

Moving from what to how? – Lessons learnt from how HTA support UHC in Thailand

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Outline of Presentation

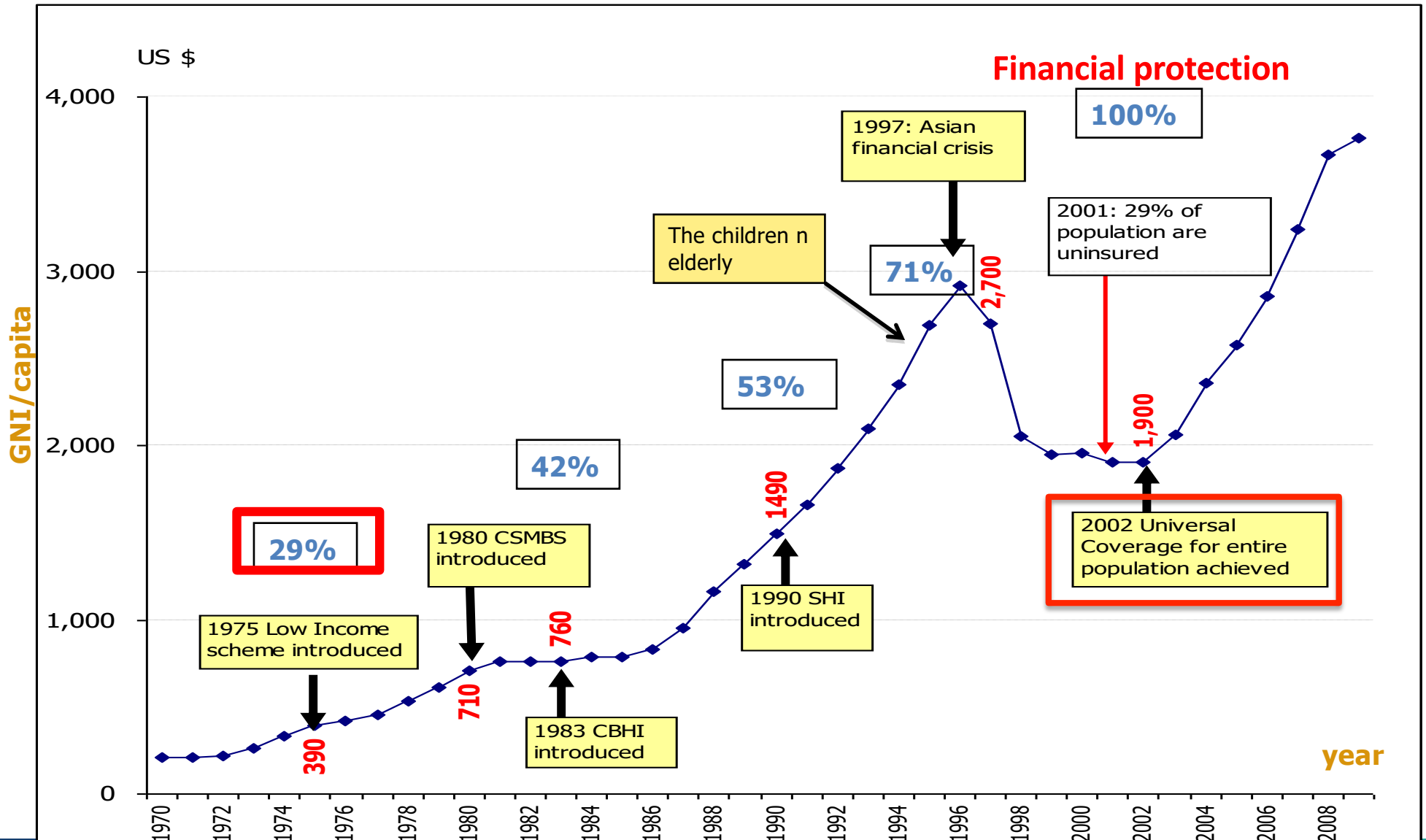
- **Thailand's Health Care Systems and UHC**
- **How do we develop the benefit package under UHC**
- **Five Lessons learnt – G-R-A-S-P**

Part 1: Thailand's Health Care Systems and UHC



- Population 69 million
- GNI (2017) \$US 6,500 (UMIC)
- Life Expectancy 75
- Doctor+nurse/midwife: 3.8/1,000
- **30%** health resources in private sector taking care of 20% OP, 10% IP
- UHC in 2002 with adequate package
- Health Budget **15% Total budget**
- Total Health Expenditure (2014)
 - 4.5- 6.0 % GDP [$<$ \$US 250-350/cap]
 - **Out of pocket 12% of THE**

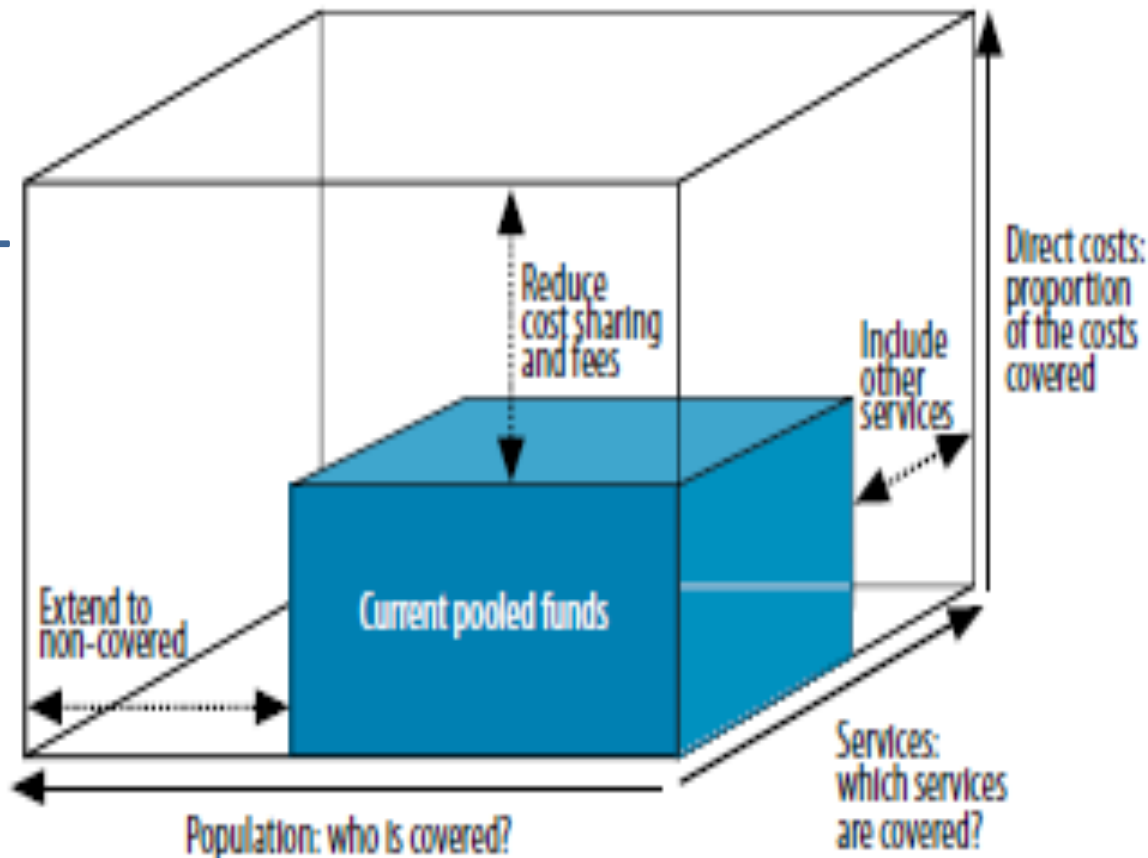
A 27 long march to achieve full population coverage, when the GDP/cap was \$US 1,900 – lowest after 1997 economic crisis



THREE DIMENSIONS OF THAI UHC

Y axis:
Financial
protection -
High

Free at the
point of
service



Z axis: Depth of
services

Comprehensive
package with small
exclusion list.

