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

Yot Teerawattananon, MD, PhD,1 Steve Russell, PhD2

1Health Intervention and Technology Assessment Program (HITAP), Ministry of Public Health, Thailand; 2School of Development Studies, University of East Anglia, Norwich, UK

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...
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 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
further discussion. The interview schedule then consisted of questions on the respondents’:

1. opinions about existing criteria and decision-making processes for including health interventions in the UC benefit package;
2. understanding about health economic evaluation and their experiences of using it;
3. attitudes, acceptance, and values relating to the use of economic evaluation for development of the benefit package;
4. opinions about the reliability and acceptability of economic evaluation evidence.

**Analysis**

All interviews were tape-recorded and transcribed verbatim. The first author read all the Thai transcripts to become familiar with the data and then each transcript was read again and a list of codes developed, with sections of the text allocated specific codes. The codes (or themes) that emerged were based on the words, concepts, and categories used by the respondents themselves but were inevitably also related to the concepts being explored through the question guideline. After coding, it was possible to explore the similarities and differences between respondents’ perspectives on economic evaluation. One of our interests was to explore whether the respondents’ different positions and duties influenced their understanding and acceptance of economic evaluation as a tool for health-care rationing.

**Results**

**Opinions about Existing Criteria and Decision-Making Processes for Including Health Interventions in the UC Benefit Package**

Policymakers at the national level, located in the NHSO and MOPH, and who had been involved in the development of the UC benefit package, reported that a range of factors influenced the inclusion or exclusion of interventions: the number of patients that needed to be treated, severity of disease, cost of interventions and affordability, equity of access, and coverage of similar services by other health insurance schemes. The reasons for using these criteria had been a familiarity with them, and because the evidence was available in administrative or routine databases. These policy actors admitted that budgetary impacts had been of particular interest because it was their responsibility to identify the budget funding for any new intervention to be included in the package. They also claimed that political pressure had played a significant role in the decision-making process. They used the example of the inclusion of antiretroviral treatment (ART) for HIV/AIDS in the package, which they believed was based primarily on political pressure and influence:

At that time the government had just appointed an expert committee to consider it (the inclusion of ART), but the committee had not reached their conclusion when the government announced publicly the inclusion of ART on “World AIDS Day” in 2002.

There had been no formal criteria for making health-care coverage decisions and none of the policymakers had used economic evaluation, or were currently using it, when they had to make a decision or provide policy advice.

Hospital directors had not been involved in the development of the UC benefit package and had little idea about the criteria used to inform coverage decisions. At hospital level, none had used economic evaluation to make resource allocation decisions. Similarly, health professionals working in the five hospitals did not know the criteria used for including or excluding interventions from the package but stressed the need for more transparent decision-making processes for making coverage decisions. They argued that because they are at the frontline of service delivery and select the medicines listed on the hospital formulary, they should be involved in decision-making processes relating to the UC benefit package:

We know our patients more than politicians and policymakers do, so why not allow us to consider the coverage of interventions that we have to provide?

Some but not all of the academics had been involved in the development of the UC benefit package, and those involved argued that even if the decisions were
made based on the best available information and in the best interest of society, there was room for improvement. The rationing criteria had been implicit and required greater transparency, including a systematic framework to help decision-makers defend their decisions. Academics also argued that the public needed to be involved in the process, although they acknowledged the difficulty of involving the public in health-care rationing.

Knowledge and Understanding
Among the 14 policymakers at the national level, only 4 (29%) were able to define the concept of economic evaluation correctly. All five hospital directors had heard about economic evaluation, but none were able to define correctly the concept and its applications, for example, describing it as a method that compares only the costs of interventions but not the health outcomes.

In Thailand, health economics is not part of the medical curriculum and therefore the 10 health professionals had very limited knowledge about economic evaluation. They misunderstood economic evaluation and referred to it as a method for unit-cost analysis or a cost-controlling instrument.

