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Case Study

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Procedural fairness and the resilience of health financing reforms in Ukraine

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Abstract

In 2017, Ukraine's Parliament passed legislation establishing a single health benefit package for the entire population called the Programme of Medical Guarantees, financed through general taxes and administered by a single national purchasing agency. This legislation was in line with key principles for financing universal health coverage. However, health professionals and some policymakers have been critical of elements of the reform, including its reliance on general taxes as the source of funding. Using qualitative methods and drawing on deliberative democratic theory and criteria for procedural fairness, this study argues that the acceptance and sustainability of these reforms could have been strengthened by making the decision-making process fairer. It suggests that three factors limited the extent of stakeholders' participation in this process: first, a perception among reformers that fast-paced decision-making was required because there was only a short political window for much needed reforms; second, a lack of trust among reformers in the motives, representativeness, and knowledge of some stakeholders; and third, an under-appreciation of the importance of dialogic engagement with the public. These findings highlight a profound challenge for policymakers. In retrospect, some of those involved in the reform's design and implementation believe that a more meaningful engagement with the public and stakeholders who opposed the reform might have strengthened its legitimacy and durability. At the same time, the study shows how difficult it is to have an inclusive process in settings where some actors may be driven by unconstrained self-interest or lack the capacity to be representative or knowledgeable interlocutors. It suggests that investments in deliberative capital (the attitudes and behaviours that facilitate good deliberation) and in civil society capacity may help overcome this difficulty.

Keywords: Health financing, health policy, implementation, taxation, fairness, ethics, accountability, transparency, participation, Ukraine

Key messages

- Transparency and open-ended dialogue are key in fostering understanding of health financing reforms, developing more nuanced approaches and garnering enduring support for such reforms.
- Health financing reforms can be met with scepticism and resentment, which can increase if people feel left out of the change process.
- In environments with low public trust and high levels of corruption, it can, however, be challenging to establish a genuinely open and inclusive dialogue with all stakeholders.
- Other perceived barriers to an inclusive dialogue may be that stakeholders lack technical knowledge or are not organized in a representative manner.
- Engaging with stakeholders and the public constructively requires investments in civil society and local research capacity. Such engagement may be facilitated by new tools for representative deliberative democracy.

Introduction

Health financing arrangements can influence the attainment of the goals of universal health coverage (UHC), namely, effective and equitable access to needed health services and financial risk protection for all. How well health financing arrangements can support progress towards these goals depends on policy choices regarding the three health financing functions of revenue generation, pooling, and purchasing. While there are general guidance and evidence on how to make decisions that will support the fair and progressive realization of UHC (Kutzin, 2012; World Health Organization, 2014; Watson *et al.*, 2021), at the country level, there remain difficult questions on how to proceed given the inevitable trade-offs among competing priorities and often intense disagreements about how to make such trade-offs (World Bank, 2023).

In this context, it is particularly important to ensure a fair—that is, open and inclusive—process for making health financing decisions. Decision-making with substantial participation by stakeholders and the public is well suited to

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addressing 'complex problems that require trade-offs', and 'long-term issues that go beyond the short-term incentives of electoral cycles' (OECD, 2020, no pagination). It can be particularly useful in making hard, potentially unpopular decisions (Gruskin and Daniels, 2008; Solomon and Abelson, 2012; OECD, 2020). In these situations, an open and inclusive process may confer greater legitimacy on the final decision (OECD, 2020).

Substantial scholarly attention has been directed to procedural fairness in purchasing decisions, using the Accountability for Reasonableness Framework (A4R) (Daniels, 2008; Byskov *et al.*, 2014; Rumbold *et al.*, 2017; Wagner *et al.*, 2019). However, few studies have explored how to understand and implement procedural fairness of revenue mobilization and pooling decisions. This study fills this gap by analysing the procedural fairness of decisions related to revenue mobilization and pooling in Ukraine. Additionally, it explores how the fairness of these decision-making procedures might have affected the legitimacy and sustainability of the country's reform efforts.

In 2015, Ukraine initiated healthcare reforms that aimed to fundamentally alter its health financing arrangements in line with generally accepted principles for progressing towards UHC (World Bank, 2019; Bredenkamp *et al.*, 2022). A milestone in this reform process was the adoption of the Law on 'Government Financial Guarantees of Health Care Services' (Law 2168) and a package of related by laws in October 2017 (S1). Law 2168 established a unified health benefit package called the Programme of Medical Guarantees (PMG) and created the National Health Service of Ukraine (NHSU) to serve as a single purchaser for this programme (henceforth collectively described as 'the health financing reform'). A fundamental feature of the PMG was that entitlements were not linked to contributions. Instead, it guaranteed a single set of entitlements to all Ukrainians funded through general taxes and managed as a single pool. This followed recommendations and evidence on health financing reforms for UHC (Kutzin *et al.*, 2016; Jowett *et al.*, 2020; Yazbeck *et al.*, 2020). The key elements of Ukraine's reform and its achievements to date have been described elsewhere (World Health Organization & World Bank, 2019; Bredenkamp *et al.*, 2022).

While the reform followed global lessons on health financing reforms for UHC (such as relying predominantly on general taxes and avoiding creation of a separate pool for the formal sector workers), since its implementation, certain parts of the reform have been challenged. For example, some have argued for changes in the source of financing, i.e. for a shift from predominant reliance on general taxes to a contributory system with substantial co-payments (Sokirchuk, 2020). Furthermore, some of the opponents of the reform attempted to use the constitutional right to health to question the legality of the PMG, including the 2020 case in the constitutional court (Riabtseva, 2020). Healthcare professionals and some high-level policymakers have also questioned the key principles of the reform and called for its revision (Cabinet of Ministers of Ukraine, 2020; Sokirchuk, 2020).

The objective of this study is to examine the decision-making process around these reforms, using the three foundational principles and seven practical criteria for procedural fairness as described in the Methods section. While the reforms in Ukraine were comprehensive and implemented in a phased approach (Figure 1), the current paper focuses on revenue mobilization and pooling decisions over the period of 2016–17 culminating in the parliamentary approval of Law 2168.

This study aims to contribute to evidence on the role of procedural fairness in health financing reforms in Ukraine and beyond. As Ukraine is continuing its health system reform process despite the war (World Health Organization Regional Office for Europe, 2022), the study provides important lessons on the limitations of technically driven reforms that eschew fully open and inclusive public engagement. However, it also highlights barriers to such engagement that may arise in many countries, namely, a lack of trust in the motives, representativeness and knowledge of some stakeholders. It suggests that investing in institutions aimed at educating deliberative participants and fostering trust among them could help overcome these barriers. In turn, this can lead to increased legitimacy and durability of reforms.

