Volume 11 • Number 7 • 2008
VALUE IN HEALTH

Citizen's Preferences Regarding Principles to Guide Health-Care Allocation Decisions in Thailand

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ABSTRACT

Objectives: The objective of this study was to investigate the extent to which five principles of rationing (lottery, rule of rescue, health maximization, fair innings, and choicism) were preferred by a sample of Thai citizens for selecting patients to receive high-cost therapies.

Methods: A self-administered survey was used for collecting data from a sample of 1000 individuals living in Thailand. Descriptive statistics, factor analysis, and multinomial logistic regression analysis were used for describing and validating the data. Out of the 1000 sample members, 780 (78%) provided usable responses.

Results: The results showed that within specific situations under budget constraints, Thai people used each of the criteria we studied to ration health care including: 1) lottery principle; 2) rule of rescue; 3) health maximization; 4) fair innings; and 5) choicism.

Conclusions: The extent to which the criteria were applied depended on the specific situation placed before the decision-maker. "Choicism" (equalizing opportunity for health) was the most preferred method for rationing when compared to each of the other four principles.

Keywords: decision-making, health-care decision-makers, health economics, preferences, resource use.

Introduction

All countries encounter situations in which resources are limited and health care cannot be provided for all who need it. Even for countries in which universal health coverage (UC) is provided by the government, issues related to gaining access to high-cost health care can be contentious [1]. On many occasions, governments or the agencies that are responsible for financing, organizing, managing, and providing health services have faced challenges related to budget constraints, in which they had to choose whether to provide treatments at all or to choose a limited number of patients to whom care was provided [2–5].

Since 2001, the Thai government has implemented UC under the 30-baht policy that aims to provide health-care coverage for all Thai people who have no other health insurance [6,7]. Because of its financial and implementation structure, a challenge to the policy has emerged as the budget for providing high-cost care (e.g., renal replacement therapy [RRT] for end-stage renal disease [ESRD]) to all eligible patients has become constrained [5,8]. This has raised the difficult choice of whether the government should strive to support this very high-cost service at all. Conforming to ethical codes of individual practitioners at the micro level, one might argue that the government should cover this high-cost care for all patients who need it. On the other hand, policymakers might choose not to provide any care at all to stabilize the financial solvency of the UC program. Moreover, policymakers could claim that if high-cost care cannot be provided to all eligible patients, it would be most equitable to deny access to everyone for an unaffordable treatment.

A third option would be to provide care for some patients, but not all of them. The challenge with this approach is identifying the most suitable patients for the high-cost care. To do this, the government would need to decide 1) who the most suitable patients are; 2) what selection criteria to utilize; and 3) how a legitimate selection process would be implemented.

Fair processes to allocate health resources could help legitimize the use of rationing criteria and could win support from the Thai public. Nevertheless, the concept of fairness may not be a universal value and might vary from society to society. Thai people may have a unique set of values regarding criteria that should be used to select patients for high-cost health care. Thus, consulting with the Thai people is a requisite first step in starting to ration high-cost health care. Our overall goal for this study was to identify acceptable criteria by which decisions could be made

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10.1111/j.1524-4733.2008.00321.x

  1098-3015/08/1194 1194–1202

regarding the allocation of high-cost health-care services under budget constraints in Thailand.

Conceptual Framework

Health resources, unlike food during a war, are not easily divisible. For example, one cannot cut a dialysis session by half to serve another ESRD patient, nor can one heart be divided for transplantation into two patients. These examples support the idea that choices must be made about giving health care to some but leaving others to live without it. Thus, rationing of care has emerged in light of the ever costlier medical interventions and scarce health-care resources.

For this study, we adopted the concept of rationing health care from work reported by Cookson and Dolan [9] in which they used five principles of rationing as a framework for their qualitative study in England. The "five rationing principles" were: 1) lottery principle; 2) rule of rescue; 3) health maximization; 4) fair innings; and 5) choicism. The lottery principle suggests that one cannot use any criteria to select patients because every life is equal. In other words, we are "not playing God." The notion of "first-come first-served" is represented by this principle because, if we cannot apply any criteria to select one patient over others, it is just to give priority to patients who wait longer on a waiting list. A survey in England showed that more than 36% of respondents chose "time on waiting list" as the most important criterion that a doctor or other health professional should take into account for allocating treatment to patients [10]. Both qualitative and quantitative studies also supported the use of this criterion to prioritize health care. Nevertheless, the preference for using this criterion can be tempered when it is directly challenged by the other principles in our conceptual model [11].

Rule of rescue emphasizes the distribution of resources according to the most immediate need. Thus, life-threatening conditions receive a high priority under this principle. Also, the severity of a disease is a justifiable criterion for preferring one patient over others. Empirical studies have confirmed the acceptability of this rationing principle [1,12].

The health maximization principle emphasizes the health of the whole community. This principle gives priority to treating conditions, patients, or situations that are likely to realize more length and quality of life compared to others (i.e., the ability to benefit the community). This principle is derived from the efficiency concept that tries to maximize benefits or outcomes from any given input or budget. This principle was the first criterion that family doctors and gastroenterologists preferred for allocating kidneys for transplantation in England [13].

Fair innings (or equalizing lifetime health) emphasizes the idea of trying to minimize inequality in health among people. This principle favors younger and disabled people. The rationale behind this principle comes from the goal of achieving a societal expected lifetime for everyone. This means that if the societal expected lifetime is 70 years, then it is fair to prefer a 20-year-old person over patients who are closer in age to 70. Nevertheless, using age as a criterion for rationing creates several arguments regarding human rights. Human rights advocates argue that it is a societal obligation to provide care for illness from misfortune or from "natural lottery" (not from self-inflicted behaviors). Thus, discrimination against old age is unjust. Nevertheless, empiric studies showed mixed responses. More than half of respondents did not prefer to use age as criterion in the survey in England and in European countries [10,14]. In a survey about allocation of donated liver grafts, the general public and family doctors tended to prefer to use age as a criterion [11]. Additionally, giving preference to children also was the first criterion the general public used in a group discussion for allocating kidneys in England [13].

Choicism (or equalizing opportunity for health) gives priority to those who suffer from diseases that are not a result of patients' own lifestyles. This principle emphasizes the responsibility of patients for their own health, such as limiting alcohol use to avoid cirrhosis. Wittenberg et al. [15] showed that people prefer to allocate scarce resources (liver transplantation and asthma treatments) to patients who are not responsible for their illness. Denier [16] extended questions for this principle and asked "Should a drunk driver bear the costs of medical care that he needs after a careless accident he has caused?" Denier [16] reported that the respondents to his survey generally answered "yes" to that question and pointed out that such costs are borne in subtle ways such as applying higher tax rates for alcoholic beverages.

In our investigation, we sought to compare the importance of each of the five principles in our conceptual model using scenarios involving a head-to-head comparison for each of 10 pairs of the allocation principles. The specific objective of this study was to investigate the extent to which five principles of rationing (lottery, rule of rescue, health maximization, fair innings, and choicism) were preferred by Thai citizens for selecting patients for high-cost therapies.

Methods

Sample Selection

To account for a variety of opinions from different cultures in Thailand, study respondents resided in four provinces from different regions: the central region, the northeastern region, the northern region, and the southern region. In the central region, we chose two hospitals in Bangkok, the capital city. In other regions, we chose a major province from each region: Khon Kaen in the northeastern region, Chiang Mai in the