Not surprisingly, the seven academics had better knowledge and understanding of economic evaluation compared to the other groups. Five had completed or were undertaking formal training in health economics and three of them had published at least one article about health economic evaluation in national or international peer-reviewed journals.

Attitudes, Acceptance, and Values Relating to the Use of Economic Evaluation
After giving an explanation of economic evaluation and verifying their understanding, all of the respondents were asked to discuss its potential relevance for decision-making. Policymakers at the national level considered economic evaluation to be a relevant tool for helping them make decisions about the acceptance or rejection of a technology, and that it had the potential to improve the existing implicit and sometimes political criteria. Nevertheless, they argued strongly that economic evaluation information should not be the only criterion for deciding the content of the package. Four policymakers (of 14, 29%) supported its use as a major criterion and 9 (64%) claimed that it would have to be one of many factors considered. They argued, for example, that political pressures had played a role in making past coverage decisions (see the example of ART previously mentioned) and that these political considerations made by the Minister of Health were legitimate, even if they included some cost-ineffective interventions. They were concerned that if economic evaluation was the only criterion used, the power to make coverage decisions would be transferred from legitimate political representatives to academics.

Policymakers were also concerned about the complexity of the method, which would make it difficult to communicate to the public and in turn might affect public perceptions and levels of support for their decisions:

There will not be much popular support for the use of cost-utility analysis because people cannot understand what a QALY really means. It is very subjective and difficult to give a clear explanation. Only researchers can understand and accept this but laypersons or even doctors, I believe, do not understand. (national policymaker)

National policymakers were confident about their decision-making skills and their ability to incorporate and balance numerous considerations. In particular they argued that they had to balance several public health insurance objectives: It should not only maximize the aggregate health benefits of the population (i.e., a utilitarian perspective that underpins economic evaluation), but also offer services that can improve equity in health across subpopulations, develop “social solidarity” by giving higher priority to services for vulnerable populations, and protect against the financial risks of catastrophic health expenditures.

One senior administrator questioned further the appropriateness of the utilitarian concept for resource allocation in health care (maximizing health benefit) by referring to the Buddhist philosophy of the “Middle Way,” implying that people may not want their healthcare system to make people live as long as possible (to maximize quality-adjusted life-years [QALYs]) because this may cause cravings to live longer but not increase happiness.

Hospital directors also argued that economic evaluation had the potential to aid health technology coverage decisions. In fact a larger proportion of the hospital directors compared to the national policymakers supported the idea of economic evaluation being the sole or major criterion for resource allocation decisions: two out of five stated that economic evaluation information should be the only criterion; two supported its use as a major criterion; and only one supported its use alongside several other criteria such as feasibility (whether there were the necessary infrastructure and human resources to provide a particular service). Nevertheless, the overall affordability for the hospital of introducing an intervention was a key concern among hospital directors who are responsible for balancing the hospital budget. They believed that there would be increasing cost pressure on healthcare providers due to new technologies and an aging population, and at the time of the interview expressed their frustration with the under-reimbursement they
were receiving from the central MOPH under the existing high-cost benefit package.

The health professionals, being closer to patients on a daily basis and prescribing numerous treatments, admitted the necessity of rationing in health care and understood the difficulties of the rationing process. None of them opposed the use of economic evaluation for making health-care coverage decisions, but their overall position on this matter was similar to the policymakers. None thought that it should be the only criterion for the development of the benefit package, with half (5 out of 10) arguing that it should be a major criterion and the other half arguing that it is one of several criteria, such as severity of disease, social solidarity, and equity.

Health professionals also raised a similar concern to that raised by national policymakers. They feared that it would be difficult to develop a simple message to communicate to the public about economic evaluation. Related to this concern, they anticipated that the public’s trust and respect for them would be undermined if they could not work in the best interests of their patients and had to apply rationing decisions based on cost-effectiveness criteria.

