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Medical savings accounts: can they improve health system performance in Europe?

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The concept of a medical savings account – in its purest form, a vehicle to allow people to save money to spend on health care – was initially developed in the United States in the 1970s. In the 1980s and 1990s the concept was translated into policy in a handful of countries, either as part of a private health insurance market (South Africa and the US) or to complement publicly-financed health care in south-east Asia (Singapore and China). Two threads link these four initiatives: a desire to address the problem of ‘moral hazard’ in health care and a belief that individuals should take some responsibility for their health care costs. It is only in the last five to ten years that medical savings accounts (MSAs) have begun to be discussed as an option for European health care systems.

Theory, history and politics

MSAs were originally developed by analysts in the US in response to problems in the private health insurance market, which then (as now) mainly covered working-age individuals not already covered by federal programmes for older and disabled people (Medicare) and federal and state programmes for low-income people (Medicaid). The key issue was concern about the impact of moral hazard on health care costs.

Economic theory suggests that when individuals are covered by health insurance, they may take less care of their health because they

know they will have access to health care if they need it. They may also use more health care than they really need because this care is essentially free at the point of use. At the same time, the fact that health care costs are borne by a third party rather than by patients themselves may give providers the opportunity to supply more care than is strictly necessary. Moral hazard may therefore lower efficiency in the allocation of scarce resources and can cause health care costs to increase.

One way of addressing moral hazard is to introduce some form of cost sharing – in other words, to make patients pay for at least part of their health care costs. MSAs build on the logic of cost sharing.¹ If people accumulate their own money to pay for health care (or accumulate savings based on contributions from their employer or the government), then they may be more likely to think twice before using health services. Instead of ‘using or losing’ the money they pay in health insurance premiums, the choice they now have is to ‘spend it or save it.’²

In theory, moral hazard poses as much of a problem for publicly-financed health insurance as it does for private insurance markets. In practice, however, as Jost³ argues, policy makers disagree about just how serious a problem it really is. This difference in emphasis suggests underlying differences in political values. Robinson has noted that the advent of MSAs in the US “reflects a

philosophical shift in emphasis from collective to individual responsibility for the management and financing of health care".² In contrast, health financing policy in Europe demonstrates a commitment to collective responsibility. So although most European health systems charge patients for using certain health services – particularly outpatient prescription drugs – the level of charges is generally low and children, poorer households and people with chronic illnesses are usually exempt. While European policy makers also worry about rising health care expenditure, their efforts to contain costs focus more on controlling health care supply than on curbing patient demand. Thus, in Europe there seems to be greater concern for the negative consequences of creating financial barriers to access than for patient-driven moral hazard, coupled with greater willingness to address provider-driven moral hazard.

Even in the context of private insurance markets in the *United States*, concern for moral hazard alone was not sufficiently overwhelming, during the 1970s and 1980s, to convince policy makers of the need for MSAs. It was not until managed care had firmly established itself in the 1990s, and consumers and, importantly, providers had become vocally dissatisfied with what they regarded as unfair constraints on patient choice and provider autonomy that MSAs were seen as a viable policy option. Against the back drop of the so-called managed care 'backlash', the idea of giving consumers greater control over how they spent their health care dollars gained traction in Washington.

At the same time, it was thought that, if combined with tax relief and a high-deductible health plan, MSAs might encourage take-up among the high numbers of US residents without any health insurance. An MSA could be used to finance health care below the level of the annual deductible – for example, to cover 'routine' expenses such as primary care visits and outpatient prescription drugs – and health insurance would cover the rest. If health insurance were limited to covering less commonly-required but

more expensive 'non-routine' care, premiums would fall. The idea is that the combination of tax-exempt savings and lower premiums would therefore make health insurance more affordable.

The 'portability' of individually-held MSAs from one job to another added to their attraction and in 1996 the Clinton administration eventually introduced a pilot scheme for self-employed people and small businesses. In 2003 the Bush administration followed this with a national system of tax incentives for voluntary take up of health savings accounts (HSAs) combined with high-deductible health plans, and in 2006 the government expanded the tax incentives even further (see Case Study).

In *South Africa* the development of MSAs was swifter and more straightforward. Market reforms introduced in the late 1980s and early 1990s effectively deregulated the country's private health insurance sector, which serves the richest 15% of the population. The abolition of community rating and minimum benefits gave insurers the freedom to design and price their own benefits. A leading insurer began to offer MSAs in 1994 as a means of promoting individual responsibility and controlling costs by making consumers more cost conscious. MSAs were soon established by most insurers, largely encouraged by a tax loophole which allowed employees to accumulate unlimited tax-free savings. Following the introduction of democratic government, the regulatory environment was strengthened. For example, in 2000 the regulator capped the tax exemption and re-instated rules such as open enrolment, community rating and prescribed minimum benefits. Since then, other steps have been taken to re-build the risk pooling and financial protection undermined by the rapid expansion of MSAs (see Case Study).