**All essential
drugs**, Renal
Replacement
Therapies, organ
transplant, CABG,
cataract, dental
services and
dentures, etc.

X axis: Population coverage
universal population coverage

Thai UHC: 3 main public insurance schemes

	CSMBS	Social Security	UC scheme
Population	5 Millions (7%)	16 Millions (22%)	48 Millions (71%)
Beneficiaries	Civil servant, spouse, vertical relatives	Employees in private and public sector	Those informal sector beyond CSMBS and SHI
Source of finance	General tax (~14,000 Baht/Cap)	Tripartite - 1.5% each (2,900Baht/cap)	General tax (3,500 Baht/Cap)
Provider choice	Free choice of public providers, Private in emergency	Annual choice of public&private hospital contractors	Annual choice of mostly public primary care based contractors with referral
Benefit package	Comprehensive	Comprehensive	Comprehensive include prevention and promotion for all Thais
Financial support to providers	OP: FFS, IP: DRG Open ended budget	Capitation Close ended budget	OP: Capitation IP: DRG Close ended budget

CSMBS; Civil Servant Medical Benefit Scheme, SHI; Social Health Insurance

Adequate and appropriately manned rural health facilities



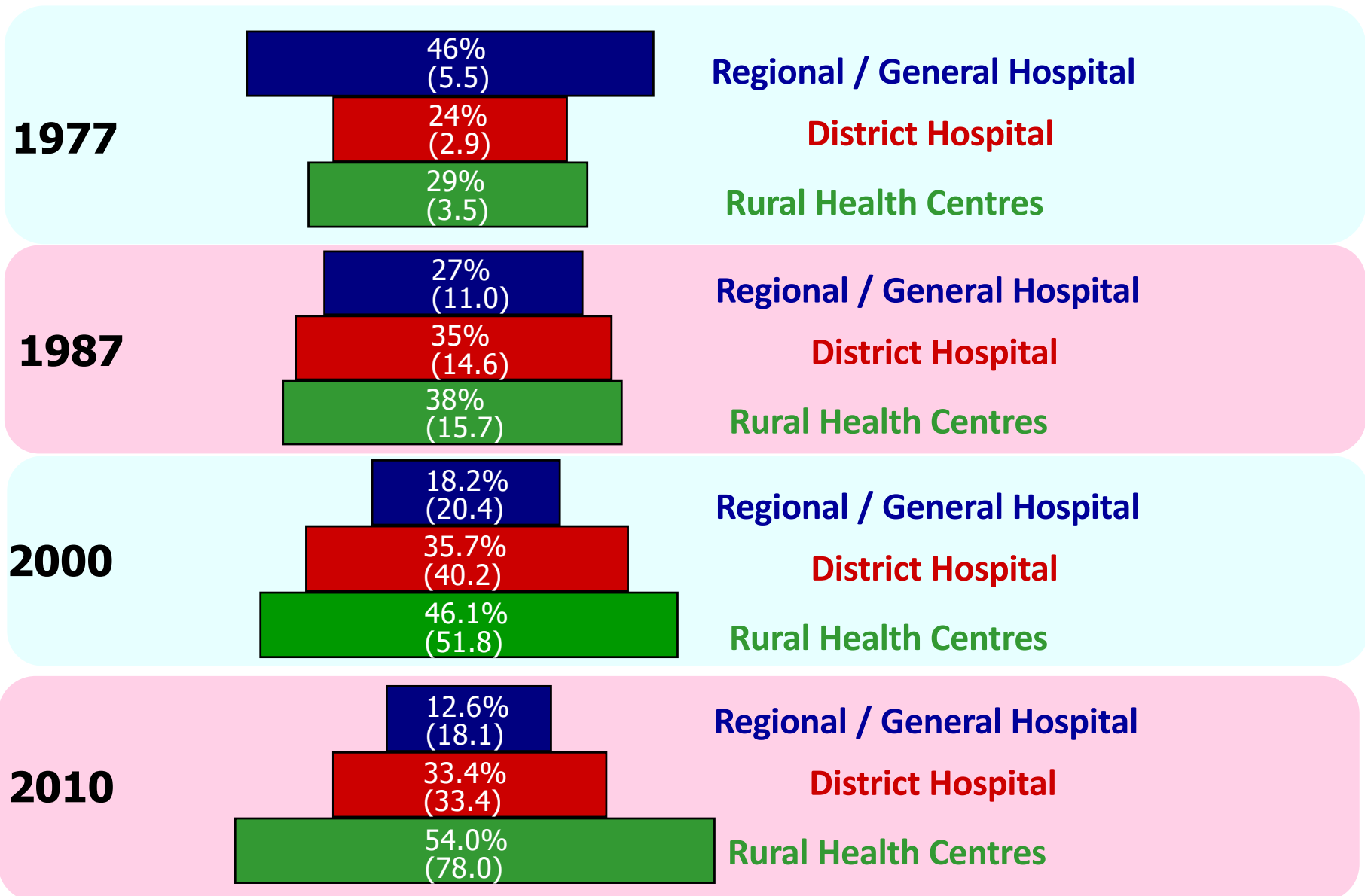
Rural health centers with 4-8 nurses and CHWs cover 2,000-5,000 population

Extensive production of appropriate cadres and motivated health personnel with mandatory public works and adequate support are essential.