Methods

Study design

This is a qualitative case study which examines why and how the following decisions were taken: (a) use of general taxes as the principal source of financing, (b) establishment of a single set of entitlements regardless of contribution and (c) regulations regarding cost-sharing (Yin, 2009). The primary data sources informing the analysis were a document review and semi-structured interviews. These were supplemented with personal observations of the decision-making processes by three of the co-authors who were involved in the reform process in various roles (Walt *et al.*, 2008).

Study setting

Decisions about the reforms analysed here must be understood against the background of the events that took place in 2014 when President Viktor Yanukovych had to flee the country after protests by civil society organizations (CSOs) in response to his rejection of the Ukrainian-European Association Agreement (Dickinson, 2021; The Economist, 2022). What became known as the Maidan Revolution brought about a transformation of Ukraine's society and state, prompting a major focus on tackling corruption, including in the health sector. Thus, already in 2015, a new system of procurement of medicines and medical supplies was piloted to improve the existing system, which was 'overly bureaucratic, impervious to many potential suppliers and rotten to the core' with 'multimillion-dollar kickbacks' (Brown, 2016, no pagination). In 2016, an outsider—Ulana Nadia Suprun, a Ukrainian-American physician and philanthropist, was brought in as the Minister of Health (Wikipedia, 2022). She brought in a young team with the task of overhauling the health system, which was considered inefficient and outdated with a large hospital network and a very weak primary care system with one of the highest levels of formal and informal out-of-pocket payments (OOPs) in Europe (Kutzin *et al.*, 2010; World Health Organization & World Bank, 2019).

In the wake of the Maidan Revolution, the Government also initiated a significant political decentralization process. Before 2014, state power in Ukraine was highly concentrated

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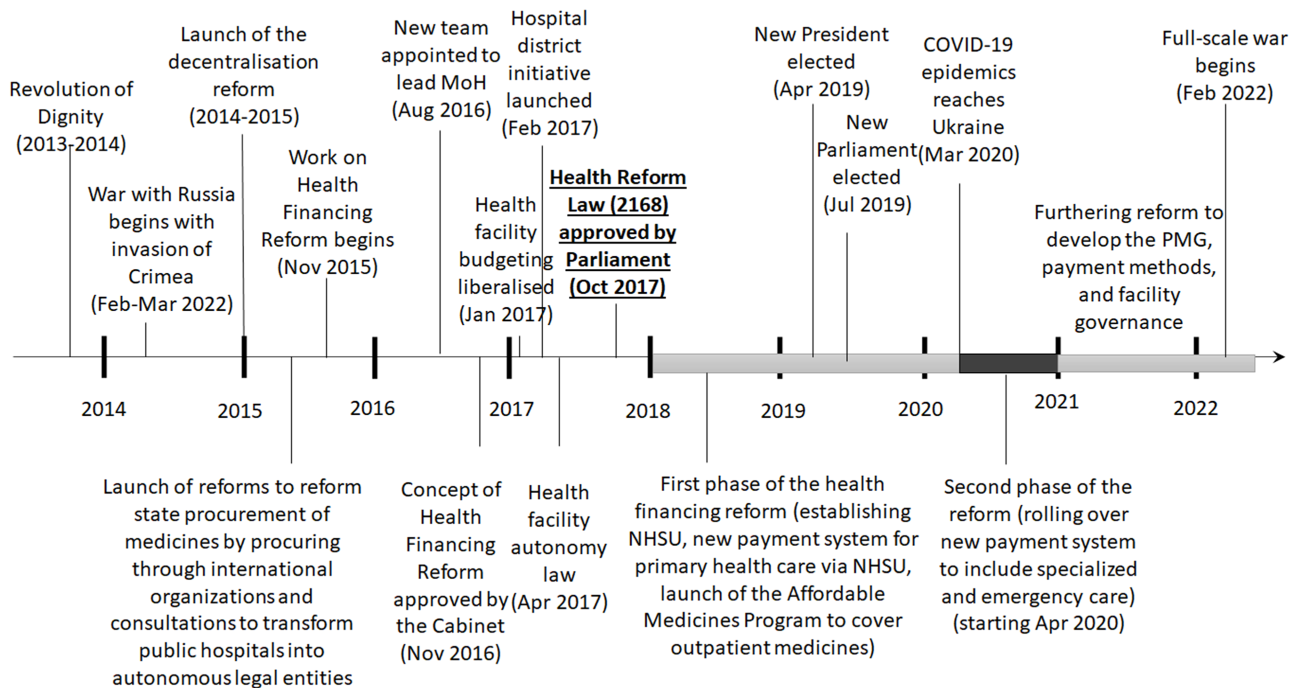

Figure 1. Timeline of the reform process

with weak local self-government and many administrative units with overlapping responsibilities (Romanova and Umland, 2019). While responsibilities for revenue mobilization and service delivery were partly clarified as part of the post-Maidan decentralization reforms, significant overlaps in responsibility between governments at different levels for service delivery to the same population continued. The reforms initiated with Law 2168, including the creation of a single purchaser and the pooling of resources at the national level, have mitigated this problem of overlap, but have not fully eliminated it (Hawkins *et al.*, 2021). Importantly, the decentralization reforms were supported by a vibrant civil society, which also engaged with health reforms, as described later.

Theoretical perspective

The guiding framework for this analysis is a framework for procedural fairness in health financing decisions for UHC that is based on three principles and seven criteria of procedural fairness. According to this framework, three principles—equality, impartiality and consistency over time—are at the core of a fair process (World Bank, 2023). Equality involves mutual respect and requires that people have equal opportunity to access information and articulate their views during a decision-making process, regardless of social status, gender, ethnicity, religion, or power. Impartiality requires decision-makers to be unbiased and stipulates that their decisions not be driven by self interest or unduly influenced by stakeholders with vested interests in the outcome. Consistency over time requires procedures for decision making to be stable and predictable, and that changes to decision making procedures are explained and justified. These principles guide implementation of the seven criteria, organized under three domains: information, voice and oversight (World Bank, 2023). Building on existing frameworks, such as Accountability for Reasonableness (A4R) (Daniels, 2008), this novel framework goes beyond decisions on benefit design and draws on a wide literature from political theory and public administration (including deliberative democracy), public finance, environmental management, psychology and health financing. The framework was developed through a scoping review (Dale *et al.*, 2023) combined with insights from expert consultations and case studies (World Bank, 2023). The information domain encompasses reason-giving, transparency and accuracy of information. Reason-giving involves decision-makers justifying their decisions to those affected by them and addressing disagreements through the exchange and respectful consideration of reasons, thereby enabling a more comprehensive understanding and evaluation of the choices being made. Transparency means sharing information abut how decisions are made, why they're made, the reasoning behind them, and what the final decisions are. Accuracy of information entails decisions being informed by a wide range of information sources, encompassing diverse evidence, perspectives and views. The second domain—voice—consists of public participation and inclusiveness. Public participation means providing the public with access to information, giving them the opportunity to express their opinions, and actively involving them in the decision-making process. Inclusiveness involves considering a broad range of views and concerns, with a particular emphasis on involving underrepresented groups and ensuring representation of diverse perspectives, even when direct participation isn't feasible. The third domain of oversight encompasses revisability and enforcement. Revisability means acknowledging that new evidence and evolving understandings of the issue can gain importance over time; thus requiring mechanisms for challenging decisions and enabling revisions to the original decision. Finally, enforcement has two dimensions: one relates to mechanisms that

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safeguard procedural fairness criteria in the decision-making process, while the other pertains to ensuring the implementation of outcomes through laws, regulations, and oversight mechanisms.