All the academics argued that the use of economic evaluation was a way to make policy decisions more transparent. They commented on the current lack of explicit criteria used for the selection of health interventions for the benefit package:

Some people think that utility is subjective but we are currently using no evidence which means it is even more subjective. (academic)

Three out of seven academics endorsed the use of economic evaluation as the sole criterion for development of the benefit package, and another three supported the use of economic evaluation information as a major criterion. Only one academic was reluctant to use economic evaluation information over other factors, for example equity, to make coverage decisions.

The majority of academics supported the specific use of cost-utility analysis because it was necessary to make resource allocation decisions across health technologies, and although not a perfect tool, it is the only method now accepted internationally.

**Opinions about the Reliability and Acceptability of Evidence**

Several respondents referred to methodological issues that would affect policy actors’ trust in and acceptance of economic evaluation data. There was a consensus across the policy actor categories that evidence must be derived from the Thai setting and not transferred from other countries. The policy actors’ concern about the transfer of economic evaluation results, particularly from North America or Europe to a country like Thailand, reflected those raised in the health economics literature [17,18]. For example, policymakers at the national level and hospital directors were concerned about the differences in both costs and health state preferences used in evaluations in other settings. Hospital directors also noted that a barrier to using economic evaluation was the lack of studies conducted in Thailand. They thought that substantial evidence was needed to inform coverage decisions, but that there was limited expertise to produce, analyze, and interpret the evidence. Health professionals worried about the application of clinical outcomes from trials conducted in the United States or European countries and also expressed serious doubts about the soundness of the method. They were not clear whether it was possible to simplify complex health and nonhealth outcomes into a single utility unit such as a QALY or disability adjusted life year (DALY).

Policy actors also noted the importance of a rigorous and unbiased process for selecting health technologies for assessment. One of the more experienced national level policymakers at the NHSO expressed an interest to learn about selection processes for technology assessment that would be unbiased and so most effective policy decision-making.

Two of the five academics also stated that they would not support the use of economic evaluation if the process for selecting technology to be appraised was not well organized. If decisions were left to individual investigators, or motivated by government or commercial sponsors, the assessments might not cover society’s best interests.

All respondents favored evidence produced by academics or independent organizations over evidence from the pharmaceutical industry. Several suggested that responsible bodies for conducting economic evaluation in Thailand should be “transparent,” “accountable,” “impartial,” “widely acceptable,” and “skillful.” Although academics considered that the NHSO and other health-care purchasers should not be directly involved in the evaluation process due to possible conflicts of interest, they suggested that these public bodies should be the main funding sources for economic evaluation studies in Thailand.

**Discussion**

Although health economic evaluation has been widely disseminated in the academic literature and found favor in real policy decisions in some developed countries, the tool has never occupied a place in the health policy arena of developing countries even though resources are scarcer and there is a need for rationing. This study is the first to explore among policy actors the potential opportunities and difficulties or complexities of introducing the method to develop a
public health-care benefit package in a middle-income country, Thailand.

**Opportunities for Introducing Economic Evaluation**

The interviews revealed some shifts in policy context that had increased policy actors’ support for economic evaluation. First, increasing pressure on constrained resources was the most important factor driving stakeholders at every level to care about priority setting. Policymakers at the national level, hospital directors, and even health professionals working with patients realized that it is impossible to include every health service that could benefit patients within the UC benefit package and that the need to ration limited resources would be even greater in the future. Increasing pressure for more efficient use of public resources stemmed from rapid increases in the availability and cost of new health technologies and an epidemiological transition that had increased demand for expensive interventions.

Second, and related to the above resource pressures, policy actors voiced the need for more transparent decision-making. It was evident that current decision-making practices lacked transparency and participation by stakeholders such as hospital directors, health professionals, or even the public. Policy actors also accepted that economic evaluation could be a means of strengthening the legitimacy of their decisions because it was a rational basis for explaining their decisions and gaining acceptance from health-care stakeholders and the public.