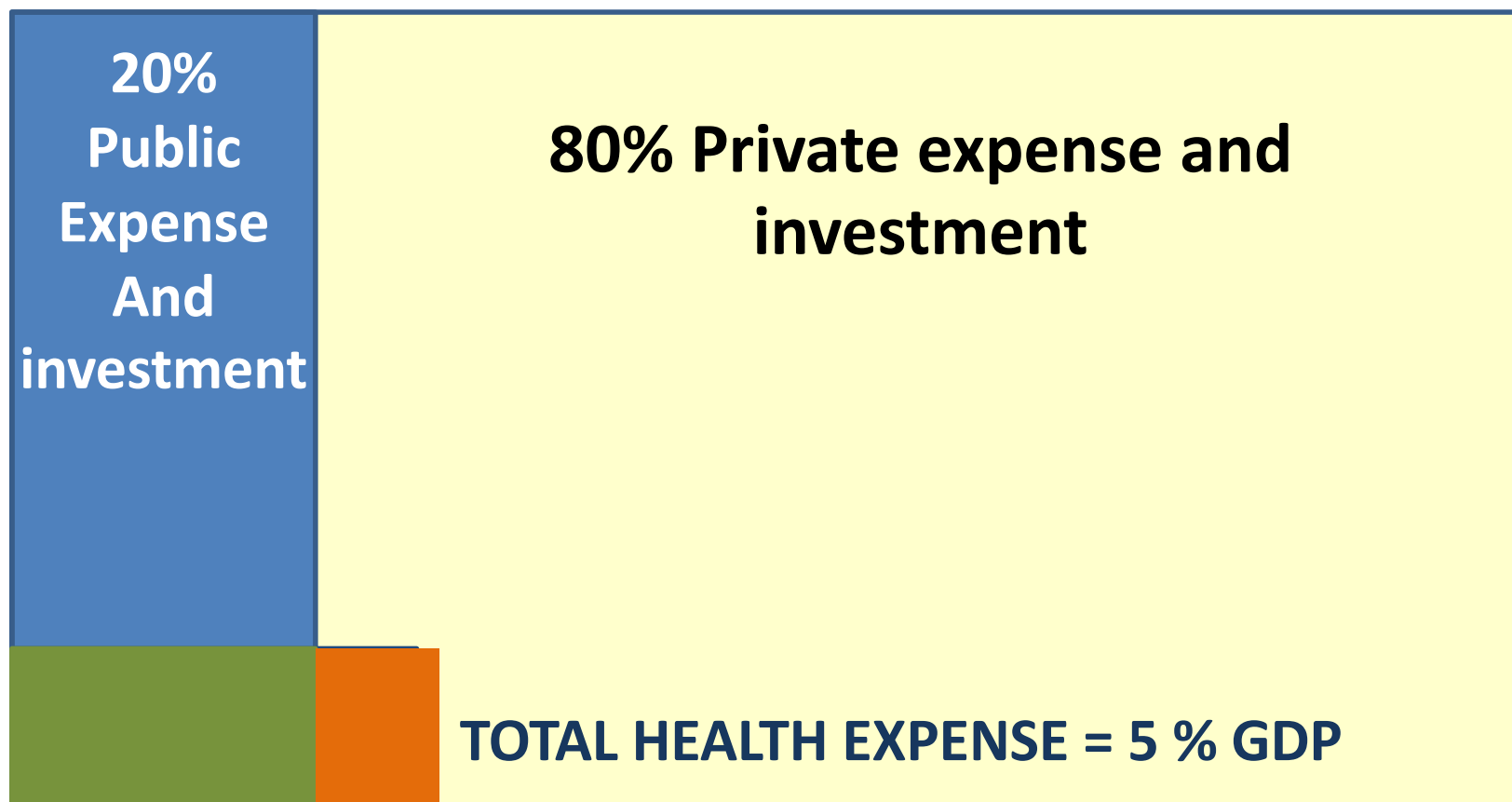
Rural community hospital with 3-10 doctors cover 30-80,000 population

Changes in out-patient utilization: from reverse to upright triangle primary secondary and tertiary 1977-2010



Structure of GDP and Health Expense in Thailand

GROSS DOMESTIC PRODUCTS



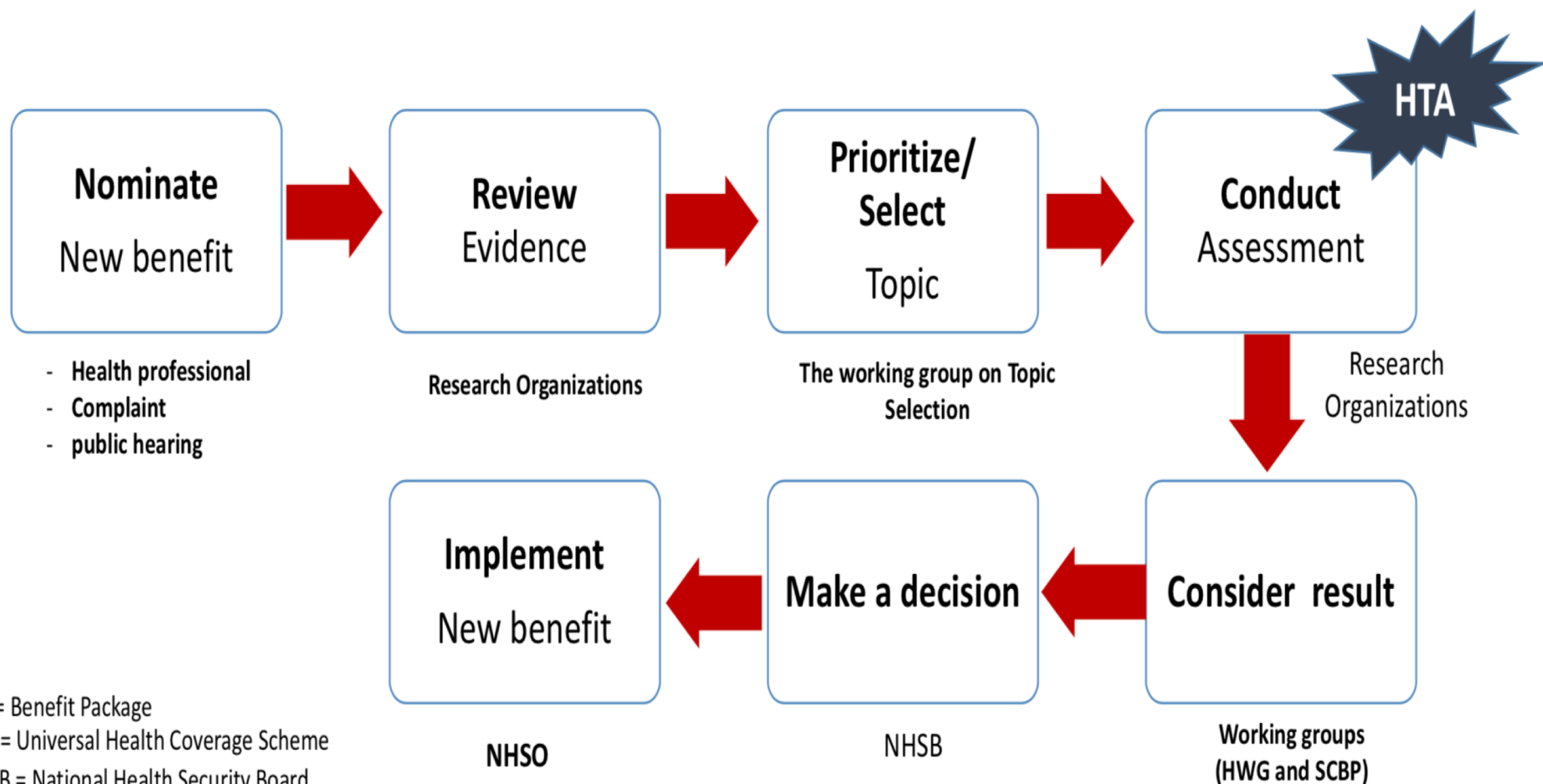
80% PUBLIC **20% PRIVATE (12% Households+8%employers)**
= 15% of total GOVERNMENT EXPENSE, 11% to the UHC

Part 2: How HTA contributes to the development of benefit package under UHC??

