Difficult trade-offs in response to COVID-19: the case for open and inclusive decision-making

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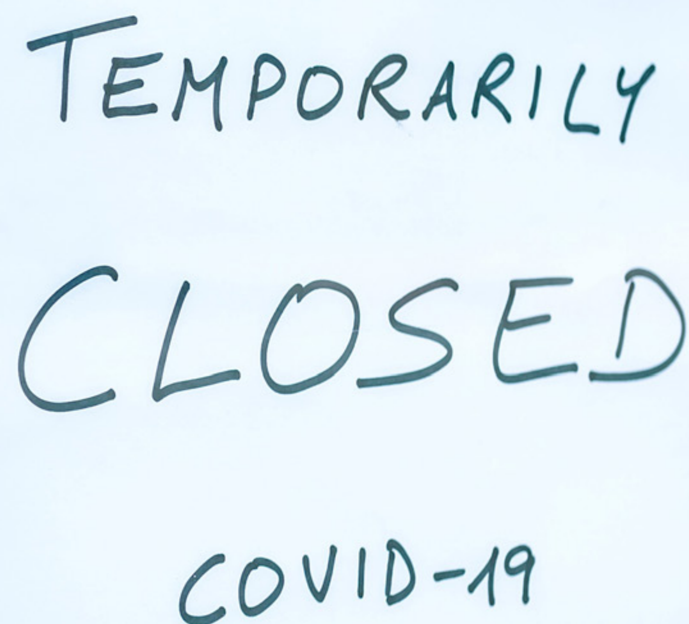

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Introduction

The COVID-19 pandemic has forced governments to make difficult choices that profoundly affect their populations' health, wealth and liberties. In order to address the public health and economic emergencies generated by the pandemic, these high-stakes decisions have often been made quickly, with little involvement of stakeholders in deliberations about which policies to pursue. Even in emergencies, however, there are important practical, moral and legal reasons for open, inclusive decision-making. This improves the quality of decisions, increases their legitimacy, engenders trust and generates greater conformity with public health and social measures. Such deliberations also show respect for people's ability to offer, assess and act on reasons and are required by the principles of human rights and rule of law. When hard policy choices and trade-offs are required regularly, the processes must be institutionalized, so that broad-based, transparent decision-making becomes a routine, central feature of governance. We characterize such decision-making, argue the case for it and offer examples of how to put it into practice.

What is at stake

Despite considerable uncertainty about the health impacts of SARS-CoV-2, the scientific consensus is that the burden on health of its uncontrolled spread would be substantial *(1)*. In the absence of policies to slow its spread, it is likely that more than 50% of the population of each country would be infected *(2)*. Estimates of the infection fatality rate depend on each country's characteristics, including demography, but are 0.23–1.15% *(3)*, suggesting that the direct effect of uncontrolled spread of COVID-19 would be the deaths of at least 0.1–0.6% of affected countries' population, concentrated among the elderly, and among vulnerable, socio-economically disadvantaged and marginalized groups *(4–6)*. Moreover, for many people, non-fatal infections may result in significant health effects (so-called "long COVID"), and the burden of caring for patients with COVID-19 could overwhelm health systems.

To limit COVID-19-related morbidity and mortality, many governments have expanded the capacity of their health care systems and invested in the development and provision of treatments and vaccines. They have also turned to a range of public health and social measures, including:

- public health messaging (such as advice on how to prevent acquiring and transmitting SARS-CoV-2), sometimes accompanied by efforts to counter misinformation and contrary opinions;
- personal protective measures (such as hand-washing and mask-wearing);
- environmental measures (such as cleaning, use of screens and ventilation);
- surveillance and response measures (including testing, contact-tracing, mandating isolation of those with the disease, those exposed and travellers from high-risk areas); and
- physical distancing measures, from requiring space in workplaces and shops to imposing limits on all non-essential social contact, often referred to as "lockdowns".

In accordance with our brief, we focus on such measures. Even if new vaccines are approved, full vaccine coverage will take time, and public health and social measures will be necessary for the foreseeable future. Each measure can be applied to different degrees. The stringency of a lockdown can vary in several dimensions:

- **severity:** the degree and extent of contact limitation, from a requirement to stay at home except for work, education or shopping for essentials to a complete ban on leaving home;
- **selectivity:** who is subject to the limitations, from people living in areas with a high prevalence to the whole country and from particular social groups, such as older or extremely vulnerable people, to the entire population;
- **start date:** the extent of spread of the virus in a given population at the time the lockdown is imposed;
- **duration:** how long the restrictions are imposed;
- **aim:** to control the spread of the virus so that the prevalence is kept at a level that the health system can manage, or to suppress it completely so that it is almost fully eliminated; and
- **enforcement:** the effectiveness with which restrictions are enforced, through state power and social norms.

