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Case Study

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Procedural fairness in decision-making for financing a National Health Insurance Scheme: a case study from The Gambia

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Abstract

Achieving universal health coverage (UHC) involves difficult policy choices, and fair processes are critical for building legitimacy and trust. In 2021, The Gambia passed its National Health Insurance (NHI) Act. We explored decision-making processes shaping the financing of the NHI scheme (NHIS) with respect to procedural fairness criteria. We reviewed policy and strategic documents on The Gambia's UHC reforms to identify key policy choices and interviewed policymakers, technocrats, lawmakers, hospital chief executive officers, private sector representatives and civil society organizations (CSOs) including key CSOs left out of the NHIS discussions. Ministerial budget discussions and virtual proceedings of the National Assembly's debate on the NHI Bill were observed. To enhance public scrutiny, Gambians were encouraged to submit views to the National Assembly's committee; however, the procedures for doing so were unclear, and it was not possible to ascertain how these inputs were used. Despite available funds to undertake countrywide public engagement, the public consultations were mostly limited to government institutions, few trade unions and a handful of urban-based CSOs. While this represented an improved approach to public policy-making, several CSOs representing key constituents and advocating for the expansion of exemption criteria for insurance premiums to include more vulnerable groups felt excluded from the process. Overload of the National Assembly's legislative schedule and lack of National Assembly committee quorum were cited as reasons for not engaging in countrywide consultations. In conclusion, although there was an intent from the Executive and National Assembly to ensure transparent, participatory and inclusive decision-making, the process fell short in these aspects. These observations should be seen in the context of The Gambia's ongoing democratic transition where institutions for procedural fairness are expected to progressively improve. Learning from this experience to enhance the procedural fairness of decision-making can promote inclusiveness, ownership and sustainability of the NHIS in The Gambia.

Keywords: Universal health coverage, health financing, national health insurance scheme, procedural fairness, equity, participation and accountability

Key messages

- Tied to democratic transition and broader governance improvements in The Gambia, the executive and the technocrats driving The Gambia's NHIS process strived for greater participation and inclusiveness than what had been common in the past.
- Expansive effort is required to secure representation of diverse voices; in the absence of meaningful opportunities for inclusive participation, the importance of meeting the information domain of procedural fairness becomes pressing.
- Shortcomings in the process should be viewed in light of The Gambia undergoing a democratic transition where institutions needed to meet procedural fairness criteria are expected to improve over time and play an increasingly important role in future adjustments of the country's NHIS.

Introduction

In a significant move towards health financing reform, The Gambia's lawmakers passed the National Health Insurance (NHI) Act in November 2021, after nearly a decade of discussions on the matter (Gambia Government, 2021). The NHI Act established a mandatory NHI scheme (NHIS) that aims to enhance access to affordable and quality healthcare services for all members through a basic benefit package. Vulnerable populations will be exempted from contributing to the scheme, and the specific criteria for identifying such groups will be defined by sub-laws.

Intensive deliberations about the NHIS have taken place in a new political climate in The Gambia following the 2016 presidential election won by the coalition opposition candidate. Since then, The Gambia has seen an increase in respect for human rights and fundamental freedoms, such as greater freedom of expression (Nabaneh, 2017; Freedom House, 2022). As a result, citizens are increasingly expressing their dissatisfaction with poor health services through social and

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print media (Jefang, 2018; Gambian Women's Lives Matter, 2022; What's on—Gambia, 2022).

The possibility of introducing a NHIS in The Gambia has been a topic of discussion for several years. Previous studies, including one commissioned by the former government, have explored the feasibility of implementing such a scheme (Shepard and Zeng, 2011; Njie, 2015). The 2021 Presidential elections in The Gambia also played a significant role in placing NHIS at the top of the policy agenda. During the election campaign, all presidential candidates highlighted health as a priority in their election manifestos and promised to address the challenges facing the health sector (Touray, 2019; Cham, 2021).

The Ministry of Finance and Economic Affairs (MoFEA) has also played a significant role in promoting the idea of a publicly funded scheme. While the early discussions were initiated by the Ministry of Health (MoH), the MoFEA elevated it to a top priority on the government's policy agenda and increased budget allocations to health over time (Ministry of Finance and Economic Affairs, 2022; World Health Organization, 2022). In short, a publicly financed health insurance scheme has increasingly gained support in The Gambia (Njie *et al.*, 2022).