Benefit package under Thai UHC

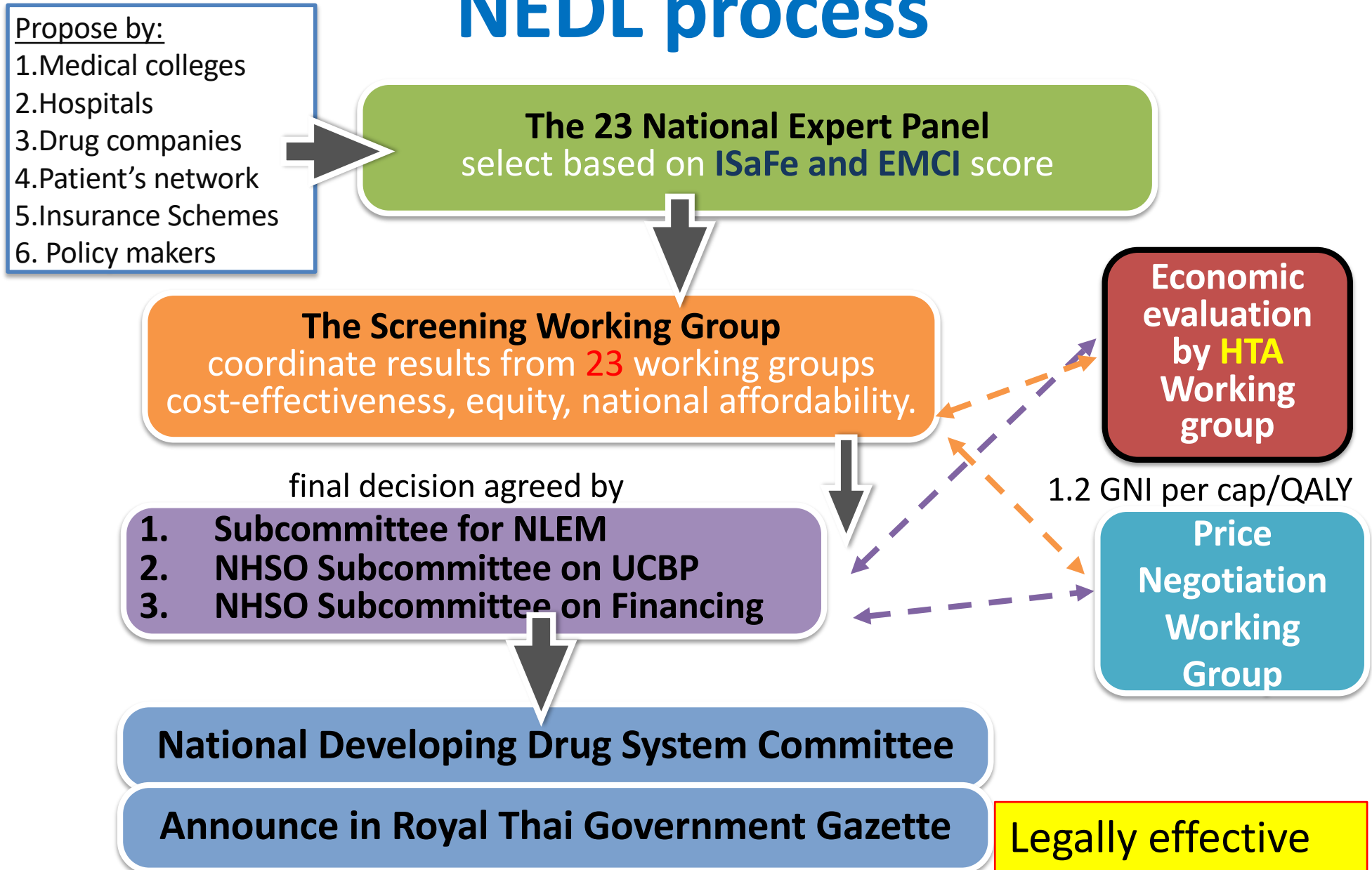
- **Medicines package** – based on National List of Essential Medicines – a **positive list approach** – gradually **add on** new high cost drugs *using HTA*
- **Services and Technologies** – based on **negative list approach** by excluding high cost services and gradually *reduce* the exclusion list *using HTA*

Key Process of Benefit Package Decision for high cost medicines and services/technologies

