Medical savings accounts: a notably uninteresting policy idea

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When one lists the issues that confront national health policymakers in Europe, few can be classified in simple black versus white terms. On the contrary: policy options in the health sector are customarily defined in subtle shades of grey. Policy proposals typically can be analysed in terms of their likely advantages, their potential disadvantages, their implications for other sub-sectors of the system, and, inevitably, their perverse consequences. Lessons learned in one country may or may not be applicable in other countries, depending on a considerable range of structural variables: history, culture, health system organization and political system. Policy debates resound with carefully couched versions of that classic academic statement: 'on the one hand, but on the other hand ...'.

What is, therefore, so striking about the notion of adopting medical savings accounts (MSAs) in European health care systems is the single consistent conclusion that emerges from all the available evidence. Far from producing a range of grey interpretations about likely outcomes, with MSAs the policy implications are starkly etched in black and white. Every dimension of analysis indicates that MSAs are not a feasible policy option for developed countries that wish to maintain an economically efficient or socially responsible health care system.

MSAs were originally developed in Singapore, funded by a mandatory deposit of 28% of salary from all employees. The fact that MSAs emerged from a developing country with an authoritarian regime should alone be sufficient to give pause to European policymakers. When one remembers that for 50 years the standard international transmission belt for health policy ideas has been from developed countries (like the UK and Sweden) to developing countries, one wonders why it is that, in the late 1990s, there suddenly is a reversal of flow, in which a policy instrument designed for use by a repressive regime in the developing world has apparently become attractive to some groups of policymakers in the parliamentary democracies of Western Europe.

The original principle behind MSAs has been adapted for use within one developed country, namely the United States. In 1996, the ultra-conservative Republican majority in the Federal Congress forced through a three-year 'demonstration project' of 750,000 MSAs.1 The MSA strategy in the US is based on a deceptively simple premise: let each individual purchase his/her own health care services with the funds currently used to purchase third party coverage.2 A small portion of these funds could then be used by this individual to purchase a so-called catastrophic insurance policy, which would cover all expenses beyond, say, $4,000 annually per family. (In the United States, private insurance coverage for a family of four costs upward of $5,000 per year.) Any funds left in the MSA account at the end of the year could be withdrawn by the account holder as personal income.

As Republican proponents explain it, this MSA model facilitates three important policy objectives. First, by creating positive financial incentives for individuals to seek less care, MSAs will reduce demand for services. Second, since individuals can keep unspent funds, patients will have strong incentives to shop around for less expensive providers. Third (and, ostensibly, not inconsistently with the second part), since patients control the funds for payment, they are guaranteed the right to choose providers that meet high quality standards.

A moment's reflection, however, indicates that the core operating mechanisms of this ostensibly new model are themselves far from new. MSAs seek to achieve the three above-described objectives by returning to a provider payment system based on two old health sector standbys: fee-for-service and large individual co-payments. MSAs

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withdraw most of an individual’s insurance premium from the broader pool based on collective risk-sharing, and transform it into a fund for 100% co-payments. The incentive to economise is tied to the ability of the individual — as in all co-payments — to keep for personal use whatever funds are not paid out to providers.

Since these two operating mechanisms are not new, one can find considerable evidence about the outcomes they have generated in the past. Specifically, one can readily review the past and probable future impact of fee-for-service and large co-payments on the clinical, economic, and social outcomes of existing European healthcare systems.

Clinically, fee-for-service discourages individuals from regularly utilising a primary care provider, instead encouraging uncoordinated services from a variety of specialists. It relies upon the anecdotal ability of each patient to process medical information and then to judge the quality of services received. In addition, co-payments discourage individuals from seeking preventive services, since they are not immediately necessary. Conversely, co-payments encourage individuals to self-diagnosis, which leads to distorted patterns of care-seeking emphasising self-limiting conditions that prevent one from going to work. Economically, fee-for-service is the most expensive way to pay providers, since it generates strong incentives for both over-utilisation of expensive specialist services and for over-treatment by those specialists. Higher long-term overall costs are associated with co-payments, since they discourage the use of cost-effective preventive services. Regarding MSAs specifically, one study concluded that, in Singapore itself, MSAs did not reduce health sector expenditures by any appreciable amount.

