KENYA'S HEALTH BENEFITS ADVISORY PANEL (HBAP) STUDY VISIT TO THAILAND

Developing Health Technology Assessment (HTA) Capacity and a Framework for Kenya
12th to 15th November, 2018
Nonthaburi, Thailand

Abbreviations

AAR	After Action Review
ADP	Access and Delivery Partnership
CSMBS	Civil Servant Medical Benefit Scheme
GDP	Gross Domestic Product
GNI	Gross National Income
HBAP	Health Benefits Advisory Panel
HITAP	Health Interventions and Technology Assessment Program
HTA	Health Technology Assessment
iDSI	International Decision Support Initiative
IHPP	International Health Policy Program
KEML	Kenya's Essential Medicines List
KWTRP	Kenya Medical Research Institute-Wellcome Trust Research Programme
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya's Essential Package of Health
KHSSP	Kenya's Health Sector Strategic Plan
LMIC	Low- and Middle-Income Countries
MoF	Ministry of Finance
MoH	Ministry of Health
MoL	Ministry of Labor
MoPH	Ministry of Public Health
NESD	National Economic and Social Development
NLEM	National List of Essential Medicines
NHIF	National Hospital Insurance Fund
NHSO	National Health Security Office
PHC	Primary Health Care
RF	Rockefeller Foundation
SSS	Social Security Scheme
SQCB	Standard Quality Control Board
TRF	Thailand Research Fund
UHC	Universal Health Coverage
UCS	Universal Coverage Scheme
GHD/MoPH	Global Health Department/ Ministry of Public Health

Contents

Executive Summary

In 2018, Kenya's President committed to achieving Universal Health Coverage (UHC) by 2022. Subsequently, in June of the same year, the Cabinet Secretary for Health formed a Health Benefits Advisory Panel (HBAP) to develop a benefits package for the UHC program. Through past engagements between the Kenyan and Thai Ministries of Health, the HBAP was invited for a study visit to the Health Intervention and Technology Assessment Program (HITAP) in Bangkok, Thailand. HITAP is one of the organizations involved with conducting Health Technology Assessment (HTA) for the health benefits package used in the Thai UHC scheme. Thus, HITAP has lessons and experiences which could be shared and discussed with the HBAP. Through the study visit, the panel aims to learn about Thailand's HTA system, including governance, frameworks, guidelines, the process, and its role in the health system, and HITAP learned about the Kenyan system. This study visit was supported by the International Decision Support Initiative (iDSI), Ministry of Health Kenya, The Access Delivery and Partnership (ADP), and KEMRI-Wellcome Trust Research Programme (KWTRP).

Introduction

The Government of Kenya announced its vision to achieve Universal Health Coverage (UHC) and has expressed its interest to learn from the Thai experience and exchange knowledge on the topic. There have been meetings between senior dignitaries from the Kenyan and Thai governments with additional engagements on the horizon. A specific request for support on the use of health technology assessment (HTA) for the development for the benefits package has been evinced in this regard. In addition, the Health Intervention and Technology Assessment Program (HITAP), a semi-autonomous research unit in the Ministry of Public Health, Thailand, is a core partner of the International Decision Support Initiative (iDSI) and reached out to the Health Economics Research Unit at the KEMRI Wellcome Trust Research Programme (KWTRP) to discuss areas for collaboration.

These discussions culminated in organising a study visit for the Health Benefits Package Advisory Panel (HBAP) which has been tasked with developing a benefits package for the UHC program. Through the visit, the HBAP aims to learn about the Thai health system and the role of the HITAP in the Ministry of Public Health, Thailand. The study visit was funded by the Access and Delivery Partnership (ADP) grant to HITAP, Imperial College London, and KWTRP.

This report provides an overview of the study visit and describes the health system in Kenya, based on discussions with the delegation, followed by a summary of discussions on developing a framework for HTA in Kenya. Supporting documents are provided in the Appendices, including an overview of the Thai experience and communications' outputs.

Overview of the study visit

This study visit aimed to enhance awareness of the HTA system in Thailand and to develop a framework for HTA in Kenya, drawing from the lessons learned. Further, as this was the first meeting of partners in the two countries, this visit was also an opportunity to identify areas for future collaboration. Participants for the visit included staff from HBAP, and the Kenyan Ministry of Health's department of Universal Health Coverage coordination. From Thailand, in light of the broader engagement on UHC, in addition to HITAP, there were participants from the International Health Policy Program (IHPP), National Health Security Office (NHSO), Global Health Department/Ministry of Public Health (GHD/MoPH), United Nations Development Program (UNDP) and Japan International Cooperation Agency (JICA).

To achieve the goals of the visit, the agenda was divided into two parts: on the first two days, participants learned about the Thai and Kenyan health system, including the role of HTA and engaged with Thai experts on priority topics in Kenya such as developing benefits packages as well as related topics such as price negotiation; on the third day, participants

learned more about institutionalizing HTA, including the infrastructure, using HTA to inform policy making, evaluating drugs, vaccines, and interventions, and development of a national HTA framework. The morning of the fourth day was reserved for drafting an HTA framework and discussing next steps for HTA, UHC, and areas for collaboration between Kenya and Thailand. Throughout, HITAP learned about the context, health system, and HTA in Kenya as well. To achieve the objectives of the study visit, the agenda was structured to include presentations, question and answer time after each presentation, discussions, and breakout activities for group work.