Such policies have complex effects. Modelling suggests and country experience demonstrates that, if these public health and social measures are deployed effectively and early enough in the pandemic, they can very effectively limit the spread of the virus and thereby greatly attenuate its direct impacts on health *(7–10)*. Many of these measures, however, also have substantial costs. Environmental measures to reduce infectiousness are burdensome. Mandatory isolation is a substantial limitation on freedom of movement and association, and contact-tracing infringes on people's privacy and generates concern about concentrating personal data in government agencies and large technology companies *(11)*. Lockdowns also severely limit people's freedom of movement and association, as well as their freedom to protest. They also have substantial short-term economic costs. Countries that imposed stringent lockdowns had sharper falls in gross domestic product per capita in the first half of 2020 compared to pre-pandemic projections, and the effect persists after correction for the severity of the pandemic in each country *(12)*. The scale of economic contraction in countries that have had stringent lockdowns varies but is substantial: from about 4% of gross domestic product in Ireland to 16% in India and more than 20% in Peru *(12)*. In high-income countries, more than half of the fall might have been due to the stringency of the lockdowns *(8,9)*. Moreover, stringent lockdowns also dissuade people from seeking the health care and preventive interventions they need and have exacerbated mental health problems, the risk of suicide, domestic violence, addiction and loneliness *(13)*. They have also affected child care, education and therefore the ability of parents to work.

People who are socio-economically worse off or otherwise marginalized have most at stake. Those who are much poorer than others are at higher risk of becoming infected because of their poor working and living conditions *(14)*. They also disproportionately suffer the negative effects of a lockdown, unless it is accompanied by targeted economic support. For example, people who rely on the informal economy (including disproportionate numbers of poor and marginalized groups, such as indigenous peoples *(15)*, migrant and undocumented workers, internally displaced people and refugees) often live in dire, crowded conditions, are badly affected by restrictions on economic activity and movement and often have less access to social safety nets or health care *(16)*. For these groups, stringent lockdowns and the associated economic downturn may impose severe, possibly life-threatening limitations on their access to basic necessities *(17,18)*. Other effects are also concentrated in disadvantaged groups. When lockdowns limit access to child care, they affect women's access to work *(12)*. When they limit in-person education, they delay learning, and this appears to be concentrated among the poorest groups *(19)*.

The policy space that countries have to address health and economic crises varies. Well-off countries with well-functioning governments and high borrowing capacity have a wider spectrum of possible policy interventions than less wealthy countries and countries with diminished State capacity. Emerging economies and middle-income countries that depend heavily on exports, foreign remittances, tourism or capital inflows will be the hardest hit by a global economic downturn and may find that their borrowing capacity (and hence their capacity to offset the economic impact of lockdowns) is constrained *(20)*. In addition, some poor and developing countries were already experiencing crises, including war, economic crisis and/or a breakdown in governance *(21)*.

All countries therefore face a difficult task in balancing the uncertain and unequal impacts of public health and social measures on health, income, liberty, education and other goods. In making such decisions, there is reason to believe that the degree of trust in government and consensus on public measures substantially influence which policies are feasible and the balance of benefits and burdens of those policies. Lockdowns and their public health and social measures are probably less costly if they are implemented before the virus has spread widely (see, e.g. *22*). Early action, before the effects of the virus on health are evident, requires confidence of the population in the state. Willingness to adhere to policies when there is a lot at stake for individuals and information about the threat is

both uncertain and complex requires trust in those who make decisions. If there is trust, adherence is likely to be more widespread, as people will more often be voluntarily motivated to act in accordance with the policies. Policies are more effective when compliance is greater, and, as noted above, compliance may depend on the extent to which the public trusts the government's effectiveness and its handling of personal data and it has the assurance that other members of the public are complying.

Although it is clear that lockdowns have substantial, identified, immediate economic and social effects, those saved by lockdowns are less well identified, and the potential economic benefits of reduced transmission are far in the future and less certain. The health gains are also insecure, unless the lockdown can be sustained until the virus is adequately suppressed. Lockdown policies are therefore a "bargain" into which the public can be expected to enter only if they have sufficient confidence that they will be effective.

Public agreement to measures that restrict people's liberty crucially determines the severity of the burdens imposed by those restrictions. While lockdowns and associated measures limit freedom, they are imposed for a purpose long recognized by defenders of individual rights: the prevention of harm to others, in this case by preventing transmission of a dangerous virus *(23)*. Although such restrictions may infringe on individuals' rights to free movement, association, public protest and religious worship, when deliberation leads to widespread acceptance, there will be fewer challenges to measures that restrict liberty. Moreover, restrictions are less invasive of the autonomy of those who accept them, as they can still live by principles they accept. Acceptance will increase voluntary adherence and thus limit the need for coercive measures. In line with this reasoning, research suggests that confidence in state institutions is an important factor in reducing the health burden of COVID-19 *(14)*.

In this article, we argue that transparent, inclusive decision-making contributes to public confidence and policy adherence. We present the broader normative case for giving a say to all those whose health, wealth and liberties are at stake, which, in a pandemic, is all of a country's inhabitants.