The introduction of MSAs in *Singapore* in 1984 took place in the context of a predominantly government-financed health system. Compulsory savings already played a central role in the government's welfare strategy for pensions and housing. Inspired by US debates about the use of savings to finance health care, the Singapore government simply added

a new health care branch to its existing savings scheme, the Central Provident Fund. Not only did the concept of MSAs fit well with Singapore's institutional approach to welfare, it also suited a government that feared health insurance-related moral hazard and wanted to minimise public spending on health care.

In contrast to the other countries, MSAs in Singapore were established as a stand-alone financing mechanism (Medisave), without any requirement for individuals to join some sort of risk-pooling scheme to cover catastrophic health care costs. Even when the government realised that savings would not provide sufficient financial protection, the complementary risk-pooling arrangements it set up (Medishield and Eldersshield) were neither compulsory nor comprehensive. More recently, however, the government has tried to increase uptake of Medishield by automatically enrolling some individuals but allowing them to opt out if they want to (see Case Study).

China set up a system of MSAs combined with employment-financed health insurance for urban employees in the late 1990s, building on an earlier pilot scheme initiated in several cities. The new system was influenced both by the Singaporean scheme and the Chinese government's own experience with compulsory savings accounts for retirement, which had recently been created for urban workers. As in the other countries, the desire to control health care expenditure by fostering consumer cost consciousness was a key factor behind the changes. In addition, the government had considered and rejected alternative options such as tax financing and private health insurance on the grounds that the country's tax system was not sufficiently developed and voluntary insurance would not provide universal protection.

One similarity between the South African and Chinese models is in the decentralized nature of MSA design. Just as insurers in South Africa were originally free to design their own MSAs, the Chinese government originally allowed each city to decide on the balance between MSAs and health insurance and to set their own cost sharing policy. Over

time, however, the regulatory framework in both countries has been tightened to ensure greater standardization and protect risk pooling (see Case Study).

Policy implementation

In each of these four countries, MSAs operate in the absence of a universal or comprehensive system of health coverage involving risk pooling. Thus, one potential policy aim or outcome might be to enhance financial protection by alleviating the burden of out-of-pocket payment for health care. So in the US and South Africa MSAs may encourage take up of voluntary pre-payment, while in Singapore and China they facilitate compulsory pre-payment and pooling across an individual's lifetime.

However, the reality is more complicated. For example, prior to the introduction of MSAs, health care in Singapore was mainly financed by the government through general tax revenues. The creation of Medisave enabled the government to begin to shift health care costs to individuals. The magnitude of this exercise in cost shifting and its effect on the composition of health care expenditure in Singapore is unique among high-income countries. In 1980 government spending accounted for three quarters of total spending on health. By 2003 it had fallen to just over a third of total spending, with most of the remainder coming from out-of-pocket payments.⁴ MSAs combined with their accompanying risk-pooling arrangements account for less than a tenth of total expenditure on health – and this is in spite of Singapore's much-noted 'savings culture'.⁵

A similar process of cost shifting has taken place in South Africa. Here, the creation of MSAs may have encouraged some new, younger people to enrol in the market. It is also true that, since MSAs were introduced at a time when insurers were cutting benefits and increasing cost sharing, they may have improved financial protection for existing enrollees who were able to set aside savings.⁶ Nevertheless, the primary aim on the part of insurers offering MSAs was probably to make those who were already covered bear a greater share of the costs of health

care. Over time, therefore, MSAs have contributed to an insurer-initiated process of de-insurance. Tax subsidies for MSAs and private health insurance more broadly also may have undermined financial protection for the 60% of the population that rely on the publicly-financed health system, by lowering the amount of government funds available for their care.

The potential for MSAs to enhance financial protection seems to be greater in China and the US, mainly because both countries have sizeable populations without any form of health coverage. However, it is not clear how many previously uninsured people in China benefit from the new risk-pooling arrangements accompanying MSAs. Many urban employees were already covered.⁷ Among this group, MSAs have effectively shifted costs from the government and employers to individuals. As in Singapore, there are concerns for equity and questions about the validity of using a savings-based approach to finance health care for an ageing population.

In the US HSAs may lower the out-of-pocket burden for those reliant on individually-purchased private health insurance (ie who do not qualify for employer-sponsored coverage). While the overall take up of HSAs has been very low to date, take up has been higher among people in the individual market, partly because they now benefit from tax subsidies and partly because deductibles in HSA plans are capped.⁸ HSAs have also been taken up by some people who were previously not insured, although probably less so by poorer uninsured people, since over half of the uninsured do not pay taxes and cannot therefore benefit from HSA tax incentives.

Among the countries that have adopted MSAs there appears to be a common belief in the ability of patient cost sharing to lower or at least contain health care expenditure. In spite of this belief, evidence of cost savings is limited. For example, HSA plans in the US do not seem to be more effective at controlling expenditure than HMO-style plans, while MSAs in South Africa have not slowed down the rate of annual increase in premiums, which have continued to

rise rapidly in real terms. In China early evidence of cost savings in one of the pilot MSA areas was not sustained in longer-term analysis. More recent evidence also suggests that the new system has created financial barriers to access for some people. The Singapore government realized relatively quickly that MSAs were unlikely to prevent cost inflation and introduced tight supply-side price controls, which have probably done more to contain expenditure than the expansion of demand-side cost sharing. Not surprisingly, the MSA experience reflects the academic literature on cost sharing, which is unable to find a link between paying for health care at the point of use and long-term cost control.

