	RRT modalities		
	Peritoneal Dialysis	**Hemodialysis**	**Kidney Transplantation**
Current policy decision according to Cabinet Resolution 30 Oct 2007, NHSO started implement Jan 2008 (FY2008)			
1. New ESRD	Free PD through phasing in from 23 provinces in 2008 to nation wide by **20XX** Year one (2008) due to limited budget, first come first serve is applied. Not clear what financial situation beyond 2008, if limited then first come first serve would be implicitly applied. Supply side training, negotiation and bulk purchasing of PD Solution, planned local production by GPO	Full pay for initial HD Free for failed PD	Free KT
2. Ongoing ESRD who are self pay for HD/PD	If maintain PD → free PD If switch from HD to PD → free PD	No financial support of the current HD, until 1 Oct 2008, 2/3 subsidies	Free KT
3. Ongoing KT	If failed KT, Free PD	Not clear	Still not clear if free supports of immuno-suppressive medicines
Future possible policy choices			
I. Better RRT program performance			
1. Better management of RRT program	Bring down cost of PD solution, program cost savings	Control, stabilize the current HD cost of 1500 B per session, and possible bring it down	Promote uptake of KT especially supply of organ donors both cadaveric and living related, through better performed Thai Red Cross National Organ Donation Centre, Cost control of immuno-suppressive medicines through the use of Generic importation, Compulsory Licensing, rationale use of medicines among professionals.

2. Secondary prevention of DM and HT, two major causes of ESRD. Active screening of CKD, CKD registry, initiate effective treatment to prevent progression to full blown ESRD	Active program implementation by the three public insurance schemes [CSBSM, SHI and UC scheme], effective clinical management and well control of DM and HT		
II. Financing mobilization			
1. Mobilize more central government resources to health sector and RRT program			
2. Local government contribution to RRT program			
3. Mobilize philanthropic contribution			
4. Catastrophic health insurance			
5. Major policy dialogues and shift from UC scheme covering the whole range of first Baht to last Baht through a comprehensive benefit package for OP, IP, high cost care and leave inadequate budget to protect catastrophic health expenditure → towards reduction of OP coverage through higher copay or not covered by the benefit package, and the savings is made to protect financial catastrophic such as ESRD			
III. Demand side interventions			
1. Based on decision in the Cabinet resolution, to introduce or increase copayment	Introduce copayment, flat rate to recoup the cost	Increase higher copayment for HD [to advocate PD, HD should have higher copay] to recoup cost	Maintain Free KT Introduce copayment for medicines, non-ED items
2. Rationing of new cases ESRD to RRT			
2.1 Existing criteria: first come first serve principle	Adhere to this principle as approved by NHSO Dec 2007	Full pay for initial HD Free for failed PD	Free KT
2.2 New rationing criteria, ruled by regional or provincial selection committee, **major inputs for DP consultations**			
2.2.1 KT eligible, <60 years + other medical criteria			
a. Transplant only	No supports	No supports	Full support for KT and medications
b. Transplant + RRT	Free PD	Free HD after failed from PD Self pay for new HD	Full support for KT and medications
2.2.2 Provide limited number of PD years, pro younger group by providing more years than the			

older [number of years is determined by financial capacity of NHSO]			
2.2.3 Start PD for different age group until patients die or get a new kidney (KT)			
a. PD starts <60 years			
b. PD starts <65 years			
c. PD starts <70 years			
2.2.4 Other national social criteria, ruled by regional or provincial selection committee.			
a. The poor			
b. Patients with dependants to support			
c. Contributions to society, e.g. kidney donors			

Arguments for and against the policy options

1. To start dialysis for patients who are eligible for KT.

Pro:

- If a person's kidneys fail, the best treatment is a transplant. Many people who get transplants are as healthy as they were before they got sick. Some people who receive dialysis rather than a transplant can have a decent quality of life, but on average they are not as healthy as those who get organ transplants, and they must spend many hours each week on the machine. Costs are lower, too. So transplants should be the first priority of Thailand's RRT program.
- (Based on the initial criterion of 60-year old cut point), approximately half of those who will need dialysis would be eligible for transplant. The UC can probably afford to offer dialysis to this number, but not to more. Thus this criterion fits UC's budget.
- This criterion calls for providing dialysis until the patient receives KT or dies of ESRD or other causes. This means that care is never withdrawn from dialysis patients; none are abandoned after starting the treatment.
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Con

- The way doctors decide who is eligible for a transplant is different from the way they decide who is eligible for dialysis. Since only 1 out of 20 patients whose kidneys fail will ever get a transplant, UC's decision on whom to offer dialysis should be based on eligibility for dialysis, not eligibility for the transplant.
- UC cannot afford to provide dialysis to all who are eligible for it, so we will need another criterion to choose among them. But there is no reason to use medical criteria for eligibility for transplant.
- Though no patients who receive dialysis would be abandoned, half of the patients who will need dialysis to live will not even be started on dialysis. That is abandonment, too – in fact, it's even worse, since they would receive no treatment at all and so be abandoned even before getting any treatments.
- Doctors presently will not permit a patient over age 60 to receive a transplant. If eligibility for transplant is used to determine who will receive dialysis, this would mean that people whose kidneys fail when they are younger than 60 would be eligible for dialysis for as long as they live, while those whose kidneys fail when they are 60 or older would be allowed to die. A patient whose kidneys fail at age 61 would be told that they will not be saved because they are too old; meanwhile, the state would continue to provide dialysis to patients who are 65, 70, or even 75 years old, just because they *started* dialysis before they were 60. This does not make any sense and is unfair.

