal point for mobilization by many advocacy groups in South Africa. Some have used litigation to empower a social movement, like in the case of the TAC and Section 27. The former is a HIV/AIDS civil society organization and the latter a public interest law centre that uses research, advocacy and litigation to ensure among others, access to health care. TAC has campaigned and litigated since 1998 for access to AIDS treatment. Their most significant success was the 2002 Constitutional Court ruling which held that government must provide treatment to combat mother to child transmission of HIV. This case enshrined South Africans' right to access to treatment proven to be a core treatment and medically necessary but noted that this access may not be available immediately and that the State ought to provide it as soon as reasonably possible. The TAC has used this same approach of advocacy alongside litigation to achieve several other outcomes, one of which was reduction in drug pricing. More recently, a collaborative project, known as Stop Stock Outs, between the TAC, Section 27 and others has focussed on using protest, advocacy and litigation to address the issue of drug stock outs in the country and to force policy makers to prioritize better. Another organization known as the Rural Health Advocacy project focusses specifically on improved access to quality health care services for people living in rural South Africa. This group uses evidence and advocacy in its aim to influence decision-making in line with rural realities. These three examples of advocacy organizations have been established independently of the state and have forced their way into the priority setting process, albeit with varying levels of success.

South Africa's broader political context committed to democratic principles provides on the one hand an enabling environment for public participation, but on the other, protects the state in its role as the decision-making authority. This context, alongside a legacy of community mobilization and protest has resulted in citizens increasingly articulating their concerns outside of government provided channels where their voice is louder. Similarly, in Korea, resort to street protest is routine since it was the means originally to convert the military regime to democracy. In 2008, the candlelight protest gathered 50,000 people worrying about mad cow disease from US beef imports on the street with candles. It symbolized the Koreans' changing interest in relation to health related issues. In 2010, a group of left-wing activists including the hospital chapter of one nationwide labour union formed a coalition for free health. This group is asking for increasing coverage of the National Health Insurance by allocating more government budget to the health sector. This coalition is still active and posted "vote against" list of candidates for the general election in 2016 in its website (<http://medical.jinbo.net/x/>).

In some countries, then, contestatory participation is so extensive as almost to be a routine element of the policy making process. This in turn suggests that we can divide our sample into two categories in two different dimensions. We can classify public representation by the extent to which it is either token or has some agenda shaping influence on the one hand, and we can classify systems by the extent to which contestatory participation is either routine or not on the other. With two categories in two dimensions we have the four possibilities illustrated in Table II.

Table II.
Representation and
contestation in
priority setting

		Contestatory participation routine	
Public representatives have agenda role	Yes	Yes (A) –	No (C) Australia Germany New Zealand Thailand UK
	No	(B) Brazil Colombia South Africa South Korea	(D) China Sri Lanka USA

Table II shows a broadly inverse relationship between representatives having some meaningful power within the system of resource allocation and an absence of contestatory participation. Although Australia, Germany, New Zealand, Thailand and England have never been entirely free of contestation, it is not the routine feature of health policy making that it is in Brazil, Colombia, South Africa and South Korea. The fact that cell A is empty is confirmation of some inverse association between significant representation and contestatory participation. There is no country that gives public representatives a serious role in priority settings decisions and that is also pervaded by the contests that are seen in the countries in cell B.

Three of the four countries in which contestatory participation is a routine part of the policy making process (cell B) are third-wave democracies, and Colombia has been a second-wave democracy under strain over decades. The process of democratization in these countries involved political mobilization on a large scale over a number of years. One important case in this context is Brazil, where mobilization over health issues was a central part of the more general community-based democratic movement. However, when the 1990 law institutionalizing public participation in the Health Councils was being debated, there was a division of views in the health movement, with significant elements claiming that it was impossible to be an opponent of the state whilst interacting with it through formalized means (Dall’Agnol Modesto *et al.*, 2007, p. 16). Where oppositional mobilization is a central element in political contestation, it may be hard to move towards effective forms of more institutionalized participation.