Relevance for Europe

Differences in the development, design and performance of MSAs in these four countries clearly reflect prevailing institutional arrangements and political priorities. As we noted above, however, policy towards MSAs across these countries reveals two commonalities: first, a belief that moral hazard is a serious issue and a key contributor to rising health care costs and, second, an expectation that individuals should bear some of the financial risk associated with ill health.

Recent debates about the possibility of using MSAs to finance health care in Europe beg a key question: do the concepts underlying MSAs have any relevance for European health care systems – particularly those in the European Union (EU) – with their very different policy emphasis not just on equitable access to health care but also, more recently, on securing value for money?

In the EU context of universal or near-universal coverage, which provides a wide range of benefits for relatively low levels of cost sharing, the potential for MSAs to enhance financial protection is extremely limited. In fact, the evidence suggests that MSAs would actually undermine financial protection because they would lead to higher levels of cost sharing. As in Singapore, MSAs would simply shift costs from government or employment to individuals. For EU health systems this would imply an

undoing of sustained efforts to pool risks across the population, with adverse consequences for equity and efficiency.

In the last 15 years most European health care systems have invested heavily in improving resource allocation and purchasing. Risk-adjusted capitation has emerged as an almost universal strategy to ensure an equitable distribution of resources, but it also attempts to secure value for money by matching resources to health needs. MSAs would replace needs-based resource allocation with allocation based on either ability to pay (if people were voluntarily encouraged to accumulate savings) or crude capitation (if, for example, the government or employers were to transfer a fixed sum to each individual's account). This would be a retrograde step. Under normal circumstances, crude capitation is likely to result in welfare loss, since those with minimal health need can accrue funds that may remain untouched for long periods of time, while those with greater health need may not have sufficient funds to cover their costs. At a time when the number of people with chronic conditions is growing, and in the current climate of economic uncertainty, a move to restrict purchaser flexibility to match resources to needs seems counter-intuitive. Even if policy makers were to emulate South Africa's recent proposal to risk-adjust allocations to MSAs, we would have to ask how this would improve on existing arrangements.

Some governments might be swayed by the thought that MSAs could contribute to cost containment by curbing patient demand for health care. But they would find little in the academic literature to support this view. MSAs may address moral hazard by making consumers more cost conscious, but this tends to have no long-term effect on costs. It may also conflict with policy goals such as equity of access.

Others might argue, as in the US, that empowering individuals by putting them in charge of purchasing their own health care will have positive effects. However, this argument should be understood in the context of the constraints many patients face in US markets for private

health insurance: employers may offer a limited selection of plans, plans may restrict choice of provider, benefits may be subject to high levels of cost sharing and employees may not be able to take their benefits with them when they change jobs. In contrast, patients in most European health systems enjoy significant choice of provider, some may have choice of health insurance fund and the portability of benefits is not an issue. Although there is certainly scope for greater patient involvement in treatment decisions, it is not at all clear whether increased cost sharing is an effective means of achieving this. Individual purchasing can also undermine attempts to secure value for money through the use of health technology assessment (HTA) to inform decisions about pricing and coverage. Advocates of MSAs probably overestimate the power of patients seeking care in relation to providers selling services. They may also overestimate the extent to which patients are willing or able to shop around. In fact, recent research suggests that patients in high-income countries are reluctant shoppers, even in self-pay markets for simple, non-urgent, elective procedures.⁹

The international experience of MSAs does little to recommend them to European policy makers, particularly those keen to ensure financial protection, equitable access and value for money in their health systems. Since MSAs are essentially a variant of cost sharing, their introduction could set in motion a process of de-insurance that may increase choice for some, but is also likely to jeopardise important health policy goals.

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Health savings accounts in the United States

Sherry Glied

Health insurance coverage in the United States is financed from a mix of private and public sources. All Americans aged 65 and over, as well as some disabled people under 65, are covered under the Federal Medicare programme. Low-income children and certain other low-income groups (aged, blind, and disabled people, pregnant women, and some parents of low-income children) receive coverage through the Medicaid programme, which is financed by both the Federal and State governments and administered by the States. All others may obtain coverage through private health insurance markets. Among the non-elderly (under 65) most – 61% of the entire population in 2007 – hold coverage obtained through employment. A further 6% of the population obtains coverage in the non-group insurance market. About 17% remain uninsured.

There has been about a quarter century of interest in medical savings account-style health insurance models in the United States. Early interest focused on the potential for this model to reduce health care spending, and improve the efficiency of that spending, by exposing consumers of services to greater cost sharing.