Data sources

Government policy and budget documents (S1) supplemented by opinion polls where available were used for a detailed and systematic reconstruction of the sequence of events that shaped the development and introduction of the health financing reform in 2016–17. To identify formal requirements, we analysed all relevant primary legislation, i.e. laws approved by the Ukrainian Parliament [the Verkhovna Rada (VR)] along with relevant legislative drafts considered by the Parliament, and secondary legislation [i.e. regulations approved by the Cabinet of Ministers of Ukraine (the Cabinet) and the government's executive agencies]. In addition, the review covered minutes of the VR and cabinet meetings. We also included official statements and materials related to the reform process released by central and subnational governmental bodies. The search was conducted via Ukraine's formal depositary of central regulations (Cabinet of Ministers of Ukraine, 2022; Verkhovna Rada of Ukraine, 2022) and official websites of the executive agencies.

The purpose of our stakeholder interviews was to supplement the document review with a range of perspectives on the reform process, as well as to provide deeper insights into how the decisions were taken, why the government chose this approach and how these procedural choices were perceived at different stages of the process. A semi-structured interview guide was designed around the procedural fairness criteria described earlier (S2). The following inclusion criteria needed to be met to be recruited for an interview: (1) being part of either the decision-making team or an interested stakeholder group during the reform's design and implementation, (2) having participated in relevant events during the decision-making process and (3) having taken a firm stance on the reform process and the decisions. Using the aforementioned three criteria, we recruited the most active and critical participants and stakeholders in the reform process via direct personal invitations. After purposive sampling to include representatives from central and subnational authorities (current and former), CSOs, the professional medical community and academia, we invited 17 persons to interview. Fifteen accepted the invitation, while two persons did not respond, likely due to the start of the full-scale invasion of Ukraine by Russia in February 2022. Table 1 presents the breakdown of the final sample in terms of the groups they represent.

Interviews were conducted online between April and July 2022 with an average duration of 80 min. They were recorded and transcribed. During transcription, each audio recording was deidentified, including removing positions and names, which may have indirectly identified the interviewees. In addition, the study uses observations made by two of the authors involved in the reform process in various roles during the development of Law 2168. It also draws on observations of a third author who was involved in later stages of the reform, following the elections that brought to power a new government. Observations come from participation in technical and high-level political meetings, monitoring of media and development of various internal policy notes. The involvement of some of the authors in the reform gives the study a unique perspective as well as access to information about how the process unfolded. Their observations were critically questioned and balanced by authors without any prior involvement in Ukraine. Studies of this kind have been claimed to 'yield the richest and most comprehensive understanding of the policy process' (p. 314 (Walt *et al.*, 2008).

Table 1. Breakdown of the sample by type of stakeholder

Type of stakeholder	*n*
Representatives from central and subnational authorities (current and former)	5
Professional medical community	5
Civil society organizations	4
Academia	1
Total number of participants	15

Data analysis

The analysis of the qualitative data involved inductive and deductive reasoning to identify key themes in the data (Yin, 2009; Braun and Clarke, 2012). The deductive reasoning was guided by the principles and criteria that form our framework for procedural fairness, which served as an evaluative benchmark for the process in Ukraine and as a structure for organizing the results. Inductive reasoning involved identifying the factors that facilitated or hindered the implementation and achievement of these criteria. In coding and organizing the interview data, we followed an iterative approach described by Yin (2015). It involved compiling the data, disassembling text fragments tied to the different features of procedural fairness described by the interviewees, reassembling these under broader categories and interpreting and formulating key themes representing central messages within and across interviews. The themes were then organized under the three main domains of the procedural fairness framework.

Results

We first present the decision-making process descriptively, outlining the key events in the legislative process and its procedural requirements. We next analyse this process using the criteria for procedural fairness, aiming to identify the extent to which these criteria were met, where the process fell short from the perspective of interviewed stakeholders and the explanations for these shortcomings.

Legal framework

Our analysis of the legal framework for introducing a new policy and law in Ukraine suggests that it is largely consistent with the criteria for procedural fairness we employ here. Moreover, we find that the reform conformed to these legal requirements. The reform choices analysed in this case study—(a) to use general taxes as the principal source of financing, (b) the establishment of a single set of entitlements regardless of contribution and (c) regulations regarding cost-sharing, which in theory abolished user fees[1] for services included in the benefit package—were introduced via two main legislative steps. First, the Government approved the Concept of the Health

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Financing Reform through the Cabinet Resolution in November 2016. A year later, in October 2017, the VR approved Law 2168, which formally launched the reform effective from January 2018 (S1).

These legislative decisions were subject to specific requirements for the process of approving new policies, as well as general requirements for sharing information with the public. When a government decides to approve a policy concept or to submit a draft law to the Parliament, it must run documented consultations with relevant government agencies and the public. The latter include a specific obligation to involve representatives of CSOs for people with disabilities, labour unions and local government associations. The rules also require the lead agency developing the concept—in this case the Ministry of Health (MoH)—to pursue all necessary measures to find consensus. For the consultations with the public, a set of rules ('On Ensuring Public Participation in the Formulation and Implementation of State Policies') requires the lead agency to ensure the following: (1) open disclosure of potentially affected stakeholders and their representation in consultations, (2) processing of public feedback to proposals and provision of expert views on alternative solutions, (3) incorporation of the consultation results into the ultimate decision and (4) public reporting of the outcomes.

The Cabinet submissions of draft laws to the VR were subject to additional rules governing parliamentary processes ('On Approval of the Regulations of the Cabinet of Ministers of Ukraine'). The Parliamentary process requires expert analysis on drafts by the main Parliamentary committee dealing with the issue as well as by other relevant Parliamentary committees. This process may involve seeking additional independent expert judgements. Finally, the draft must be reviewed by the Parliament in three readings. For the Cabinet, it is mandatory to submit draft decisions along with standardized explanatory notes outlining objectives, legislative grounds, costing and financial projections. These notes must also include expected results; stakeholder views; an evaluation of its anti-corruption, anti-discrimination and environmental impacts and additional documents outlining reasons for the proposals.

