CHAPTER 5
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This study aims to propose possible health welfare policy option(s) for the elderly in Thailand under considerations of equity. The analysis is based on data of elderly health expenditure and utilization under the Public Assistance Scheme of the MOPH for 1997-1998 and on lessons which Thailand can learn from Singapore, Japan and the United States.

The Thai Government provides free medical care for the elderly. Health expenditure as a charge on the public provider has been rising dramatically. At the same time, the expenditure on the elderly group has become higher than expenditure on other groups within the Public Assistance Scheme. The results of analyzing the equity of the distribution of health expenditure on the elderly among the provinces under this scheme using a Lorenz curve and the Gini coefficient index reveal that the Lorenz curve lies below the diagonal but is not far from the line of perfect equality both for outpatients and inpatients. The results are slightly different between 1997 and 1998. The Gini coefficient of outpatient care is 0.121 for 1997 and 0.111 for 1998, while the Gini coefficient of inpatient is 0.195 for 1997 and is also lower at 0.175 for 1998. In addition, the analysis of equity of the distribution of utilization in the same period uses the same method. The Lorenz curves are similar to those for health expenditure in that the curves are not far from the line of perfect equality for both outpatients and inpatients and are also slightly different between 1997 and 1998. But there is a difference in the value of the Gini coefficient of outpatient utilization which is higher (from 0.116 to 0.130) while inpatient utilization has the same value. However, the value of the Gini coefficient the value of Gini coefficient of health expenditure are more than the value of Gini coefficient of utilization. This suggests that the distribution of elderly health expenditure is more

unequal than the distribution of utilization under the assumption of equal demand and need for health care of the elderly in the different provinces.

In contrast, many reviews have indicated that inequalities in the distribution of income are associated with poor health. It should be noted that the elderly who live in provinces with a lower level of income are poorer in health than those who live in provinces with a higher level of income and should be more in need of health care services than the richer, especially from the Public Assistance Scheme. The NESDB has classified a household as poor if its per capita income is below the per capita poverty line. If a household is classified as poor, all persons living in that household are classified as poor. This refers to the incidence of poverty which varies widely across the provinces. For this reason, the poverty incidence is used to examine the correlation with the distribution of elderly health expenditure under the assumption that the elderly in poorer provinces (high poverty incidence) need more health care services (as well as more expenditure) than the elderly in richer provinces (low poverty incidence). The results show a positive correlation in 1997, but the true coefficient is not significantly different from zero for both outpatient care ($r = 0.051$) and inpatient care ($r=0.031$). The results in 1998 change to a negative correlation but the true coefficient is not significantly different from zero for both outpatient care ($r = -0.064$) and inpatient care ($r = -0.069$). Also, the results of the correlation coefficient between the incidence of poverty and utilization show a similar pattern as expenditure that is a positive correlation in 1997 and a negative correlation in 1998. However, the true coefficient is not significantly different from zero for both outpatient care ($r = 0.181$ and -0.059 for 1997 and 1998, respectively) and inpatient care ($r = 0.099$ and -0.013 for 1997 and 1998, respectively). The results show that there is no linear relation between the distribution of elderly health expenditure (also utilization) under the Public Assistance Scheme and the incidence of poverty. This implies that the elderly population in the poorer provinces receive slightly more or less benefits than the elderly population in richer provinces and is not associated with the incidence of poverty.

However, an assessment of equity does not find it easy to determine what it means to be "fair", either in principle or in practice. Hsiao (1998) has stated that the studies of equity in the finance of health care without exception begin with the premise that health care ought to be financed according to the ability to pay. The principles used to ensure and assess equity derive from a variety of fields; philosophy, ethics, law, and politics. This study is concerned with the fair distribution of health welfare for the elderly which has a direct impact on the health status of the Thai elderly, in particular, those who are poor. Vertical equity, refers to the imperative to distribute unequal amounts among differently-situated recipients in proportion to the degree that they are differently situated. It is noted that the incidence of poverty varies widely across the provinces. The health status of the elderly who are associated with poverty correspondingly varies widely across provinces. Therefore, those poorer groups that are associated with poor health need more expenditure and utilization than the richer groups. This study has found that on the contrary the distribution of elderly health expenditure and utilization under the Public Assistance Scheme are not associated with the incidence of poverty . At the same time, the results of the Lorenz curve found that the curves are not far from the line of perfect equality for both expenditure and utilization, while the value of the Gini coefficient indicates that the distribution of health expenditure is more unequal than the utilization. However, this different distribution among the provinces is not based on the incidence of poverty. This means that the elderly poor receive slightly more or less benefits in the Public Assistance Scheme, that is the province with greater health needs does not necessarily receive a greater share of the expenditure and utilization.