Later, proponents argued that the medical savings account model would preserve cost containment without subjecting consumers to the restricted provider networks and interference with medical decision-making that they saw as characterizing the prevailing managed care models. Interest in these accounts was translated into law during the late 1990s through a series of ever-more expansive tax incentives, culminating in the passing

of the Health Savings Account (HSA) provisions included in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

This legislation provided a substantial tax break for Americans who established such accounts when coupled with qualified high deductible health plans. As of January 2008, about 6.1 million privately insured Americans held a health savings account coupled with a qualified high deductible health insurance plan, about 3.3% of the privately insured population under 65.¹

Legislation

A person (or an employer on behalf of an employee) may make contributions to an HSA as long as the account holder is covered by a qualified high deductible health plan; that is, a plan with an annual deductible (in 2009) not less than US\$1,150 for individuals or US\$2,300 for family coverage, and maximum out-of-pocket costs, including both deductibles and co-payments, that do not exceed a legislated threshold (US\$5,800 for individuals and US\$11,600 for families in 2009).*

People who hold qualified plans, and their employers, may make annual contributions to their HSAs; the maximum contribution is fixed in law and stood at US\$3,000 for individual plans in 2009. Regardless of the source of contributions, the account belongs to the individual, is portable from job to job, and account balances roll over from year to year. HSAs provide account holders with three tax benefits. Money contributed to these accounts by individuals or by employers on their behalf are not subject to tax

(including payroll taxes); the funds held in these accounts can accumulate interest tax-free; and funds may be used to pay for qualified medical expenses without incurring tax. Spending from the savings account on anything that is not a qualified medical expense is subject to a tax penalty.

Plan design

While there are few requirements for HSAs and qualified plans, most arrangements contain similar components. Insurers generally offer a high deductible plan with an accompanying HSA account, managed by the insurer or by a financial institution that partners with the insurer. Account holders are often provided with a credit-type card which they may use to draw down their HSA fund balances. The insurer usually offers a network of preferred health care providers who provide services to enrollees at negotiated rates. Enrollees have the option of going to providers outside the network but may have to pay higher rates (which will not count against the health plan deductible). Almost all insurers offering HSA-qualified plans offer members information about provider costs and, often, quality through special member websites.

An immediate concern about high deductible HSA-qualified plans has been that they would discourage use of preventive services. However, regulations interpreting the legislation have allowed plans to exempt certain preventive health care services from the plan deductible without losing their status as qualified plans. Preventive services that may (but need not) be exempt from the deductible include periodic health evaluations, well-baby and child-care (routine preventive check-ups for infants and children), immunizations, tobacco cessation, the

* Regularly updated figures on deductibles, out-of-pocket maximums and contribution levels are published by the Internal Revenue Service.

removal of polyps during a diagnostic colonoscopy, and prescription medications for chronic illness. In fact, most qualified plans today exempt preventive services and some medications for chronically-ill people from the plan deductible, making these services free at the point of use.

Participation

High deductible plans and their accompanying HSAs may be purchased in the non-group market (where about 5% of Americans obtain their principal insurance coverage) or in the employer-group market. In the non-group market, decisions about the nature of coverage are made entirely by the individual purchasing this coverage. The extent of regulation of benefits and premiums in this market varies considerably from state to state.

For those purchasing coverage in the non-group market, where deductibles and co-insurance had always been relatively high, the new HSA provisions are a boon. They provide a new tax subsidy that applies to the plans people in this market had been buying all along. About 1.5 million people, or about 10% of those enrolled in the non-group market, have selected this plan form. They constitute about 25% of HSA enrollees.¹

In employment settings, workers' choices are limited to the health plans offered by their employers. HSA participation varies substantially depending on the choices offered by employers and the terms of these choices. If employers do not aggressively promote HSAs (either by replacing existing coverage entirely with these plans, or by offering them at highly favourable rates), participation rates are quite low (in some cases, as low as 5%). On average, among firms offering HSA plans as one of several choices, about 19% of employees selected the HSA option.²

Some advocates had hoped that the new tax exemption for HSAs would lead to increases in coverage among those without insurance. However, the structure of the HSA tax benefit provides few advantages for most uninsured

Americans as about half of uninsured adults do not face any income tax liability because their incomes are so low, so they do not gain any benefit through the HSA tax exemptions. Even those uninsured people who do face tax liabilities typically have few assets and are unlikely to accumulate substantial savings in HSAs. Moreover, there is no evidence to suggest that the availability of HSAs has made a dent in the uninsured population of the United States.

Performance

Premiums in HSA-qualified high deductible plans are generally lower than in other insurance plans, consistent with the design of these plans which shift costs from premiums to out-of-pocket payments. Studies that examine the total cost of care received under HSAs find surprisingly inconsistent results. At best, these studies suggest that even in settings where HSAs are the only plans offered, cost savings are modest.³

Similar variability is found in the literature on the health outcomes of people enrolled in HSA plans. Some studies – particularly those in settings where people self-select into HSA plans – find that participants increase their use of preventive services. Other studies find that those in high deductible plans are more likely to avoid, skip, or delay receipt of needed health care.³

Most studies of enrollee satisfaction have found that participants in HSA-qualified plans are less pleased with their coverage than are those who hold traditional plans. Some of this dissatisfaction stems from the higher cost sharing associated with HSA plans. Enrollees also report dissatisfaction with the quality of the information available to them.³ Without adequate information with which to balance costs and quality, the consumer incentives that form the basis of this model have little traction.