Background on KenyaFeatures of Kenya's healthcare system

Kenya has a population of 48 million people and a Gross Domestic Product (GDP) per capita of $1,455 making it a Lower-Middle Income Country (LMIC). Kenya has a large informal sector of 83% and a poverty incidence of 36%. Currently, about 81% of the population are uninsured, and the 19% who are insured are in the formal sector. When looking at the health indicators, the maternal mortality rate is 362 per 100,000 live births and the under 5 mortality rates is 52 per 1,000 lives. In 2016, the Government expenditure as a percentage of total government expenditure was 78.6 USD per capita. Kenya has a devolved system of governance which consists of a national or central government and 47 county governments. The National Ministry of Health is primarily responsible for policy and regulation and the county governments are responsible for service delivery. The total number of healthcare facilities in the country is approximately 10,000. Kenya has a pluralist system where 50% of the healthcare facilities are public owned and 50% are private. The health system in Kenya comprises four levels of care: from the grassroots level are the Community Health Services; then Primary Healthcare Services; County Referral Services; and the larger National Referral Services.

The purchasing arrangements in Kenya include 1) Integrated public mechanisms where the national Ministry of Health purchases tertiary care services from tertiary public hospitals or national referral hospitals using the global budget and the County department of health (47 counties) purchases secondary and primary healthcare services from public hospitals, health centers and dispensaries using a line item budget, salaries, and commodity procurement. 2) The public contract systems consist of a purchasing entity, the National Hospital Insurance Fund (NHIF) and various public healthcare providers from national referral hospitals to health centers and dispensaries. 3) Private contract systems with 34 private health insurers, 96 community-based health insurers, and employer or company managed schemes.

Commitment to Universal Health Coverage (UHC)

The President of the Republic of Kenya, His Excellency Uhuru Kenyatta, has committed to implementing the "Big Four": 1) Food security and agriculture, 2) Affordable housing, 3) manufacturing, and 4) Affordable Healthcare for all, which are interlinked and together they "will create jobs, which will enable Kenyan's to meet their basic needs". In the health sector,

the Government's vision is to achieve UHC by 2022, to 1) provide access to essential healthcare and public health interventions to Kenyans across all 47 counties, 2) lower financial barriers to health by increasing the health budget progressively from 6.7% to 15% of the annual budget by 2021 and beyond, and 3) improve the overall quality of health services and the number of health facilities. According to the World Health Organization's (WHO) UHC cube, the government needed to identify the population to be covered under UHC, identify the health benefit package to be offered to the identified population and determine the financing of the health benefit package.

When identifying whom to cover, there are key characteristics of the population that need to be considered, such as the large informal sector, rural population, number of uninsured persons, and the number of people who are impoverished. With this in mind, deliberation on the costs, resource needs, and pros and cons was done for these three scenarios: 1) all uninsured persons in Kenya 80.9% (38.6 million people); 2) the poor and the near poor 68% (32.5 million people); or 3) target the vulnerable and indigents 40% while removing user fees (19.1 million people) was done. The final decision was made to build on existing programs and cover the entire population. However, there are several challenges related to ensuring that the large informal and poorest quintiles have access to care.

Implementation plan for Universal Health Coverage (UHC) in Kenya

Implementation of UHC will be done in a phased approach. A pilot phase will run from November 2018 through October 2019 in which four counties, Isiolo, Kisumu, Machakos, and Nyeri, will receive funding allocations. During this period, health systems strengthening activities will take place in the other 43 counties in preparation of UHC rollout. Between November 2019 to December 2021, UHC will be scaled up to the remaining 43 counties. The overall focus on primary health care, through improved access to services will add benefits such as fewer hospitalization, less utilization of specialist and emergency centers and less chance of being subjected to inappropriate health interventions. Additionally, by having the Kenya Medical Supplies Agency (KEMSA) as the central procurement entity, bulk procurement of materials can achieve economies of scale and competitive prices. KEMSA prices are 20-30% lower than the market price and have a shorter turnaround time for distribution of commodities (7-10 days). However, there were procurement challenges that KEMSA faced and have undergone reform to revamp the system, but the concern is whether KEMSA is able to handle the increase in demand and ensure satisfaction from counties and patients. A stock-out feedback loop in drug committees within counties is being developed to provide signals to KEMSA when shortages arise. Audits are also being systemized to ensure that there are no leakages and that usage is in line with the essential list.

Key priority setting exercises and strategies in the Kenyan health sector

Currently, several exercises have been undertaken to provide guidance on priority setting and decision making. National Health Policy and Strategy formulation is encapsulated in the

Kenyan Health Policy (KHP) and Kenya Health Sector Strategic Plan (KHSSP). The service package of health for the public sector is Kenya's essential package of health (KEPH) which is linked to KHP and KHSSP. There is an essential drugs programme that focuses on the management of Kenya's essential medicines list (KEML). The NHIF is involved with the benefit package development. There are also health programme specific strategies for vertical programmes, such as malaria, tuberculosis, HIV/AIDS and immunization. There is annual budgeting and planning work done at the national and county level. However, these exercises and strategies have been developed independently, with varying levels of explicitness and evidence, and institutionalization, thus creating fragmented efforts. In June 2018, the Government formed a Health Benefit Advisory Panel (HBAP), to develop a health benefit package with costings, identify priority setting criteria and methods to operationalize them through various processes. *(more details below in the Health Benefits Advisory Panel section)*

Health Benefits Advisory Panel (HBAP)

In June 2018, a Health Benefits Advisory Panel (HBAP) was appointed by the Cabinet Secretary for Health with a mandate for two years. The HBAP is comprised of 14 members with representations from academia, national and county governments, health professionals' associations, purchasers, regulatory authorities, and health civil society. The function of the panel is to: 1) develop standard criteria for assessing inclusion and exclusion of services, procedures, drugs, medical supplies, and technologies in the UHC-Essential Benefit Package; 2) define an evidence-based benefit package for Kenyans, including its cost and provider payment rates and mechanisms; and 3) define a framework for institutionalization of HTA. In order to develop the health benefits package, the Panel applied a systematic process shown in the diagram below.