**Potential Difficulties of Introducing Economic Evaluation**

Although policy actors thought that economic evaluation information was potentially useful, it was rarely accepted as the only criterion for making coverage decisions; respondents voiced several difficulties or complexities. Figure 1 presents a simple framework for categorizing these reservations or difficulties with using economic evaluation expressed by policy actors. It illustrates how their attitudes toward economic evaluation must be understood within wider contexts, in particular their organizational allegiances and the institutionalized “ways of doing things” within these organizations or among their social and professional groups, which are reinforced by the norms, rules, and values of those groups or wider society.

Following the numbered components in Figure 1, the first barrier to the adoption of economic evaluation to inform the UC benefit package relates to the availability of Thai studies of adequate quality. The respondents rejected the use of foreign data because they were aware of diversities in costs and outcomes that might occur from the same intervention in different settings (see [9] for a review of these informational barriers in more detail).

The second barrier against the use of economic evaluation relates to policy actors’ limited understanding of it, revealed by their misuse of terminology and frequent failure to distinguish between it and cost analysis. Lack of training in health economics for medical students in Thailand makes this finding across respondents unsurprising. Without improved understanding among national policymakers, hospital directors, and health professionals, the use of economic evaluation in decision-making in Thailand is unlikely to happen. Some respondents also revealed a lack of trust in economic evaluation methods and results that stemmed partly from the fact that economic evaluations are complex simulations and biases can be introduced in many ways at various steps in the analysis. Many of these problems were well described by academic respondents and are fully supported by evidence [9]. Policymakers also believed that the results could be manipulated unless studies were conducted transparently and by neutral agencies.

---

**Figure 1** The difficulties and complexities of introducing economic evaluation into health technology coverage decision-making processes.
A third difficulty with the introduction of economic evaluation was based on philosophical and ethical positions that contrasted with the philosophy of “health maximization” underpinning economic evaluation. Some respondents expressed doubt as to whether the utilitarian notion of “QALY maximization” would lead to an equitable or just distribution of scarce health resources, or would be in the best interests of society. They said it was also morally justifiable to offer interventions that are less cost-effective to more vulnerable groups in society such as the young or those of old age, those living in poverty, or living with disabilities. In their opinion, the public’s acceptance of economic evaluation would be limited if the societal values of equity or justice were not incorporated into decision-making.

Fourth, organizational allegiances and institutionalized modes of thinking and behavior made policy actors cautious about the introduction of economic evaluation, although to differing degrees. For example, policymakers at the national level were allied to the objectives of these organizations, which are not solely to improve (or maximize) the overall health of the population but also to promote equity in health care and overall social welfare.

Hospital directors operate in a slightly different organizational environment where the primary objective is to maintain the overall financial sustainability of the hospital, delivering health services within budget and containing costs wherever possible. Moreover, the UC capitation payment system provides incentives for hospital directors to contain costs because the hospital is relatively autonomous financially and responsible for overspending in any given year (and can retain any underspending). Hospital directors’ relatively more enthusiastic acceptance of economic evaluation as a tool to promote efficiency was therefore not surprising. Equity in health care was a relevant but relatively less pressing organizational concern.

Social institutions refer to “ways of doing things,” which might be formalized through law or be less formalized rules governing behaviors based on norms and values. A dominant mode of thinking and behavior instilled in medical professionals is the primacy of the right to treatment and health. In Thailand, the right to treatment (traditional and later allopathic) without concern for economic issues has a long history [19], and although the Thai health-care system has evolved, the health profession has retained a strong public health tradition that prioritizes the giving of treatment over economic questions. A rights-based approach to health care was formally reinforced by the 1997 Thai Constitution (section 52), which gives the right to health and health care:

A person shall enjoy an equal right to receive standard public health services, and the indigent shall have the right to receive free medical treatment from public health centres of the State. . . . [20].