Prospects

The initial introduction of HSAs was

greeted with tremendous enthusiasm and optimism by advocates of consumer-driven health care and by intimations of doom by opponents. Early projections anticipated that nearly three quarters of employers would offer these plans by 2006 and enrolment would grow proportionately.⁴ The reality has been rather more restrained. Fewer than 15% of employers offer these plans, enrolment is growing slowly, and costs have not moderated. On the other hand, even in settings where participants face no choice of plan, they do not appear to have significantly worse outcomes than those enrolled in other plan types. Plan designs that exempt preventive services and medications for the prevention of complications of chronic conditions from cost sharing have softened the potentially injurious effects of this plan design.

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Medical savings accounts in South Africa

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South Africa has a health delivery system which is a mix of robust private sector, struggling public sector and some non-governmental not-for-profit organizations. Private health insurance (PHI) cover, delivered through 'medical schemes', is voluntary and serves only 14.8% of the population (those with higher incomes). Health care is mainly delivered to this group in the private sector (for example, private general practitioners and specialists, private for-profit hospitals) which is well developed, resource intensive and highly specialized.¹

A further 21.0% of the population uses private primary care doctors and private pharmacies but depends on the public sector for specialist and hospital care. The remaining 64.2% of the population is dependent on the tax-funded public sector for all their conventional health care services.

Medical savings accounts (MSAs) were first included in PHI medical schemes in 1994 and their usage has grown rapidly to cover 87.5% of 'open' medical scheme beneficiaries and 49.0% of 'restricted' medical scheme beneficiaries (schemes typically run by employers or unions for their employees/members only) in 2005.

The introduction of MSAs in the 1990s

The increasing involvement of insurers as administrators in the PHI market in the late 1980s resulted in calls for greater individualization of health care expenditure. Free-market reforms at this time culminated in the abolition of long-standing norms in the PHI market, such

as community-rating and minimum benefits. The development of MSAs in South Africa dates from this period of de-regulation.

In a paper setting out the basic design of MSAs, Gore,² the founder of a leading health insurance group, argued strongly in favour of individuals becoming the principal buyers of health care. Gore was able to create a tax-effective structure where instead of employees paying for care through out-of-pocket payments with after-tax money, a portion of the PHI medical scheme contribution was diverted to a MSA and was therefore effectively pre-tax money under the control of employees.

The South African private health insurance environment is highly competitive and with the lack of regulatory oversight, many PHI medical schemes followed this lead and introduced their own versions of MSAs. The basic design of MSAs allowed the savings account to be used for 'day-to-day' care like primary care visits, medicines, and dental and optical benefits. Coverage of medicines for chronic conditions and hospital care typically remained within the PHI medical scheme's risk pool.* Thus, the MSAs could be used to cover co-payments or any benefits not covered by the risk pool. MSA balances are rolled over at year end and only paid out on death or transfer to another medical scheme. These amounts become taxable income when paid into an estate or member's hands.

The use of brokers was encouraged by the insurance mentality of the 1990s. Brokers and employers rapidly used the new structures to create tax breaks for

employees and more money flowed to PHI medical schemes. Initially, there was no limit to the amount that could be contributed to the MSA. Aggressive selection of healthy lives and medical underwriting became widespread during this period. The Department of Health³ found that by 1999 the majority of PHI medical scheme members were in an environment that excluded vulnerable groups (those aged over 55 and those with chronic disease) from cover, where medical costs continued to rise (due to the retention of fee-for-service reimbursement of providers) and where non-health care costs were driven up (through profit-taking and hidden commission costs).

Reining in MSAs from 2000

The new democratic government in 1994 began a period of returning to solidarity principles, culminating in a completely revised Medical Schemes Act which came into effect in 2000. The Act introduced a new independent regulatory body so that the governance of the industry and of individual medical schemes was considerably strengthened. Community rating and prescribed minimum benefits were re-introduced and the tax loophole was narrowed by limiting the amount that could be paid to MSAs to 25% of annual PHI medical scheme contributions.

