

## **Medical savings account no answer to health care challenges**

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**By Dr. Gordon Guyatt**

Medical savings accounts are becoming a serious consideration in debates about health care reform. Most Canadians know little about medical savings accounts, and less about whether they might improve Canadian health care.

Medical savings accounts involve two key features. The first is an insurance plan that covers large expenditures for catastrophic health problems. This plan involves a very high deductible, and some co-payment above the deductible. In other words, you have to pay a large sum toward health care before your insurance coverage kicks in, and also pay some of the costs even after that point.

The second is a fund to cover your costs before the insurance plan begins to pay. The fund or account – which is where the medical savings account gets its name – might come from the government, from your own income, or from your employer. For instance, the fund could work like many current pension plans, with mandated contributions by both employer and employee.

Any private or employer contributions to the MSA would likely be tax free. Given our tradition of public funding of health care, in Canada it is likely that the government would pay a large part of both the MSA fund and the cost of the insurance premiums, and companies or individuals a smaller portion.

Once the MSA ran out, and before the catastrophic insurance kicked in, you would pay out-of-pocket for health care. Thus, the MSA plan would provide you with an incentive to limit your health spending. Depending on the rules, restraining health spending would mean either that you could spend left-over money elsewhere, or that you would not have to spend non-MSA money to cover future health care costs. Thus, the attraction of MSAs is that they might reduce costs by decreasing health care demand.

MSA advocates point to experience with MSAs in Singapore, China and the US. In their analysis, MSAs, introduced in Singapore in 1984, have led to

that city-states's success in delivering quality health care with manageable costs. MSA advocates note that since their introduction in two China cities in 1994, the Chinese government has decided on major expansion, and MSAs now operate in over 40 Chinese cities. Finally, they cite cost savings achieved by American companies that introduced MSAs.

MSA critics see things differently. They note that in 1993, Singapore's health costs were out of control despite the MSAs. At that time, Singapore introduced other measures to control spending. These included restrictions on technology in government hospitals, price caps on services delivered in these institutions, restrictions on bed numbers, and tighter controls on the number and mix of physicians. These controls, MSA critics suggest, are responsible for Singapore's relative success in containing costs. Finally, MSA critics point to Singapore's ranking in fairness of health care financing by the World Health Organization: 101st of 191 countries ranked. MSAs have not helped achieve high levels of equity.

Turning to the China experience, critics note the limited MSA evaluation, and the mixed results of the evaluations that do exist. Finally, since Canadian health care costs about half of that in the US, critics are unimpressed with modest American cost savings with MSAs.

Professor Jerry Hurley of McMaster University, an economist, has analyzed the likely impact of MSAs. In Canada, the tradition of public funding of health would mean that the government would pay a substantial part of both MSA funds and the premiums for catastrophic insurance. Professor Hurley believes that, under these circumstances, MSAs will increase, rather than decrease, health care costs.

First, Hurley notes that a small proportion of the population who suffer catastrophic illness or have serious chronic diseases are responsible for the bulk of health care expenditures. Under a Canadian MSA plan, most spending would therefore be covered by the catastrophic insurance component. Governments would still have to fund MSAs for individuals who used few health services. Substantial decreases in use of resources for catastrophic illness would be required to make up the difference. Health care use for a serious illness is not, however, under the discretion of the patient. As a result, overall government expenditures will increase.

Second, Hurley points out the knowledge imbalance between health service providers and individual consumers. The American experience with direct-to-consumer advertising shows how a service provider can use sophisticated marketing to induce demand, even in the face of high prices. There is no reason to think the Canadian public would be any less vulnerable.

Finally, MSAs would entail administrative costs that are not part of our current system.

Hurley points out that not only are MSAs unlikely to decrease costs, but adverse consequences are probable. Strong evidence suggests that patients are unable to distinguish between needed and unneeded health care. In particular, poor Canadians with chronic diseases, nervous about their MSA running out, are likely to ration their use of health care that could prevent subsequent deterioration in their condition.

Health status is strongly influenced by income. Since the poor are sicker, they are at greater risk of having their MSA run out, and the requirement for additional out-of-pocket payment. Simulation models consistently show that high income individuals at low risk of illness gain the most financial benefits from MSAs, while low income people at high risk suffer the most.

Professor Hurley's bottom line is compelling. "Critical analysis suggests that MSAs have little to offer, especially within publicly financed health care systems, and put much at risk."