Microeconomics of healthcare research paper examples

Economics, Microeconomics

\n[toc title="Table of Contents"]\n

\n \t

\n[/toc]\n \n

Abstract

The purpose of this paper is to identify how the healthcare system has notable affects on social and functioning bodies dependent on the healthcare system. Healthcare is also affected by decisions from nationwide governing bodies distribute financial and medical aid where individual people can make their own decisions and play out the key microeconomic concepts to achieve the most beneficial medical plans. The healthcare system in North America constantly experiences changes to its healthcare plan regardless how protocols differ between the U. S. and Canada. The decisions implemented by individual members act as the instigators to change when they foresee unfavorable repercussions. However, any decision made and any suggested research and inquiry conducted yields a definitive benefits package. This report includes how individual decisions and their goals toward healthcare

result in the finished healthcare contribution concepts and how they branch out to governing bodies that dictate the improvement or the fate of healthcare funding. The healthcare system displays triggers to the economic and taxation status where decisions are made in the first place followed by individuals. In the final analysis, each individual and the entities they form a part of, require decision making to reflect the contemporary status of the healthcare system they wish to benefit from. Examples of both American and Canadian healthcare are included to illustrate the promises and the pitfalls on decision based health benefits.

Keywords: microeconomics, healthcare, affordable health benefits, healthcare spending, healthcare taxes

Introduction

As microeconomics is based on decisions made by individuals who make up the whole for businesses, governments, and other various organizations, it also examines the basic components of the health care system on how it is managed and sustained as an end result. How does the definition of healthcare economics differ between the conditions of the healthcare system between now and one hundred years ago? How do opposing views coincide in the same mind? The question can be phrased on how the healthcare system affects the economy, transfers, and taxes. Do these items also affect the healthcare system in reverse? Historically, not everyone could afford medical prescriptions or consulting with private or alternative practices, especially when such practices were non-existent. Hence, the healthcare system was established to render the care of patients and related services

affordable for everyone. Whenever alterations and diverse financial engineering takes place, it is possible micro-economically from within each respective item here how they branch nationwide.

It can be deemed as inconclusive as to how the healthcare system can be beneficial or disadvantageous depending on a selected plan, but many grey areas remain when choosing the best plan. The best possible procedure to maximize health benefits can be to choose a more consumer-directed approach where the sole decision shall be up to the individuals to search for themselves. This approach will result in competition between insurance companies. Whenever competition becomes the attentive topic, insurance companies then find ways to provide better relationships between the patients and the doctors, and design the healthcare plans where the patient has the option of selecting a preferred doctor instead of being assigned to one. As long patients consistently pay visits to the doctors of their choice, more trust for treatments and examinations develop. Close relationship with medical practitioners can enable the medical profession to allow general practitioners to provide better assistance to their patients in selecting beneficial healthcare plans.

Common Microeconomic Studies and Concepts

When variables of microeconomics undergo change, it does not continue without the changes of other fellow variables, and equalization is required among variables to sustain the health care system to keep cost consistent with different income levels. As the health care system can be flooded with abundant patient accessories, it remains important to discern the sensitivity

of the component players affected by or instigating the integrity of healthcare. Statistics may indicate accurate comparisons between paying for healthcare and living comfortably, except practically not all contributors to healthcare are always accounted for, and statistic alone cannot summarize the value and needs for healthcare. When it comes to decide what is the best or a reasonable healthcare plan, equilibrium usually cannot be achieved in the short term because payment adjustments in expenditures need to be studied to prevent added costs and keep them affordable.

On the topic of abundance, a fair sized company’s employees often place a vote to gain the dominant theory of the healthcare system to ensure the most relevant coverage is assured, but wary as not to put forward excessive benefit spending for healthcare items they do not presently need. This is why larger companies require a balance between supply and demand because the demographics of the employees vary and continue to alter over the natural course of time. For example, older employees or employees closer to retirement prefer extended health care as they may have higher chances of becoming terminally ill or extended sick leave. The younger employees may not immediately require extended health and may demand only minimal coverage. Unless unusual and unexpected circumstances force younger employees into extended leave, a minimal coverage would be a wise decision. This microanalysis can help reroute the healthcare plan wisely, similar to a strata contingency plan when needed for pressing matters.