Participation as a human right

Transparent, inclusive, accountable decision-making is required by the principles of human rights and of the rule of law to which most countries are committed through their participation in international treaties and the provisions of their domestic laws, including constitutions. The right to participate directly and indirectly in political and public life is recognized for example in the Universal Declaration of Human Rights (Art. 21) *(24)* and the International Covenant on Civil and Political Rights (Art. 25) *(25)*, which has been ratified by 173 states:

> **Article 25: Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions:**
> **(a) To take part in the conduct of public affairs, directly or through freely chosen representatives; ….**

As the United Nations Human Rights Committee stated, "Article 25 lies at the core of democratic government based on the consent of the people and in conformity with the principles of the Covenant" (General Comment No. 25, para 1). The Committee has also made clear (para 8) *(26)* that

> **[c]itizens also take part in the conduct of public affairs by exerting influence through public debate and dialogue with their representatives or through their capacity to organize themselves. This participation is supported by ensuring freedom of expression, assembly and association.**

In September 2016, the United Nations Human Rights Council, concerned that many people continued to face obstacles to the enjoyment of their right to participate in the public affairs of their countries, requested the Office of the High Commissioner of Human Rights to prepare guidelines for States on effective implementation of Article 25 (A/HRC/RES/33/22, 6 October 2016). The guidelines presented 2 years later (A/HRC/RES/39/11, 5 October 2018) are grounded on the following general principle:

> **Participation makes decision-making more informed and sustainable, and public institutions more effective, accountable and transparent. This in turn enhances the legitimacy of States' decisions and their ownership by all members of society *(27)*.**

Several clarifications and recommendations of the guidelines are directly relevant to the current health crisis and the arguments we put forward in this paper. The guidance emphasizes, for instance, that Article 25 is not limited to so-called "electoral rights", i.e. rights to participate in periodic, free, fair elections as a voter or a candidate. It also addresses direct and indirect participation in non-electoral contexts, covering, broadly, all aspects of public administration and the formulation and implementation of policy at international, national, regional and local levels (para 49). The instruments for such participation include referenda, popular assemblies, consultative bodies, public hearings, as well as free public debate and dialogue (para 50). Moreover, participation should be enabled at all stages of decision-making, before, during and after a decision is made (e.g. agenda-setting, drafting, decision-making, implementation, monitoring and reformulation, para 53).

The current health crisis has exposed the insufficient, fragile status of the right to participation across the globe, including in better-established, democratic regimes. This is a particular concern in the light of what is at stake. As discussed above, the arsenal of measures available to governments to respond to pandemics includes tools that could infringe on fundamental rights such as freedom of movement, freedom of assembly and the right to protest, in particular when a state of emergency is declared, which gives the government powers that it does not have during normal times. In this context, the

right to participation recognized in Article 25 of the International Covenant on Civil and Political Rights becomes even more important, as it enables an additional layer of popular accountability, which can enhance the legitimacy of measures and, by increasing acceptance of the measures, the effectiveness of countries' responses to the health crisis.

Elements of open and inclusive decision-making

While acceptance of policies can improve adherence, the complexity of the issues makes it difficult for individuals to reach a comprehensive conclusion about whether a policy is acceptable. For this reason, trust in authorities – understood as "a person's belief that another person or institution will act consistently with their expectations of positive behaviour" *(28)* – is often necessary for acceptance. Trust in governing authorities can result in adherence to directives in the belief that the authorities are acting in the interests of the people *(29)*. Trust enables and motivates cooperation, and thus policies are implemented with fewer protests. In this sense, trust can forestall the use of force to ensure compliance.

Trust is not irrational and is not automatic in new circumstances; it must be earned *(30)*. A major challenge for authorities is to be and to present themselves as trustworthy when making difficult choices in a pandemic. To provide reasons to be trusted, they should make themselves accountable to the public. By describing how they manage evidence and uncertainty and just distribution of burdens and benefits and by ensuring that policies are decided after dialogue with the people who are affected and are open to challenge and revision, members of society are given opportunities to influence and assess the authorities' choices. Authorities thus allow people to place justified, and not blind, trust in their governance strategies.

The case for fair processes

In order for people to accept burdensome policies and to adhere to them willingly, the policies must be perceived as fair. The fairness of a decision can be assessed substantively, in terms of its impacts on people's lives and freedom, and/or procedurally, in terms of how the decision was made *(31)*. The assumption behind procedural justice is that, even in the face of widespread disagreement about the just distribution of burdens and benefits, the affected parties can sometimes be expected to reach agreement on the conditions that must be in place to make decision-making fair *(32–34)*. Procedural fairness allows people to consider a policy fair even though they would have preferred another policy or are unable to reach a conclusion on the substantive fairness of the policy. This general framework is broadly supported by political philosophy and empirical research on procedural fairness *(31–37)* and recognized and enforced by human rights law (see previous section). The key arguments for transparent, inclusive decision-making are listed in the box.