Decisions to establish NHISs have wide-ranging implications for stakeholders including existing insured population groups (Agier *et al.*, 2016; Mathauer *et al.*, 2019). Experience from other settings shows that determining specific revenue sources to finance the scheme, including the extent to which the scheme is financed through general taxes as opposed to contributions, can involve confrontation and disagreements between stakeholders with conflicting values and interests (Daniels, 2007; Debie *et al.*, 2022), with the tensions between solidarity and freedom of choice often at the forefront (González *et al.*, 2021). To promote trust and acceptance of these decisions, attention to procedural fairness in decision-making is necessary. This requires equal opportunities for all stakeholders to participate and voice their views, mutual respect between decision makers and participants and accessible justification for decisions (Leventhal, 1980; Daniels and Sabin, 2002; Weale *et al.*, 2016; Bächtiger *et al.*, 2018b). The importance of procedural fairness is particularly compelling for issues with long-lasting consequences that extend beyond electoral cycles (Solomon and Abelson, 2012; OECD, 2020).

The accountability for reasonableness (A4R) framework has significantly advanced research on procedural fairness in health financing, particularly in examining health benefit package decisions (Martin *et al.*, 2002; Baltussen *et al.*, 2013; Byskov *et al.*, 2014). However, less attention has been given to procedural fairness in revenue mobilization and pooling. The A4R framework proposes four conditions that must be met to ensure procedural fairness for priority-setting decisions: relevance, publicity, revisability and enforcement. Evaluations of the A4R framework suggest the need to re-assess certain criteria or broaden its focus, such as by considering the role of public participation and mitigating power differences in ensuring inclusivity (Gibson *et al.*, 2005; Friedman, 2008; Kapiriri *et al.*, 2009).

Against this background, the decision-making processes leading up to the enactment of the NHI Act are a relevant case for examining procedural fairness. The primary objective of our study was to explore how principles and criteria of procedural fairness were reflected in the decision-making processes that shaped key decisions on revenue sources for the NHIS in The Gambia.

Methods

Study design

This is a qualitative case study that focuses on the decision-making process in The Gambia regarding the NHI Act in 2021. Specifically, the study examines the events and actors that shaped the determination of revenue sources for the scheme, with a particular emphasis on procedural fairness.

Study setting

The Gambia has a population of ∼2.5 million people, with the majority residing in urban areas. The health sector is primarily publicly financed and delivered, with limited private sector involvement (Sine *et al.*, 2019). Between July 1994 and December 2016, Gambians experienced 22 years of turbulent political climate under the autocratic rule (Ifeanyi *et al.*, 2020). Since 2017, the country is progressively transitioning to a democracy.

Theoretical perspectives

This case study utilizes two theoretical perspectives to offer a thorough analysis of the events in question. The first perspective is the policy cycle for health sector reform developed by Roberts *et al.* (2008), which identifies six crucial steps for successful health policy reform: problem definition, diagnosis, policy development, political decision, implementation and evaluation (Roberts *et al.*, 2008).

This study focuses on the process between diagnosis and the political decision to establish a NHIS. In The Gambia, the diagnosis stage of the policy cycle for health sector reform identified NHI as the primary solution for improving access to health services and safeguarding against financial risks, particularly for vulnerable populations. The political decision phase involved the National Assembly's adoption of the NHI Act 2021, following the submission of the NHI Bill by the executive branch and its examination by the legislative body.

The second theoretical perspective utilized in this case study is based on principles and criteria that define the fundamental components of procedural fairness. These criteria are classified into three domains of information, voice and oversight. The identification of these criteria was informed by a scoping review of theoretical and empirical literature from political theory and public administration (including deliberative democracy), public finance, environmental management, psychology and health financing (Dale *et al.*, 2023). The development of these criteria was also informed by international expert consultations and this procedural fairness framework is outlined in the NIPH-World Bank-BCEPS report on "Open and Inclusive: Fair Processes for Financing Universal Health Coverage" (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

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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 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.

The implementation of these criteria is guided by three overarching principles: equality, impartiality and consistency over time. The principle of equality is about all stakeholders having equal representation and access to information and that their views are given equal consideration regardless of social status, gender, ethnicity, religion or power (Barasa *et al.*, 2016; Beauvais, 2018; Bächtiger *et al.*, 2018a). The principle of impartiality is about decision makers producing unbiased assessments and that decisions are not unduly influenced by stakeholders with vested interests in the outcome (Leventhal, 1980; Murphy, 2010). Finally, the principle of consistency over time requires decision-making procedures to be stable and predictable, especially in the short term, to foster trust and acceptance among stakeholders (Leventhal, 1980). Any modifications to decision-making procedures should be clarified and justified through an open and inclusive process.