In addition, Srithamrongsawat (1998) has stated that the Public Assistance Scheme has been under-financed by the government. Health facilities have to fund their extra expenditure on free care from other income sources, such as the general budget, cross-subsidies from other schemes and user fees. Moreover, data on the provision and charge for free care as shown in Table 1.2 indicate that health expenditure on the

elderly is higher than for the other groups. The elderly's share of expenditure was 37.42%, 40.78% and 41.76% in 1995-1997, respectively.

Statistical evidence points to the fact that the percentage of the elderly in Thailand will be significant larger in the future. The demand for health care services is likely to rise along with the larger number of elderly people. To avoid this problem, health welfare policy for the elderly must be developed to deal with the problem of caring for the elderly. The Public Assistance Scheme is faced with a limited budget, and the basic question of distributive justice needs to be addressed. At the same time, a discussion of fairness in the design of health welfare policy is not possible without taking the issue of equity in the finance of health care into consideration. More specifically, the lessons learned from experience in Singapore, Japan and the United States can be related to these issues. The final section of this study consists of recommendations for further policies.

The review in Chapter 2 and the summary of the strengths and weaknesses of the health welfare program for the elderly in Chapter 4 indicate that the older population has grown dramatically in all countries, especially in Japan which has the longest life expectancy in the world. While the vast majority of older persons continue to be a vital resource for their families and communities and lead healthy and productive lives, the risk of dependency grows with increasing age. Health expenditure for the elderly is growing as a proportion of total national health expenditure. Traditional support systems for older persons faces challenges in all countries and Japan and the United States are searching for cost-saving measures while Singapore has achieved an appropriate balance through a savings scheme.

There are three basic functions of health care services for the elderly, redistribution, savings and insurance which are just as applicable for financing health care as for security in old age. The system is different in each country. The elderly in

Singapore have access to health services through their own or their children's Medical savings accounts which include catastrophic insurance (Medishield) and Medifund for those who can not afford. This system is based on individual responsibility for maintaining good health. Medisave provides incentives to reduce wasteful and unnecessary consumption, and offers protection against extraordinary events and free rider abuses. At the same time, the Government plays a leading role in developing the necessary infrastructure. The system in Singapore enhances everyone's ability to pay while equity and equal access to basic medical services are assured by heavily subsidized primary care and different classes of hospital bed. The comparable approach in Singapore works very well, the health status of the people is improving and the national investment in health care is surprisingly low. Singapore has enjoyed lower growth in health care spending relative to GNP than many other countries (about 3.2 percent of GDP in 1995). This can be compared with Japan where national medical costs continued to rise every year but have held at about 7.2 percent of national income since 1996. There are at least two factors in this expenditure growth. The first is high hospital use, including high per person drug costs. This is because of the specific features: 1) freedom to set up a practice and to choose a place of treatment, and 2) fee-for-service payment. This system lends itself to excessive and unnecessary treatment. The second and most important factor is the aging population. There is universal coverage with virtually unlimited access to all health care facilities for every citizen. People who are over 70 years of age old and bedridden people aged 65 or older are entitled to the medical service benefits provided by the Health and Medical Services Law for the Elderly. Health service costs for the elderly are met from: 1) co-payment of patients at the point of service, 2) contributions (from respective insurers Medical Insurance), and 3) public costs. Under this insurance system, the purpose of joint contributions is fair cost-sharing for the elderly from all of the Japanese but this may lead to a cost burden on the younger generation as a result of an aging population and greater use of medical technology. Japan has a system of out-of pocket expenses for co-payment to enhance awareness for maintaining the health of the elderly and medical

expenses but there is no regulation to control the supply side. The government takes responsibility of ensuring equity by providing subsidies and managing this insurance system for the elderly. The local government act as the insurers and the central government provides direct subsidies. Moreover, Long-term Care Insurance was set up to achieve quality of life in old age but at lower cost. This plan will be implemented in the year 2000. It can be noted that the development of health services and a health insurance system in Japan have been successful under the law.