From the perspective of political philosophy, procedural fairness requires that decisions that affect people's interests are taken: (a) on the basis of evidence; (b) with equal consideration of everyone's interests and of their legitimate perspectives; (c) on the basis of reasons that people can share, that is, recognize as relevant from their differing views of a good life and substantive fairness; (d) in an open, accessible manner; and (e) through institutional means that permit challenge and revision of decisions. Such procedures promote inclusion, require openness and make the decision-makers accountable, all of which contribute to the perceived legitimacy of and trust in the decision-makers and to adherence to the policies *(38)*. Evidence from empirical research on fairness shows that people's assessments of the fairness of a legal decision are also influenced by how the decision was made *(35)*. Fair procedures are the aspect that determines the legitimacy of authorities and, with that, people's willingness to defer to their decisions *(36)*.

This approach might be seen as placing demanding requirements on the capacity of the participants

in the deliberation to reason and to propose impartial reasons for and against policies. This could therefore exclude the voices of those who do not always express their concerns in such terms. Such "silencing" must be avoided to ensure that a broad range of perspectives is heard on contested policies, while at the same time finding ways to filter out partial suggestions and to give equal consideration to the expressed interests of all *(39)*. In particular, people who express aggressive resistance to policies for reducing exposure to the virus or lack of fair-mindedness in finding solutions should be invited to contribute their perspectives to collective deliberation *(39)*. Their concerns must be addressed respectfully, and, if it is found that they cannot be accommodated, the people involved should be given an accessible justification of why their views cannot be determinant in the content of the public health and social measures. In a pandemic, the equality of concerns is crucial. Perceived unfairness of exclusion of a person's critical perspectives can lead to lack of adherence and undermine the effectiveness of public health and social measures.

Seminal socio-legal work on procedural fairness describes the elements of decision-making and procedural components and rules that may be relevant for perceived fairness *(40)*. Some of those rules are as follows.

Consistency requires that allocative procedures are uniform among people and over time and that the distributions of harms and benefits are assessed according to the same standard for all.

Bias suppression requires abstinence from exclusive promotion of self-interest and giving up ideological preconceptions. This is important for how broadly participants are invited and how their views are listened to and addressed.

Accuracy demands that decisions be based on the best available evidence and informed opinion. Of course, robust evidence on any harmful consequences of proposed policies may not be available when decisions are made. Open communication of what is not known thus becomes essential for accurate presentation of conclusions *(41)*.

Correctability indicates that it must always be possible to revise a decision in the light of emerging reasons. This is particularly important in an emergency or crisis, when decisions are based on uncertain, evolving evidence. A policy might therefore cause unforeseen harm, and new reasons for adjusting policies might be proposed by those affected.

Representativeness requires that the concerns, values and perspectives of all groups in society are presented. In a pandemic, especially when drastic measures are necessary, it is essential to include the voices of the people who would be adversely affected by a potential policy. Moreover, inclusion of representatives of subgroups by allowing them equal opportunities to have a say on decisions manifests actual power-sharing and democratic influence and thus mitigates power imbalances *(42)*.

We would also add that **transparency and accessibility**, including for those who were not directly involved in a decision, are crucial for perceived fairness. These attributes broaden the reach of the process and thus enhance the effects of the rules on accuracy, correctability and representativeness.

The relevance of these procedural principles depends on the circumstances *(40)*. For policy-making in a pandemic, however, when extraordinary measures are called for and the stakes are high, these principles are important to protect rights and ensure respect. By promoting respect for everyone's perspective, the procedures foster and protect self-esteem and empowerment in a crisis.

In principle, all members of the public are affected by policies that will profoundly shape their health and living conditions and should therefore have the opportunity to have an input. This ideal is realized by making all relevant information publicly accessible for scrutiny and criticism, with established channels for appeals.

The role of experts

Given the importance of using evidence in fair process, we look closely into the role of scientific experts in deciding on public health and social measures. The involvement of experts is core to any fair process for public decision-making, because the public has the right to decisions that are as well-informed as possible. Ideally, research facilitates policy-making by providing well-confirmed models or generalizations that indicate the possible consequences of different scenarios that are relevant to local decision-makers *(43,44)*. Trustworthy decision-making thus involves experts and builds on the evidence they provide as far as possible. It is, however, difficult to ensure that the manner in which experts interact with the public is consistent with the democratic and participatory principles that this report seeks to advance *(45)*, and the principles that should guide such interactions should be formulated.

Generally, we agree with and generalize the claim by Gurdasani et al. *(46)* that

> **governments [...] ought to conduct regular briefing and be open, honest, and transparent about where we are. [They] must admit to and learn from mistakes, not overstate [their] capabilities and achievements, and must treat the public as equal partners, working with communities to develop effective health promotion strategies.**

For achievement of this ideal, we highlight three high-level principles to guide governments and expert bodies. Experts should communicate in a way that is (i) transparent with regard to empirical uncertainties, (ii) transparent with regard to values and (iii) receptive to public feedback.