However, such an analysis cannot be over-generalized. Thailand lacks a history of continuous democracy. However, it does have a politics of mass mobilization. In priority setting, however, it lacks the contestatory style of Brazil, South Africa and South Korea. One possible explanation is that, following from its experience of dealing with AIDS in the 1980s when it engaged intensely with patient groups and representatives, Thailand institutionalized patient involvement in policy making in more than a token way (Rasanathan *et al.* 2012; Tantivess and Walt, 2008). The case would suggest that it is not the general experience of democratic politics or mass mobilization for democracy that is important, but the institutionally specific ways in which public participation is facilitated or inhibited together with the larger confounding variables of political structure.

The three interesting off-diagonal cases are in cell D. These exhibit different routes to the same outcome: public participation with low significance for priority setting but the absence of contestatory participation. In the case of China the outcome is to be

explained by the general restrictions on freedom of association and political protest. Sri Lanka stands out as a particularly interesting null case. The early establishment of universal health coverage in the 1930s together with the inherited system of professional domination seems to have left a legacy in which a traditional medical domination is still to be found. Finally, in the USA the absence of a single national priority setting agency means that there is nothing for political protest to mobilise around. Individual law suits may be common, and they may have class action effects, but the institutional dynamic is different from one in which a central decision provides a focal point of protest. None of these three off-diagonal countries has an HTA agency with the scope and significance of those found in other countries, and none are likely to have one in the near future.

Conclusion

Our comparative review has highlighted some basic issues of theory and organization that have been identified for some time (Marmor and Klein, 2012, chapter 10), involving the character of public participation, the accountability of public representatives to the public they are supposed to represent, the effectiveness of those representatives and the place of state structures and capacities when considering the role of the public in priority setting.

Although public participation is often advocated and promoted by activists and policy makers, there remain conceptual ambiguities as to its character that are seldom, if ever, resolved in the policy process. Whether we are talking about the public in the formal decision-making process or a selected sample of citizens in a minipublic, we are always referring to representatives of the public when we are thinking of public participation. Conditions of assembly government, in which all citizens come together to determine the conditions of their common life, do not exist in the modern world outside particular places like some communes in Switzerland. Moreover, there is often an ambiguity as to what portion of the public representatives are supposed to represent and the extent to which they are consulted or become more actively involved or engaged, so that they become partners in the process. Sometimes they are characterized as consumers, sometimes as patients and sometimes as citizens. These distinctions matter in priority setting. If public representatives have a role in commenting on how health services are delivered, then there is unlikely to be a serious discrepancy between the roles of patient, consumer and citizen. It is reasonable for citizens to want consumers of health services to be satisfied with their care, and one of the best ways of knowing whether they will be satisfied or not is to obtain the views of those patients who have had experience of care. By contrast, with resource allocation, there are many built-in conflicts of interest: among different patient groups, as well as between citizens as consumers and citizens as tax-payers. If public participation is to be more than a slogan in relation to priority setting, then those responsible for the design of institutions and practices need to address the differences in the roles and responsibilities that different forms of public representation involves.

Second, the use of minipublics prompts a number of questions. The concept of representation in minipublics is normally a descriptive one. Members of a minipublic are supposed to be a microcosm of society, partly with the aim of rectifying the imbalance of voice among different social groups in the broader political and policy making process. The basis of this descriptive representation is normally demographic. However, it can be argued that this is only one possible basis of selection, and that equal, if not more, attention should be given to religious, cultural or social attitudes.

After all, in relation to the priority to be given to IVF or the extent to which personal responsibility should be taken into account, conviction is likely to be more important than membership of a particular social group. The issue is partly a practical matter for health service management, but it is also one that carries wider implications, since it highlights the extent to which administratively sponsored participation reflects some of the problems of “engineering democracy” (Blaug, 2002). It would go too far to say that sponsored or engineered democracy is problematic in and of itself; public organizations have good reasons for wishing to enhance their engagement with the public. However, it would also be misleading to say that minipublics can be a substitute for a vibrant civil society.