As in the review, the aging of the population is also one of the greatest challenges facing the health care system in the United States. The Medicare program is an important source of transfer to the elderly (aged 65 and over) and disabled beneficiaries, the numbers will grow rapidly in the future. National health expenditure in the United States is one of the highest in the world both as a ratio of GNP (the figure stabilized at 13.6 percent of GDP in 1993-1996) and in per capita terms. In 1997, Medicare alone had grown to account for 42 percent of public spending on health. Under Medicare, beneficiaries have to pay a deductible co-payment and coinsurance to deter unnecessary health care consumption. Since Medicare was reformed in 1983 it reimburses hospitals and inpatients are paid under a Prospective Payment System instead of a retrospective system, and full-cost reimbursement is based upon the DRGs. The DRG-based method of compensating hospitals appears to help constrain Medicare expenditure for hospitals with the idea of deterring hospitals from piling on unnecessary services to boost their bill. Moreover, the United States implemented a medical savings account project with the purpose of cost control in 1997. Medical savings accounts in the United States give individuals a new way to pay for health care as out-of-pocket for cost sharing. This is quite different from Singapore. Medical savings accounts in Singapore are linked to a strongly pro-poor price discrimination strategy in the public hospitals that serve most patients. Medical savings accounts help absorb the growing pressure on public subsidies. In contrast, the political economy of Medical savings accounts in the United States has been forced by the paramount need to contain costs.

The U.S. approach to Medical savings accounts does not incorporate any features favoring equitable access to medical care.

From 1970 to 1975, Medicare grew from 4 percent of the Federal budget to 11 percent. Congress is seeking way to reduce expenditure but Medicare's share of GDP is expected to claim from 2.5 percent in 1994 to 6 percent in 2020. (The Twentieth Century Fund, 1995). The failure is because the health care sector serves valuable purposes. Its growth poses a problem to the extent that resources are used inefficiently under the belief in free market and American-style third- party protection.

5.2 Recommendations

The implementation of the Public Assistance Scheme is an attempt to protect the poor who would often wise have no access to health care due to financial barriers. The implementation of this scheme has faced many problems, such as financing and services delivery. Since this scheme was expanded in 1992 to cover all of the elderly, the share of expenditure for this group has increased dramatically along with the number of old people. The problems will be more complicated in the future. More specific approaches must be concerned with how to provide health welfare for those elderly, based upon the Thai traditional, cultural values and the ethnic community, adapted to the priorities and material capacities of the country.

The following policy options based on the above remarks, are provided for future policies;

1) The analysis of equity in health expenditure and utilization using Lorenz curve and the Gini coefficient together with the correlation between the incidence of poverty and the distribution of elderly health expenditure (also utilization) indicate that the distribution of elderly health expenditure and utilization are not equitable. The provinces

with greater health needs do not receive a greater share of the distribution. To prepare for the demographic change and financing it will be faced. It is necessary to modernize and reform health welfare for the elderly under the Public Assistance Scheme. The budget allocation from the national government should be associated with poverty that varies widely across the provinces. With a limited budget it is expected that it will not be enough to provide health services for all of the elderly. The system may assure accessibility during time of catastrophic illnesses and include certain outpatient care. Sources of finance include government subsidies and premiums based on the financial status of the elderly and their families. For this purpose, this health welfare for the elderly should be separated from the other groups under the Public Assistance Scheme and a special scheme for the elderly should be established. The responsibility for the managed program should be shifted from central to the local government. The local government acts as insurer and manages its own fund. However, cost-sharing must be determined to avoid unnecessary consumption. The poor who can not afford to pay for themselves should be supported by the government by using a means-tested program. The system should be developed taking into account the role of family and community. For outpatient services, we assume that they can be afforded under heavy subsidization from the government for primary and basic medical care. At this point, the elderly should pay low prices. Moreover, safe use of medications, household chemicals and other products should be encouraged. At the same time, home health care and nursing home and long-term care should be promoted and encouraged through private provision.

2) Establish a Health and Medical Service Law for the Elderly. For this purpose all of the elderly in various different schemes should be unified in this one program. The responsibility for managing the program should rest with local government. Management of the system should be similar to the first option, except that Medical savings accounts should be introduced, with the aim of promoting individual responsibility for maintaining good health and for building up financial resources to create the means to pay for medical care during illness, being explicitly linked to any pro poor elements. MSAs

should find it possible to start with people who are under the Civil Servant Medical Benefits Scheme and Social Security Scheme and those who have permanent salaries. The elderly poor who can not afford to pay for care should be supported by the government using means-tested program. The MSAs can act as out-of-pocket for themselves or their parents and provide strong incentives for people to be cost conscious and to avoid moral hazard. Afterward, the scheme should be extended to the self- employed.

5.3 Recommendations for Further Research

1) This study does not provide information on potential economic and other determinants of health expenditure and utilization patterns of the elderly. Therefore, future research may focus on an analysis of equity in health expenditure on the elderly by collecting data through censuses or surveys for the formulation and evaluation of policies for the elderly and for ensuring the development of the process.

2) Dramatic demographic changes have implications for the health care sector. The demand for health care is likely to rise when there is a large number of elderly people. This study has found that Medical savings accounts are an important element in the design of health care financing instruments. Therefore, further investigation of the feasibility of establishing Medical saving accounts in Thailand should be undertaken.