



Medical Savings Accounts—a possible health reform option for Australia?¹

Introduction

In recent years, the importance of addressing the rising cost of health services has been underlined by many observers of the health system. For example, in a 2005 report, the Productivity Commission warned that that health spending by all Australian governments, 'could almost double from around 6 per cent of GDP currently to about 10 per cent by 2044–45'.²

While this rapid increase in spending has primarily been a consequence of increased demand for services and the emergence of new medical technologies, an additional source of increasing costs in coming decades will be the ageing of the population.³ Thus, projects the Commission, by 2044–45, people aged 65 or over could account for nearly 55 per cent of government spending on health care, compared with about a third now.⁴

Medical Savings Accounts (MSAs) (also known as Health Savings Accounts) have been suggested as one way of addressing the question of how Australia can pay for its future health needs. First introduced in Singapore in 1984, MSAs are similar to compulsory superannuation—individuals save a proportion of their income into an account which can only be used for health expenses. In theory, these accounts accumulate when people are young and healthy, so that they can pay for health costs when people are older and need to spend more. Further, some have argued that, by making individuals more directly responsible for their own expenditure, MSAs can provide incentives for consumers to make positive changes in health behaviour (such as adopting more healthy lifestyles and other preventative forms of healthcare).⁵

This Research Note examines the case for MSAs by explaining what they are and what they are intended to do, presenting evidence from overseas about their efficacy, and discussing issues raised by any attempt to introduce them into Australia.

What are Medical Savings Accounts?

MSAs are often raised in Australian and overseas health reform debates as an alternative funding model.⁶ While there is a variety of types of MSA, they can be generally defined as 'the voluntary or compulsory contribution of payments by individuals, households or firms into a personalised savings account that serves to spread the financial risk of poor health over time'.⁷

While, generally, MSAs make use of private funds for the payment of health expenses, they differ from private health insurance in that, instead of premiums paid to an insurance fund, deposits are made to an individual or family account and remain under the control of the account holder(s). Also, with an MSA the risk of ill health is borne by the account holder, unlike an insurance arrangement where the risk of payment is spread across a pool of money from a large number of contributors and the healthy in effect subsidise the unhealthy.

The main component of an MSA is a single or family savings account from which routine medical expenses are paid.

Contributions are made by some combination of the individual, employers or government. There may be restrictions on the type of health services that can be purchased to contain expenditure. As with private health insurance, the use of an MSA to pay for health expenses may have deductibles or co-payments attached.⁸

The precise design of MSAs varies from country to country. Variations between MSA models include the mix between public or private funding, the way in which catastrophic medical expenses is addressed,⁹ whether there is a 'safety net' mechanism for disadvantaged persons, whether contributions to MSAs are voluntary or compulsory, and whether MSAs cover all or only a particular segment of the population.

Why MSAs?

Three arguments are generally used in favour of MSAs:

- to encourage savings for the expected high costs of future medical care
- to encourage consumers to avoid over-consumption of health services (known as the problem of 'moral hazard') by exposing them to the cost of health services—as opposed to private or national insurance models which tend to mute this 'price signal' effect, and
- to mobilise additional health system funding.¹⁰

An Australian commentator on health funding matters, Paul Gross, has also suggested that, in addition to the above, MSAs could (among other things) help boost overall *national* savings and increase financial incentives for adoption of healthy lifestyles and use of preventative services.¹¹

International experience with MSAs—the case of Singapore

MSAs have been introduced in Singapore and to a more limited extent (mainly in the form of demonstration or pilot projects) in China, the United States, and South Africa.¹² This section focuses on Singapore because it has had the most extensive experience.¹³

MSAs in Singapore

The Singapore health system relies on a combination of public and private provision of health services. Currently, the public sector provides around 80 per cent of hospital care and 20 per cent of primary care.¹⁴