The Law 'On Access to Public Information' (2011) governs the public's access to information. It requires public authorities, as well as publicly owned and funded organizations to share unclassified information related to their functional activities, including any draft policy proposals. Information holders are required to systemically publish—online and in the press—a comprehensive description of their organization, activity plans, decisions, proposals, reports, service provision rules, as well as relevant e-data in a format that is downloadable and suitable for automatic processing. Any citizen or organization can request additional information, and such requests need to be addressed within 5 days. Although there are gaps in compliance and a lack of an effective independent body to oversee the enforcement of this law, international organizations assessed the law to have a powerful impact on strengthening transparent governance in Ukraine (Oleksiyuk, 2018). During the preparation of the pooling reform in Ukraine, this law required details of the process to be published on the Government websites, including the composition and activity plans of working groups developing the reform concept.

Overall, the decision-making process around the Government's approval of the reform Concept in 2016 and the Parliamentary approval of the Law 2168 in 2017 met the formal procedural requirements laid down by existing legislation. The requirement to have consultations with and sign off from other government agencies through the Cabinet process was accompanied by reason-giving and exchange among these agencies, resulting in important compromises (Box 1). Accordingly, if evaluated strictly in terms of the legal requirements of the process, the reform can be judged to have pursued transparency, reason-giving and inclusiveness.

Box 1 **Changes to the reform resulting from discussions in the run-up to the adoption of the Law 2168**

These consultations led to significant compromises and changes to the original reform design. In revenue mobilization, consultations were focused on reaching agreement with stakeholders in two areas: (1) the alternative option of premium-based insurance and (2) the outlook for co-payments.

- The original reform concept labelled the new tax-funded system as the one which would be 'funded through state medical insurance, based on the principle of solidarity'. This initial term was used to highlight the fact that while the tax-funding approach was not insurance in its traditional sense, it still achieved the main aim of insurance through prepayment and risk pooling. Opponents rejected these arguments and expressed that it violated key aspects of insurance, which is when everyone knows their contribution and benefits. They also feared that by using the term 'insurance' to describe the tax-funded option, the government would foreclose the option of introducing an additional premium-based system in the future, supplementary to the NHSU, which was indeed something the MoH hoped to achieve. Responding to this concern, the draft law was reformulated to modify the terminology. The compromise was to remove all references to insurance in the draft law, making the law focused on financial guarantees of medical services to the population funded from the state budget. This change may appear cosmetic, yet it represented a major compromise, since it left doors open for supplementing the tax-funded benefit package with an 'insurance-based' option.
- The second major issue was about private co-payments from the patients. The initial concept and the first drafts of the law assumed that some services would be provided with co-payment, e.g. for specialized, highly specialized care and outpatient medicines. During the Parliamentary passing of the law, a range of MPs felt that formalizing private co-payments was unacceptable for their constituencies and strongly objected to the idea. As compromise, the option of co-payments was entirely removed from the final draft.

There were also other compromises, but these are not described here as they go beyond the scope of decisions examined in this paper, whch focuses on key revenue mobilization and pooling decisions described earlier.

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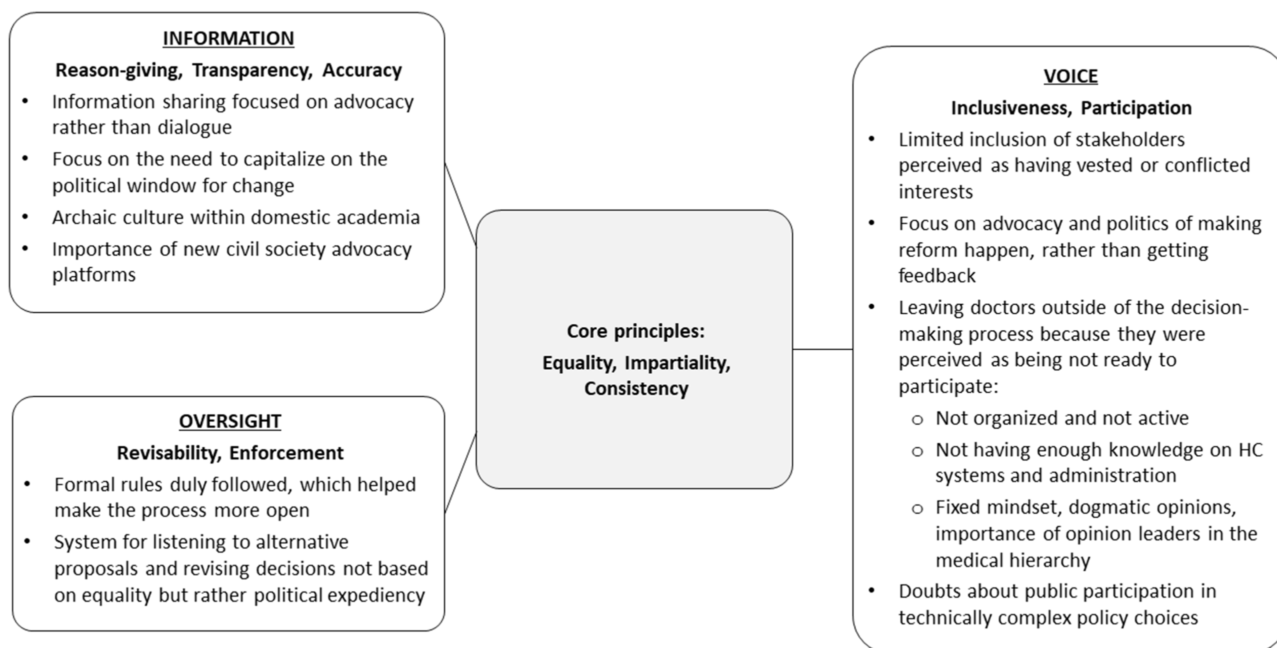

Figure 2. Thematic coding of the interview data

However, as we detail in the following sections, there was no effective platform for meaningful exchange of opinions with some important stakeholders such as health workers and ordinary citizens who may have not understood the reform, had questions about it and who eventually opposed the change.

Aspects beyond the legal requirements

We identified several core themes tied to the procedural fairness criteria. Focusing on each of the domains of procedural fairness in our conceptual framework, these themes help explain the perception of the reform process by important stakeholders, why particular criteria for procedural fairness were satisfied, and why the process fell short of fully meeting other.

Our analysis of the interview data suggests that while legal requirements for the approval of a new policy and law were met, the way they were implemented did not ensure meaningful dialogue with the public and those stakeholders who resisted change. One factor that heavily shaped the information and voice domains of procedural fairness was the reform team's emphasis on capitalizing on the short political window for change. This meant that they prioritized the speed of the reform process over investing time in the process of decision-making. Accordingly, features of procedural fairness were less likely to be optimized if these introduced what were regarded as unmanageable risks to the speed of the process. Figure 2 summarizes the thematic interpretation of data identified through our qualitative analysis.