On the opposite end of the spectrum, some employees of smaller companies, on a contract basis, or on sole proprietorship prefer the option of

providing coverage with private healthcare entities, except they can be impacted promptly by price elasticity on demand because of minimal coverage. However, even contract employees of larger firms have little or no coverage because they are not permanent employees, and also must rely on private healthcare. Despite lack of coverage from the company, competition between individuals for variable benefits do not always equalize, almost negating the game theory notion, because of differing results.

Healthcare Economic Effects

Are the healthcare systems in USA or Canada any different from each other? Many sources dictate that the American healthcare system is more expensive, as operation and mammogram costs are enormous. In Canada, many larger scaled employees provide extended health care. But regardless of the debate on which has the better system, the demand for better health budgeting fall under the same economical backdrop where long run production of essential healthcare tools become finite because of many healthcare facilities heading towards privatization which is not a preferable option to healthcare employees or their patients (Howlett 2010).

In the USA, about 15 cents of every dollar spent in the last three years was used for health care costs, and the costs are projected to increase. Health care expenses affect the economy in multiple and sometimes complex ways (Dyches 2012). All Americans are directly or indirectly affected by the funds needed to provide access to health care, yet both the American and Canadian healthcare systems have their advantages and disadvantages. Complementary goods and services available in America are also accessible

in Canada, but may require longer waiting periods when the economy forced budget cuts. The budget cuts do not necessarily mean that complementary goods supplies are limited in quantity, but limited within given time periods. The same goes for mammogram examinations, for example. In some locations free mammograms are available at no extra cost, where the absence of costs is pitted against a lengthy waiting period to receive healthcare.

The American healthcare system has a secure hold on the economy because their healthcare giants Medicare and Medicaid are in charge of the national budget. For people who cannot afford higher medical costs must solely rely on these healthcare giants who absorb their costs and the trend becomes an economic trigger (Harney 2012). Alternatively, the private healthcare option must be exploited, as too many people already rely on public health, and the decreases the workplace moral where mostly lower income people are employed. Employees have no further option but to utterly postpone early treatment plus avoid preventive care because of high medical costs. The workforces that were once great in numbers suddenly drop due to expensive health costs, reducing production functions with more people out of work.

Another disadvantage of rising costs of healthcare in both respective countries is the effect of consumer buying power. It is demeaning enough that lower income people cannot afford higher costs that affect their abilities to buy essential resources in the first place. This becomes a staircase effect where medium income people also feel the impacts of rising medical costs even if prices are relative. With limited budgets, medical costs are no longer

paid and become a pool of unpaid debts weighing down economic efficiency. The healthcare system suffers from the domino effect and is forced to either find alternatives for affordability or instigate cutbacks.

Healthcare Taxes

Whatever the result of the Affordable Health Care Act (ACA), the debate in the American healthcare system occurs whether healthcare is categorized as a tax or a penalty, and transitions beyond the 2012 election. According to a July 2012 poll by Quinnipiac University in Connecticut, 55% of American voters said the ACA is a tax hike, where 48% agreed with the U. S. Supreme Court decision to uphold the law, while 49% believe that the U. S. Congress should repeal it (Baratz 2012). The argument dictates who will end up paying and is determined by the level of income acquired, and collective outfits such as employers, healthcare providers and insurers end up paying the difference. Tax or penalty, the ACA’s notion will prompt decisions made by the average income wage earner on which health benefit package to contribute to.

This can shift the balance of collective outfits into turning to alternative methods of payment rather than health benefits per se, and individuals therein will prefer to cover via taxes instead of health benefits. For some, seeking a lower tax bracket for health coverage, as in the case of extended health, is preferable for contributors and taxpayers.