In order to select and develop a list of criteria to assess whether an intervention should be included or excluded in the HBAP, the panel applied the 5 step Nominal Group Technique (NGT). After applying a menu of 18 priority setting criteria through the 5 steps, the Panel agreed to a set of 10 criteria and their weights. The 10 criteria that were selected are:

1) effectiveness and safety
2) cost-effectiveness
3) equity
4) burden of disease
5) severity of disease
6) service, health commodities and technology requirements
7) health workforce requirements
8) affordability (budget impact)
9) catastrophic health expenditure
10) congruence with existing priorities

To operationalize each criterion, short-term (60 days) and long-term (2 years) methods of appraisal were defined. The Panel then chose a "shape" for the HBP, which is that it will be explicit and positive i.e. what is included and will be built on the existing health care system. The proposed health benefits package is the UHC-Essential Benefit Package, which will mostly cover Public and Community Health Services, Basic Services and Specialized Services. These Community Health Services include: emergency services, mental health care, non-communicable diseases screening (diabetes and hypertension) and care, and improved/enhanced medical and surgical services, maternal health services, child services, and major infectious diseases. Overall, the package aims to cover more Kenyans and promote health care utilization of primary health care.

Financing health services identified in the HBAP

The Government of Kenya has decided to continue to provide funding for existing programs such as the 2013 directive to remove user fees in Level 2 (dispensaries and clinics) and Level 3 (health centers) facilities, provide free maternity services with an annual set allocation of funds, provide conditional grants to counties with Level 5 county referral hospitals, and provide support for health system strengthening till 2022. For delivery of key services, the proposed resources will be apportioned into four components as follows: community services 2.07%, basic and specialized services 80.91%, health system strengthening at 16.96%, and public health services at 0.08%. These spending proportions were determined by applying the 10 criteria for allocation informed by existing evidence and best practices. For the first phase, the four pilot counties will each receive funding allocations for public health services, community health services, health system strengthening, and basic and specialized services. Each of the four county governments will contribute USD 40 million and the national government will match the amount of USD 40 million. Furthermore, funding has been allocated for Monitoring and Evaluation, Communication and Advocacy, and Specialized Services. Additionally, the Kenyan government has invested USD 140 Million into the system for various health system strengthening needs.

For the scale-up phase, the Government of Kenya has estimated that it will need to provide USD 340 million to cover the remaining 43 counties per year. Commodities will be supplied in-kind (70% of the funds allocated will be allocated for essential medicines and supplies through KEMSA with counties getting drawing rights from KEMSA. The remaining 30% including other grants will be sent directly to the facilities as conditional grants for facility improvements, operations and maintenance of facilities. Counties shall retain the current budget allocation for health and demonstrate an increase in the subsequent years. Counties shall be responsible for hiring of Human Resources for Health and other Health System Strengthening purposes.

Learning between Kenya and Thailand

Given the request by the Cabinet Secretary for Health in Kenya to the Thai Minister of Public Health to collaborate on healthcare, there were discussions on the lessons that could learned given Thailand's implementation of a UHC scheme in 2002. During the study visit, this was done through presentations and discussions with senior experts who shared their experience implementing UHC and HTA in Thailand (see overview in Appendix 3).

Through learning about the Kenyan and Thai contexts, UHC journeys and HTA, participants recognized that there are important similarities and differences between Kenya at this time and Thailand during the launch of the UHC that are worth noting. These similarities further emphasize the importance of knowledge and experience sharing between countries. Some of the similarities between the two countries at the start of their UHC journeys that were identified are:

- Similar income level
- Large informal and rural populations
- Level of Out of Pocket (OOP) Expenditure (Annually healthcare of OOP pushes 453,470 Kenyans into poverty)
- Incidence of catastrophic healthcare expenditure
- Short timeframe to launch the UC scheme
- Launch of UHC in a few provinces before scaling up to the entire country
- Small number of HTA studies and critical efforts to advocate for HTA and build capacity

Examples of key lessons learned from Thailand relate to building the rural health sector and ensuring enough health workers through monetary and non-monetary incentives. Further, the Thai experience highlights the importance of giving ownership and a voice to the people to sustain UHC and HTA work and policy through changing governments. This can be enhanced by reaching out to "champions", who steadfastly carry on the work, and experts who are trusted and can be the backbone of the change. In terms of the health benefits package, it may be useful to provide a comprehensive health package and start small.

Health Technology Assessment (HTA) in Kenya

One of the mandates of the HBAP is to define a framework for institutionalization of HTA. Within the larger framework for the development and revisions of the health benefit package, the panel has identified when and for what HTA will be used. HTA will be used for appraisals of new or existing technologies and to conduct budget impact assessments. However, HTA in Kenya is still in its nascent stage and very few studies have been conducted. Therefore, the Panel is working to identify a framework, develop guidelines, and outline the processes for institutionalizing HTA. In order to initiate this work, the Kenyan Government reached out to the Thai Government asking to learn from the Thai experience and have support from Thai experts. This request formed the basis for the study visit.