Information: reason-giving, transparency accuracy of information

Ukraine's health reform process was driven by technocrats who focused on basing its design on global guidance and evidence on how to realize UHC. Interviewees supporting the reform's objectives repeatedly highlighted its sound design—something which was also recognized by the international expert community (World Health Organization & World Bank, 2019). The reform team was convinced of the correctness of the reform's key principles and wished to capitalize on a short political window for change. Accordingly, interviewees indicated that the reform team's efforts at information-sharing and public communication were focused on marketing the reform rather than on facilitating a genuine dialogue with stakeholders and the public about various policy options and their short- and long-term benefits and costs. For example, reform advocates promised a quick reduction in OOPs once the reform was rolled out (Vysokii Zamok, 2020). Due to the emphasis on promoting the reform, the information that was shared with the public lacked diversity of perspectives (in particular, it lacked coverage of views from the medical community) and omitted complicating evidence (e.g. some countries' positive experience with a higher reliance on payroll contributions or co-payments). The reform campaign focused on the longer-term benefits, rather than recognizing the entire spectrum of risks, including how fast informal OOPs could be expected to decline, or the risk that public financing in future might decrease due to changes in budget priorities.

Another factor that inhibited genuine deliberation was the reform team's sceptical perspective on the capacity and motivation of the domestic scientific community. Among the reform group, the general perception was that academic appointments and promotions were not merit-based and that academics had not kept up with the latest scientific research in economics and health financing. One of the interviewees representing the reform group put it as follows:

> [Our universities are plagued by] nepotism, and similar issues (…) in academic circles. [Appointments] were often linked to corrupt interests, therefore there was very little of scientific knowledge and too few experienced academics.

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> Moreover (in the health care management field) our scientific community was mostly comprised of retired practitioners, for example former ministerial workers, so their experience was mostly about the past, not about how to do things better. The scientific community was more of a barrier to than a driver of changes (KII).

This feeling was echoed in several other interviews among those who supported the reform. As a consequence, while inputs were sought from this community, mostly in the form of expert roundtables, which included representatives of academia, subnational governments and health administrators, the communication was rather unidirectional. As an illustrative example, a regional expert roundtable at the Poltava School of Law under the Yaroslav Mudryi National Law University on 25 March 2017 organized by the MoH reform design team was described by the host University as 'aimed at informing society and the professional healthcare community on what they should expect in short- and medium-term if the Parliament approves the proposed reform' (Prihodko, 2017). Therefore, even when such consultations were held, there was no genuine deliberation underpinned by respect and equality.

In contrast to how the majority of the domestic scientific community was viewed by the reform group, civil society was perceived as being driven by a strong commitment to moral values and as a vibrant and constructive force. New reform-coordination platforms set up after the 2014 revolution by CSOs became viable fora for the dialogue with the domestic expert community and for collecting their feedback on the policy process. Most importantly, interviewees noted that these new CSOs were set up to promote new societal values such as anti-corruption, self-governance and accountability. In addition to the CSOs focused on these values, the reform team actively engaged organizations working for the rights of patients, persons with disabilities and local government associations. Because of the strong focus of the reform on achieving UHC, the changes it aimed to bring were seen as highly beneficial for vulnerable groups suffering from limited access to healthcare because of high OOPs, low income, informal employment, chronical illness or geographical isolation. Patients and their organized groups were, therefore, central to the reform and acted as its active promoters. They facilitated significant independent feedback on the establishment of a single pool at the national level, which in theory could have been perceived as being against the trend towards decentralization. Therefore, having a strong civil society in this area whose views were respected by the reform team allowed for better quality deliberation with these stakeholders.

Voice: participation and inclusiveness

To capitalize on the political window of opportunity and protect reform objectives, the reform team limited the inclusion of stakeholders perceived as having vested interests or as being poorly informed.

Questions about the inclusiveness of and the extent of participation in the decision-making process provoked the greatest number of reactions from interviewees. The central theme was that despite the communication efforts outlined earlier, as well as significant compromises to achieve consensus during the Cabinet approval process, the policy process had overlooked some of the major groups. Chief among them were doctors affected by the hospital-level financial turbulence triggered by the reform's resource pooling.

Interviewees unanimously acknowledged that the inclusion of health professionals in the decision-making process was limited and that this limitation was sometimes deliberate. An extensive discussion ensued in every interview about why this happened and whether this should have been avoided. Most agreed that the healthcare community ended up feeling overlooked and resentful about the changes. For example, an interviewee representing a critical view on the reform process described this exclusion as follows:

> Therefore, we [Ukraine in general] have won, but we have also lost. We won because we approved this reform, but we have lost because we have demotivated a large number of doctors who experienced this reform as their defeat. The reform was so patient-oriented, everything was communicated only for the patients, while everything related to the previous health system was vilified. Doctors felt that they were enemies and that the reform was meant to somehow weaken them. (KII)

Interviewees explained that the exclusion of the professional medical community was based on a perception that health workers lacked basic knowledge about healthcare system administration and were not organized in a way that would permit them to actively participate. They were therefore deemed unprepared for a meaningful dialogue. Moreover, the medical community was described as suffering from a fixed mindset culture and prone to dogmatism—especially the authorities and opinion leaders in the medical hierarchy. An interviewee summarized these perceptions as follows:

> Medical workers opposed the reform not because they understood and disliked it, but because their authorities were against it, and their authorities opposed it because it threatened their corrupt status quo. Doctors were not represented, not because they were not invited, but because they are not represented anywhere, they do not have representative structures. They are simply not organized in Ukraine, and this is a disaster, it is hard to believe, but this is the case. Their feudal elite opposed changes by default, and the medical community was not represented, because they are not a community, they are just people working separately from each other. (KII)

A further challenge, also voiced in this interviewee's comments, was the perceived political capture by supposedly corrupt representatives of the health sector. Reformers feared that consultations with such representatives could be heavily influenced by corrupt stakeholders with substantial conflicts of interest and consequently excluded them from the dialogue. Some respondents praised this development, while others perceived that such exclusion had created powerful opposition to reforms. Illustrating the former, one interviewee defended the decision to exclude allegedly corrupt stakeholders on the grounds of the depth of corruption and that an inclusive approach to these stakeholders through dialogue would be futile:

> There was a problem of conflicted interests, because the (healthcare) system was built as a very…corrupt system, it

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> took years to achieve that balance, and because [of that] it is a very rigid system which was extremely difficult to dismantle or change. It had no problems in itself for its own interests, they had a constant cash flow, they had no crises but only a well-established good process, and everybody knew this and no one made any checks on anyone. (KII)

Supporting this view, the entrenched opposition to change was quoted as a major barrier to meaningful engagement:

> There were tours around the country to communicate with regional health administrations and hospital managers (chief doctors). There were definitely platforms to communicate. I am a full proponent of participation, but I think they had a conflict of interest… and this question of participation when stakeholders have conflicted interests is so unresolved. They would like everything to stay as it was. (KII)

In contrast, other respondents regretted the exclusion of the possibly compromised stakeholders from the decision-making process, arguing that doing so was a strategic mistake:

> It is a nice headline to say that "we do not make compromises with evil". But maybe it is better to think how to turn this evil into good, rather than how to destroy it? Because this evil is, after all, (…) it is all that we have, we don't have any better. (KII)

Some interviewees also expressed the view that this exclusion created a highly polarized environment where there was no longer room for nuances or middle ground:

> These were double standards. If you are a supporter of the reform – then yes, the doors are open for your ideas, if not – you are on security list to never get in. My point is that this approach has created losses even for those who opposed the reform: because instead of thinking about changes, trying to understand, to prepare, they threw all their energy on fighting against the reform team. (KII)

Turning to public engagement, our findings indicate that in-depth engagement with the lay public to understand their views on a system where benefits were not linked to contributions and with services free at the point of delivery was not prioritized. Interviewees from the reform team acknowledged that public communication during the reform design was primarily motivated by a desire to promote the reform rather than by a desire to foster dialogue. However, some noted that the lack of active engagement with citizens was because they did not see ways of doing so effectively with the limited resources and short time available.