It is inevitable that action must sometimes be taken before scientific enquiry allows anything like certainty *(47)*. This is true especially in this pandemic, with uncertainty about the values of key parameters, about relevant causal mechanisms and about how people will respond to novel events. In order to reason about these uncertainties sensibly, the public should be made aware of where the uncertainties arise and how they may be dealt with *(48)*. The way in which uncertainties are represented can make a huge difference to what kinds of decisions can be supported rationally *(49–51)*. Further, the public is highly sensitive to expressions of disagreement or uncertainty by scientists *(52,53)*. If people are not appropriately informed about what uncertainties mean, they will be open to manipulation by well-resourced groups acting in bad faith *(52,53)*. More generally, in order to combat the "infodemic" of misinformation spreading on social media, which is interfering with rational attempts to address COVID-19, transparent, frank dialogue should be maintained among scientists, policy-makers and the broader public *(54)*.

In order to justify a particular approach to addressing uncertainties, scientists must often appeal to ethical or political values in deciding which risks are worth taking more seriously than others *(55)*. Such value-laden decisions affect not only what scientists consider to be true but how they communicate their uncertainties and the measures they used to weigh and assess the outcomes of interest. Science communication should hence prioritize communication of the nature of the value-laden decisions that scientists must make, including what the stakes are and how the legitimate interests of different parties are assessed and weighed.

People who communicate science should ensure that scientists are appropriately receptive to public feedback, including challenges to their knowledge. They should therefore themselves understand that public input into research can be legitimate and important, and they should be receptive to bidirectional communication between the public and scientific experts.

In considering how these principles for science communication can be put into practice, policy-makers can draw on a wealth of examples. For instance, "mini" public exercises have been conducted in which experts are called as "witnesses" by deliberative panels of citizens and asked to explain points such as "What we are uncertain about and why", "Whose interests are at stake", followed by questioning and scrutiny by representatives of the public *(56)*. Work is under way to update these models with respect to COVID-19 *(57)*.

Challenges for vulnerable countries

Difficulty in meeting the conditions for fair processes discussed above differs by country. Some experiences have been positive. Countries that have managed to mitigate the socioeconomic impacts of the pandemic include both those with authoritarian regimes and democracies and both low- and high-income countries. Many countries with weak, untrustworthy institutions, scarce health care resources and budgets, and limited fiscal space will be unable or unwilling to meet all the requirements of fair processes and fair conditions, some because of structural constraints (e.g. weak institutions or limited fiscal capacity) and others because they are unwilling to engage with all the parties affected.

A particular set of challenges stems from inequality. There is preliminary evidence that countries with greater income inequality tend to have higher numbers of deaths from COVID-19, partly because the poorest have high risks of infection and limited access to treatment and partly because high inequality reduces trust in government institutions *(14)*. South Africa, which is the country with the most inequality in the world, has the highest mortality rate on the African continent and twice the world average number of deaths per million. Brazil, the Russian Federation and the USA, where there are wide gaps between the rich and the poor, have also experienced high number of deaths from the virus. A deadly surge of cases is being experienced in Lebanon *(21,58)*, the most unequal country in the Arab world (Gini index 50.7), and its population is facing a concatenation of crises – socioeconomic, banking, financial, political, humanitarian, environmental and sanitary – with more than half of its population now poor. Other challenges face Latin America, which has some of the highest rates of mortality due to COVID-19. Peru is among the hardest hit countries *(59)*. While the Peruvian Government's initial response appeared to be exemplary (a swift, strict lockdown and a generous economic package), the pandemic exposed the fragility of an emerging state with weak and untrustworthy institutions, a weak, deeply unequal health care system, a high level of corruption and a large informal sector. Hence, generally, the more equal (albeit poor) a society is, the more likely are fair processes; conversely, the more unequal a society is, the more challenging it will be to meet the conditions of fair process.

Lack of trust in governments and institutions in these contexts is a major obstacle to compliance with public health and social measures *(28)* and also to finding common ground among all affected parties. Nonetheless, these countries could improve decision-making processes under COVID-19. At a minimum, civil society and nongovernmental organizations could mobilize and join efforts to make sure that their governments:

- intervene early in a cooperative, transparent manner that includes all private and public stakeholders and especially local communities;
- communicate clearly, frequently and consistently with the public both online and through traditional channels of communication. Because of widespread mistrust in official sources, authorities could enlist the help of civil society organizations, village councils and religious and traditional leaders to disseminate information and engage with communities in finding workable strategies *(18)*;
- make health-related data openly available, and consult experts as widely as possible in an open, transparent way, both for countering disinformation and to help all affected parties in making evidence-based decisions;