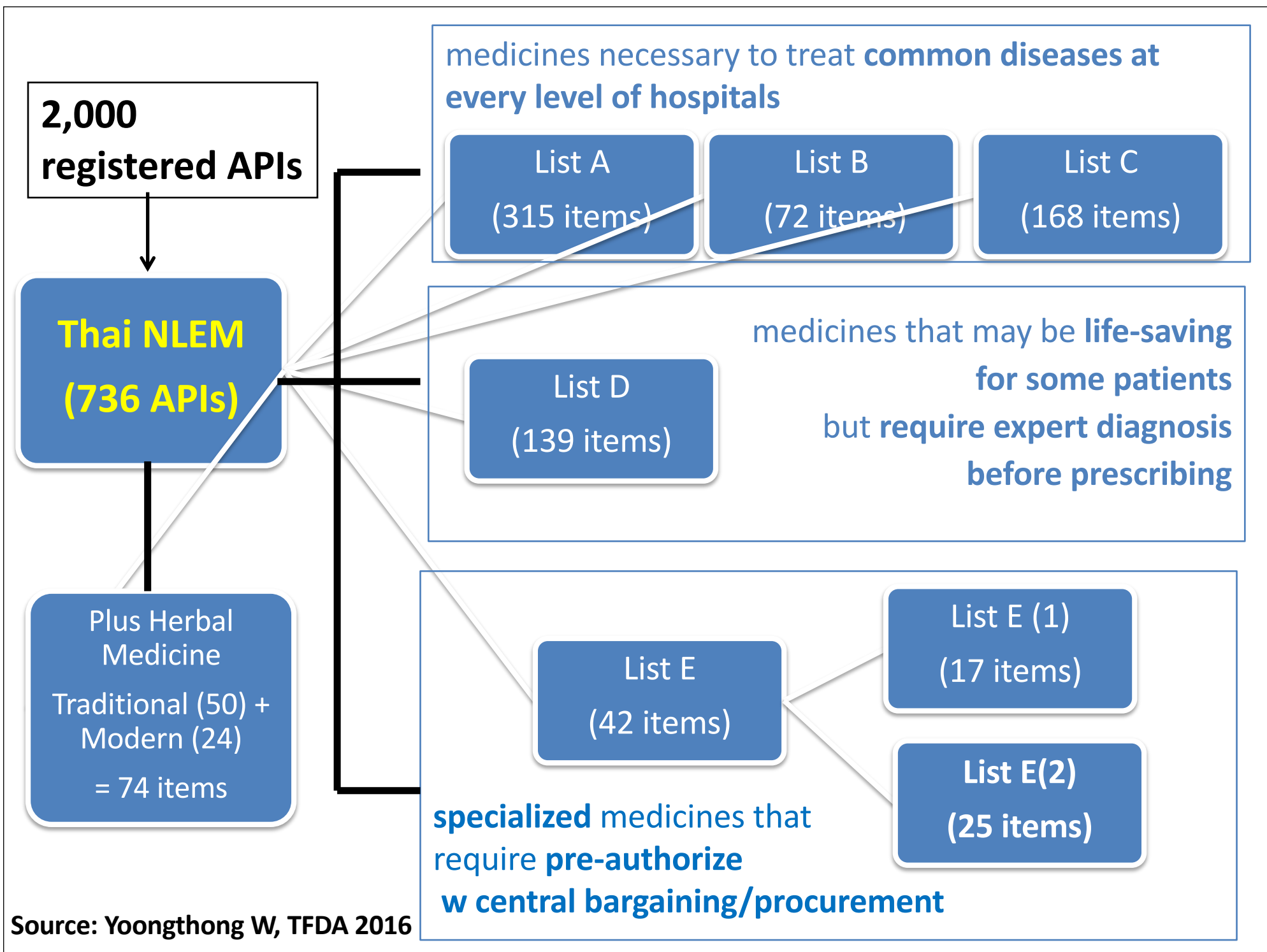


BP = Benefit Package
 UCs = Universal Health Coverage Scheme
 NHSB = National Health Security Board
 NHSO = National Health Security Office
 SCBP = Sub-committee for the development of Benefits Package and Service Delivery
 HWG = Health Economics Working Group

NEDL process



Source: Yoongthong W. Thai FDA 2017



**2,000
registered APIs**

**Thai NLEM
(736 APIs)**

Plus Herbal
Medicine
Traditional (50) +
Modern (24)
= 74 items

medicines necessary to treat **common diseases at every level of hospitals**

List A
(315 items)

List B
(72 items)

List C
(168 items)

medicines that may be **life-saving for some patients but require expert diagnosis before prescribing**

List D
(139 items)

specialized medicines that require pre-authorize w central bargaining/procurement

List E
(42 items)

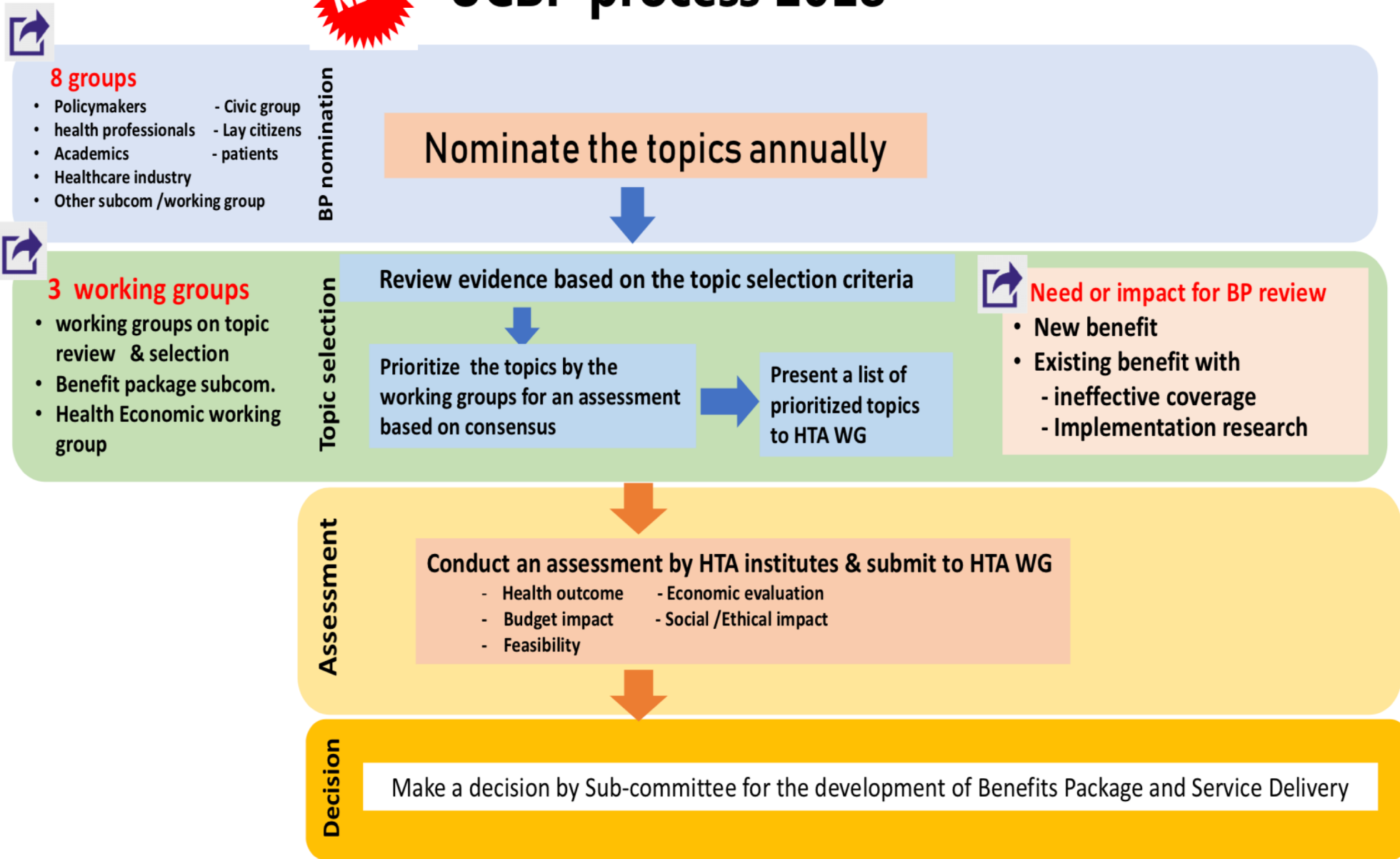
List E (1)
(17 items)

List E(2)
(25 items)

Source: Yoongthong W, TFDA 2016



UCBP process 2018



Multiple criteria are used in the 'political processes'

- © Incremental Cost Effectiveness Ratio (ICER) of 1.2 GNI/capita (willingness to pay)
- © Budget impact – consult with financial supporters
- © Prevention of Medical Poverty
- © Fairness
- © Feasibility to deliver the services

Appraisal Results and Decision Making

Policy recommendation	Assessment results*			
	Cost-effective (ICER \leq 1 per-capita GDP/QALY)		Not cost-effective (ICER $>$ 1 per-capita GDP/QALY)	
	Low budget impact [†]	High budget impact [†]	Low budget impact	High budget impact
Recommended	<ul style="list-style-type: none"> ● Lamivudine for treatment of people with chronic hepatitis B ● Intravenous cyclophosphamide + azathioprine for treating severe lupus nephritis ● Smoking cessation program 	—	<ul style="list-style-type: none"> ● Imiglucerase for Gaucher type 1 	<ul style="list-style-type: none"> ● PD-first policy for ESRD
Not recommended	<ul style="list-style-type: none"> ● Implant dentures for people who have problem with conventional complete dentures 	<ul style="list-style-type: none"> ● Pegylate interferon alpha 2a + ribavirin for treating hepatitis C ● Absorbent products for urinary and fecal incontinence among disabled and elderly people 	—	<ul style="list-style-type: none"> ● Anti-immunoglobulin E for severe asthma

ICER, incremental cost-effectiveness ratio; GDP, gross domestic product; QALY, quality-adjusted life-year; THB, Thai baht.