The demographics of health benefit contributors prepare for decision-making depending on the level of gross income. The average medium income earner

expressed the least concern of the mandated tax law, notifying the tax hike is almost insignificant. The impact, however, would be felt mostly by larger companies that can afford higher tax hikes. The only positive impact currently would drop the unemployment rate, and once the unemployed have landed a job, their respective employers or representatives will provide health coverage. Still the ACA is striving to prevent excessive taxation to the health care system by leveling the gap between health insurance and taxes. For fairly large corporations, not all carry health insurance, and may be sent a notice by the federal agency, especially if they make the decisions for their employees because their health plans are already established on their behalf, whether individuals were involved in the decision making process or not. But some hired employees having insurance may still benefit from their employers because health care contribution has become mandatory. Employees still have the option to contribute to health benefits other than those provided by the employer, as many employers prefer. Similarly in this case, the decision again rests upon the individual if they seek further benefits additional to what is provided by employers. For smaller companies or sole proprietors, many do not provide health coverage, and the individual may need to provide his own coverage. Since the early 1990’s, although the number of small companies, sole proprietorship, and contract workers has been increasing, a unified formation for individual coverage is becoming more common, as many do also seek self-employment, as long as they contribute somehow to healthcare insurance. But larger employers offering health care insurance in higher-risk industries are now receiving options to control health care costs especially if they include more people in their plan.

Health Transfer Plans

When seeking a better health benefit plan, the evaluation comes down to how much the spending is really involved in healthcare. Today Americans are spending a good one-sixth in healthcare, an amount doubled over the last 30 years, and targeting the elderly as well the average income earner (Porter 2012). However, when compared to the cost of redistribution on the dollar, the value of health care benefits becomes lost. As planning for lower income families is a dedicated effort, still the costs for these families is surprisingly higher than usual. They may be able to meet the minimum health care requirements for better medical plans, but they must cut back on basic necessities, only slightly bridging the gap towards a common health plan. Between the years 2000 and 2010, government healthcare spending increased as a required premium due to unexpected inflation rates (Pauly 2003). So why shall in-pocket cash be squandered further for the same benefits package? All members in the plan would not be able to cover for a full, essential plan, and life-saving services would require a large portion of those funds to recirculate to assist lower income families who cannot, in turn afford their current benefits plan. Additional coverage other than healthcare undergoes reclassification, for example, beneficial employment earnings, as income. Employers who provide their workers with health insurance must have their healthcare deductions reevaluated by insurance providers in a manner that coverage contributions are at lower values.

A number of factors are not included in the value of healthcare such as non-cash benefits to establish a precise poverty rate. When Medicare and

Medicaid were valued by sources determining a clear poverty rate, including costs to be covered by the poor, they were valued as almost equal to each other (Porter 2012). When the Medicaid study was approached further, it was proven to provide healthcare benefits to lower the poverty rate, even without the desperate need for basic necessities. As health costs continue to rise, the spending power of household finances is a surefire target. Families that need their income for household goods, education, and even retirement, seem to be funneled toward expenditures of healthcare services, where not all services are required for all families. A better route would be to incur only minimum premiums for less constrained health services, and accounting for the type of occupations involved shall be factored in. But for lower income families, this is not a preferable option as families are faced with an ultimatum to their basic necessities (May and Cunningham, 2004). Unfortunately, the majority of lower income families at times found equal difficulty in paying for healthcare and to sustain their basic necessities.

Essentially, healthcare transfers operate no differently from property transfer taxes. Yet it is argued that higher income families will not be affected by transfers because they are balanced and paralleled with higher costs. But since healthcare funding varies internally within different provinces or states, the federal government is normally slow in continuing the flow of funds, because of the variables traveling along with gross domestic product. The criticism is reached when funding redistribution from one place to another of less capacity removes health coverage, and access to the essentials of healthcare is more unlikely. The problem also arises from difference in tax

rates during transfer payments where smaller communities must yield tax hikes in key benefits plans which the only reliable facility. The economic integrity is then undermined and unavailable funding swings in the direction of collective debts all over again. Essentially healthcare transfer is not the wisest decision to subsidize local or neighborhood costs and demand for more health coverage becomes too much of a long shot, unless cutbacks in one discipline are proposed to supply another in a remote location that may not view the specific need or a certain healthcare service.