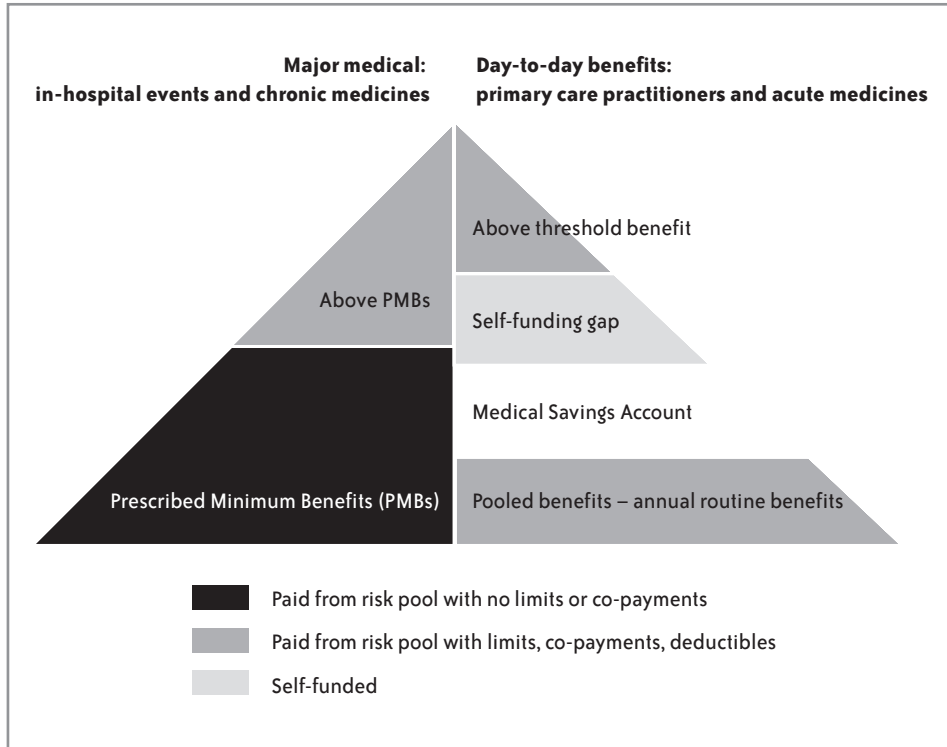
Figure 1 (overleaf) illustrates the typical structure of medical scheme benefit design at present. While the regulator, the Council for Medical Schemes, acknowledges that much work remains to simplify and standardize benefit structures,⁴ it has increasingly tightened the annual process of registering benefit design changes.

Continuing policy concerns

The Department of Health³ does not view MSAs in a positive light. A major

* Deductibles were almost unknown initially. Since the introduction of the 25% maximum contribution to MSAs, deductibles are now used for some expensive procedures like MRI scans or endoscopies.

Figure 1 Generic benefit design of medical schemes in South Africa



Notes:

1. The PMB package is a list of 270 diagnosis-treatment pairs (DTPs) primarily offered in hospital (introduced in 2000); all emergency medical conditions (defined in 2003); and diagnosis, treatment and medicines for 25 defined chronic conditions on the Chronic Disease List (CDLs) (introduced in 2004).
2. 'In-hospital events' cover the total event in hospital, including stay, surgery and medicines on discharge; 'chronic medicines' are typically taken for chronic conditions for the rest of life (for example, diabetes, hypertension).
3. 'Acute medicines' are for 'acute' (self-limiting) conditions.
4. The 'self-funding gap' represents true out-of-pocket payments paid by the individual once the MSA is exhausted. Self-funding gaps only came into benefit designs when the size of MSAs was limited to 25% of contributions.
5. 'Above threshold benefits' are paid from the risk pool after the MSA is exhausted and after the self-funding gap has been paid in full. If there are any limits or co-payments, these need to be paid from out-of-pocket funds.

concern is the effect on reducing risk-pooling in PHI medical schemes. The Department found no objective evidence that self-insurance reduces the cost trends of necessary medical services. Individual purchasing of needed health services fragments purchasing power as well as access to services. The Department has recommended that the MSA policy be revisited with a view to phasing them out of PHI medical schemes, or substantially diminishing their impact. However, while PHI remains voluntary there is a delicate cross-subsidy balance at work, leading to a reluctance to completely remove MSAs, which also might encourage the young and healthy to leave the PHI system.*

Evaluation

MSAs have been a successful strategy for highly-competitive open PHI medical schemes to grow their business. Schemes with MSAs also have been somewhat successful in keeping younger people in the PHI system. MSAs have brought some benefits for individuals in that they were introduced at a time when PHI benefit packages were being reduced and co-payments increased. Funds in MSAs could be used to cover the increasing burden of out-of-pocket payments. However, a vicious circle has developed with medical schemes using MSAs as a means to further reduce cover and keep the increase in PHI premiums seemingly low.

In reality, MSAs have not increased financial protection, as individuals can only benefit to the extent that they or their employers personally contribute.

In addition, MSAs have the effect of shifting some of the rationing decisions in health care from health care funders to individuals and their families. MSAs have contributed to the problem in private health insurance in South Africa in that there has been a greater focus on benefit design and cream-skimming than on engaging with health care providers for cost-effective and quality delivery of care.

Moreover, private health insurance has had a profoundly negative impact on the overall health system in South Africa, particularly in relation to:

- its contribution to rapidly spiralling health care expenditure;
- its contribution to growing disparities in the public-private mix and undermining the public sector by draining health professionals from the sector which serves the majority of people; and

* In general, those aged under 45 (except for the group of very expensive children aged under one) are net contributors to the risk pool while those over 45 are net recipients. As contributions are community-rated (i.e. one flat rate charged to everybody purchasing the same level of benefits), there is an incentive for PHI medical schemes to 'cream-skin' (attempt to select the better risks) and thereby reduce their community rate. On the other hand, there is also substantial evidence of the younger employed population that could afford cover not entering medical schemes until later in life, typically close to age 40 or when they expect to have children.

- severely limiting the potential for income and risk cross-subsidies in the overall health system.