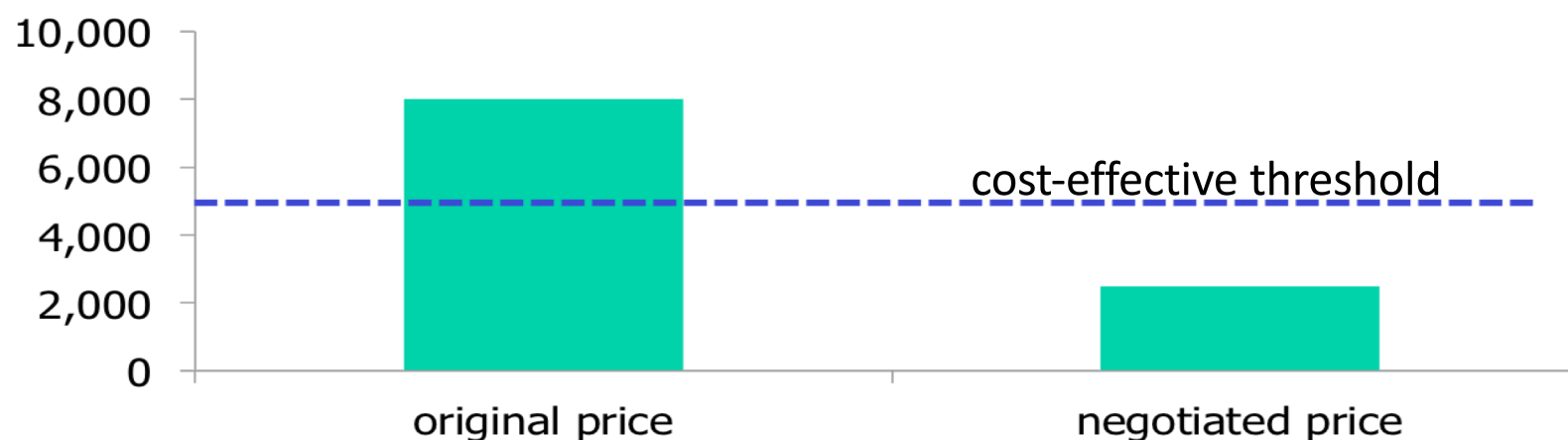
* Two cost analysis studies, that is, screening for risk factors for leukemia in people living in the industrial areas, and system for screening, treatment, and rehabilitation of alcoholism, are not included in this table.

[†] High budget impact $>$ THB 200 million per annum; low budget impact \leq THB 200 million per year.

NLEM price negotiation – effect of volume on price

Medicine	Original price (THB)	Negotiated price (THB)	Potential saving (THB per year)
Tenofovir	43	12	375 million
Pegylate interferon alpha-2a (180 mcg)	9,241	3,150	600 million
Oxaliplatin (injection 50 mg/25 ml)	8,000	2,500	152 million

Threshold analysis for price of oxaliplatin

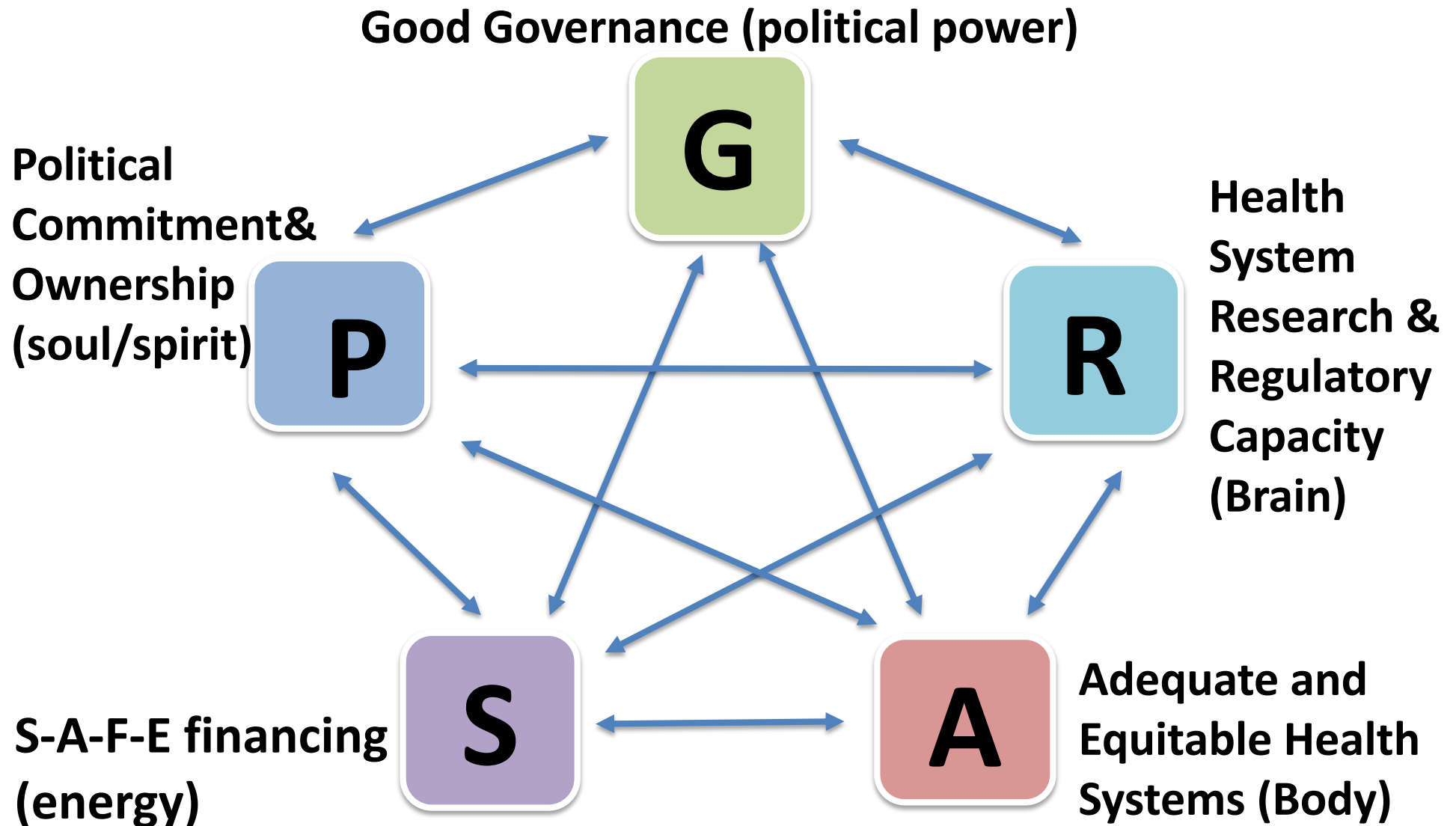


Ensuring quality and participation in conducting meaningful HTA

- ◎ Formulate standard national guideline for economic evaluation study thru evidence and participatory processes
- ◎ Continuous capacity building: based on **'INNE' concept** – IHPP/HITAP/academic partners - **Champions**
- ◎ Regular researches e.g. EQ5D, Willingness to pay
- ◎ HTA conducted by networks of qualified institutes, including HITAP, **with rigorous peer review on each spread sheet, funded by public funding (HSRI)**
- ◎ Publication of the study especially in peer reviewed international journal