Developing a framework for HTA in Kenya: Group Activity

During the study visit, the participants learned how HTA was introduced in the Thai health care system and how it evolved over time. After learning about HTA in Thailand, the Kenyan delegates participated in a group activity where they were asked to deliberate and discuss various topics related to introducing HTA in Kenya. Delegates and Thai participants were split into two groups. Each group was presented with a list of questions from which they selected questions for the discussion. The small group discussion sessions were for 45 minutes, followed by 30 minutes of a larger group discussion where key discussion points and findings were shared. The selected questions and main discussion points were:

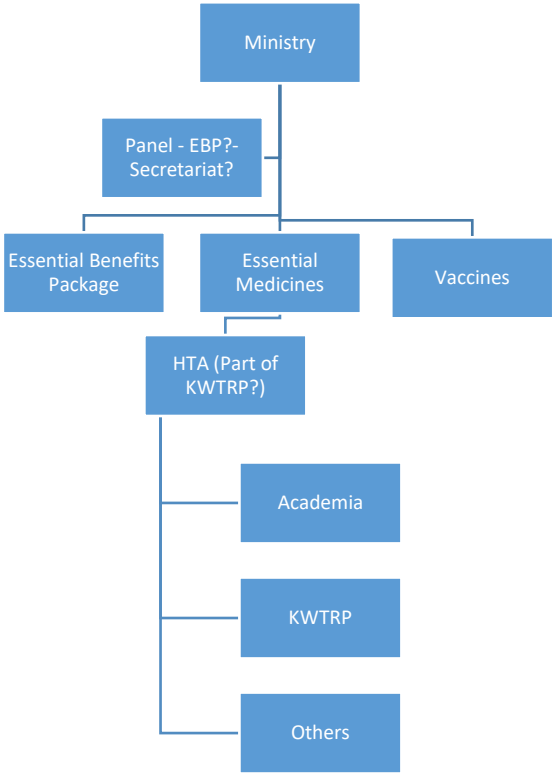
Discussion question 1: What should be the mandate of the HTA system in Kenya?

It was widely agreed that Kenya needs to have an institutionalized HTA mechanism as it is the only way to have a rational, evidence-based, results oriented mechanisms to take decisions on the benefit package. A complementary question raised was whether the need for having HTA is felt or understood by the ministry. Despite having the Terms of Reference (TOR) for the Panel, it is necessary to have demand from the ministry to ensure that the mandate ca fulfil its purpose. Another issue is the fact that while the HTA forming process may have begun and there is now a Panel created by the law, but there is no clear legal binding policy to link HTA to decision making. There needs to be further policy configuring to establish how binding the HTA output/s will be. HTA should be protected legally, sustained and implemented. For example, in the process of negotiating with pharmaceutical companies to lead to better cost saving. Otherwise, the intention of HTA gets lost.

Discussion question 2: What should be the vision and mission for the system?
Proposed vision: Appropriate and affordable health interventions and technologies for the achievement of UHC in Kenya
Proposed mission:

- To develop systems and processes to promote optimal selection, procurement and management of health technology
- To assess health interventions and technologies to inform policy formulation, implementation and resource allocation
- To disseminate findings and educate the general public

Figure 3: Proposed HTA Framework (from group work activity)



Discussion question 3: Is there a process for linking HTA to policy making in Kenya?
It was clarified that the Panel reports to the Cabinet Secretary. As a temporary measure, they can recommend housing the HTA agency strategically to make stakeholders confident. The overarching HTA unit is suggested to be housed in KWTRP. The Panel needs to start thinking who will be involved in HTA, such as representatives from Pharmacy, from KEMSA, etc. There needs to be a decision on the governance arrangements to have ownership and to avoid HTA being just in name.

Discussion question 4: What is the position and process development. How to institutionalize the process?
The roles for stakeholders in the evaluation and appraisal stages need to be determined. When the benefit panel was developed, there was a realization that certain aspects of their work overlap with that of other panels in the ministry. Therefore, it is necessary to harmonize the work of all the panels that are currently in the system. It was also discussed whether HTA have an advisory or a regulatory role. The panel plans on taking a middle ground position. It was recommended that Kenya should have a conversation to decide if the process should still be separated and how it is organized. It was further suggested that their committee should do only appraisals. The other committee should not be conducting CEA and only be taking decisions.

Next steps and future collaboration between Kenya and Thailand

Based on the priority areas of the HBAP, the following areas for collaboration were identified between Kenya and Thailand:

1. Universal Health Coverage (UHC)
    - Quality assurance mechanism (e.g., accreditation system)
    - Communications with various stakeholders
    - M&E of UHC (during the pilot process), e.g., patient satisfaction survey
    - Monitoring of health financing (e.g., provider payment reform)

2. Health technology Assessment (HTA)
    - HTA Infrastructure
        - Methodological guidelines and tools
        - Threshold analysis plan
    - Institutionalization of HTA process
        - Stakeholder engagement (technical teams and delivery institutions e.g. KEMSA) and policy advocacy
        - Process guidelines
    - Technical HTA capacity building with local partners (e.g., academic institutes)
        - Study visit with technical team and delivery institutions e.g.: KEMSA, NHIF, and other relevant agencies in Kenya.
        - Training on HTA
        - Conduct HTA pilot study (with Kenyan researchers as the lead)
    - HTA knowledge sharing
        - African Health Economics and Policy Association (AfHEA) conference on 11-14 March 2019 in Accra, Ghana
        - HTAsiaLink Annual Conference on 24-26 April 2019 in Seoul, Republic of Korea