Third, there is a case to be made for saying that presence matters (Phillips, 1995). It is hard to find evidence that the public’s representatives are enormously influential in policy making. Nonetheless, this is not to say that their presence in decision-making is unimportant, rather than expectations of their feasible role need to be more finely calibrated. As our case studies have shown, there are instances where formal representatives do seem to exercise some agenda-setting power in relation to specific issues, inducing policies that would not otherwise have occurred, or they have some influence on the way in which issues are constructed and determined. More generally, it is an open question as to the extent to which their presence in the decision-making system reconciles the public at large to the decisions that have been made.

Fourth, the cases of contestatory participation highlight the importance of state structures and administrative capacity in the policy making process. Contestatory participation is typically prompted by failures of implementation, problems of corruption or a lack of state capacity to create the conditions of citizenship for all, an issue that is particularly important when priority setting involves fundamental interests. It grows out of a contrast between ambitious constitutional promises and poor system performance. Large macro variables like state structure and capacity ought to influence how policy makers think about how public participation is best fostered and responded to in the context of an understanding about what state structures facilitate or inhibit. State structures evolve and are changed over time, but just as it is easier to create the formal rules of democracy than its effective practice, so it is easy to borrow forms of public participation without that participation articulating legitimate interests.

Acknowledgement

This paper arises from a collaborative project: author names have been listed randomly. The work arises from a Brocher Foundation Workshop on “Improving Equitable Access to Health Care through Increasing Patient and Public Involvement in Prioritisation Decisions”, November 10-13, 2015, Geneva. The authors should like to take this opportunity to thank the Brocher Foundation for its support, as well as two referees for comments expeditiously delivered. The authors also thank Alexandra Melaugh for valuable research assistance. Renata Curi Hauegen is supported by the National Institute for Science and Technology on Neglected Diseases (INCT/IDN). Sophie Staniszewska is part funded by the NIHR CLAHRC West Midlands initiative. This paper presents independent research and the views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. Aviva Tugendhaft is supported by funding to PRICELESS SA from the international Decision Support Initiative (IDSi) through the Bill and Melinda Gates Foundation, Grant Number 740671. The slides presented at the workshop can be found at: www.clahrc-southlondon.nihr.ac.uk/public-health