MSAs were introduced in Singapore as part of a major reform of the health system. Prior to 1984, healthcare was provided through free hospital care and subsidised government clinics. Reform of the system was initiated in response to concerns about rapidly increasing costs, lack of efficiency in the public hospital system (stemming from such factors as high levels of bureaucracy and low labour productivity) and inadequate consumer focus of

public hospitals (for example, opening hours that suited staff rather than patients).¹⁵

In considering a range of options for health reform, Singapore's political leaders were guided by four basic principles:

- consumer choice
- consumer self-reliance and self-accountability
- the need to make greater use of free market competition, and
- the belief that the public system should shift from a universal provider to a safety net system.¹⁶

Medisave, the primary component of Singapore's MSA-based system, strongly reflects these principles. Medisave is a compulsory program designed to be used to pay for personal and immediate family expenditure on health services. Employees contribute 6 to 8 per cent of their monthly wages to their Medisave account depending on their age (the older the employee, the greater the rate of contribution). Patients have freedom to choose between health providers but pay directly for the service at the point of delivery, thereby ensuring that patients themselves are fully aware of the cost of their treatment.

Medisave funds can be used to pay for all expenses of patients staying in subsidised wards in public hospitals and some expensive out patient services (such as chemotherapy, HIV drugs and kidney dialysis).¹⁷ Features of Medisave designed to encourage prudent use of health services include a cap on contributions (monthly and over a lifetime) and limits on how much of an MSA can be used for daily hospital charges, physician fees and surgical fees.¹⁸

Since Medisave was implemented it has been supplemented by the following programs designed to ensure that certain categories of patient are not severely disadvantaged by particular circumstances:

- **Medishield**—a voluntary catastrophic insurance scheme run by the government, introduced to address the risk that Medisave account holders could have their savings depleted by catastrophic illness
- **Medifund**—a safety net program designed to assist those patients who are unable to pay for their medical expenses. Patients seeking Medifund assistance must apply and have their cases assessed by a social worker and reviewed by the hospital's Medifund committee, and
- **ElderShield**—a program designed to provide elderly Singaporeans with basic financial protection against expenses in the event of severe disabilities.

Analysis—impact of MSAs in Singapore

Some observers of the Singapore health system have argued that the country's use of MSAs offers an important reform model for other countries. In doing so, they have tended to point to areas of success such as:

- continuing excellent health outcomes (for example, low infant mortality and high life expectancy) since the introduction of MSAs,¹⁹
- systemic efficiency (for example, 'minimal' waiting times for surgery),²⁰ and
- relatively low expenditure on health (approximately 3 per cent of GDP, compared with a global average of 8 per cent).²¹

However, other reviews of the Singapore experience with MSAs have noted that evaluation is hampered by a number of factors, including the difficulty in distinguishing the impact of MSAs

from other components of the system (Medisave was implemented as part of a broad set of health sector reforms) and limited access to relevant data.²²

Despite the absence of such data, reviews of the available evidence suggest the following:

- Medisave spending remains a relatively small share of total health expenditure at this stage (around 10 per cent). Government and out-of-pocket funds (co-payments) play the predominant role in health financing²³
- while evidence of accumulation of funds in Medisave accounts suggests the existence of resources for future health spending (around S\$22 billion had been saved by 2000), it is not clear that the poor and chronically ill will be capable of accumulating sufficient funds for their future needs²⁴
- there is no clear, direct evidence that Medisave has contained costs by encouraging consumers to avoid over-consumption of healthcare²⁵
- evidence of the impact of MSAs on equity is sparse. While some argue that Medishield and Medifund have provided a relatively effective safety net, others have suggested that the poor, unemployed and women are not as well served as more privileged members of society,²⁶ and
- the success of the Singapore health system owes much to factors specific to the social-political system and economic context of Singapore—for example, sustained economic growth, a 'savings culture', and strong, centralised government control.²⁷

MSAs for Australia?