Respondents were also divided on whether seeking public participation generally on technically complex or unpopular reforms was worth the cost and time. Most believed that while excluding large groups of stakeholders carries a risk, the windows of political opportunity for structural reforms are normally so narrow that a 'fast track' may be strategically justified. Even if weaker public participation during these fast-track changes would jeopardize reform sustainability, the changes, even if short-lived, would still make a longer-term impact in a form of institutional memory. As explained by one respondent:

> Even in the short period of time since the reform started to roll out, a lot had changed already, and it is already in the minds of those who experienced these changes. They are already carrying institutional memory in the system. Even if there will be a setback, people will say: but we remember how it was different once before. (KII)

In contrast, those with a critical view of the reform argued that there was large support for a more contributory system. One potential source of evidence to back up this claim is population surveys. However, these show a mixed picture and do not permit firm conclusions on the public's views on key aspects of the reform. In 2017, when the reforms were only just initiated, most of the population (97%) supported the proposition that everyone should have access to medical care, regardless of their financial status (Група "РЕЙТИНГ" [Survey group "RATING"], 2017). Concerning the policy instruments that might be used to promote such solidarity, 69% supported the introduction of a national health insurance for all using general government funding, while 19% did not support this policy, with 12% having difficulty in responding to this question (Група "РЕЙТИНГ" [Survey group "RATING"], 2017). In 2021, a somewhat differently worded survey found that between 69% and 80% of the population (depending on the income group) supported the introduction of 'medical insurance' (Група "РЕЙТИНГ" [Survey group "RATING"], 2021). However, the survey did not specify whether such 'medical insurance' should be taken to mean government-organized insurance for all funded through general taxation or instead contributory medical insurance. The 2021 survey also reveals that much of the population supported a form of cost-sharing rather than full coverage of medical costs by the government: 83% of the respondents expressed support for a proposal in which patients would be responsible for covering up to 30% of treatment cost. In sum, these findings suggest both that there was (at least in 2017) broad support for the type of solidarity that motivated the decision to use general taxes as the main source of revenue under the PMG, and that (at least in 2021) there was broad support for co-payments that might be taken to be at odds with such solidarity and the PMG's abolition of co-payments. This mixed picture and the lack of surveys that established citizens' views on policy options with greater clarity indicate that there was scope for greater public engagement, to both clarify and engage with the public's views.

Interviewees expressed a range of thoughts about how to improve public participation in the future and thereby potentially strengthen the reform's sustainability. One idea proposed was to focus communication with the public on understanding issues and problems to be addressed by the reforms and on risks that matter to these groups, rather than seeking their feedback on complex technical solutions. Another point highlighted was to invest in public awareness and gradual change in culture to prepare grounds for future breakthroughs.

Oversight: revisability and enforcement of the process

Oversight criteria were only partially met. Reform experiences shared by the respondents showed that formal rules were duly followed and played an important role in promoting specific

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features of procedural fairness. According to several interviewees, the MoH at times had a perfunctory approach, aiming to only meet the legal requirements on public consultations and transparency, e.g. by releasing documents for public consultations precisely when it was required but not proactively sharing them. At the same time, they agreed that the government had complied with the rules and that this had helped secure at least some level of participation and transparency:

> Yes, some processes were sometimes very formal. But bureaucracy is also important. If someone wants to do things really well, these formal rules can also help. Those who are not keen to do things with top quality can always at least follow the formalities. But it depends on the leader, and formalities are definitely not a burden or a problem for making things happen. (KII)

Mechanisms for revisability were largely guided by political expedience. According to some of the interviewees, not all proposals for change were given equal consideration. One interviewee, representing a critical view on the reform process, noted that only proposals from more powerful actors or those whose approval was needed for the reform to pass were given due attention by the reform team:

> Sometimes technical feedback submitted from outside the Government was not incorporated, because I know that they were prepared to change their vision only for political purposes and only to have their documents passed, not for the technical merit. (KII)

Overall, it seems that the system for listening to alternative proposals and revising decisions was not based on the principle of equality where all objections and questions were treated with the same level of respect. The aim was to ensure that formal rules were met, and only the views of powerful potential allies were considered to secure their support for the Law 2168.

Discussion

The first key observation on Ukraine's experience is that meeting formal requirements, while a significant contributor to procedural fairness, does not suffice for a fully fair process. In Ukraine, the formal requirements for information-sharing and consultation during policy development were duly executed. Moreover, the reform team made efforts beyond these requirements in response to stark differences of opinion. These additional measures included a communication campaign, roadshows and roundtable discussions with selected stakeholders. These measures helped the government make reforms clearer to the population, to explain the expected benefits of these changes and to identify some concerns that required clarification and fine-tuning of the reform design—thereby, to some extent, meeting key procedural criteria in the information domain: accuracy of information, transparency and reason-giving.

CSOs played an important role in providing independent oversight of the process and ensuring voice. A range of new CSO platforms developed after the Maidan Revolution proved to be highly beneficial for sharing independent expert opinions on the reform proposals. However, these new platforms entered the health financing field by expanding from an anti-corruption and decentralization agenda and were therefore focused on reform dimensions related to the prevention of corrupt practices and promoting transparency, patient rights and dignity, rather than on details of revenue mobilization or pooling. To ensure that they can take on this role too, CSOs require time to build up their technical expertise and research skills.

Nonetheless, the process was not fully inclusive: certain views were disregarded because they were perceived as being driven by strong self-interest or as lacking up to date, relevant knowledge. In particular, the reform team viewed domestic academics and organizations of medical professionals as being unable to take on the role of critical interlocutors because of multiple failures, including a dearth of specialized knowledge in health administration and financing and widespread conflict of interest. Accordingly, to overcome this barrier to genuinely dialogic engagement with all stakeholders in the future, it seems advisable to strengthen local research capacity, stimulate the creation of representative associations of medical professionals, find ways to safeguard against unconstrained conflict of interest and nurture collaboration between various parts of academia, professional organizations and policymakers.