References

- Arnstein, S. (1969), "A ladder of citizen participation", *Journal of the American Institute of Planners*, Vol. 35 No. 4, pp. 216-224.
- Barnes, M. and Coelho, V.S. (2009), "Social participation in health in Brazil and England: inclusion, representation and authority", *Health Expectations*, Vol. 12 No. 3, pp. 226-236.
- Berry, J.M., Portney, K.E. and Thomson, K. (1993), *The Rebirth of Urban Democracy*, The Brookings Institution, Washington, DC.
- Blaug, R. (2002), "Engineering democracy", *Political Studies*, Vol. 50 No. 1, pp. 102-116.
- Blechler, M.S., Day, C., Dove, S. and Cairns, R. (2008), "Primary health care financing in the public health sector", in Barron, P. and Roma-Reardon, J. (Eds), *South African Health Review*, Health Systems Trust, Durban, pp. 179-194.
- Center for Health Market Innovations (2016), "Universal health coverage Thailand", available at: <http://healthmarketinnovations.org/program/universal-coverage-scheme-thailand> (accessed January 2016).
- Center Intelligence Agency (2014), "The World Factbook", available at: www.cia.gov/library/publications/the-world-factbook/ (accessed January 2016).
- Class, A., Rajkumar, S., Cavagnero, E. and Montenegro-Torres, F. (2014), "Colombia – health financing profile", available at: www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2014/07/11/000469252_20140711095807/Rendered/PDF/893770BRI0P1230LIC000Colombia0final.pdf (accessed January 2016).
- Conklin, A., Morris, Z. and Nolte, E. (2015), "What is the evidence base for public involvement in health-care policy? Results of a systematic scoping review", *Health Expectations*, Vol. 18 No. 2, pp. 153-165.
- Cornwall, A. and Coelho, V.S. (2007), "Spaces for change? The politics of citizen participation in new democratic arenas", in Cornwall, A. and Coelho, V.S. (Eds), *Spaces for Change? The Politics of Citizen Participation in New Democratic Arenas*, Zed Books, London, pp. 1-32.
- Dall'Agnol Modesto, A.A., Costa, A. and Bahia, L. (2007), Health and social determinants in Brazil: a study on the influence of public participation on the formulation of the expanded concept of health and liberating practices", available at: <https://extranet.who.int/isacs/case/1076> (accessed March 30 2016).
- Davies, C., Wetherell, M. and Barnett, E. (2006), *Citizens at the Centre: Deliberative Participation in Healthcare Decisions*, Policy Press, Bristol.
- De Votteri, E. (2014), "2015 Health care outlook – Brazil", available at: www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/gx-lshc-2015-health-care-outlook-brazil.pdf (accessed January 2016).
- Dittrich, R., Cubillos, L., Lawrence, G., Chalkidou, K. and Li, R. (2016), "The international right to health: what does it mean in legal practice and how can it affect priority setting for universal health coverage?", *Health Systems & Reform*, Vol. 2 No. 1, pp. 23-31.
- Gauvin, F-P., Abelson, J., Giacomini, M., Eyles, J. and Lavis, J.N. (2010), "It all depends': conceptualizing public involvement in the context of health technology assessment agencies", *Social Science & Medicine*, Vol. 70 No. 10, pp. 1518-1526.
- Greer, S.L., Wismar, M. and Figueras, J. (2016), "Introduction: strengthening governance amidst changing governance", in Greer, S.L., Wismar, M. and Figueras, J. (Eds), *Strengthening Health System Governance*, Open University Press, Maidenhead, pp. 3-26.
- Greer, S.L., Wismar, M., Figueras, J. and McKee, C. (2016), "Governance: a framework", in Greer, S.L., Wismar, M. and Figueras, J. (Eds), *Strengthening Health System Governance*, Open University Press, Maidenhead, pp. 27-56.

- Health Insurance Review & Assessment Service (2007), "Healthcare system", available at: www.hira.or.kr/eng/about/06/02/index.html (accessed January 2016).
- Huntington, S.P. (1996), "Democracy's third wave", in Diamond, L. and Plattner, M.F. (Eds), *The Global Resurgence of Democracy*, 2nd ed., The Johns Hopkins University Press, Baltimore and London, pp. 3-25.
- Jones, R.S. (2010), "Health-care reform in Korea", OECD, Paris, available at: [www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=eco/wkp\(2010\)53](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=eco/wkp(2010)53) (accessed January 2016).
- Kahandaliyanage, H.A.P. (2003), "Annual health bulletin- organisation of health services", Ministry of Health, Nutrition & Indigenous Medicine – Sri Lanka, available at: <http://203.94.76.60/AHB2003/Chapter%202.pdf> (accessed January 2016).
- King, G., Keohane, R.O. and Verba, S. (1994), *Designing Social Inquiry: Scientific Inference in Qualitative Research*, Princeton University Press, Princeton, NJ.
- Kitschelt, H. (1986), "Political opportunity structures and political protest: anti-nuclear movements in four democracies", *British Journal of Political Science*, Vol. 14 No. 1, pp. 57-85.
- Klein, R. (2013), *The New Politics of the NHS*, 7th ed., Radcliffe Publishing, London and New York, NY.
- Kuchenbecker, R. and Polanczyk, C. A. (2012), "Institutionalizing health technology assessment in brazil: challenges ahead", *Value in Health Regional Issues*, Vol. 1 No. 2, pp. 257-261.
- Landman, T. (2000), *Issues and Methods in Comparative Politics*, Routledge, London and New York, NY.
- Littlejohns, P. and Rawlins, M. (2009), *Patients, the Public and Priorities in Healthcare*, Radcliffe Publishing, Oxford.
- McIntyre, D., Garshing, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., Ally, M., Aikins, M., Mulligan, J. and Goudge, J. (2008), "Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania", World Health Organisation, Geneva, available at: www.who.int/bulletin/volumes/86/11/08-053413/en/ (accessed January 2016).
- Marmor, T. and Klein, R. (2012), *Politics, Health, and Health Care*, Yale University Press, New Haven, CT and London.
- Marmor, T. and Oberlander, J. (2011), "The patchwork: health reform, American style", *Social Science and Medicine*, Vol. 72, pp. 125-28.
- Marshall, M.G. and Gurr, T.R. (2014), "Policy IV project: political regime characteristics and transitions, 1800-2013", Center for Systematic Peace, available at: www.systemicpeace.org/polity/polity4.htm (accessed January 2016).
- Mitton, C., Smith, N., Peacock, S., Evoy, B. and Abelson, J. (2009), "Public participation in health care priority setting: a scoping review", *Health Policy*, Vol. 91 No. 3, pp. 219-28.
- Mohara, A., Youngkong, S., Velasco, R.P., Werayingyong, P., Pachanee, K., Prakongsai, P., Tantivess, S., Tangcharoensathien, V., Lertiendumrong, J., Jongdomsuk, P. and Teerawattananon, Y. (2012), "Using health technology assessment for informing coverage decisions in Thailand", *Journal of Comparative Effectiveness Research*, Vol. 1 No. 2, pp. 137-146.
- Mosquera, M., Zapata, Y., Lee, K., Arango, C. and Vorela, A. (2001), "Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation", *Health Policy and Planning*, Vol. 16 No. S2, pp. 52-60.
- Mossialos, E., Wenzl, M., Osborn, R. and Anderson, C. (2015), "International profiles of health care systems", The Commonwealth Fund, available at: www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014 (accessed January 2016).