3. Crosscutting activities
    - Public and health professional communications
    - Formal capacity building (e.g., education support)
    - Scholarships for HTA and UHC (6 short-term and 4 PhD level)
    - M&E (both policy and technical levels)

- One or two study visits to Kenya by Thai team in 2019

4. Potential signing of a Memorandum of Understanding (MoU)

   Signing of an MoU between Kenya and Thailand during the 2019 Prince Mahidol Award Conference (PMAC) on 29 Jan – 3 Feb 2019, to formalize collaboration on UHC and HTA. Thailand plans to invite the Kenya's Cabinet Secretary for Health and Council of Governors for a signing ceremony.

Lessons learned from the study visit

Shortly after the study visit ended, an After-Action Review (AAR) was conducted to reflect and share lessons learned from the study visit. The main points that were discussed were:

- There are several similarities between Kenya today to Thailand during the launch of UHC in 2002 and learnings from the Thai experience that are applicable to Kenya
- Kenya's government has made a great commitment to their people and is investing a substantial amount of resources to achieving UHC
- The county governments play a significant role in ensuring the health infrastructure, human resources, medical supplies, health financing, and overall systems are set up according to the needs of the local communities
- The Panel has applied a systematic and well-informed process to their work and has made significant progress to achieving its goals
- The two countries can benefit from knowledge sharing and technical collaboration on UHC implementation especially healthcare priority setting and evidence-informed policy development

Appendices

Appendix 1: Agenda

Study Visit on Health Technology Assessment (HTA) and Developing an HTA Framework for Kenya

Introduction:

The Government of Kenya announced its vision to achieve Universal Health Coverage (UHC) and has expressed its interest to learn from the Thai experience and exchange knowledge on the topic. There have been meetings between senior dignitaries from the Kenyan and Thai governments with additional engagements on the horizon. A specific request for support on the use of health technology assessment (HTA) for the development for the benefits package has been evinced in this regard. Further, the Health Intervention and Technology Assessment Program (HITAP), a semi-autonomous research unit in the Ministry of Public Health, Thailand, a core partner of the International Decision Support Initiative (iDSI), had reached out to the Health Economics Research Unit at the Kenya Medical Research Institute (KEMRI) to discuss areas for collaboration. These discussions have culminated in organizing this study visit for the Health Benefits Package Advisory Panel (HBAP) which has been tasked with developing a benefits package for the UHC program. Through this visit, the HBAP aims to learn about the Thai health system and the role of the HITAP in the Ministry of Public Health, Thailand. This study visit is funded by the Access and Delivery Partnership (ADP) grant to HITAP, Imperial College London, and KEMRI.

The agenda for the visit has been divided into two parts: **on the first two days**, participants will learn about the Thai and Kenyan health system, including the role of HTA and will engage with Thai experts on priority topics in Kenya such as developing benefits packages as well as related topics such as price negotiation; **on the third day**, participants will learn more about institutionalizing HTA, including the infrastructure needs for HTA to inform policy making, evaluation of drugs, vaccines, or other interventions. The afternoons on the third and fourth days have been reserved for drafting an HTA framework and planning next steps (action plans). The sessions will be presentation, discussion, and group-work based.

Dates: 12th – 15th November 2018
Venue: HITAP Meeting Room 1, 6 Floor, Building 6, Thanon Tiwanon - Pathum Thani, Mueang District, Nonthaburi, 11000

Objectives:

- To understand the HTA system in Thailand. Specifically:
  - The mandate, functions, and processes for health technology assessment
  - Institutional/organizational and governance arrangements for an HTA system
- To develop a framework that defines the objectives, principles, stakeholders, and key processes to institutionalize HTA in Kenya
- To discuss next steps on future collaborations

Participants:

Staff from Health Benefits Package Advisory Panel, and the Kenyan Ministry of Health's department of Universal Health Coverage coordination, International Health Policy Program (IHPP), National Health Security Office (NHSO), Global Health Department/Ministry of Public Health (GHD/MOPH), and HITAP.

Outcomes:

- Increased understanding of Health Technology Assessment (HTA) system in Thailand
- Deliberation on the lessons learned from the Thai experience with HTA to the Kenyan context
- Draft conceptual framework and action plan for HTA development in Kenya

DAY 1: Monday, 12 November 2018

Time	Session	Speaker(s)
9:00 – 9:30	Welcome • Opening remarks • Introduction • Meeting objectives	All HITAP – Dr. Wanrudee Isaranuwatchai / Ms. Avnee Patel / Ms. Saudamini Dabak
9:30 – 10:30	Universal Health Coverage (UHC) in Thailand	HITAP – Mrs. Netnapis Suchonwanich
10:30 – 10:45	Coffee/tea Break	
10:45 – 11:30	Implementing the Universal Coverage Scheme	NHSO – Ms. Waraporn Suwanwela
11:30 – 12:30	Universal Health Coverage in Kenya • Discussion	Kenyan Delegates
12:30 – 13:30	Lunch	