Together, these principles and criteria form a framework for procedural fairness that extends beyond the A4R framework. We applied this extended framework for procedural fairness in recognition of the perceived limitations of A4R in adequately addressing the importance of participation and inclusiveness (Gibson *et al.*, 2005; Friedman, 2008; Kapiriri *et al.*, 2009), which, as different areas of the literature suggest, are important for people's perceptions of fairness and legitimacy (Dryzek and Niemeyer, 2008; Mansbridge *et al.*, 2012; Weale *et al.*, 2016; Begg, 2018; Tugendhaft *et al.*, 2021).

Data collection: document review and interview recruitment

The authors conducted a review of three key documents related to the Gambia's universal health coverage (UHC) reforms to inform subsequent collection and analysis of interview data. These documents were The Gambia health financing policy 2017–2030, which outlines the pathway for resourcing UHC agenda; The Gambia national health financing strategic plan 2019–2024; and the NHI Bill, 2020.

The first stage of our sampling strategy involved mapping key stakeholders from public, private, local government, civil society organizations (CSOs), pressure groups, media and academia with a stake in the NHIS policy. Purposive sampling was then used to recruit participants from the public and private sectors who had a detailed and in-depth understanding of the NHIS policy processes. Reflecting the centralized nature of governance and administration in The Gambia, this study conducted interviews with urban-based participants who participated in or otherwise were close to NHIS policy-making, budget negotiations and debates on the Bill by lawmakers. These participants included policymakers, legislators, technocrats, hospital chief executive officers and members of the private sector.

To identify civil society actors, the authors utilized the registry of all CSOs registered with The Association of Non-Governmental Organizations in the Gambia (TANGO) and mapped 12 CSOs operating in the health sector. To ensure a balanced representation of perspectives and experiences with the NHIS decision-making process, we also invited key CSOs that were left out of the NHIS policy deliberations. The lead author conducted a total of 16 semi-structured interviews and two focus group discussions (FGDs) using an interview guide to explore how each of the principles and criteria for procedural fairness were reflected in the decision-making process. Two of the mapped CSOs did not participate in the FGD, and a representative of academia was unable to grant an interview due to unforeseen circumstances.

The lead author also supplemented the interview data with observations of ministerial budget discussions and virtual proceedings of the National Assembly's debate on the NHI Bill. All interviews and FGDs were audio recorded, and the recordings were transcribed and de-identified to protect the confidentiality of the interviewees.

Data analysis: deductive and inductive reasoning

An iterative approach to analytical coding and interpretation with deductive and inductive reasoning was used to identify key themes (Yin, 2005). We applied deductive reasoning by using the key criteria from the procedural fairness framework and associated domains to understand the fairness of the decision-making process leading to the NHI Act. To analyse and interpret the qualitative data, we compared the experiences and perspectives expressed in the interviews with the procedural fairness standards represented by these criteria. We used the domains as a priori–defined framework to organize the main findings. Finally, within each domain, inductive reasoning was applied to interpret the coded text fragments and identify key themes explaining the challenges and enablers for implementing the fair process criteria (Yin, 2005).

Results

First, we present a descriptive section that defines the sequence of events leading to the enactment of the NHI Act and their temporal relationship. Following this, we analyse the decision-making process using the three domains of procedural fairness—information, voice and oversight—and identify the key factors that influenced each of these domains during the decision-making process.

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Timeline and key events during policy development and political decision-making

The analysis of the decision-making process of the NHI Act of 2021 found that the problem definition and diagnosis had been ongoing for years but gained momentum after the incumbent president's inauguration.

The starting point for our analysis was in 2019, when a steering committee was established by the Minister of MoFEA to draft the NHI Bill, with representatives from the public and private sectors. The drafting team prioritized identifying revenue sources for the scheme, including tobacco and telecommunication levies. These were reflected in a Cabinet paper jointly produced by the MoH and MoFEA, leading to the publication of the NHI Bill by the Ministry of Justice in the Gazette in 2019.

The NHI Bill, 2020 was presented to the National Assembly in December 2020. It was referred to a joint committee of the National Assembly consisting of members from the Health, Public Accounts and Public Enterprise committees. The committee had extensive powers, including summoning stakeholders to provide written position papers and attend in-person hearings. However, a lawmaker emphasized the importance of upholding democratic ideals: 'we want to be democratic and we want to be liberal. We can impose our will but we don't want to do that as far as our committee is concern. We always consult with them'.