- ensure that grants and funds received from international organizations are well spent and allocated to social and health sectors. The International Monetary Fund has approved debt service relief via grants to the 29 poorest countries and has provided lines of credit (US$ 100 billion) to 81 countries *(60–62)*. While this support is vital, the decisions were taken in an unprecedented expeditious manner, with few checks and balances to ensure compliance with the terms of the loans and the commitments of countries to reallocate the funds appropriately to crisis mitigation. The Fund has stated its intent to monitor emergency lending, but it has yet to publish or share the detailed mechanism for each country that has voiced its "intent" to reallocate funds to COVID-19 *(63)*. Given the significant increase in lending to poor countries, the organizations involved do not have the capacity to monitor the conditions of their loans as carefully as in the past. Moreover, as called for in the Paris Declaration on Aid Effectiveness (2005) and the Accra Declaration for Action (2008), the participation of local nongovernmental and civil society organizations is essential in pressuring governments to spend the funds appropriately, hence enhancing their effectiveness *(64)*; and

- try to regain public trust and confidence by ensuring open, inclusive, and transparent decision-making. While it is true that in Kerala, a poor but equal Indian state, trust in local authorities was a prerequisite for the implementation of pro-active public health and social measures, the transparent, comprehensive strategy that was successfully implemented also helped reinforce that pre-existing public trust to the extent that state actions were complemented by voluntary actions by the people: wealthy families donated their homes for quarantine and isolation, village councils monitored cases locally, and students volunteered to set up COVID-test kiosks in their neighbourhoods *(65)*.

Experiences of participatory processes in the context of COVID-19

After decades of lobbying by patient groups and civil society organizations, a growing number of countries have institutionalized systems for more open, inclusive decision-making, including for health. In many countries, this has been developed within the Open Government Partnership *(66)*. With few exceptions, however, these systems have been side-lined during the COVID-19 pandemic, leading to poorer decisions and preventable deaths *(67,68)*. Notable exceptions are the Republic of Korea and Taiwan (China), where inclusive decision-making has been seen as central to their successful responses to the pandemic.

Several countries with a history of inclusive health governance and systems appear to have benefitted from those systems to some extent in the early stages of the pandemic, although they were not used to their full capacity. Successful COVID-19 responses have been ascribed partly to a reservoir of trust in the public health system and in authorities and to effective communication strategies and social support mechanisms that ensured compliance. These have been linked to previous practices of stakeholder participation and health democracy and to unified, robust public health systems. As the strains of the pandemic increase, trust is wearing thin in most countries, and decision-making systems must urgently be revitalized and made inclusive.

Experimentation with inclusive, deliberative decision-making provides useful guidance on making the process more inclusive, transparent and accountable in the context of the COVID-19 pandemic *(68,70)*. Many participatory mechanisms have been introduced throughout the world in recent years to improve the quality and legitimacy of public decision-making, including in health. A catalogue, including initiatives taken in relation to COVID-19, can be found at https://participedia.net/. Studies have shown that when such initiatives were carefully set up and implemented, they were useful and robust, indicating that they could be promising for the type of decision-making required in response to COVID-19, involving value-based questions and complex trade-offs *(71)*.

As discussed above, four groups of actors must be included in decisions: scientists and experts in relevant fields; stakeholders who can express the concerns of affected groups (such as patient associations, trade unions, cooperatives and student organizations); members of the public more broadly and especially members of groups that are likely to be missed by stakeholder associations; and the politicians responsible for making the decisions.

Some deliberative processes, such as certain large assemblies of citizens, can and have included all four types of actor; however, most participatory mechanisms centre on one or two groups. For complex decisions that must be taken quickly and revised regularly, complementary processes and mechanisms may have to be coordinated. From a pragmatic point of view, it is thus important to identify the existing participatory mechanisms that contribute to COVID-19-related decision-making and to consider how they can best be integrated, not least in ensuring that public and stakeholder deliberations are informed by and inform scientific expertise. The elements that can and increasingly do form part of such systems include the following.

(i) **Inclusive deliberative bodies** set up to include relevant voices and provide well-considered advice, "mini-publics", may consist only of randomly selected members of the public or also include experts, stakeholders and/or politicians. Even when they are not members, experts and

organized stakeholders are usually brought in to provide evidence and answer questions. Some of these deliberative forums are large, ad-hoc citizens' assemblies, while others are permanent public panels set up to address new issues as they arise, and others are advisory councils with expertise in a particular area. Such bodies, when properly constituted, can be particularly useful for reaching trustworthy, legitimate decisions on difficult ethical questions and complex trade-offs. A great advantage of these bodies, besides the deliberative process, which allows views to be shaped and reshaped in the light of evidence and arguments, is that they are often broadly representative of the population and ensure inclusion of particularly affected groups. Deliberative forums have always been held face-to-face, over several days, but are increasingly conducted online, often at shorter intervals. While certain groups may face practical challenges of technical access, online communication is relatively easy to facilitate for limited, selected bodies. Examples of deliberative bodies that have been set up and used in the context of the pandemic include: the COVID-19 Culturally and Linguistically Diverse Community Forums *(72)* and a Deliberative Consultation on Trade-offs Related to Using "COVIDSafe" Contact Tracing Technology *(73)* in Australia, the Oregon Citizens' Assembly on COVID-19 recovery in the USA *(74)* and planning recovery in the West Midlands by a citizens' panel in England *(75)*. The last is a good example of coordination among different mechanisms. It was formed to represent a cross-section of the public by the West Midlands Recovery Co-ordination Group (which itself is a collaboration among local authorities, emergency services and local enterprise partnerships) to complement the Economic Impact Group, which consists of business leaders, central Government, banks, trade unions and local authorities.