13:30 – 15:00	Historical development of HTA in Thailand, and conducive factors and key components for HTA development in Asia • Discussion	HITAP – Dr. Yot Teerawattananon
15:00 – 15:15	Coffee/tea Break	
15:15 – 16:15	HTA in Kenya: Past, Present, and Plan for the Future	Kenyan Delegates
16:15 – 17:15	Reflection and discussion	All
17:30 – 20:00	Dinner at Dhabkwan Resort and Spa, Nonthaburi (Bus leaves at 17:30)	All

Page Break

DAY 2: Tuesday, 13 November 2018

Time	Session	Speaker(s)
9:00 – 10:00	Recap and today's overview	HITAP – Ms. Avnee Patel All
10:00 – 10:15	Coffee/tea Break	
10:15 – 12:00	HTA for developing the National List of Essential Medicines (NLEM) in Thailand • Discussion	HITAP – Ms. Waranya Rattanavipapong
12:00 – 13:00	Lunch	
13:00 – 14:30	HTA for developing the Universal Coverage Scheme Benefits Package (UCBP) and NLEM in Thailand: Case studies • Discussion	HITAP – Mr. Danai Chinnacom / Ms. Suthasinee Kumluang
14:30 – 14:45	Coffee/tea Break	
14:45 – 17:00	Reflection and discussion	All

DAY 3: Wednesday, 14 November 2018

Time	Session	Speaker(s)

9:00 – 9:30	Recap and today's overview	HITAP – Dr. Wanrudee Isaranuwatchai All
9:30 – 11:00	Understanding health care systems to design priority setting mechanisms for UHC • Discussion	IHPP – Dr. Walaiporn Patcharanarumol
11:00 – 11:15	Coffee/tea Break	
11:15 – 12:30	Using evidence to inform UHC implementation: the experience from IHPP • Discussion	IHPP – Dr. Walaiporn Patcharanarumol
12:30 – 13:30	Lunch	
13:30 – 14:00	Communication of HTA Results	HITAP – Ms. Benjarin Santatiwongchai
14:00 – 15:30	HTA impact evaluations: Case studies	HITAP – Dr. Yot Teerawattananon
	Resources for HTA Studies • Discussion	HITAP – Dr. Yot Teerawattananon
15:30 – 15:45	Coffee/tea Break	
15:45 – 17:00	Reflection and discussion	All
17:30 – 19:30	Dinner at the Best Restaurant, Nonthaburi (Van leaves at 17:30)	All

DAY 4: Thursday, 15 November 2018

Time	Session	Speaker(s)
9:00 – 9:30	Today's overview	IHPP/HITAP All
9:30 – 11:00	Thai Ministry of Public Health/Ministry of Foreign Affairs collaboration with Kenya	Kenyan Delegates, IHPP, NHSO, MoFA, HITAP, TICA
11:00 – 11:15	Coffee/tea Break	
11:15 – 12:30	Priority areas for collaborating on HTA: workplan and timeline	All
12:30 – 13:30	Lunch	
End of Meeting		

Appendix 2: Participants list

Sr. No.	Name	Organization
1	Dr. David Karuiki	Ministry of Health, Department of Universal Health Coverage Coordination
2	Dr. Claver Kimathi	Ministry of Health, Department of Universal Health Coverage Coordination
3	Prof. Joseph Wangombe	Kenya Health Benefits Advisory panel
4	Dr. Mercy Mugo	Kenya Health Benefits Advisory panel
5	Dr. Edwine Barasa	Kenya Health Benefits Advisory panel
6	Dr. Meshack Ndolo	Kenya Health Benefits Advisory panel
7	Dr. Andrew Mulwa	County Executive Council Member for Makueni County
8	Dr. Rahab Mbau	KEMRI-Wellcome Trust Research Programme
9	Dr. Walaiporn Patcharanarumol	International Health Policy Program (IHPP)
10	Ms. Waraporn Suwanwela	National Health Security Office (NHSO)
11	Ms. Chanya Lohvongpaiboon	Global Health Division/Ministry of Public Health (GHD/MoPH), Thailand
12	Dr. Yot Teerawattananon	Health Intervention and Technology Assessment Program (HITAP)
13	Mrs. Netnapis Suchonwanich	Health Intervention and Technology Assessment Program (HITAP)
14	Dr. Wanrudee Isaranuwatchai	Health Intervention and Technology Assessment Program (HITAP)
15	Dr. Pattara Leelahavarong	Health Intervention and Technology Assessment Program (HITAP)
16	Ms. Waranya Rattanavipapong	Health Intervention and Technology Assessment Program (HITAP)
17	Ms. Suthasinee Kumluang	Health Intervention and Technology Assessment Program (HITAP)
18	Mr. Danai Chinnacom	Health Intervention and Technology Assessment Program (HITAP)
19	Ms. Akanittha Poonchai	Health Intervention and Technology Assessment Program (HITAP)
20	Ms. Benjarin Santatiwongchai	Health Intervention and Technology Assessment Program (HITAP)
21	Ms. Avnee Patel	Health Intervention and Technology Assessment Program (HITAP)
22	Ms. Saudamini Dabak	Health Intervention and Technology Assessment Program (HITAP)