The committee invited ministries, departments, agencies, private health insurance companies and CSOs to provide input for the Bill. A lawmaker interviewed recounted: 'we had an engagement, a retreat, where we invited civil society like the union, there were of course the ministries, agencies, departments that are relevant as far as the NHI bill is concerned'. However, the umbrella body of non-governmental organizations (including CSOs), TANGO, was not formally invited to identify stakeholders for the deliberations.

After completing their deliberations, the joint committee presented their report to all members of the National Assembly. The report was adopted, and the NHI Bill was subsequently enacted into an Act in November 2021.

Information: accuracy of information, transparency and reason-giving

A broad evidence base and cross-country learning informed the development of the Bill

All participants involved in the drafting team affirmed that different sources of evidence informed key decisions. The evidence included expert opinions and local evidence such as public expenditure reviews, national health accounts, health financing policy and strategy and the national development plan (Ministry of Finance and Economic Affairs, 2018). Local evidence was emphasized by all participants, including informants from the policy analysis unit of the MoH: 'all these evidence [local] were put together and discussed as a sector with stakeholders that matter in this policy formulation, and we realized this is something that definitely needs to be addressed'.

While the use of international evidence was limited, Ghana's experience with the NHIS implementation was an important source of evidence, and the decision to use tobacco and telecommunication levies for NHIS was first proposed in Ghana during the drafting team's visit.

Mutual exchange and reason-giving were limited to ministries and remained closed to the public

The Bill outlined several revenue sources for the scheme, which were extensively discussed among stakeholders after their return to The Gambia. Our informants reported instances of disagreement, trade-offs and consensus building during these discussions. However, evidence of the deliberations and consensus on contentious issues including internal documents was not accessible to the public.

According to our informants who were privy to Cabinet discussions on the NHI Bill, the MoH and MoFEA jointly proposed tobacco and telecommunication levies as revenue sources for the scheme. On the one hand, MoH had previously advocated for all proceeds from the tobacco tax to be remitted to the health sector since the health consequences arising from tobacco consumption are managed by the health sector. MoH's position was recounted by a senior decision maker: 'so from the side of the MoH, it was a proposal to increase or to tap 100% of the tobacco revenue but this was reversed to 50% and later reversed again'. On the other hand, the MoFEA argued that some proportions of the tobacco levy should be allocated to other sectors. Cabinet ultimately allocated 25 percentage points of all taxes on tobacco products to finance the scheme, and the National Assembly did not contest this proposal during legislative discussion of the Bill.

Initially, the Cabinet rejected the proposal to allocate a share of the taxes levied on telecommunication services to the scheme due to objection from the Ministry of Information and Communication Infrastructure, which argued that the Information, Communication and Technology industry was highly taxed, and any additional tax imposed on the sector would be passed on to consumers. Nevertheless, the National Assembly approved the allocation of 5 percentage points of taxes levied on telecommunication services and 2.5 percentage points of all revenues generated from the gateway monitoring system to finance the scheme.

The executive also proposed that all injury and compensation funds managed by Social Security and Housing Finance Corporation (SSHFC) be allocated to the NHI Fund. SSHFC objected stating that civil servants do not contribute to the fund. After submitting a position paper, an agreement was reached with the National Assembly committee to allocate 30% of the injury compensation fund to the NHIS. A technocrat from the MoH who witnessed the deliberation shared this account: 'when they presented their proposal and they were able to adequately justify it, all the parties agreed to it. So there was a consensus at the end of the day to let go of the pension funds for now and tap into injury compensation funds, and that has been unanimously agreed to by both the National Assembly and MoH'.

While our analysis revealed evidence of mutual exchange, deliberation and consensus building between ministries, lack of access to internal documents prevented further interpretation and assessment of the reason-giving criteria at this stage of the decision-making process.

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Limited public availability of documentation on National Assembly proceedings renders the process suboptimal on transparency and reason-giving towards the public

The NHI Bill underwent scrutiny from different stakeholders, including private health insurance companies. The representative of these companies recounted that 'it was very consultative as far as the private sector participants in the steering committee are concerned'. The approved Act was made publicly available through various channels such as the government's official publication medium, the Gazette, National Printing and Publishing Corporation and National Assembly's website. Although the proceedings of the National Assembly were open to the public and broadcasted live by various media outlets and citizens had the opportunity to contact their representatives for input, there were concerns about transparency due to the lack of publicly available documents regarding the edited versions of the Bill and minutes of stakeholder engagements, making it difficult to understand the reasoning and justification for key choices shaping the NHI Bill.