As noted above, MSA-style reforms have been suggested by a number of commentators in recent years as a way of addressing likely increases in health costs over the next three to four decades in Australia. Based on the available evidence and the various relevant factors particular to Australia, it is possible to nominate a number of issues that would need to be considered in relation to implementation of (some form of) MSAs.

What kind of MSA for Australia?

There would be numerous design questions associated with any attempt to introduce MSAs into Australia, including:

- would *participation* be compulsory or voluntary? Compulsory MSAs would potentially be less prescriptive (for example, involving fewer restrictions on how they may be used) than voluntary MSAs—perhaps meaning that they are blunted somewhat in pursuit of their objectives. Unlike voluntary MSAs, compulsory MSAs would not require incentives for participation
- would *contributions* be compulsory or voluntary? What sort of maximum and/or minimum limits would there be? Maximum limits may be essential to avoid MSAs being used for tax shelter purposes
- who would undertake administration and fund management: public agencies (existing or new) or private organisations (banks, super funds, private health insurers, other)?
- could MSA funds be used for all health-related services (including hospital, GP, specialist, diagnostic, pharmaceutical, residential care, complementary, ancillary) or a more limited range of services?

Integration with current health system

The introduction of MSAs into Australia would raise numerous questions about how this would be integrated with existing programs. These questions would include:

- would MSAs be introduced as part of comprehensive reform of the health system (as in Singapore) or something more limited (as in the China, US and South African programs)?
- would MSAs replace Medicare and the PBS? If so, what types of transitional arrangements would be put in place to protect those using these programs? If not, what would be its relationship to these programs?
- would public hospitals be expected to charge patients for their services?
- what would MSAs mean for private health insurance?

Limitations

MSAs have a number of important limitations that would need to be considered prior to adoption in Australia. These include:

- MSAs by themselves are not effective instruments for financing the health expenses of the chronically ill and poor (both of whom tend to deplete their accounts more quickly than they can add to them and therefore require some form of safety net). Given that, under the *current* Australian system, it is the cost of treating patients in these categories that consumes much of government expenditure, it could be argued that MSAs would not significantly reduce government expenditure on health
- demand for health care is a function not only of consumer purchasing power but also of consumer expectations and health needs
- the assumption that, under MSAs, 'consumer power' might also be decisive in reducing the cost of health services tends to underplay the important role of government involvement in keeping health costs under control,²⁸ and
- some argue that MSAs may lead to 'perverse' decisions by consumers in relation to their healthcare—for example, healthy people with high balances may be encouraged to seek relatively trivial services, while the very sick, afraid of exhausting their MSAs, may be more likely to economise their use of services.²⁹ On the other hand, there is some evidence from the US provider of MSAs, CIGNA Healthcare, indicating that consumers *can* reduce healthcare expenditure *while also* making greater use of preventative health measures.³⁰ While the evidence from CIGNA was mainly about the use of medication in control of chronic illnesses such as diabetes, Paul Gross has argued that with proper information and support, MSAs can also be used to provide incentives for consumers to adopt more healthy lifestyles.³¹

Values

An attempt to introduce MSAs-based reforms into Australia would potentially involve a shift in core values of the current health system.

According to Gross, Singapore's move towards MSAs reflected the view of that country's government 'that the free market was preferable to egalitarian welfarism, with the caveat that the government would intervene where there are imperfections in the market'.³² Further, as noted, the move towards MSAs was based around a commitment to particular values such as individual self-reliance and self-accountability.

In contrast, it is often argued that core values in the current Australian system include such concepts as equity and universal access to quality care.³³ A key idea behind these values is community rating—that is, the idea that risk of ill health is 'pooled' (rather than borne by individual patients) so that access to health services is determined on the basis of need, rather than income. In principle, MSAs turn this situation on its head by shifting risk onto individual patients and determining access on the basis of funds available in an account. While this situation can be, as has been the case in Singapore, ameliorated by a safety net health system for the poor and chronically ill, this would arguably shift the Australian system in the direction of 'two-tiered' healthcare—a situation potentially at odds with the values underpinning the current system.