MSAs undermine income and risk cross-subsidies even more than risk-pooled private insurance. While private health care funders are currently raising serious concerns about the decision by the ruling political party to introduce a system of national health insurance, it is precisely their actions in systematically undermining risk pooling that has created the rationale for the introduction of these reforms.

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Medical savings accounts in Singapore

Mukul Asher, M Ramesh and Anna Maresso

Singapore was the first country to introduce Medical Savings Accounts (MSAs) as part of a broader government reform strategy to reduce public health expenditures. Echoing the recommendations of the 1983 National Health Plan, the aim was to establish higher levels of cost sharing for households, particularly for hospital services, limit public financing to a safety net for the lowest income groups, and introduce greater user choice and competition among health care providers.

A compulsory medical savings scheme – Medisave – was introduced in 1984 to enable consumers to pay for the higher user charges that were to be introduced. The use of individual medical savings accounts, as well as increased out-of-pocket payments, was also seen as a way of curtailing (unnecessary) demand for medical services. At the same time, reform of the hospital sector converted public hospitals into government-owned but commercially run enterprises with significant autonomy and established four categories of wards incurring different levels of user charges (ranging from 20–100% of the costs).*

Over the last 20 years these cost shifting policies have resulted in a steep decline in the public financing of health care, which accounted for 75% of total health care expenditure in 1980 but had fallen to about 36% in 2003.² Moreover, despite the introduction of compulsory savings in Medisave and additional voluntary private medical insurance schemes –

Medishield set up in 1990 and Eldersshield set up in 2002 (see below) – together these make up a small proportion of total health care spending (less than 10%), with approximately 60% of national health care expenditure borne out-of-pocket by households.**^{3,4}

Plan design

Medisave forms part of Singapore's Central Provident Fund (CPF), established in 1955 as a compulsory programme in which employees and their employers contribute a fixed percentage of wages to a retirement savings fund. The Fund was successfully extended in the 1960s to provide finance for home ownership and by 1984 a new component of individual savings for health care was earmarked as a separate scheme within the CPF to cover the hospital costs incurred by households.

All employed persons resident in Singapore are required to contribute to Medisave, even those otherwise exempt from contributing to the retirement component of the CPF, like the self-employed.*** While coverage is nearly universal, with approximately 80% of the resident population subscribing to Medisave, there is some concern over the level of compliance of self-employed people. It is estimated that in early 2007 one third of this group was not contributing to Medisave.⁵ Also, nearly one million foreign workers who are classed as non-residents are not covered.

* Private hospitals are used almost exclusively by upper-income Singaporeans and international patients, whose use of private facilities is promoted by medical tourism.¹ All fees are paid directly by the patient.

** Authors' estimates based on these sources.

*** Self-employed people earning less than SGD \$6,000 per annum are exempt.

Table 1: Central Provident Fund and Medisave contributions structure, 2007

| Employee age (years) | Paid into CPF | | | Credited into (% share of contribution) | | |
|----------------------|-----------------------------------|-----------------------------------|--------------------------------|---|------------------------------|---------------------------|
| | Employer contribution (% of wage) | Employee contribution (% of wage) | Total contribution (% of wage) | Ordinary account (housing and other) | Special account (retirement) | Medisave account (health) |
| 35 & below | 14.5 | 20.0 | 34.5 | 67 | 14 | 19 |
| 35–45 | 14.5 | 20.0 | 34.5 | 61 | 17 | 22 |
| 45–50 | 14.5 | 20.0 | 34.5 | 55 | 20 | 25 |
| 50–55 | 10.5 | 18.0 | 28.5 | 46 | 25 | 30 |
| 55–60 | 7.5 | 12.5 | 20.0 | 58 | 0 | 43 |
| 60–65 | 5.0 | 7.5 | 12.5 | 28 | 0 | 72 |
| Over 65 | 5.0 | 5.0 | 10.0 | 10 | 0 | 90 |

Note: The maximum wage ceiling for contributions is SGD \$4,500 per month.

Source: Central Provident Fund (<http://mycpf.cpf.gov.sg/Employers/Gen-Info/cpf-Contri/ContriRa.htm>)

Contribution rates from employees and employers to the CPF, and the amounts earmarked for the Medisave scheme, vary according to age, with the Medisave proportion increasing as beneficiaries get older (Table 1).

All Medisave contributions, investment earnings and withdrawals enjoy tax free status. There is a maximum contribution ceiling of SGD \$33,500 per annum but this level is reached only by a small, high-income percentage of the population, with the majority earning and contributing considerably less.⁶ There is also a minimum total amount (SGD \$14,000 in 2008, rising to \$25,000 in 2013) that each account holder should accumulate by the age of 55 but by 2006, only 58% of enrollees aged 55 had reached the minimum.* Medisave balances can only be used to pay for services at hospitals approved by the Ministry of Health. Typically, such services include daily

ward charges, doctors' fees, surgical operations, inpatient charges, investigations, medicines, rehabilitative services, medical supplies, and implants and prostheses used during surgery. Restrictions are imposed on how much can be withdrawn per day and per medical intervention.