According to a member of the National Assembly's committee, all the relevant stakeholders were engaged. He recounted 'well I don't think they will stand there and say they were not consulted. Almost, all that came to our mind, unless we have forgotten were invited. Am yet to hear a stakeholder, any stakeholder who is claiming that they have not been consulted'. During a follow-up discussion, the member clarified his earlier assertion that the committee had the powers of a high court, explaining that the committee had chosen not to use their full powers in this case. This decision, he argued, indicated that the committee preferred a collaborative and consultative approach to the legislative process.

A concern, however, was that there was little clarity or documentation regarding how rejected position papers or opinions were managed by the National Assembly committee. This could raise questions about the transparency and fairness of the legislative process as some of our informants do not have a clear understanding of how their input or position papers were considered and evaluated.

Voice: participation and inclusiveness

Mechanisms for stakeholder participation reflected an intent to make the legislative process more inclusive and participatory than was previously common

The importance of involving multiple stakeholders in the policy-making process for the NHI Act was acknowledged by all participants in the study. An informant who was involved in the policy formulation shared her experience: 'I can say it is inclusive because when we include the private sector, and also looking at the involvement of the civil society and other ministries, departments and agencies and the public through the media. At least they have an idea of, what the government is coming up with'.

However, certain civil society representatives contended that some CSOs were invited based on their prior working relationship with the MoH, which they believed raised questions about the transparency and inclusiveness of the process. One of these CSO representatives echoed this concern: 'some CSOs were invited to take part in the discussions but that was on an individual basis based on their working relationship with the MoH. Approaching the civil society as a group is how we operate, we were not part of the process. That is what happened'. In addition, some marginalized groups, such as the Network of Farmers Association, believed that they were unfairly excluded and argued that they could have submitted proposals to improve the equity impact of the scheme had they been given the opportunity to participate: 'It is very important that when you talk about any insurance, health is a cross cutting issue, it does not have a boundary. So as farmer organizations at grass root level, I think we have a very significant role to be part of this process and to be involved, so that we can also advocate, sensitize and involve our farmers in the scheme'.

Invited stakeholders treated as passive recipients of information rather than agents in the deliberative process characterized by mutual respect

Some stakeholders expressed uncertainty about whether their inputs or position papers were incorporated into the final NHI Bill. One interviewee, for instance, stated: 'considering the people that needs it [NHIS] most, also considering the people that live far in the hard-to-reach areas. I think I was very concerned about having those people put onboard and it was noted. But then since I didn't have the opportunity to see the document, the reviewed document and what the inputs [where], the recommendations that were made, whether it was inputted or not like in the final document, I cannot say for sure that it was added, or it is included in the final document [Bill]. Still now, I didn't see the final document [NHI Act]'.

While all participants acknowledged that there were multiple consultations, some argued that they did not facilitate genuine deliberations. Several individuals who participated in these engagements reported that they were treated as passive recipients of information rather than actively being engaged. A hospital administrator who was engaged also expressed this sentiment: 'well I can speak for myself, we were passively, I was passively involved! That was the only interaction. I further went on to read about the document [Bill] at my own private time and have my reservations. And I don't think those at the health facility level or even the regional health directorates were that much involved'.

During the legislative phase, the National Assembly committee enabled stakeholder participation through consultations and written submissions. According to a lawmaker, the process of stakeholder engagement followed the standard government procedure, although the public scrutiny of the NHI Bill was more prolonged than usual. The decision to extend the public engagement period was made to allow all Gambians and institutions to contribute to the Bill. A lawmaker who participated in these discussions recounted: 'after the committee reports to the plenary [all members], the plenary will agree to dissect, let's say, clause 1 states this and this is what the witnesses say. So what do we do? Do we incorporate these ideas from the stakeholders? If the plenary agrees, then that stands out in the bill. So this is how it works at the National Assembly'.

Similar to the assessment of the reason-giving criteria, the absence of documentation regarding the number of submissions and how inputs, including position papers, were evaluated during the finalization of the Bill made it challenging to assess whether the process was genuinely participatory for all stakeholders involved.