Part 3: Five Lessons learnt from Thai UHC and HTA

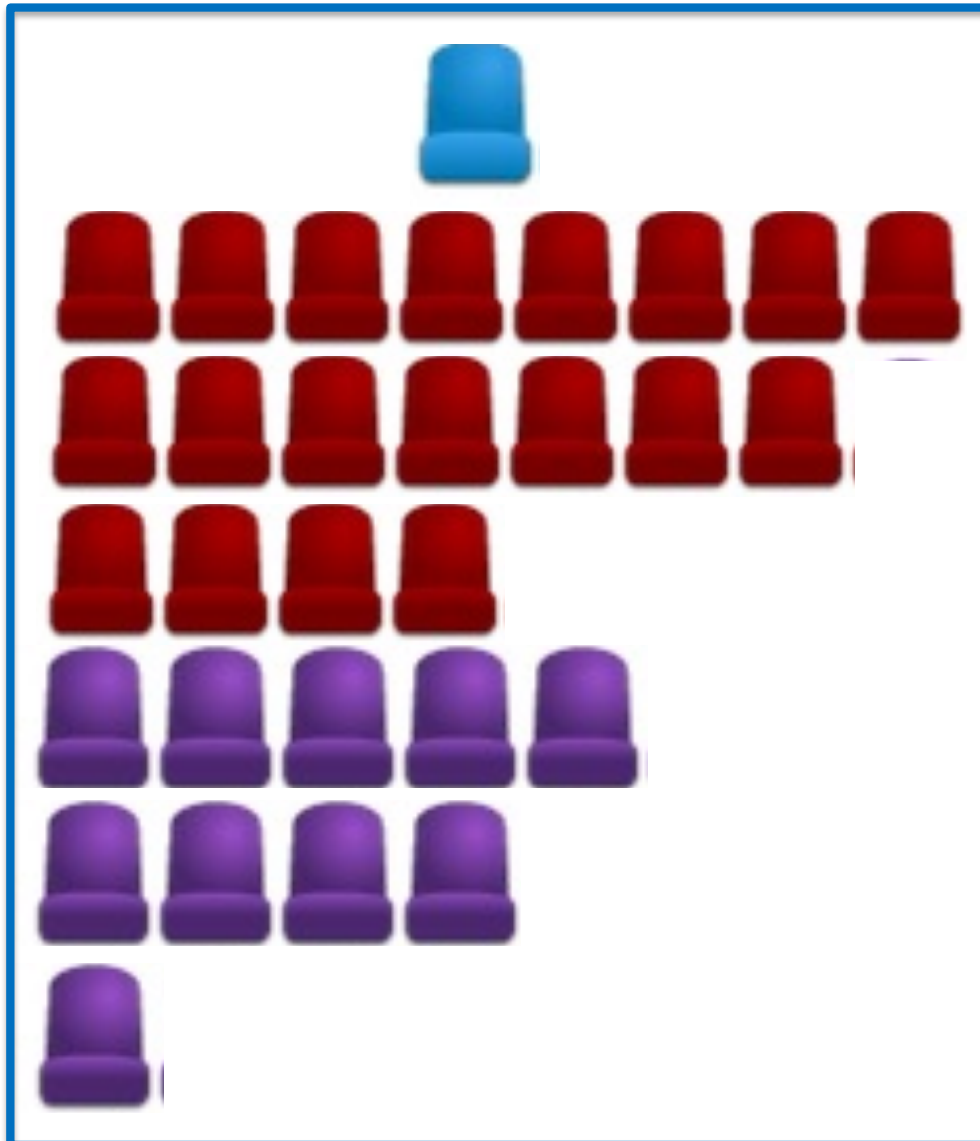
Five lessons learnt – ‘G-R-A-S-P’



G- GOOD GOVERNANCE (JUDGEMENT OF SYSTEMS)

- **Transparency** – all information on website, board meetings are webcasted
- **Accountability** – responsiveness and auditing systems
- **Participatory** – public hearing and members of **the UHC board**
- **Rules by law** – clear legal frameworks
- **Fair** – to both providers and patients
- **Efficiency** – best value for money

Participatory structure in Thai UHC board



Minister of Public Health(1)

**Permanent Secretary of
Government Ministries(8)**

Experts from the fields(7)

Local Government(4)

NGOs(5)

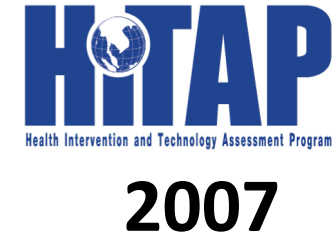
Professional Councils(4)

Private Hospital Association(1)

Source: National Health Security Act 2002

R – HEALTH SYSTEM RESEARCH AND REGULATION CAPACITY (BRAIN)

Health Systems Research Institute



The Healthcare
Accreditation Institute (HAI)



2002



Capacity building based on INNE – Individual, Node, Network and Environment

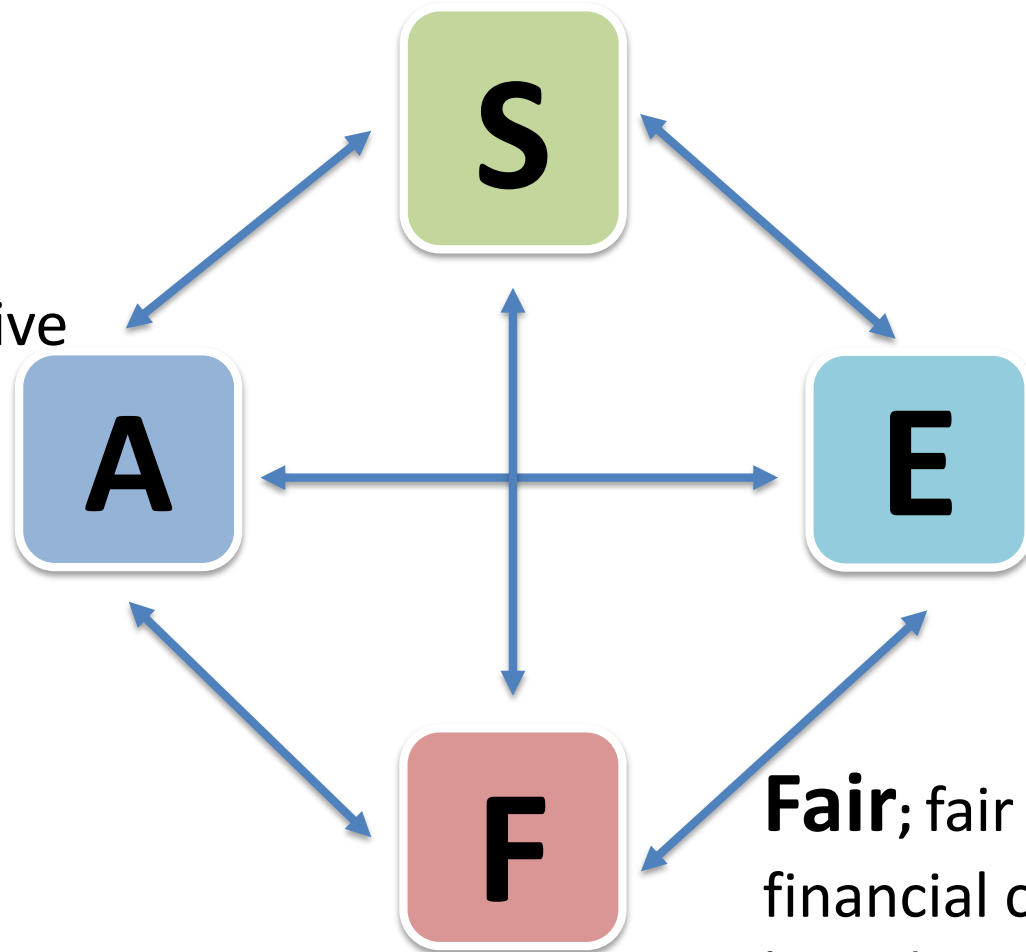
A - ADEQUATE AND EQUITABLE HEALTH CARE SYSTEMS BASED ON PHC (STRONG AND BALANCE BODY)