The question of values is also somewhat complicated by the emerging distinction between 'necessary' and 'lifestyle' medical treatments and the question of whether we, as a society, regard it as essential to fund access to every kind of available healthcare product. Perhaps MSAs, by more strongly emphasising price signals present some kind of opportunity for addressing this complicated issue. On the other hand, a move in this direction would, potentially, by devolving the power to make health decisions to individual consumers, erode the capacity/responsibility of the state to make informed policy interventions on behalf of health consumers.

Conclusion

MSAs offer an alternative approach to dealing with projected rapid increases in the cost of healthcare over the next few decades. In essence, MSAs seek to encourage individuals to save for the future costs of their own healthcare, to encourage consumers to avoid over-consumption of health services and to mobilise an additional source of health system funding. Some also argue that they can be used to promote greater engagement by consumers in making decisions about their health (such as the use of preventative treatments and adoption of more healthy lifestyles).

As discussed, the evidence of direct benefits to the health system in those countries in which MSAs have been established is somewhat inconclusive. However, as one Canadian commentator, David Gratzer, has suggested, the evidence (such as longitudinal studies) often demanded by those who are sceptical of MSAs can be 'impractical' and require 'a standard we apply to no other health reform idea'.³⁴ Nevertheless, he argues, evidence remains important:

... 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.³⁵

The same might be argued for Australia: perhaps some experimentation with MSAs might be necessary before making conclusions about their potential value. At the very least, advocates for this might argue, MSAs would mean that some money (from an additional non-government source) was being put away for future health costs.

However, there would most likely be many who would argue against any move towards MSAs in Australia on the principle that they erode the concept of community rating (pooling of risk). As Richardson and McAuley argue, 'by shifting health expenditures into the private realm, [MSAs] would reduce community sharing. For the less wealthy and educated, MSAs may generate anxiety over both their financial resources and the

quality of their decision making when facing a medical crisis'.³⁶ On the other hand, some may argue that MSAs might provide the opportunity to engage consumers more closely in decisions related to their healthcare and hence move towards other types of values such as self-reliance and self-accountability. In other words, the debate over values is likely to play an important role in any future debate about the introduction of MSAs into Australia.

