Editorial

Microeconomic Considerations for A National Health Insurance Policy: "Thirty Baht Copayment for All"

As national health insurance is becoming one of the most interesting policies of the new government, there are concerns regarding the possibility of this controversial program. From the health economists' standpoint, this welfare entitlement is apparently redistributed income from the upper decile of society into the lower level and the disadvantaged, such as the poor, the disabled, and the elderly. Though we are in a democratic society, the rationale underlying this seemingly socialist principle is derived from "the unequal should be treated unequally", so called **vertical equity**[1]. Under a fair tax system, people with a greater ability to pay should make a greater contribution to the insurance program. People who possess insufficient supplies of labor and resources cannot survive in a competitive free market. The poor rarely reside in an environment healthy enough to avoid preventable communicable diseases. More often, they are blamed for their ignorance, but are not able to meet the minimum level of standard healthcare programs just because of their low level of knowledge and incomes.

The idea behind national health insurance is that it is one form of redistribution of wealth, by apportioning taxes from one group to subsidize another. This policy can be justified by the principle of interdependent utility functions. This means the people who are eligible to receive welfare will be made better off and benefit the whole society. Because healthcare services and educational provision are considered to have externality, the spillover advantages not only to those who get this aid but also to the donors as a whole. The most frequently found problem is from the so-called "free-rider" group. This group of people shares the benefits gained from the healthy community but, they contribute nothing, although they are able to do so. The behavior of the free-rider group will adversely influence those who are willing to pay. The government can provide vertical equity by specifying the eligibility criteria for universal health insurance, and financing this program by progressive taxes levying an increasing fraction with increasing income.

From the microeconomic point of view, the campaign "health insurance for all by 30 baht" is tempting to provide equitable healthcare for the whole society, especially the needy. This policy is validated according to the Rawlsian theory that believes in equality of access rather than equality of use[2]. For simplicity's sake, the basic requirement must be able to be achieved for all, while differential use of sophisticated medical technology is allowed selectively. In principle, the idea that will create the preferential healthcare delivery system should be addressed by other sectors of the economy as well. However, if we take into consideration the possibility of this policy, there are concerns about escalating health care expenditure and problems with the quality of medical care provided.

The tendency for the cost of medical treatment to rise can be anticipated as demonstrated in Figure 1. The quantity needed for medical services is explained by the law of demand[i], which demonstrates the equilibrium condition between price and quantity of medical care in the perfect competitive market. The demand curve is a downward slope because the more expensive healthcare is, the smaller the quantity of care that will be solicited. Vice-versa, the supply curve is an upward slope. Now the government has announced universal health insurance with 30 baht copayment, the equilibrium will be shifted.

[i] Law of demand-supply is the tendency in a free market for the price to change until the market clears, that is the quantity supplied equals the quantity demanded.

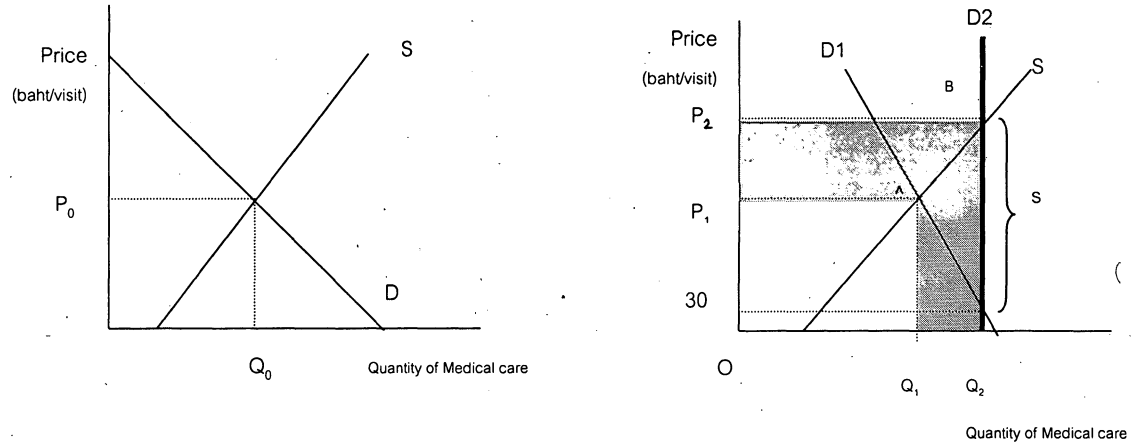


Figure 1. **A. Demand-Supply Curve: in competitive markets.** Patients would pay at price P_0, for the quantity of medical care at Q_0.
B. Demand-Supply Curve: in health insurance scheme. After policy "30 baht for all" is implemented, the demand for healthcare will be shifted from Q_1 to Q_2, and the cost of medical expenditures will be at P_2*Q_2 (shaded area depicted the area of increasing disbursement)in which subsidy (P_2-30)*Q2 is necessary.

Under the assumption of "all else being equal", patients can access healthcare by paying only a trivial amount of coinsurance, therefore, the demand curve will become more inelastic[ii] (from D1 to D2) and the quantity required will be increased from Q_1 to Q_2. To maintain this level of care, the government has to subsidize healthcare providers the amount of (P_2 - 30)*Q2 baht. The estimated budget to support this program should expect a change of total expenditure from P_1*Q_1 (the area of rectangle OP_1AQ_1) or 60 billion baht (roughly computed from the fiscal budget in Ministry of Public Health and related Ministries) to P_2*Q_2 (the area of rectangle OP_2BQ_2). Consequently, the considerable amount of subsidy ((P_2-30)*Q_2 baht) will be required to sustain healthcare providers and, ultimately, the insurance program.

Other concerns arising from this model are the ability of hospitals to handle the increasing volume of patients and limits of government subsidy, not to mention the quality of care that will definitely alter. There are many other factors influencing the success of a health insurance program, as experienced by the United States and European countries. For example, the demographic changes in the elderly population will increase the need for medical services. The pattern of longer waiting lists will become common, particularly in elective procedures.

We are falling into the dilemma of individual and collective responsibility. Individual freedom of choice of healthcare services will eventually increase the cost of the care and expose the patients

[ii] Price elasticity of demand measures the sensitivity of quantity demanded to price changes.

to financial risk. For collective responsibility, some choices in access to medical treatment are limited but cost containment is made possible. There is always a trade-off in decision-making. Moreover, when Thailand's economy is still in a critical state, the trade-off determination is crucially dependent on balancing the needs of every single sector in the system.

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