Conclusion

In order for the healthcare system to be efficient and effective, due diligence from both the medical professors and the patients need to be done. Perhaps a great length of time will pass before equivalent healthcare is available globally, but presently seeking all possible benefits can be a great achievement when an understanding among all parties laced into the healthcare system can bring about newly proposed business models starting with individuals and proposing these models to higher levels of authority. This initiative approach can aid individuals in determining a better healthcare plan instead of being too intertwined in the game theory and long-run production of the system that shall be in the individual’s best interests.

Healthcare can be improved and attained by researching the microeconomic aspects of the healthcare industry. But no single entity can provide the answers alone. Rather than just studying the microeconomic concepts and only pursuing the end result to maximize healthcare, sometimes a collective

approach shall be applied. Tying in aspects of research and patient care analyzing all plans across the board shall be undertaken in producing favorable results for the average person. A model known as big data is very useful in determining the expedient methods of handling the healthcare system that involves detailed patient record keeping. This means a general focus can help understand the entire healthcare cycle, and keep a track record of each patient to perform a history check on what previous plans they used to be enrolled in.

Although the argument whether healthcare is necessary, be it in contributing by taxes or insurance, more than just monetary values need to be considered. The matters to be addressed in streamlining and centralizing healthcare would reduce medical bureaucracy. If only the healthcare system can be revised to reflect the majority needs, where patients do not require lengthy waiting times for to visit their doctors or receive treatment, less complications within the system would occur, vast amount of funds could be saved, and improvements in medical technology and procedures would advance.

For patients who travel frequently, whether for business or pleasure, or travel for necessity, especially between USA and Canada, the healthcare system shall be unified to reflect the needs of these frequent travelers. This way, medical practitioners in the same practice can tend to patients with their out of town counterparts and render medical procedures more smoothly, and would operate in tandem with resident health practitioners.

Since the healthcare system is formulated by a microeconomic model built upon individuals seeking comfortable health plans, it can only proceed so far that external factors also have considerable impacts. One of the leading factors is government decision because it determines and influences the behavior of individuals and companies they form a whole of. The government often imposes taxes that can slow down supply and demand for healthcare facilities. Hence it is importance for collective bargaining and agreement healthcare planning, because proper and affordable healthcare on a relative scale can be deemed the lifeblood of the economy. As long as a public strategy is implemented, perhaps a worldwide healthcare plan will benefit all walks of life and be labeled as a comprehensive to produce effective microeconomic concepts.

Work Cited

Kavilanz, P. (2012) Health Care Reform Stands: How It Impacts Your Coverage. CNN Money.

Baratz, D. (2012) How The New Healthcare Tax Affects You. Money Morning – Only The News You Can Profit From.

Porter, E. (2012) Health Care As Income For The Poor. Economic Scene. Business Day. The New York Times.

Pauly, M. (2003) Should We Be Worried About High Real Medical Spending Growth in the United States. Health Affairs.

Howlett, K. and Picard, A. (2010) Provinces Brace For Health-Care Transfer-Payment Showdown With Ottawa. The Globe and Mail.

May, J. H. and Cunningham, P. J. (2004) Tough Trade-offs: Medical Bills,

Family Finance: and Access to Care. Center for Studying Health System Change, Issue Brief No. 85, June 2004.

Harney, K. R. (2012) Health-care Law’s 3. 8 Percent Surtax Will Not Affect Many Home Sellers. Real Estate. The Washington Post.

Dyches, D. (2012). What Ways Do Health Care Expenses Affect the Economy? Health Care Industry.