23	Mr. Jatuporn Apichadsupapkajon	Health Intervention and Technology Assessment Program (HITAP)
24	Ms. Rachel Archer	Health Intervention and Technology Assessment Program (HITAP)
25	Ms. Alia Luz	Health Intervention and Technology Assessment Program (HITAP)
26	Ms. Manushi Sharma	Health Intervention and Technology Assessment Program (HITAP)
27	Mr. Sven Engels	Health Intervention and Technology Assessment Program (HITAP)
28	Ms. Juliet Eames	Health Intervention and Technology Assessment Program (HITAP)
29	Mr. Francisco Cervero Liceras	Health Intervention and Technology Assessment Program (HITAP)
30	Ms. Evelyn Thsehla	Health Intervention and Technology Assessment Program (HITAP)

Appendix 3: Summary of Universal Health Coverage and Technology Assessment in Thailand

UHC journey in Thailand

Properly launching the UHC system was a journey that started in the early 1970's; like all journeys, there were ups and downs, challenges and gaps, and continuous learning and Improvements. In order to explain how UHC developed in Thailand, the participants were taken back in time from the beginning when the foundation of the health system was being placed, to when the system was developing with necessary processes, policies, infrastructure, human resources, and institutions, and finally to when the UHC scheme formally started. After the launch of the scheme, further developments and adjustments were undertaken, with the UHC system evolving and growing to meet the population's needs.

Building a solid foundation for UHC came in two parallel strands of development: 1) **Infrastructure development** to ensure availability of services through equitable access to health facilities and adequate number and equitable distribution of workforces; and 2) **Expanding financial risk protection** through increasing the population covered (formal sector, informal sector, the poor and vulnerable) and expansion of the benefit package. However, for the two strands of development to succeed, a conducive **political environment** and commitment was required.

Infrastructure development began in 1942 with the establishment of the MoPH and the district health system, comprised of district hospitals and health centers. In 1972, key health workforce policies helped ensure there were enough healthcare providers in rural parts of the country. Examples include: compulsory rural service of 2-3 years for doctors, dentists, pharmacists, nurses, and recent graduates; workforce expansion through an increased number of nursing and public health schools; recruitment of rural health providers, rural training and hometown placement; the Collaborative Project to Increase Production of Rural Doctors (CPIRD) and providing both financial incentives and non-financial incentives to health workers in rural areas. In 1975, the district health system was scaled up through increased investments in building health facilities to ensure that each district has at least 1 district hospital and 1 health center. In 1980's the Civil Servant Medical Benefit Scheme (CSMBS) was established, followed by the voluntary health card in 1983. In the 1990s the Social Security Scheme (SSS) was established. Through these efforts, there was a huge increase in access to primary health care in rural health centers from 29% in 1977 to 54% in 2010. Further, it was important to take a multisectoral approach and collaborate with other sectors for health promotion activities. For example, the Ministry worked with the education sector to train and implement eye testing in schools.

Though infrastructure development and health system strengthening were vital to the success of achieving UHC in Thailand, there were **intangible factors** that contributed to

these successes. For example, to increase uptake of primary health care an improved trust in the health centers by the communities was achieved by ensuring that there were enough medical supplies and healthcare providers who came from the district. The commitment from village health workers (community health volunteers) is another strength of the Primary Health Care (PHC) system which makes UHC successful. They provided health knowledge and spread important messages to people living in hard to reach areas. With minimal (or just adequate) financial support, they work hard to take care of their community.

Expanding financial risk protection was a key component of developing a strong foundation for UHC. Two key methods of expanding financial risk protection were through increasing the population covered and expanding the benefit package. Together these aimed at reducing impoverishment due to health care costs of households, catastrophic health expenditure, and increasing primary health care utilization and reducing unmet needs. In order to understand how Thailand achieved 93% health insurance coverage of the population in 2003 from 29% coverage in 1975, it is critical to learn about the historical development of the public health insurance schemes. In 1975, at GNI US$ of 380 per capita the Medical Welfare Scheme was launched and covered about 29% of the population. In 1980, the CSMBS was launched and, in 1983, the Voluntary Health Card was launched. In 1997, the Asian Economic Crisis hit, but the Government at the time used this opportunity to redirect funding to invest in developing the health infrastructure of rural Thailand.

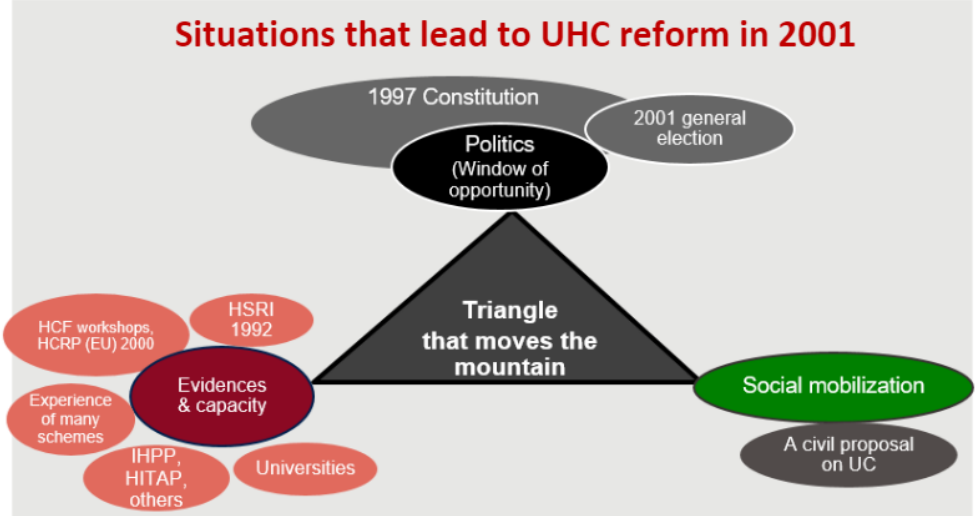
Before the UC scheme, there were several fragmented schemes that left 30% of 60 million people uninsured. In 2002, when UCS was introduced all the residual populations who were not insured were covered by the UCS. Today, there are three public health schemes that cover 99% of the population. The three schemes that comprise the UHC scheme are the CSMBS, the Social Health Insurance Scheme, and the UC scheme that covers 75% of the population. The CSMBS is managed by the Comptroller General Department in the Ministry of Finance (MoF). The Social Health Insurance is managed by the Social Security Office in the Ministry of Labor (MoL). The UC scheme is governed by two boards: 1) the National Health Security Board (NHSB) that is responsible for making decisions on UCS policies, guidance and rules, and health benefit package and, reimbursement mechanisms; and 2) the Standard and Quality Control Board (SQCB) that is responsible for setting and producing standards and guidelines to ensure standards for health facilities and the quality of services are met.