- National Health Commission of Thailand (2006), "Health assembly", available at: http://en.nationalhealth.or.th/Health_Assembly (accessed January 2016).
- OECD (2014), "OECD Health Statistics 2014 - How does South Africa compare?", available at: www.oecd.org/els/health-systems/Briefing-Note-SOUTH-AFRICA-2014.pdf (accessed January 2016).
- OECD (2016), "Governance of health systems", available at: www.oecd.org/els/health-systems/governance-health-systems.htm (accessed January 2016).
- Oh, J., Ko, Y., Alley, A.B. and Kwon, S. (2015), "Participation of the lay public in the decision-making for benefit coverage of national health insurance in South Korea", *Health Systems & Reform*, Vol. 1 No. 1, pp. 62-71.
- Okma, K.G.H. and De Roo, A.A. (2009), "The Netherlands. From polder model to modern management", in Marmor, T.R., Freeman, R. and Okma, K.G.H. (Eds), *Comparative Studies of Modern Medical Care*, Yale University Press, New Haven, CT and London, pp. 120-152.
- Petramale, C.A. (2016), "CONITEC-National Committee for Technological Innovation", International Network of Agencies for Health Technology Assessment, available at: www.inahta.org/our-members/members/conitec/ (accessed January 2016).
- Phillips, A. (1995), *The Politics of Presence*, Clarendon Press, Oxford.
- Rasanathan, K., Posayanonda, T., Birmingham, M. and Tangcharoensathien, V. (2012), "Innovation and participation for healthy public policy: the first national health assembly in Thailand", *Health Expectations*, Vol. 15 No. 1, pp. 87-96.
- Robertson, R., Gregory, S. and Jabbal, J. (2014), "The social care and health systems of nine countries", The King's Fund, London, available at: www.kingsfund.org.uk/sites/files/kf/media/commission-background-paper-social-care-health-system-other-countries.pdf (accessed January 2016).
- Rowe, G. and Frewer, L.J. (2005), "A typology of public engagement mechanisms", *Science, Technology & Human Values*, Vol. 30 No. 2, pp. 251-290.
- Sanchez, G. (2016), IETS- Instituto de Evaluacion Tecnologia en Salud", International Network of Agencies for Health Technology Assessment, available at: www.inahta.org/our-members/members/iets/ (accessed January 2016).
- Stewart, E. (2016), *Publics and their Health Systems*, Palgrave Macmillan, Houndmills, Basingstoke.
- Tantivess, S. and Walt, G. (2008), "The role of state and non-state actors in the policy process: the contribution of policy networks to the scale-up of antiretroviral therapy in Thailand", *Health Policy and Planning*, Vol. 23 No. 5, pp. 328-338.
- Tritter, J.Q. and McCallum, A. (2006), "The snakes and ladders of user involvement: moving beyond Arnstein", *Health Policy*, Vol. 76, pp. 156-168.
- Vargas-Zea, N., Castro, H., Rodrigues-Paez, F., Tellez, D. and Salazar-Arias, R. (2012), "Colombian health system on its way to improve allocation efficiency-transition from a health sector reform to the settlement of an HTA agency", *Value in Health Regional Issues*, Vol. 1 No. 2, pp. 218-222.
- Weale, A., Kieslich, K., Littlejohns, P., Tugendhaft, A., Tumilty, E., Weerasuriya, K. and Whitty, J.A. (2016), "Introduction: priority setting, equitable access and public involvement in health care", *Journal of Health Organization and Management*, Vol. 30 No. 5, pp. 736-750.
- Whitty, J.A. (2013), "An international survey of the public engagement practices of health technology assessment organizations", *Value in Health*, Vol. 16 No. 1, pp. 155-163.
- Wilsdon, T., Fiz, E. and Haderi, A. (2014), "A comparative analysis of the role and impact of Health Technology Assessment: 2013", Charles River Associates, available at: www.efpia.eu/uploads/documents/cra-comparative-analysis.pdf (accessed January 2016).