A second key finding is that the perception that the political window for change was narrow and that potential deliberative partners had shortcomings shaped the reform team's view of what type of information-sharing, participatory opportunities and representation was desirable. Our research indicates that this perspective may have underestimated the instrumental value of these elements of procedural fairness in building trust and enduring support for the reforms. The opinion polls discussed earlier indicate that while there was overwhelming support for a health system where access to medical care was not linked to ability to pay, there was also significant support for substantial co-payments. Moreover, while the surveys indicate support for the introduction of 'medical insurance', there was a lack of clarity on the meaning of this term. Pro-reform groups used the term in the broad sense of providing protection against an unwelcome eventuality (and therefore consistent with tax-funded provision), but it may have been understood among some citizens in a more traditional sense as a premium-based insurance where benefits were linked to contributions. Importantly, the reform team did not seek to clarify the public's views in these respects, since it did not use these or other opinion polls and did not create a platform for meaningful engagement with the public's views.

In retrospect, efforts to elicit more informed citizen recommendations on policy questions through methods such as Citizens' Assembly or Panels (Chwalisz and Česnulaitytė, 2020) and going beyond quick polls and marketing tactics might have been more productive in the long run. These would have more clearly revealed citizens' attitudes to specific aspects of the reform and would have permitted the reform team to engage with them constructively. Such in-depth engagement might have also made citizens less prone to manipulations by interest groups promoting private insurance. The reformers' 'marketing approach' may also have contributed to very high expectations of what the reforms could achieve. Inclusive deliberations, where the public and other stakeholders, including those who disagreed with proposed

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policies, were fully informed of various choices they faced and which provided a balanced picture, could plausibly have provided stronger foundation for the reform to be sustained through changes in political leadership.

The third key finding is that the team did not recognize the intrinsic values of an inclusive and open process (Gutmann and Thompson, 1998; Mansbridge *et al.*, 2012; Landemore, 2017; Kuyper, 2018). These intrinsic values include treating the views of others with respect and treating everyone involved as open for cooperation. The pursuit of these values requires a degree of trust in others' ability to propose fair terms for social cooperation and an attempt to elicit their motivation to abide by these terms if they are assured that others will do so too. During Ukraine's health financing reform process, public communications were set up to market reform objectives and persuade the public about its benefits rather than inviting stakeholders into a genuine dialogue about its design and the values underlying the reform. Moreover, the reform team perceived some stakeholders—especially representatives from the medical community and parts of local academia—to be ill-motivated, ill-informed and insufficiently organized. It concluded that deliberating with them would risk compromising reform objectives. However, communicating the reform and excluding stakeholders this way violates the foundational principle of equality, which requires giving all affected an opportunity to table their concerns and treating those opposing policy objectives with respect; it also violates the practical criteria of inclusiveness, participation and reason-giving. Moreover, the exclusion of technical experts, stakeholders as well as the public ignores the epistemic benefits of greater inclusiveness (Landemore, 2017; Kuyper, 2018).

Acknowledging these losses in procedural fairness does not, by itself, show that the reform team's approach was misguided. The reform team's situation, and its decision to prioritize the goals of UHC and the values of solidarity, improvements in population health, and concern for the most vulnerable members of society over some of the aspects of procedural fairness, might simply be seen as exposing a potential tension between procedural fairness and the political economy approach to analysing decision-making processes for UHC that has dominated the literature (Reich *et al.*, 2016; Shiffman, 2019; Sparkes *et al.*, 2019a). The political economy approach emphasizes strategic framing, coalition-building with sites of power and countering and suppressing arguments against one's policy objectives (Sparkes *et al.*, 2019b; Carriedo *et al.*, 2021). On this account, the reform team can be viewed as strategically located 'policy entrepreneurs' who were capitalizing on a unique window of opportunity to promote technical solutions in the pursuit of UHC (Béland & Katapally 2018; Tangcharoensathien *et al.*, 2020). Moreover, their procedural choices can be interpreted against the backdrop of the urgency of the healthcare reform given that Ukraine had rising rates of catastrophic OOPs and a large unmet need for health services, particularly among the poor (Goroshko *et al.*, 2018). The intrinsic value of transparency, participation and inclusiveness does not play a prominent role in this political economy approach to examining health financing reforms for UHC.

However, we believe that there are reasons to resist an interpretation of the reform team's situation as involving a straightforward trade-off between procedural fairness and getting the reform through. Focusing solely on technical imperatives without recognizing the value of political deliberation can render progress towards UHC vulnerable to populistic backlash (Fukuyama, 2014; Esmark, 2017) or organized opposition (Savedoff *et al.*, 2012; Greer and Mendez, 2015). Moreover, to build sustained support for a health policy that relies on general taxation to fund health care, the solidaristic motivation for such a policy must be understood and, after due consideration, broadly accepted by the public and key agents in the health sector. In the absence of such broad understanding and acceptance, in Ukraine, signs of a backlash against the reform have become visible with the continuous attempts by the opponents to push proposals that would reverse key principles of the reform by introducing contributory-based insurance and significant cost-sharing (Riabtseva, 2020; Sokirchuk, 2020; Strashkulich, 2022). In these attempts, the opponents have exploited weaknesses in the process, described earlier, including insufficient engagement with the lay public through the robust deliberative methods (OECD, 2020). Through such engagement, citizens could be given opportunities to understand what was meant by labels such as 'insurance', which reform options existed regarding revenue mobilization and pooling and why certain proposals were sounder than others. Moreover, alienating a key stakeholder (the medical professionals) arguably weakened the reform, since their cooperation would be required for the reforms to succeed and generate real changes in how services are delivered. Therefore, even from a narrow, 'results-oriented' perspective, there are advantages in engaging in a more inclusive and respectful dialogue. This study reveals that there was, among the reform team, an under-appreciation of the importance of active two-way engagement with the lay public where they were viewed not simply as passive recipients of information but as active agents in deliberations who could provide valuable insights. Furthermore, there was lack of trust among stakeholders, including those driving the reforms, which inhibited a dialogue founded on a key principle of a fair process, which is equality based on mutual respect. Importantly, our study suggests that both procedural fairness and policy effectiveness may be advanced if key actors undertake efforts to overcome these barriers in the future.

One step that may help overcome these barriers in the future is to persuade as many stakeholders as possible that, if others are willing to do so too, it is in their long-term interest to start investing in 'deliberative capital'. This capital consists in mutual understanding, a willingness to listen, a willingness to move beyond narrow self-interest and social norms that codify and help incentivize these attitudes (Afsahi, 2022). Investing in technical capacity of medical professional associations, local academic institutions and CSOs would create an enabling environment for creation of such deliberative capital.