1. Thanks to the following for assistance with the production of this paper: Paul Gross, Institute of Health Economics and Technology Assessment; Ian MacAuley, School of Management and Policy, University of Canberra; and colleagues from the Parliamentary Library.
2. Productivity Commission, *Economic Implications of an Ageing Australia*, Research Report, Canberra, 24 March 2005, p. 143.
3. For example, see Productivity Commission, *Economic Implications of an Ageing Australia*, op. cit., Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, Research Report, 31 August 2005.
4. Productivity Commission, *Economic Implications of an Ageing Australia*, op. cit., p. 172.
5. For example, see T. Richards, *Benefiting from Health Savings Accounts*, CIGNA Healthcare White Paper Series, April 2005, p. 3; P. Gross, 'Three bitter pills to cure health care', *Sydney Morning Herald*, 9 June 2005.
6. For Australian examples, see Will Delaat, Chairman, Medicines Australia, *PBS reform for a healthy Australia*, speech, National Press Club, Canberra, 3 August 2005; Australian Medical Association, *Submission to the House Of Representatives Standing Committee on Health and Ageing Inquiry into Health Funding*, May 2005; P. Gross, 'Three bitter pills to cure health care', op. cit.; P. Gross, 'Radical reform of Medicare and private health insurance inevitable, says Gross', *Healthcover*, December 2002—January 2003. For international examples, see D. Gratzler, 'It's time to consider Medical Savings Accounts', *Canadian Medical Association Journal*, 167:2, 2002; J. Gollatz et al., 'Combining mandatory health insurance and Medical Savings Accounts', *Health Insurance and Managed Care Interface*, April 2002; C. Ramsay, 'Medical Savings Accounts: Universal, Accessible, Portable and Comprehensive Health Care for Canadians', *Fraser Institute—Critical Issues Bulletin*.
7. A. Dixon, 'Are Medical Savings Accounts a viable option for health care?', *Croatian Medical Journal*, 43 (4), 2002.
8. The term 'deductible' in this context refers to the out of pocket amount the person with the MSA must pay before MSA payments for covered services begin.
9. The term 'catastrophic medical expenses' is generally used to refer to major health costs. It is generally based not on the type of illness/injury but rather the impact on household income. While there is no consensus on the proportion of household expenditure on health that should be considered catastrophic, studies have tended to use a threshold of between 5 per cent and 20 per cent of total household income. See K. Xu, et. al., 'Household catastrophic health expenditure: a multicountry analysis', *The Lancet*, 362, 12 July 2003, p. 112.
10. P. Hanvoravongchai, *Medical Savings Accounts: lessons learned from international experience*, Discussion Paper No. 52, World Health Organisation, 15 October 2002, p. 1.
11. P. Gross, 'Three bitter pills to cure health care', op. cit.
12. A New Zealand private health insurer, Southern Cross Healthcare, has also announced the introduction of an MSA designed to attract those without health insurance. See P. Gross, 'Time to try the Kiwi way on health cover', *Australian Financial Review*, 29 September 2005.
13. For reviews of the experiences of China, the US and South Africa with MSAs see A. Dixon, 'Are Medical Savings Accounts a viable option for health care?', op. cit. pp. 411–14; P. Hanvoravongchai, *Medical Savings Accounts: lessons*

learned from international experience, op. cit., pp. 21–32; and Allen Consulting Group, *Medical savings accounts—a discussion paper*, op. cit. pp. 10–16.

14. P. Hanvoravongchai, *Medical Savings Accounts: lessons learned from international experience*, op. cit., p. 5.
15. W. Hsiao, 'Medical Savings Accounts: lessons from Singapore', *Health Affairs*, 14, 1995, p. 261.
16. *ibid.*
17. R. Taylor and S. Blair, 'Financing health care—Singapore's innovative approach', *Private Sector Infrastructure Network*, The World Bank Group, Note No. 261, May 2003, p. 2.
18. *ibid.*
19. D. Gratzler, 'It's time to consider Medical Savings Accounts', op. cit. p. 151.
20. *ibid.*
21. R. Taylor and S. Blair, 'Financing health care—Singapore's innovative approach', op. cit., p. 2.
22. Allen Consulting Group, *Medical savings accounts—a discussion paper*, op. cit., p. 9.
23. for example, see *ibid.*, p. 10.
24. for example, see *ibid.*, p. 10.
25. for example, see P. Hanvoravongchai, *Medical Savings Accounts: lessons learned from international experience*, op. cit., p. 14.
26. for example, see A. Dixon, 'Are Medical Savings Accounts a viable option for health care?', op. cit. p. 411.
27. for example, see *ibid.*, pp. 414–5.
28. J. Richardson and I. McAuley, 'Medical Savings Accounts', *New Matilda*, November 23, 2005, p. 2.
29. *ibid.*
30. For example, see *CIGNA Choice Fund(SM) study provides new insights on consumer decision-making in consumer-driven health plans*, media release, CIGNA Healthcare, 2 February 2006.
31. For example, see P. Gross, 'Three bitter pills to cure health care', op. cit.
32. P. Gross, 'Radical reform of Medicare and private health insurance inevitable, says Gross', op. cit., p. 42.
33. for example, see Allen Consulting Group, *Medical savings accounts—a discussion paper*, op. cit., p. 28.
34. D. Gratzler, 'It's time to consider Medical Savings Accounts', op. cit., p. 152.
35. *ibid.*
36. J. Richardson and I. McAuley, 'Medical Savings Accounts', op. cit., p. 3.

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