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Inclusiveness fell short due to logistical barriers, communication methods and misidentification, leading to dissatisfaction with the process among excluded voices

Some of our participants observed that there was a rural–urban divide in the participatory processes. A representative of a rural-based CSO argued that the National Assembly committee organized a retreat about 100 km away from the city, and only urban participants were transported to the venue. The representative argued that rural-based CSOs were not invited, and communities were given fewer opportunities to provide input through mechanisms like town hall meetings. An urban-based CSO occasionally invited to workshops organized by the MoH reinforced the argument that government officials commonly invite few urban-based CSOs when public policies are formulated. The member further expressed that some officials are more comfortable working with familiar CSOs and opined that rural-based CSOs are hardly invited due to financial implications such as transportation costs or higher transport refunds.

Our findings further showed that some key stakeholders were not invited to participate due to misidentification. While regulatory bodies such as the Gambia Medical and Dental Council and the Nurses and Midwives Council were invited to participate, professional associations representing healthcare workers were not invited. The president of one of these associations expressed surprise at their exclusion and stated that there was no avenue or medium to object, especially when the Bill was already presented in the National Assembly for adoption: 'Personally, I am not aware of the institution I represent being engaged. I just heard it in one of the interviews of the Minister that they are planning on implementing a NHIS. But I was never aware of the processes that were involved until they come up with the policy [NHIS]. Whether the policy document is even existing, I don't know'. An informant from the MoH involved in the stakeholder mapping process observed that there may have been confusion between the roles of professional and regulatory bodies, which resulted in the wrong body being invited to participate.

The Local Government Act of The Gambia empowers local government authorities to provide services to communities. However, one of the local government representatives stated that they were excluded from the policy processes and the finalization of the Bill. The representative argued that local government authorities, who oversee health service delivery in their respective jurisdictions, should have a voice in the design of NHIS, including what revenue sources to consider. He recounted: 'I was not opportune at all, I just heard it [NHIS] from a politician you know in a political platform talking about it. So, I do not know where, at what stage we are. But if at all it has even taken off, I would say that it is not inclusive at all'.

Another CSO excluded from the engagement process expressed that they held a significant role in the deliberations of the NHIS, especially when it came to matters concerning individuals with disabilities. An executive member of the Gambia Federation of the Disabled lamented their exclusion from the process: 'we are advocating for inclusion or full participation of persons with disabilities in decision-making processes, policy-making, programme and planning. But obviously we are not actually being consulted. And you can see that the consultation of persons with disabilities here will be very, very, very important because otherwise, there are issues that affect us. So, it will be a problem to address issues that cover persons with disabilities in terms of national health insurance'.

Another shortcoming of the process was the lack of public engagement organized by the National Assembly despite the availability of funds as recounted by a lawmaker: 'the only element missing is the public engagement but as I said earlier, that is not a serious defect as far as the outcome is concerned'. The main reason given for the lack of public consultation was the busy legislative schedule of the National Assembly. Some CSO representatives expressed that public consultations could have given communities a platform to voice their concerns.

Oversight: revisability and enforcement

Reaping the benefits from new accountability and legal frameworks will require time as The Gambia's democratic transition evolves

Our analysis of governing and accountability frameworks revealed that the Public Finance Act and the National Assembly Standing Orders serve as accountability and legal frameworks. These frameworks ensure that public funds are properly implemented and that public officials are held accountable. A technocrat in the MoFEA acknowledged the effectiveness of these frameworks. With the Bill now passed into law, a lawmaker stated that the MoFEA is expected to remit the different revenue sources outlined in the Act to the scheme. He recounted: 'if it is brought to the National Assembly and the appropriation is made by the National Assembly, it becomes law. Appropriations are law, anything that passes through the National Assembly and there is approval and passed, it becomes law and it is binding'. Another significant legal framework identified during the document review was the Gambia Access to Information Act, 2021. Although it did not affect the NHIS consultative processes, it could enhance transparency and accountability in the future.

Discussion

This study explored The Gambia's decision-making process in establishing a NHIS as a crucial step towards achieving UHC, focusing on procedural fairness. Exploring this process is especially relevant considering the ongoing democratic transition in The Gambia. While more progress is needed, independent monitoring and assessments have reported improvements in press freedom and less interference in the activities of CSOs (Freedom House, 2022). The most recent Open Budget Survey showed a significant improvement in budgeting and fiscal transparency, primarily due to increased public access to budget information and decisions (Open Budget Survey, 2021). To further enhance the public's understanding of fiscal information and decisions, the MoFEA has produced citizens' budgets since 2020. These simplified and accessible public finance documents aim to improve the public's understanding of how resources are allocated (Lizundia, 2020). These general developments represent a significant departure from the bureaucratic-driven approach to policy-making that was prevalent prior to the political changes in 2016, where civil society participation was limited.