Socially, fee-for-service based on 100% co-payment has traditionally excluded poorer individuals from receiving necessary services since they lack sufficient funds to pay for care. With MSAs, if poorer individuals are given sufficient funds to purchase health services (for example, from taxes), they face a similar trade-off. They may well choose not to seek necessary curative or (especially) preventive services in order to keep unspent funds for other, more immediate necessities. MSAs would thus encourage lower utilisation despite the well-known reality that poorer individuals typically need more health services than do their economically better off counterparts. Moreover, this self-payment arrangement would seriously damage social solidarity in the health sector. By separating out each individual or families’ health care funds, MSAs drive a stake into the heart of each of the four cross-subsidies that form a socially responsible payment structure: from rich to poor, from healthy to sick, from young to old, and from single individuals to families. Instead, MSAs are rooted in the possessive individualist notion that 'fairness' is achieved only when each separate individual receives back from the insurance system exactly what he or she paid into it. Hence, the ability of each individual to 'withdraw' whatever portion of his/her health care premium that goes unspent on his or her personal medical services. This understanding of 'fairness' as personal repayment also forms the conceptual core of several government sponsored but self-funded pension systems in the United States (known as IRAs, or Individual Retirement Accounts, as well as 401(k) and 403(b) employer-sponsored funds), all of which have been designed to privatise pensions based on individual income and investments. Obviously, this individually-based understanding of 'fairness' is exactly opposite to the concept of cross-subsidy that underscores European social insurance and tax-based health funding systems. It is even antithetical to the basic concept of risk-sharing among groups of individuals inherent in the very notion of insurance itself.

From a US perspective, MSAs represent precisely the opposite strategy from managed care. Whereas managed care trumpets the advantages of co-ordinated services, corporate quality management, and an emphasis upon primary care gatekeepers rather than specialist care, MSAs promote sporadic and erratic individual decision-making about the medical services a patient receives. Whereas managed care pursues efficiency through economies of scale tied to a complex webler of negotiated contracts and capitated payments, MSAs pursue efficiency through the presumed skill of the individual patient negotiating one-off payment agreements with health care providers, based on the notion of consumer sovereignty. Whereas managed care subjects individual physicians to strict utilisation and quality audits, MSAs are viewed by some conservative physicians in the US as a way to escape external review and to return to the autonomous private practice.

One cannot help but notice the intellectual confusion in the fact that, in the United States, many of the same conservative politicians and neo-classical economists who supported managed competition are now championing the oppositely configured MSAs. After a decade of preaching about the anticipated efficiency of a corporate profit-making model for health insurance, these groups now argue that the true path to economic efficiency in health care is to repeal almost all collective insurance and to revert to a pure market of individual buyers and sellers. It also is worth noting that the concept of MSAs follows what available evidence indicates is the least effective path to successful, sustainable health care reform. MSAs (like managed competition) seek to generate reform on the funding or demand side of the health care system. Yet experience in Europe accumulated over ten years of health sector reform strongly suggests that reforms most likely to achieve their objective have taken place on the production or supply side of the health system. This point has recently been acknowledged by several health economists in North America.

It should further be noted that one ostensible concern of MSA proponents — to preserve patient choice of provider — can be readily achieved without instituting either a corporate for-profit version of managed care or fee-for-service-based MSAs. In the solidaristically financed social-insurance health systems like those found in Germany and The Netherlands, patients continue to be...
able to choose any service provider. In some tax-funded health systems such as Sweden, patients also can choose both their primary care provider and their hospital. Thus, it is not necessary to jettison social responsibility for the primitive market arrangements that MSAs would reintroduce to the health sector.

MSAs have been fiercely fought in the United States because, even there, the damage that they will do to the remaining social and fiscal fabric of its health care system is painfully apparent. When one weighs up the havoc that MSAs would cause to the clinical, economic, and social character of existing European health care systems, that is, in developed countries which already have universal health care funding in place, MSAs could well be the single worst health policy proposal in many years. It is an idea whose time in Europe should never come.

REFERENCES


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