(ii) **Hearings** are institutionalized in many countries to gain insights from experts and stakeholders on draft legislation and policy. Their advantages, particularly when they are mandated in laws and regulations, are that they are closely linked to formal decision-making and can inform and spur public debate and confer legitimacy on decisions for interested stakeholders. Most importantly, they can increase the knowledge base and enhance the quality of deliberations by governments and legislatures by broadening the points of view and interests considered. Hearings do not, however, have an inclusive, deliberated output, as the participants in hearings do not jointly deliberate difficult ethical issues or trade-offs. As submissions are usually public, participants often engage with the considered views of adversaries. Most institutionalized hearings are not open to the general public. Mandated consultations with indigenous peoples, set up to protect their autonomy and rights, could be extended to COVID-19-related decisions, as indigenous groups are particularly vulnerable *(76–78)*. Hearings related to the pandemic have been conducted in Norway on the "Corona-law" and changes in the regulation; however, although mandated in law, it was enacted only after lobbying by civil society groups, academics and the National Human Rights Institution *(79)*. In the USA, where hearings are optional, the National Academies of Sciences Engineering and Medicine provided opportunities for public comment on a draft of a Preliminary Framework for Equitable Allocation of COVID-19 Vaccine *(80)*.

Most of the public participation and inclusive decision-making initiatives that have emerged in the pandemic, belong, however to the third type of element.

(iii) **Open, self-selective public participation mechanisms.** Such mechanisms are set up by national or subnational governments or by civil society to ensure that, in principle, everyone can make their voice heard. They take a variety of forms, including deliberative "town halls" and village or municipal meetings, which may be face-to-face or, increasingly, online in the form of "virtual democracy platforms", radio and television call-in shows, calls for petitions and crowd-sourcing of legal provisions, guidelines and policies through "Wikipedia-style" drafting and editing. Mechanisms are often set up to collect the participatory input and make it available to decision-makers, and efforts are made to determine how the input is taken

into account in decision-making. A common criticism of these mechanisms is that they are used de facto more often by those with the most resources and do not usually ensure that the views of the most vulnerable are enabled or represented *(69,81)*. Online platforms are crucial in facilitating such mechanisms, not least during the pandemic, but, unlike organized "mini-publics", for which variable access to the Internet and technology can be compensated, access is a greater barrier to open participation. Mechanisms for public engagement related to COVID are many and diverse (for more examples, see https://participedia.net/collection/6501). In Scotland, a national crowd-sourcing exercise was undertaken to create a framework for decision-making in the context of COVID-19, in which the Government "sought public input on the on approaches and principles that would guide decision making related to transitioning out of the coronavirus (COVID-19) lockdown arrangements" *(82)*. In Brazil, the federal health system has set up an extensive mechanism for transparency and public engagement in COVID-19 *(83)*; Senegal has established several citizen initiatives *(84,85)*; and civil society in Lebanon has set up the Independent Committee for the Elimination of COVID-19 *(86)*. In the United Kingdom, the Government expert body, SAGE *(87)*, has a civil society counterpart in Independent SAGE (88). In the USA, deliberative town halls on COVID-19 are set up by Connecting to Congress *(89)*, and academics offer an ambitious transnational resource for public engagement, Endcoronavirus.org *(90)*.

A participatory system of government for answering complex questions will usually consist of a combination of mechanisms to involve different groups for different purposes. To serve their purpose and build public trust, they should be institutionalized rather than ad hoc, thus making inclusive, transparent, accountable decision-making a routine feature of governance, beyond the pandemic, as part of efforts to build back better.

Concluding remarks

Deliberative decision-making that is inclusive, transparent and accountable gives everyone a say in decisions that may profoundly affect them. It respects people's ability to offer, assess and act on reasons and is required by the principles of human rights and the rule of law. Crucially, evidence even before COVID-19 showed that this kind of decision-making can contribute to more trustworthy, more legitimate decisions on difficult ethical questions and challenging trade-offs. Institutionalising and broadening deliberative processes should therefore be a priority in the pandemic response. In the short term, it can build legitimacy and support for the difficult decisions that must be made in response to the pandemic and prevent further erosion of trust. In the long term, it can contribute to virtuous cycles of trust-building and more effective policies.