The political environment during the launch of UCS was peaceful and allowed international trade within the big fiscal spaces to include social sectors such as health. The power of stakeholders in the UHC system was essential to advocating for UHC. Qualified health professionals and experts called “champions” in health economics and research promoted and appealed to the government. The 2001 general election provided a window of opportunity to introduce the UCS reform. Additionally, influential civil society organizations and public support provided an added pressure. During the launch of the UC scheme in 2002

the health budget was 1,202 baht per capita, but by 2017 the health budget increased by almost 3-fold to 3,100 baht per capita. However, this increased budget is not sustainable without political commitment that can persist through changing governments and health ministers.

Collectively, the three powers; the political, social, and intellectual powers make-up the "triangle that moves the mountain", which has been essential towards achieving an acceptable consensus on UCS policies and processes.

Figure 1: Triangle that moves the mountain



Source: Image extracted from a presentation by Dr. Yot Teerawatanannon during the study visit

HTA in Thailand

Thai UCS started with a simple health benefit package that was designed in an ad hoc manner. Prior to 2005, there was a small number of HTA studies that were of poor quality and missed the target. However, in 2006/7, the HITAP, a research unit within the MoPH was established and a year after the 1st national HTA guidelines were published. In 2009, HTA was used to inform a comprehensive health package. The governance structures that support the use of HTA include several stakeholder groups such as the NHSO Board, the Health Benefit Package subcommittee, and the Health Economic Working Group (NHSO staff as the secretariat), HTA agencies such as HITAP and the International Health Policy Program (IHPP), and health professionals such as the National Drug Committee, the National List of Essential Medicines (NLEM) subcommittee, and the Health Economic Working Group (Food and Drug Administration as the secretariat). However, for HTA to take root there were Champions who were the backbone for gaining support and ensuring continuity of the work. Over the years, the Ministry trusted experts and champions to lead and direct the work of HTA to inform UHC. And most importantly is that these champions worked together toward one goal, achieving UHC and with public interest.

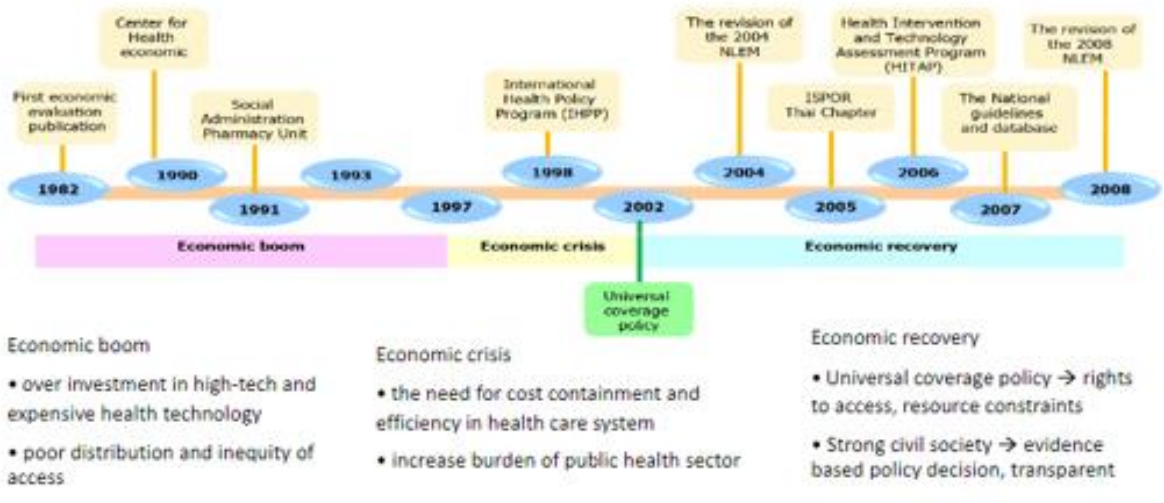


Figure 2: Milestones of HTA development in Thailand, 1982-2008

Source: Image extracted from a presentation by Dr. Yot Teerawatanannon during the study visit

Appendix 4: Communication products from this visit

Interview conducted by HITAPs Communication team to Kenyan delegates who attended the study visit https://www.youtube.com/watch?v=b1FUuZPogpg

News post on HITAP's International Unit website
http://www.globalhitap.net/newsandevents/hitap-welcomed-kenyas-delegates-to-study-visit/