Tied to broader governance changes in The Gambia, this study identified that the Executive and National Assembly strived for greater participation and inclusiveness when

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formulating the NHIS policy than what was common in the past. The process allowed some of the stakeholders deemed to have stake in the NHIS design to participate. On the one hand, this marks a significant advancement compared to the period before The Gambia's democratic change, where CSOs were restricted from participating in public policy formulation (Freedom House, 2022). On the other hand, the process was limited to a small group of stakeholders, and it did not incorporate a diverse range of opinions and preferences regarding the scheme's design. Chiefly, our study identified lack of substantial engagement with healthcare providers and communities, including vulnerable groups and those residing in rural areas. The participation of healthcare providers in health policy-making has been a topic of intense debate (Denis and Van Gestel, 2016; Chiu *et al.*, 2021; Hajizadeh *et al.*, 2021). Inclusion of health worker perspectives and their ownership of decisions about provider payment methods are increasingly necessary for making responsive and sustainable health financing decisions towards UHC (Andoh-Adjei *et al.*, 2019; Moosa, 2022).

With respect to including communities and citizens, this study revealed certain shortcomings in the public engagement process concerning the development of the NHI Bill and its subsequent legislative procedures. Two main shortcomings were identified, namely, the lack of adequate time for public engagement, despite the availability of funds, and financial and logistical barriers faced by communities in participating in the review and finalization of the Bill. The National Assembly in The Gambia has introduced a mechanism for public consultations known as 'citizen bantaba', which are platforms that allow citizens to engage in open dialogue, share perspectives and participate in decision-making processes on matters of public interest. This mechanism was not utilized due to legislative overload and limited quorum during the engagement process. Prioritizing such activities could have enabled a larger proportion of the population to provide input on issues related to financing sources, exemption criteria and other aspects affecting equity. Despite the mixed evidence from participatory budgeting on the impact of public participation on pro-poor benefits (Williams *et al.*, 2017; Campbell *et al.*, 2018), it is probable that greater inclusion of marginalized populations could have facilitated greater attention to the equity impacts of the scheme.

Inviting CSOs to public consultations and similar forums may alone not suffice for achieving inclusiveness; it requires engaging communities in their languages and adapting methods for public consultation to suit their needs. Scholarship underscores the inherent value of including diverse views and voices in decision-making, promoting mutual respect and treating individuals as competent agents, while also emphasizing the instrumental value that such inclusion can bring in terms of epistemic benefits to policy-making (Richardson, 2014; Landemore, 2017; Estlund and Landemore, 2018; Abelson *et al.*, 2013). For example, evidence highlights the importance of considering the distinct needs of the disabled population when formulating policies to advance UHC (Abodey *et al.*, 2020; Smith *et al.*, 2021)—a population that expressed a sense of exclusion from the processes in The Gambia. The experience of The Gambia underscores the challenges involved in including rural, low-income or otherwise marginalized populations in policy-making processes. Similar challenges are faced in other settings, such as Thailand's National Health Assembly, where representation of people with lower income or lower educational levels required active outreach by local networks of CSOs (Rajan *et al.*, 2019). In addition, methods for public consultation may need to be adapted with active participation by those who are meant to benefit from these opportunities. In South Africa, locally responsive deliberation about healthcare priorities was achieved by adapting a tool for deliberation about health priorities together with community members and policymakers from rural areas (Tugendhaft *et al.*, 2020).

In situations where inclusive and meaningful participation is not feasible due to time and resource constraints, other criteria for procedural fairness, such as transparency, reason-giving and accuracy of information become even more important. It is essential to document and publicly disclose how inputs and proposals submitted during the legislative process were considered. However, the study's data collection process could not identify any publicly available documentation that substantiates claims of written submissions being duly considered. In contrast, in South Africa, the National Treasury provided point-by-point responses to objections and comments before the Health Promotion levy (tax on sugar-sweetened beverages) was finalized, demonstrating a more transparent approach to procedural fairness (National Treasury, 2017). However, such efforts represent a considerable investment in time and administrative capacity of the government.