Our study has identified that interviewees driving the reform process were open to new practices that could help facilitate deliberation on the needs, values and practical concerns underpinning complex technical dilemmas in health financing. If open deliberative processes articulate the values guiding the policy choices, the needs that are intended to be met by them and the implications for implementers (e.g. health service providers or administrators), the public will be able to formulate and express their preferences and engage in a discussion more easily. To this end, future health

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financing reforms in Ukraine may benefit from processes that create space for learning and well-informed recommendations, which, in turn, can foster greater acceptance and trust over time (Abelson *et al.*, 2003; Solomon and Abelson, 2012; Chwalisz, 2020a, b). At the same time, the case of Ukraine demonstrates that when reforms are perceived as urgent and some of the key stakeholders are polarized (e.g. the reform team and parts of local academia and the medical profession), developing feasible platforms for fostering true deliberative approaches is challenging. It therefore highlights the need for research on how to successfully use representative deliberative processes in polarized societies with limited trust in the motives and knowledge of some stakeholders.

The war makes further health reform in Ukraine more urgent and more challenging at the same time. Stronger efficiency in health service provision is now critically needed as demand for health services is increasing while resources are getting scarcer (World Bank, et al., 2022). A shrinking revenue envelope also raises the question of whether the pre-war benefit package is still affordable. If not, the government may need to either revise the benefit entitlement and facilitate more private financing of the health system or introduce bold efficiency measures to maintain universal coverage funded from general taxation (Dzhygyr, et al., 2022). But most importantly, these sharper policy dilemmas have arisen among citizens who now expect more from the state which they are defending at the cost of their lives. Between 2021 and 2002, the share of Ukrainians preferring democratic decision-making increased from 48–56% to 68%, while the share of supporters of more authoritarian policies decreased from 18–24% to 11.5% (Разумков центр [Razumkov centre], 2022). The Ukrainian people expect to have a major say in how policy decisions are made, making deliberative democracy instruments central to future policymaking.

Limitations

This study has three limitations. The first relates to researcher positionality (Walt *et al.*, 2008). Three authors of the study were involved in the reform examined in the paper in various roles. Insider views are inherently biased. To mitigate this bias, the study was carried out by a diverse group of researchers, combining both insiders and outsiders, where all authors were actively engaged in discussions of the findings and their interpretation.

Second, the timing of the data collection coincided with the full-scale invasion of Ukraine by the Russian Federation. However, we do not believe that these events substantially affected the results of the interviews. The interviewees remained engaged in activities or discussions related to healthcare reform and keenly interested in supporting this research and potential improvements in the health reform process to which it hopes to contribute.

Third, in the interviews, there is limited representation of the voices of the poorest and most vulnerable population groups. While there is indirect representation of some of the vulnerable through interviewees from CSOs representing patient organizations, there is no direct voice of the poor. However, there are also several challenges to seeking direct representation of poor and vulnerable populations. Chief among these is that it is not always straightforward to identify who the legitimate representatives of the poor and vulnerable are. For example, although the CSOs recruited for our study advocated for the interests of the poor and vulnerable populations during health financing reform, their agenda may not necessarily align with the broader interests of the poor on every issue. One way to overcome this would have been a more inclusive approach to public engagement with the research's ideas, such as convening citizens' panels with sampling techniques to ensure diverse representation. However, it would not have been feasible for this study to adopt such an approach, particularly in the context of the war.

Conclusion

In Ukraine, following the Maidan Revolution, there was a push for reform in several areas, including health. At the same time, it was not certain that an environment conducive to these changes would last. With fresh elections coming up, the team that led the health sector saw a short window of political opportunity to achieve massive structural change in support of UHC. Importantly, this study shows that in pursuit of these reforms, formal requirements regarding transparency and public participation of the legislative process were met. At the same time, it has uncovered ways in which decision processes around the reform fell short of being fully open and inclusive. In relation to citizens, the reform team focused on marketing the reforms rather than on creating a dialogue where citizens would be given adequate opportunities to understand various reform options and the reasoning behind them and to provide their perspectives. Moreover, stakeholders in the medical profession and academia were excluded due to lack of faith in their motives, representativeness and knowledge. These shortcomings likely contributed to continued questioning of the reform's key elements and attempts to instead introduce contributory-based health insurance with increased cost-sharing by patients.

Finally, this study highlights challenges that many countries with low trust in some institutions and stakeholders and high perceived levels of corruption, as well as limited health financing expertise among local academia and civil society, may face in building a fully fair decision-making process. It thereby demonstrates the value of the research on how such countries can build the knowledge, mutual understanding and cooperative motives that enable open and inclusive deliberation about health financing reforms for UHC.

Supplementary data

Supplementary data is available at *Health Policy and Planning* online.

Data Availability

The data on legal documents underlying this article are available in its online supplementary material. The interview data underlying this article cannot be shared publicly due to protection of privacy of individuals that participated in the study.

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Author contributions

Y.D., E.D. and U.G. contributed to conception of the work. K.M. and Y.D. contributed to data collection. Y.D. and K.M. contributed to data analysis and interpretation. E.D., K.M. and Y.D. contributed to drafting of the article, with inputs from U.G. A.V. and U.G. contributed to critical revision of the article. All named authors approved the paper prior to submission.

Reflexivity statement

The key challenge in undertaking the desk review and interpreting interview data was to control for the researcher subjectivity bias and to ensure a sufficiently reflexive approach. Two of the main authors were involved closely in the conceptualization and implementation of the health reform in Ukraine. In addition, one of the authors was also involved in a role of external partner, monitoring and facilitating the dialogue around the reforms discussed in the paper. Their personal experience may have influenced their perspective and interpretation of the events. We tried to mitigate these risks by outlining the authors' perspective throughout the analysis, as well as by subjecting the process to peer debriefing and supervision by colleagues from the wider research team. A key tool against subjectivity was to supplement the desk study with stakeholder interviews, where respondents with diverse opinions on the process and outcomes of the reform were deliberately recruited. Accordingly, the sample included stakeholders who agreed and disagreed with the process, as well as interviewees who had supported some procedural choices but strongly disagreed with others. Yet, building the sample with a significant share of reform supporters is a natural shortcoming of this research given that attempting to understand the process by which decisions were made, one naturally recruits those closest to it. Two female authors, both from lower-middle income countries, are among the three key contributors to the paper.

Ethical approval. Ethical approval to conduct research was obtained from the Institutional Review Board of the state enterprise 'Public Health Center of the Ministry of Health of Ukraine' (Institutional Review Board # 00013025). All study participants were given an information sheet explaining the project and the voluntary nature of participation in the study and were asked to sign a written consent form before proceeding to interview. The information sheet and consent form were both reviewed and approved by the ethics committees prior to the research.

Conflict of interest. None declared.

Note

1. New regulations adopted as part of the reform abolished user fees for services in the benefit package; however, in reality, OOPs remained high. Prior to the reform, providers could legally charge semi-voluntary charitable contributions from patients. According to a 2015 survey, these contributions generated an additional 30% of hospital financing compared to resources that hospitals receive from public sources. For more details, see World Health Organization, World Bank (2019). Ukraine Review of Health Financing Reforms 2016–19.

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