It is rare for health professionals or even professional associations to consider the costs or value for money of the services they offer to their patients because such considerations, at least in public, would conflict with their professional ethic to improve health and save life. These historical and institutionalized ways of operating help to explain health professionals’ caution about introducing economic evaluation. In principle, health professionals must act in the patient’s best interest, that is, where the basis of trust between the patient and provider resides, and they will be reluctant to deny an individual patient treatment on abstract rationales based on “society’s interest” derived from economic evaluation (unless, perhaps, rationales such as cost-effectiveness can be explained clearly). The Constitution has added strength to health professionals’ caution, through fear of serious criticism or even allegations of criminal negligence from the public if they refuse treatment to patients. Other policy actors’ caution about economic evaluation was also influenced by these institutional contexts, particularly health policy decision-makers at the national level (politicians and bureaucrats) who are also medically trained and are primarily responsible for ensuring health-care services are available according to the Constitution.

The political context and changing political pressures on policymakers (number 5 in Fig. 1) were perceived to be inevitable and legitimate forces influencing decision-making, particularly for senior politicians and bureaucrats. Economic evaluation information could only be considered and weighed up in the light of these political pressures, for example, the need to sustain political legitimacy and popularity. Furthermore, the introduction of economic evaluation would have implications for the distribution of power within the decision-making process. The interviews revealed policymakers’ concerns that if economic evaluation was to be used as a significant criterion for making coverage decisions, their power and authority would be diminished and transferred to academics or economists.

Conclusions and Policy Recommendations

This study demonstrates that introducing economic evaluation into health-care decision-making in settings like Thailand is more complicated and likely to be more difficult than is commonly presumed to be in the economic academic literature. In-depth interviews with 36 policy actors located in different positions in the health sector showed their lack of understanding in the method. A basic policy measure to encourage the use of economic evaluation among policymakers would therefore be to offer awareness and education
programs aimed at making policymakers more confident in using and interpreting economic evaluation evidence and more able to explain it to others.

In addition, many policy actors questioned the ethical values underpinning QALY maximization. QALY maximization may not be the only goal for resource allocation and economic evaluation may not be the only tool for decision-makers to ration health care. Equity, necessity (severity of disease), social solidarity (helping the poor and vulnerable), and protection against catastrophic expenditure also play a significant role. These criteria are particularly important in the context of the UC in Thailand because an explicit objective of the UC policy was to increase equity of coverage and reduce catastrophic spending. Therefore, proposals to use economic evaluation should not disregard or eliminate other criteria concerning resource allocation, and a priority is to develop an alternative approach for economic evaluation, which incorporates criteria like equity and social solidarity to enhance political and public acceptance of a health-care package.

This exploratory research has highlighted two areas for further research. First, the opportunities and difficulties of introducing economic evaluation into the specific context of Thailand may be different in other settings due to differences in health-care infrastructure, institutions and incentives, and different policy processes and political pressures. It would therefore be valuable to learn to what extent the barriers to the use of economic evaluation identified in Thailand are distinctive or similar to those operating in other low- and middle-income countries.

Second, the findings revealed that public involvement of some sort in coverage decisions was necessary because decision-makers and health professionals were sensitive to the public’s responses to their decisions. Nevertheless, the study did not explore public or patient perspectives on priority setting. Public perspectives on health-care rationing cannot be ignored if economic evaluation is to be accepted and trusted as a legitimate means of resource allocation. More research is therefore required to examine the public’s acceptance of using economic evaluation or alternative resource allocation criteria for health-care coverage decisions, and to examine possible mechanisms for incorporating these public perspectives into decision-making.

We would like to acknowledge and thank Prof. Miranda Mugford who guided the development of the study.

Source of financial support: We are grateful for the joint financial support to the Health Intervention and Technology Assessment Program by the Thai Health Foundation, Health System Research Institute, National Health Security Office, and Bureau of Health Policy and Strategy, Ministry of Public Health. At the time this study was conducted the first author was supported by the World Health Organization under the Fellowship Program award to study at the University of East Anglia.

References

9 Teerawattananon Y, Russell S, Miranda M. A systematic review of economic evaluation literature in Thailand: is the data good enough to be used by policy-makers? Pharmacoeconomics 2007;25:467–79.
15 Teerawattananon Y, Mugford M. Is it worth offering a routine laparoscopic cholecystectomy in developing


Constitution of The Kingdom of Thailand 1997. [Cited September 26, 2006].