It's time to consider Medical Savings Accounts

David Gratzer

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Buried deep in the newly released fifth report from the Standing Senate Committee on Social Affairs, Science and Technology on the state of Canada's health care system[1] is a gentle reminder of why we discuss health care reform. The report details the struggle of a patient to get the care he needs. After being diagnosed with 2 herniated discs on Apr. 19, 2001, the patient was promptly put on a waiting list for surgery. His procedure was classified as "elective but urgent" — a category that applies to most of the hospital's cancer surgery cases. Eight months later, the patient testified before the committee. He had not had his surgery. Indeed, it had not even been scheduled.

Notes the report: "It appeared that the only way for the patient in question to move to the top of the list was for his condition to deteriorate. It was not enough for him to be in constant pain and unable to work."[2]

Health care reform is a topic on the minds not only of health economists and policy analysts, but also of doctors, their patients and the public at large. Where do we go from here? Some would suggest that we look to other countries to find new, innovative approaches. The concept of Medical Savings Accounts (MSAs) appears particularly compelling.

MSAs are not an academic idea. Singapore began experimenting with the concept in 1984 through a mandatory worker's contribution plan.[3] Today, Singapore boasts more diagnostic machinery for its population than Canada (waiting times for MRI scans in the city-state are a couple of days versus months here).[4] Singapore has a lower infant mortality and a longer life expectancy than we do.[4] Waiting times for surgery are minimal. Singapore, incidentally, spends less than 4% of its gross domestic product (GDP) on health care; we spend 3 times that.

China's experiment with MSAs has dramatically lowered health care expenditures. The cost savings from the original pilot project amounted to 24.6%; this is particularly impressive given that in neighbouring cities, where citizens still enjoy "free" health care, spending grew by 35%–40%.[5] The initiative is expanding to include Shanghai, Beijing and more than 40 other cities, accounting for some 70% of China's urban population.[6] In South Africa, MSAs are the most popular type of private health insurance, covering 4.6 million people.[7] As a backlash against managed care, American companies such as Quaker Oats and many others have offered employees a type of MSA that allows them to accumulate unspent funds in their health accounts and either withdraw the money at year's end or spend the funds on preventive care. The concept won the endorsement of the American Medical Association. Some projections, including those cited by Samuel Shortt[8] in this issue (see page 159), indicate that the MSAs in the United States have matched managed care at containing costs (the main strength of health maintenance organizations) while being less restrictive of patient choice (the main weakness of managed care).

All of these experiments with MSAs should catch the eye — and interest — of Canadian health care experts. Unfortunately, Shortt's dismissive paper is all too common in the medical literature.

Let's be clear: None of these MSA experiments is perfect. MSAs in Singapore, for example, cover only hospital-based care; primary care is left to a patchwork of government and private clinics. Shortt is correct in noting that "most outpatient expenses are born out-of-pocket."

Also, health care systems are complicated: successes are often multifactorial. A case in point is China's inclusion of not just MSA-style plans in its reforms but also changes to hospital reimbursement plans. Time will tell how skillfully government managers are able to expand the project.

Shortt's overall criticisms of the MSA system in Singapore (like his criticisms of their use in China and other countries) read like a trial lawyer's attack: he depicts spending as being out of control in Singapore, ignoring the fact that total spending on health care accounts for less than 4% of the city-state's GDP. He suggests that part of the low spending is because of the heavy use of traditional Chinese medicine and that this type of health care "serves to reduce reliance on Western therapies." Such a statement requires quite the leap of faith to accept. Shortt notes the lack of generosity in programs for poor and elderly people (which speaks more to government callousness than to the failure of MSAs) and the resultant poor showing in the "fairness of financing" category of the Word Health Organization (WHO), but he fails to mention that the WHO ranked Singapore's health care system sixth in the world; Canada's came a paltry 30th. And strangest of all, Shortt attributes part of Singapore's success to the "supply-side tactics" it has in addition to the MSA program — as though, somehow, favouring MSAs excludes the possibility of also reforming the provision of health care.

There is no "perfect" health care system that Canada can simply copy. Western European nations struggle with waiting lists; the United States' experience is coloured by

extraordinarily high per capita expenditures (atypical of almost all other countries); Asian nations such as Singapore face aging populations. Still, it is important to recognize that lessons can be drawn from other countries. MSAs have offered interesting results in varied experiments.

Shortt suggests that, in order to truly assess MSAs, we would need "longitudinal studies in various jurisdictions that would examine expenditures, utilization patterns, equity issues, patient and provider satisfaction, and health outcomes." Although he is correct, his demand is impractical and calls for a standard we apply to no other health reform idea (consider how many longitudinal studies have been conducted on primary care reform, an initiative championed by so many of his colleagues).

Still, there is a point here: in order to learn whether MSAs are the right fit for Canada, we need to know more. One approach worth considering is to experiment with the idea right here in this country.

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Medical Savings Accounts will not advance Canadian health care objectives

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In his review of the literature on Medical Savings Accounts (MSAs) and the implications for the integration of MSAs into Canada's health care system[1] (see page 159 of this issue), Samuel Shortt rightly emphasizes that MSAs must be assessed, not against a predominately privately financed system such as the one in Singapore, or a fragmented, multi-payer system such as the one in the United States, but rather against Canada's publicly financed system and the objectives set out for it. Evidence of "success" in these other contexts may still imply failure against Canadian goals.

MSA-based financing would represent a radical departure from Canada's current system of health care finance. Under publicly financed MSAs, the government would provide individuals and families with a lump sum of money annually to be spent (paying full price) on purchasing health care services. This would be supplemented with comprehensive, universal catastrophic health insurance for severe illnesses. Those who do not spend the annual allotment would be able to accumulate funds over time that could be spent on a broader range of goods and services. Thus, MSAs are designed to give people greater choice and control of health care services, provide them with an incentive to use fewer services and encourage them to shop around with their MSA funds, thereby inducing competition among health care providers. In economic terms, these are "demand-side" controls.

Like Shortt, I believe that MSAs are unlikely to advance key Canadian policy goals with respect to expenditure control and health system equity. Demand-side controls have historically been used extensively and found wanting: they do not lead to effective expenditure control, they generate widespread inefficiencies, and they are incompatible with equity in the financing and utilization of health care services.

For well-understood reasons, health care markets do not operate the same way most markets for ordinary consumer