

A Difficult Balancing Act: Policy Actors' Perspectives on Using Economic Evaluation to Inform Health-Care Coverage Decisions under the Universal Health Insurance Coverage Scheme in Thailand

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ABSTRACT

Objectives: In Thailand, policymakers have come under increasing pressure to use economic evaluation to inform health-care resource allocation decisions, especially after the introduction of the Universal Health Insurance Coverage (UC) scheme. This article presents qualitative findings from research that assessed a range of policymakers' perspectives on the acceptability of using economic evaluation for the development of health-care benefit packages in Thailand. The policy analysis examined their opinions about existing decision-making processes for including health interventions in the UC benefit package, their understanding of health economic evaluation, and their attitudes, acceptance, and values relating to the use of the method.

Methods: Semistructured interviews were conducted with 36 policy actors who play a major role or have some input into health resource allocation decisions within the Thai health-

care system. These included 14 senior policymakers at the national level, 5 hospital directors, 10 health professionals, and 7 academics.

Results and Conclusions: Policy actors thought that economic evaluation information was relevant for decision-making because of the increasing need for rationing and more transparent criteria for making UC coverage decisions. Nevertheless, they raised several difficulties with using economic evaluation that would pose barriers to its introduction, including distrust in the method, conflicting philosophical positions and priorities compared to that of "health maximization," organizational allegiances, existing decision-making procedures that would be hard to change, and concerns about political pressure and acceptability.

Keywords: decision-making, economic evaluation, health-care benefit package, Thailand.

Introduction

Health economic evaluation is designed to guide explicit health resource allocation decisions by comparing the marginal costs and consequences of alternative health-care interventions. In some industrial countries, economic evaluation studies are increasingly being used to inform more explicit and transparent health-care coverage decisions [1]. Nevertheless, in low- and middle-income countries, economic evaluation has rarely been used as a tool to inform decisions about the content of health-care benefit packages [2,3].

In Thailand in recent years, as in other Asian countries, policymakers have come under increasing pressure to justify resource allocation decisions in the health sector [4,5]. The Universal Health Insurance

Coverage (UC) policy implemented in 2001 offers a package of health-care interventions at public facilities to all Thai citizens not covered by other benefit packages [6]. Nevertheless, as a result of rapid implementation, only limited evidence was used to guide decisions on the services included in the UC package. The government now needs to clarify and make more transparent the benefit package, especially for high-cost interventions, which are likely to absorb a disproportionate amount of resources and are an attractive target for providers to cut provision to contain costs.

Two broad types of barrier to the introduction of economic evaluation into policy decision-making can be envisaged for middle-income countries like Thailand. First, there is a very limited supply of good quality economic evaluation studies [7,8]; In Thailand, policymakers face these informational barriers [9]. Second, even if economic evaluation data were available, decision-makers may not understand, accept, or be willing to use economic evaluation as a tool in their decision-making on resource allocation. As analysts have argued for many years, policy decisions are not

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just technical questions but are inherently political processes, involving questions of power and resources [10]; for example, decision-makers will be aware that the exclusion or inclusion of an expensive treatment in the UC package will have important implications for sections of the public, government expenditure, their colleagues who have to implement the decision, and perhaps the government's political standing.

In industrial countries, there have been a small number of studies on policy actors' attitudes to economic evaluation as a tool in decision-making for health-care priority setting [11,12]. In middle-income countries, where the pressure for more explicit rationing is growing, there have been even fewer studies to explore decision-makers' attitudes toward and acceptance of economic evaluation [3].

This article presents findings from a larger piece of research that assessed the feasibility of doing economic evaluation studies in Thailand (by undertaking economic evaluation studies for two high-cost interventions) and the acceptability of using economic evaluation as a tool for the development of health-care benefit package. It focuses on Thai policy actors' general understanding, acceptance and valuation of economic evaluation, the multiple factors that they must weigh up in their decision-making about health-care coverage, and therefore the difficulties of introducing economic evaluation into this decision-making.

Design and Methods

Semistructured face-to-face interviews were used to generate qualitative data on policy actors' attitudes toward economic evaluation. A semistructured interview technique could capture the complexity and depth of policy actors' perspectives, and allowed the researcher to explore a wide variety of issues, enabled flexibility in the discussion, and gave the respondents room to tell their own story [13].

Respondents

A broad definition of a policy actor was adopted for this study, defined as any individual or group involved in the public policy process, for example, working to change or maintain the policy agenda, presenting information that feeds into policy processes, sitting on committees that make policy decisions, and those actors involved in policy implementation [10]. Respondents were selected purposively to cover four groups of policy actors who play a role in health resource allocation within the Thai health-care system. These were: 1) policymakers at the national level who were senior administrators at the Ministry of Public Health (MOPH) and National Health Security Office (NHSO; NHSO is an autonomous health-care institution in Thailand that manages the UC scheme); 2) hospital directors who are responsible for allocating

resources within Thai health-care institutions; 3) health professionals who are responsible for resource allocation decisions at the patient-level; and 4) academics who produce and/or use economic evaluation information to inform decision-makers.

The qualitative data generated from a purposive sample of policy actors is not intended to be "representative" in statistical terms. Rather, the data can be used to build conceptual understanding and explanations of actors' attitudes, positions, and vested interests relating to economic evaluation. The policy relevance of the qualitative material did rely on ensuring that an appropriate range of policy actors for this particular setting were covered, to ensure that a "typical" range of perspectives were captured [14].

An invitation letter and consent form were sent to each of 38 potential participants. For policymakers at the national level, letters were sent to the top seven senior administrators at the MOPH, both politicians and bureaucrats, and the top seven senior administrators of the NHSO. The five hospital directors invited to an interview were based at the public hospitals where the authors had previously conducted the two economic evaluation studies [15,16]. The invitation letters were also sent to health professionals at those five public hospitals, selected purposively to include different medical specialists, including two internists, two surgeons, two nephrologists, one pediatrician, one oncologist, one ophthalmologist, and one otorhinolaryngologist. Seven Thai academics whose names were identified from publications about health-care rationing were also invited to participate in the study.

Thirty-six respondents were interviewed between December 2004 and May 2005 (95% response rate). Table 1 presents the characteristics of all respondents: They were predominantly male, more than 45 years old, and medically qualified (34 out of 36 respondents had qualified in medicine), which reflects the composition of senior management in the health sector in Thailand more generally. Only six respondents had had training in health economics.

Interview Schedule

It was expected that many respondents would have limited knowledge about health economic evaluation, so first the interviewer asked if respondents knew about cost-minimization, cost-effectiveness, cost-utility, and cost-benefit analysis. Those who revealed that they knew about these terms were asked to give a brief explanation to verify their understanding. Regardless of whether respondents stated they understood about economic evaluation, every respondent was given a brief introduction to the subject to enable them to understand the basic concept and its applications. Respondents were free to ask questions after the explanations and before the interview moved on to

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