The identified shortcomings in the procedural fairness of the NHIS carry the risk of reducing the scheme's legitimacy and trust in its design, ultimately hindering its effective implementation and sustainability. This is because individuals' willingness to pay premiums and health workers' willingness to accept the scheme's provider payment rates are crucial for its implementation and sustainability. Inadequate representation of health workers in NHIS decisions that affect them can result in a lower willingness to accept the scheme, leading to reduced availability and quality of healthcare services for members of the scheme. This can further erode trust and legitimacy, leading to a decline in participation. Although it is too early to tell how the lack of stakeholder representation in The Gambia's NHIS processes will affect its implementation and sustainability, evidence from other countries supports this argument. An example of suboptimal decision-making processes in health financing policy implementation is from Ghana's NHIS. In 2012, a regional pilot for capitated payments for primary healthcare was introduced to control costs and ensure the scheme's sustainability. However, studies have shown that the choice of the pilot region was poorly explained and stakeholders affected by the new policy, such as professional associations and NHIS clients, were not engaged, leading to resistance to the reform and its discontinuation in 2017 (Atuoye *et al.*, 2016; Abiiro *et al.*, 2021; Amporfu and Arthur, 2022). Another example, from the Indian state of Kerala's primary health care reform (Aardram) initiated in 2017, illustrates the benefits of using a consultative approach to implement health reform through a legislative process and pre-existing decentralized participatory structures (Anju *et al.*, 2023; Krishnan *et al.*, 2023; Sankar *et al.*, 2023). Initially spearheaded by a group of health bureaucrats, the process evolved into inclusive deliberations with key stakeholders, notably local governments that are key implementers of the

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reform, which facilitated collective learning and revisions to the original concept of improving primary health centres (Krishnan *et al.*, 2023). Overall, these experiences highlight the importance of transparency, inclusiveness and providing reasons for policy acceptance and implementation in health financing.

Limitations

One of the main limitations of this study was the difficulty in accessing documents such as minutes from Cabinet and National Assembly meetings. These documents would have provided valuable information on how inputs from the public were considered and negotiated during the decision-making process. While interview data provided significant insight, corroborating the findings against official documentation would have strengthened assessments of the criteria for procedural fairness.

Another limitation is the study's recruitment of interviewees primarily among stakeholders who participated in the process, which restricts a comprehensive understanding of inclusiveness. Although efforts were made to recruit participants from rural settings, the concentration of participants from urban areas represents a clear limitation to understanding broader inclusion. Future research should seek to address this limitation by expanding recruitment efforts to include a broader range of participants from diverse backgrounds and locations.

Conclusion

It is crucial to prioritize procedural fairness criteria in health policy-making to foster ownership, equity and sustainability. The study identified several shortcomings in the NHIS decision-making process in The Gambia, which risks reducing the scheme's legitimacy and trust in its design and ultimately hinder implementation and sustainability. However, these observations should be interpreted in the context of Gambia's ongoing democratic transition. The institutional improvements required to meet the various criteria for procedural fairness can be expected to strengthen over time. Lessons from our study can inform future decision-making processes shaping the NHIS in The Gambia.

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Supplementary data

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

Data availability

Dataset used and/or analyzed in this study are available from the corresponding author on reasonable request. Please edit and align with the journal's outline.

Author contributions

H.N., E.D. and U.G. contributed to conception and design of the work, critical revision of the article and final approval of the manuscript. H.N. contributed to data collection. H.N. and U.G. contributed to data analysis and interpretation and drafting the article.

Reflexivity statement

The lead author (H.N.) is a health financing specialist from a low-income country where the health policy question was studied; this ensured that interpretation of findings from document review and interview data was led by an investigator with in-depth understanding of the country's context and social and political conditions. He has worked in the MoH and is currently a PhD student at the University of Oslo. His closeness to the decision-making process analyses necessitated the involvement of a bigger research team where the analysis could benefit from outsider views with relevant expertise on the subject matter. The second author (E.D.) is a female health financing specialist from a lower-middle income country, who currently with the third author (U.G.) is leading work on defining key principles and criteria for procedural fairness in health financing, which have been applied to this country case study. The balanced composition of the research team in terms of regional representation, relevant expertise and gender facilitated a balanced interpretation of the data, which involved seeking alternative explanations.

Ethical approval. Ethical approval for this study, conducted as part of a larger PhD project, was received from the Gambia Government/ Medical Research Council Gambia joint ethics committee (R018026v4.1).

Conflict of interest. None declared

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