- Wing, J. (2016), "CMeRC- Charlotte Maveke research cluster", International Network of Agencies for Health Technology Assessment, available at: www.inahta.org/our-members/members/cmecrc/ (accessed January 2016).
- World Health Organisation (2015a), "Countries", available at: www.who.int/countries/en/ (accessed January 2016).
- World Health Organisation (2015b), "Global health observatory data respiratory-health expenditure ratios, all countries, selected years estimated by country", available at: <http://apps.who.int/gho/data/node.main.75?lang=en> (accessed January 2016).

Author Affiliations

Jean Slutsky, Patient-Centered Outcomes Research Institute, Washington, District of Columbia, USA

Emma Tumilty, Department of General Practice & Rural Health, Bioethics Centre, University of Otago, Dunedin, New Zealand

Catherine Max, Catherine Max Consulting: The Future Health Partnership, London, UK

Lanting Lu, School of Public Administration and Policy, Renmin University of China, Beijing, China

Sripen Tantivess, Health Intervention and Technology Assessment Program, Ministry of Public Health, Bangkok, Thailand

Renata Curi Hauegen, Center for Technological Development in Health, Oswaldo Cruz Foundation, Rio de Janeiro, Brazil

Jennifer A. Whitty, Norwich Medical School, University of East Anglia, Norwich, UK and School of Pharmacy, University of Queensland, Brisbane, Australia

Albert Weale, Department of Political Science, University College London, London, UK

Steven D. Pearson, The Institute for Clinical and Economic Review, Boston, Massachusetts, USA

Aviva Tugendhaft, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa and Priceless SA, Wits School of Public Health, Johannesburg, South Africa

Hufeng Wang, School of Public Administration and Policy, Renmin University, Beijing, China

Sophie Staniszewska, RCN Research Institute, Warwick Medical School, University of Warwick, Coventry, UK

Krisantha Weerasuriya, National Medicines Regulatory Authority of Sri Lanka, Colombo, Sri Lanka

Jeonghoon Ahn, Department of Health Management, Ewha Womans University, Seoul, South Korea

Leonardo Cubillos, Dartmouth Hitchcock Medical Center, Dartmouth Medical School, Lebanon, New Hampshire, USA

Corresponding author

Albert Weale can be contacted at: a.weale@ucl.ac.uk

For instructions on how to order reprints of this article, please visit our website:

www.emeraldgroupublishing.com/licensing/reprints.htm

Or contact us for further details: permissions@emeraldinsight.com

This article has been cited by:

1. Katharina Kieslich, Peter Littlejohns and Albert Weale Katharina Kieslich Department of Primary Care and Public Health Sciences, King's College London, London, UK Jeonghoon Ahn Department of Health Management, Ewha Womans University, Seoul, South Korea Gabriele Badano Centre for Research in the Arts, Social Sciences and Humanities and Girton College, University of Cambridge, Cambridge, UK Kalipso Chalkidou NICE International, London, UK Leonardo Cubillos Dartmouth Hitchcock Medical Center, Dartmouth Medical School, Lebanon, New Hampshire, USA Renata Curi Hauegen Center for Technological Development in Health, Oswaldo Cruz Foundation, Rio de Janeiro, Brazil Chris Henshall Health Economics Research Group, Brunel University London, London, UK Carleigh B Krubiner Berman Institute of Bioethics, Johns Hopkins University, Baltimore, Maryland, USA Peter Littlejohns Department of Primary Care and Public Health Sciences, King's College London, London, UK Lanting Lu School of Public Administration and Policy, Renmin University of China, Beijing, China Steven D Pearson The Institute for Clinical and Economic Review, Boston, Massachusetts, USA Annette Rid Department of Social Science, Health & Medicine, King's College London, London, UK Jennifer A Whitty Norwich Medical School, University of East Anglia, Norwich, UK and School of Pharmacy, University of Queensland, Brisbane, Australia James Wilson Department of Philosophy, University College London, London, UK . 2016. Public participation in decision-making on the coverage of new antivirals for hepatitis C. *Journal of Health Organization and Management* 30:5, 769-785. [[Abstract](#)] [[Full Text](#)] [[PDF](#)]
2. Katharina Kieslich, Peter Littlejohns and Albert Weale David James Hunter Centre for Public Policy and Health, Durham University, Stockton on Tees, UK Katharina Kieslich Department of Primary Care and Public Health Sciences, King's College London, London, UK Peter Littlejohns Department of Primary Care and Public Health Sciences, King's College London, London, UK Sophie Staniszevska RCN Research Institute, Warwick Medical School, University of Warwick, Coventry, UK Emma Tumilty Bioethics Centre, Department of General Practice & Rural Health, University of Otago, Dunedin, New Zealand Albert Weale Department of Political Science, University College London, London, UK Iestyn Williams Health Services Management Centre, School of Social Policy, University of Birmingham, Birmingham, UK . 2016. Public involvement in health priority setting: future challenges for policy, research and society. *Journal of Health Organization and Management* 30:5, 796-808. [[Abstract](#)] [[Full Text](#)] [[PDF](#)]
3. Katharina Kieslich, Peter Littlejohns and Albert Weale Albert Weale Department of Political Science, University College London, London, UK . 2016. Between consensus and contestation. *Journal of Health Organization and Management* 30:5, 786-795. [[Abstract](#)] [[Full Text](#)] [[PDF](#)]
4. Katharina Kieslich, Peter Littlejohns and Albert Weale Albert Weale Department of Political Science, University College London, London, UK Katharina Kieslich Department of Primary Care and Public Health Sciences, King's College London, London, UK Peter Littlejohns Department of Primary Care and Public Health Sciences, King's College London, London, UK Aviva Tugendhaft School of Public Health, University of the Witwatersrand, Johannesburg, South Africa and Priceless SA, Wits School of Public Health, Johannesburg, South Africa Emma Tumilty Bioethics Centre, Department of General Practice & Rural Health, University of Otago, Dunedin, New Zealand Krisantha Weerasuriya National Medicines Regulatory Authority of Sri Lanka, Colombo, Sri Lanka Jennifer A Whitty Norwich Medical School, University of East Anglia, Norwich, UK and School of Pharmacy, University of Queensland, Brisbane, Australia . 2016. Introduction: priority

setting, equitable access and public involvement in health care. *Journal of Health Organization and Management* 30:5, 736-750. [[Abstract](#)] [[Full Text](#)] [[PDF](#)]