2. To start dialysis for patients below 60 years until they die or get KT

Pro:

- Younger patients – those under 60 – deserve to be given first priority. They deserve the same chance to live a normal lifespan as others. Those who are over 60 when their kidneys fail have already lived a long life and should be saved only if younger patients are saved. At this time. UC could not afford to treat patients over 60 if all patients under 60 are treated.
- Younger ESRD patients are more likely to have dependents. Keeping them alive benefits the dependents in addition to the patient.
- This criterion places no time limit on treatment for those who are started on dialysis. This means that no patients will be abandoned after they have started the treatment.

Con:

- It may be a good idea to give priority to younger patients, but this criterion does not really do that. Since it does not set any time limit, it is likely that it would provide dialysis to some very old patients – those whose kidneys failed just before they were 60 and who continued to live for a long time thereafter. As with the first criterion, patients whose kidneys fail at age 61 would be told they must be allowed to die so that younger patients can live, but they would see that many patients who were 65, 70, and even 75 were still being treated at government expense.
- Though younger patients may deserve some priority over older patients, older patients deserve consideration as well. Kidney failure need not result in immediate death. Patients over 60 need time to make arrangements for loved ones, and to say a final good-bye. In some cases, patients who are given some extra time may be able to find another way to remain alive – for example, by finding a loved one who is willing to donate a kidney.

3. To start dialysis for patients below 65 years old, and continue only until 65 years old or get KT

Pro:

- This criterion gives priority to the young, which is fair.
- By imposing an age cut-off to government-provided dialysis, more money will be available. The result is that UC would be able to pay for dialysis for patients up to age 65, not just 60. The population would be better served by being entitled to dialysis up to age 65.

Con:

- Patients whose kidneys fail after age 65 would be allowed to die. They should be given at least some time to make arrangements for loved ones, and to say a final good-bye. In some cases, patients who are given some extra time may be able to find another way to remain alive – for example, by finding a loved one who is willing to donate a kidney.

- This criterion withdraws care from patients who have been receiving dialysis, when they turn 65. As they approached their 65th birthday, they would know that unless they found some other way to arrange for treatment, it would be their turn to die.

4. To provide a limited number of years for all patients, with the younger getting more.

Pro:

- This criterion offers some treatments to every patient whose kidneys fail, providing that they could be kept alive through dialysis. No one is left out at the start.
- Younger patients are given priority, though not absolute priority, over older patients. This criterion balances and combines the value of treating everyone with the value of giving priority to younger patients.

Con:

- Entitlement to dialysis, with this criterion, would be limited in time. Each would know that at some point, they would know that unless they found some other way to arrange for treatment, it would be their turn to die.
- Though this criterion gives some priority to the young, it does not offer as much to the young as #3 does.

5. No support for dialysis, the government would provide KT only.

Pro:

- If a person's kidneys fail, the best treatment is a transplant. Many people who get transplants are as healthy as they were before they got sick. Some people who receive dialysis rather than a transplant can have a decent quality of life, but on average they are not as healthy as those who get organ transplants, and they must spend many hours each week on the machine. Costs are lower, too. So transplants should be the first priority of Thailand's RRT program.
- This criterion would motivate UC patients to seek living donors. If the number of transplants greatly increases, as a result, this criterion would lead to the greatest improvement in the quality of life of UC patients whose kidneys have failed.
- This is fair to rich and poor alike: all it takes to remain alive is having someone willing to donate a kidney. Since kidney-selling is illegal, having money is no advantage.
- Though there may be some risk that this criterion would lead to an increase in illegal kidney selling, the risk is limited by the fact that the poor could not afford to pay for them.

Con:

- Only 5% of patients whose kidneys have failed receive transplants. We cannot know if this number will increase in the future. This criterion allows too many people to die who could be kept alive with dialysis.
- UC can afford to provide dialysis to many patients, even if not to all. They should not be allowed to die.
- Even if many people could and would find a loved one or friend willing to be a living donor of a kidney, many patients would need dialysis to stay alive until the operation took place. The poor could not afford dialysis even for a short time. Thus this criterion permits the better-off to live and allows the poor to die. That is not fair.
- This program could lead to more kidney selling since UC will pay for the expense of transplant but not dialysis.
- The patients older than 60 cannot have the transplant.