- Strong political will to reallocate resources to build up good rural infrastructure in 1980s
- Extensive production of rural community health workers and health professionals
- Measures to retain and motivate/incentivized health professionals

S- S-A-F-E financing systems (energy)

Sustainable; affordable by people, government & country

Adequate;
resource for
comprehensive
essential
services &
financial
protection



Efficient;
Measures to
ensure more
health for
money

Fair; fair and progressive
financial contribution – Tax
based

'Best Value for Money' under the UHC

- **Health Promotion and Disease Prevention** as priority with secured budget (>15% of UHC budget)
- Primary Care as the gate keeper
- **Capitation, bundle payment, and fixed fee schedule, with close end budget**
- Extensive use of **Economic Evaluation** in the formulation of benefit packages with serious **price negotiation**
- **Central** and regional **bargaining** and **procurement**

COST SAVING FROM CENTRAL PROCUREMENT (\$US)

Year	ARV-NonCL	ARV_CL	ED Cat E(2)	EPO/CAPD	Total Saving
2010	8,907,677	24,750,922	3,037,543	15,258,756	51,954,898
2011	17,871,763	49,509,529	49,670,753	23,111,379	140,163,424
2012	29,500,819	66,257,010	33,501,682	28,237,894	157,497,405
2013	43,745,449	67,915,751	40,828,581	42,295,357	194,785,139
2014	52,219,778	82,000,880	64,246,998	55,159,629	253,627,285
2015	44,649,801	107,097,868	20,091,332	48,943,980	220,782,981
2016	48,006,380	75,873,013	78,358,114	55,544,497	257,782,004
Total	244,901,666	473,404,974	289,735,003	268,551,493	1,276,593,137

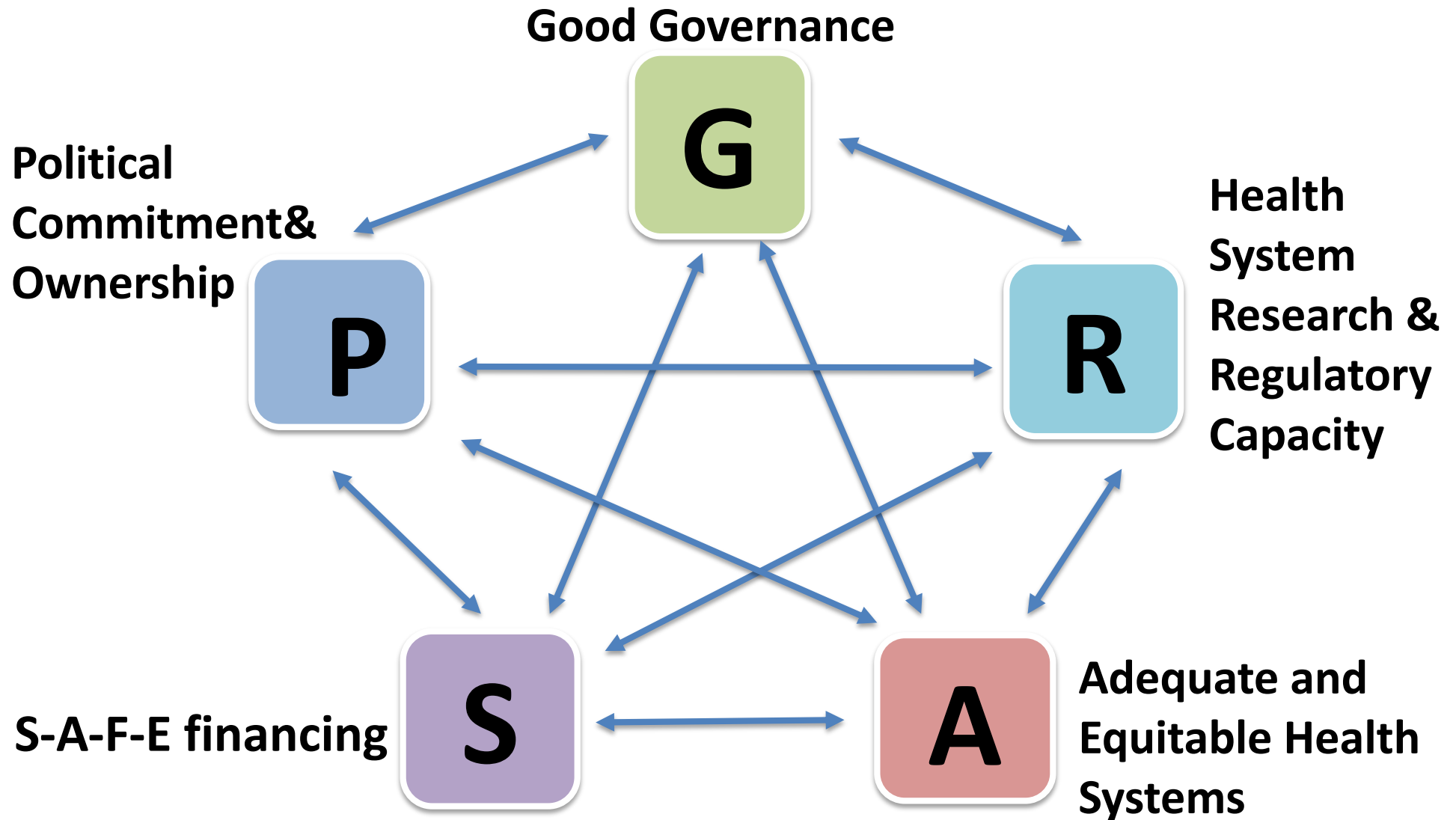
Saving based on Purchasing price in 2009

Source: National Health Security Office

P- POLITICAL COMMITMENT AND OWNERSHIP (SOUL AND SPIRIT)

- UHC was used in the 2000 election – gone thru 7 PMs, two main parties, two military governments
- 50,000 citizens proposed UHC bill to the parliament in 2001
- Civil Society Rep sat in the parliamentary commission and now five influential seats in the UHC board (out of 30)
- Regular annual public hearing required by the National Health Security Act – improvement of the management

Summary - Opportunities favor prepared mind – be well prepared to ‘GRASP’ any political, economic and social opportunities



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