Box. Open, inclusive decision-making under COVID-19

A. SUPPORTING REASONS

Political equality and human rights

- Inclusive decision-making ensures that governments act according to the rights of political participation enshrined in national and international law, in particular human rights law and the principles of accountable government.
- Broad-based, transparent decision-making fulfils the ideal of procedural fairness, which requires that decisions that affect peoples' interests be taken: on the basis of evidence; with equal consideration of everyone's interests and perspectives; on the basis of reasons that people can share; in an open, accessible manner; and through institutional means that permit challenge and revision of decisions.
- Inclusive decision-making rests on the democratic ideal that all people should have a fair opportunity to participate in decisions that affect them.
- Inclusion of all those affected promotes self-esteem and mutual respect.
- Transparency allows the public to form informed opinions.
- When decisions are based on reasons that can be appreciated by all, such as the importance of protecting health and limiting economic impact, all participants are considered capable of understanding and acting on those common reasons.
- Procedurally fair decision-making processes contribute to trust in decision-makers and to the legitimacy of the decisions.
- Inclusive decision-making may lessen social disagreement, because, even in the face of polarized opinions about what to do, it may nonetheless be possible to achieve agreement on fair procedures for arriving at policy decisions. Policies resulting from fair procedures may then be accepted even by those who disagree with them on substantive grounds.
- Restrictions on freedom are more readily accepted if they are the outcome of a fair process. Acceptance reduces the burden of restrictions and renders them more consistent with autonomy.

Effective communication

- Policy decisions are better targeted and more effective if they are informed by accurate descriptions of the circumstances and evidence of what works.
- Critical scrutiny of evidence and uncertainty can improve decisions.
- Communication of clear rationales and uncertainty engenders trust.
- Transparent, publicly accessible evidence prevents disinformation and builds trust.

Trust and adherence

- Open, inclusive decision-making builds trust. This improves adherence to policies, making them more effective. Greater effectiveness, in turn, engenders more trust in policy-makers. Open decision-making can therefore contribute to a virtuous cycle of increasing trust, adherence and policy effectiveness.

Box. Open, inclusive decision-making under COVID-19 (continued)

B. KEY ELEMENTS

Political leaders

- Decision-making is built on evidence.
- The ethical, legal, scientific, economic, social and political reasons for a decision are transparent.
- In order to facilitate consensus, as far as possible, the reasons can be shared by people with dissimilar moral and political outlooks.
- Decisions and their rationale are communicated in a manner that everyone can understand.

Experts

- Experts are drawn from a variety of fields, including the humanities and medical and social sciences.
- Experts communicate transparently about what works and for whom and about uncertainty and values.
- Experts publish their findings and recommendations for critical scrutiny.
- Epidemiological, statistical and other relevant national data are open to access.
- Experts participate in forums that leave them open to critical feedback and adjust those elements of their practice that are legitimately challenged by members of the public.

The public

- All affected parties are included, listened to and have a say.
- Special attention is given to vulnerable and marginalized groups and to the perceived harm and benefits to people who cannot easily raise their voices.

Accountability

- All affected individuals and groups can challenge decisions.
- Mechanisms are in place for feedback and revision when new challenges or evidence emerge.
- The input of affected parties is documented.
- Mechanisms are in place for budgetary transparency and ensuring that loans and grants are allocated appropriately.

Box. Open, inclusive decision-making under COVID-19 (continued)

C. PRACTICAL EXAMPLES

Countries with established systems of participatory health governance, even when they are not used, benefit from a base of public trust, which, with effective communication strategies and unified public health systems are central to a successful COVID-19 response. Examples include: Mongolia *(91,92)*, New Zealand (93,94) and Rwanda *(95)*.

Elements of systems for open and inclusive decision-making include:

Inclusive deliberative bodies: ad-hoc citizens' assemblies, permanent citizens' panels, advisory councils

- Australia: COVID-19 Culturally and Linguistically Diverse Community Forums: South Australia *(72)*
- England: Citizens' Panel Planning the West Midlands' Recovery *(75)*
- USA: Oregon Citizens' Assembly on COVID-19 Recovery *(74)*

Hearings: mandated in law or optional

- France: Commission d'enquête pour l'évaluation des politiques publiques face aux grandes pandémies à la lumière de la crise sanitaire de la COVID-19 et de sa gestion *(96)*
- Norway: Corona-law and regulation changes *(79)*
- USA: National Academies of Sciences Engineering and Medicine. Public Comment Opportunities: Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine *(80)*

Open, self-selective public participation mechanisms: town halls, village meetings (face-to-face or online), radio and television call-in programmes, petitions and crowd–sourcing, initiated by either government or civil society

- Brazil: mechanism for transparency and public engagement on COVID-19 in the federal health system *(83)*
- France: Citizens' committee in Grenoble *(97)*
- Lebanon: Independent Committee for the Elimination of COVID-19 *(86)*
- Scotland: Coronavirus (COVID-19): framework for decision-making, national crowd-sourcing exercise *(82)*
- Senegal: several citizens' initiatives *(84,85)*
- United Kingdom: Independent SAGE *(88)*
- USA: Connecting to Congress, deliberative town halls on COVID-19 *(89)* and Endcoronavirus.org *(90)*

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