Medisave and the wider health system

Today Singapore's health system is characterized by a dual system of provision where inpatient (hospital) services are predominantly provided by the public sector while outpatient and primary care are supplied by the private sector. Only around 25% of ambulatory care is provided by 26 government polyclinics which offer heavily subsidized services (generally 50% for adults; 75% for children and older people) to those who cannot afford private services. Since the few supplementary medical insurance plans on the

market** have minimal coverage, private sector ambulatory care needs to be paid for out-of-pocket (although some employers provide subsidies to cover such care).

Public hospitals in Singapore are unconventional in that they are given incentives to recover much of their costs from users. Funds held in Medisave are used specifically to cover inpatient hospital services for members and their dependants. Even so, after it became apparent that funds in individual savings accounts would be insufficient to cover large hospital bills, voluntary, low cost (but low benefit) health insurance – Medishield, operated by the CPF Board – was introduced in 1990 for citizens and permanent residents under 85 who want to purchase additional cover for catastrophic illness and hospital expenses. However, Medishield does not cover pre-existing illnesses or certain categories of treatments such as

* While the government has no explicit provisions to top up deficient accounts, it does occasionally provide one-off transfers to Medisave or CPF accounts.

** These are available from five approved insurers under the Private Medical Insurance Scheme (PMIS).

congenital anomalies, cosmetic surgery, maternity-related costs, or treatment for mental illnesses and personality disorders.* The premiums vary by age and gender, and are payable by individual enrollees through their Medisave accounts. By 2005, 54% of Medisave members also held this additional voluntary insurance, and recently the government has decided to enrol all children (although parents, who pay the premiums directly or through their Medisave accounts, may subsequently opt out).

In 2002 another voluntary insurance scheme, Eldershield, was launched to provide long-term care to older people requiring intensive levels of care (ie. for those who cannot perform three or more of six daily living activities). Premiums are risk adjusted according to age and sex and can be paid from Medisave funds. In 2006, approximately 86% of Medisave enrollees had chosen to subscribe to Eldershield, even though the current benefit payout of SGD \$400 per month would be too low to meet a significant proportion of costs.⁷

Finally, a stringent, means-tested government programme, Medifund, has existed since 1993 as a safety net for those who cannot meet their medical bills irrespective of whether they subscribe to Medisave or other private health insurance schemes. Nearly one third of Medifund beneficiaries are over 65 years of age and in 2006, 290,000 cases were approved for funding, with an average payout of a modest SGD \$138.

Prospects

The government has persistently advocated the use of MSAs, opposing alternative health insurance arrangements that would involve public risk pooling.** However, it is clear that Medisave accounts have not been sufficient to meet

the costs for which they were intended. In a step towards acknowledging such difficulties, the Medisave scheme was reformed in 2006 to allow higher amounts of withdrawals and to expand the number of procedures and treatments (such as diabetes, hypertension, stroke and asthma) that may be covered by an individual's account. Even so, in 2006 Medisave withdrawals equalled roughly half of all contributions and in 2005 account payments formed only 5.4% of total health care expenditures.⁶ Thus, after more than two decades of operation, as a source of health care funding, Medisave still plays only a marginal role.

A striking feature is that despite paying taxes and contributing to a compulsory medical savings account, most of the population still pays the bulk of its health care costs, specifically primary and out-patient care, directly from household income. Moreover, the very fact that additional voluntary health insurance has been introduced via Medishield and Medifund indicates the significant gaps in Medisave's benefit coverage that have needed to be met from alternative health insurance sources. The effects of these limitations are felt most acutely by low-income earners and women.

High levels of employment and wage growth are needed to ensure an adequate accumulation of funds in Medisave accounts. However, in the face of rising inflation and stagnating wage levels (particularly as a result of downward pressure from increased contractual and part-time employment), it is unclear whether Medisave accounts will be able to sustain their real value in the future. While Singapore's demographic and economic profiles up to the 1990s were favourable to fostering higher levels of private health care spending by the population, with changed conditions, including the current

global economic crisis which has severely reduced Singapore's growth and employment prospects, the efficacy of medical savings accounts will come under increasing scrutiny and pressure.

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* Premiums are age-adjusted and enrollees must be under 75 years old to enter. Restrictions apply on how much may be claimed per day and per episode of illness, with a maximum of SGD \$50,000 per policy year and \$200,000 per lifetime. Deductibles of \$1,000–1,500 per year and co-insurance of up to 20% apply. Only 35% of hospitalization costs for the top two categories of wards can be claimed.

** The official argument against public risk pooling is partly attributable to concerns about moral hazard leading to escalating health care costs.

Medical savings accounts in China

Yunni Yi and Alan Maynard

Until the late 1990s, China operated the compulsory Government Employee Insurance Scheme (GIS) and the Labour Health Insurance Scheme (LIS) to provide almost free health care for public sector employees and employees of state-owned enterprises (respectively) in urban areas. It also ran the voluntary Cooperative Medical System in some rural areas but left the majority of rural people and half the urban population without any insurance. Facing a rapid increase in health insurance costs and unequal coverage among insured urban employees, in 1998 China formally

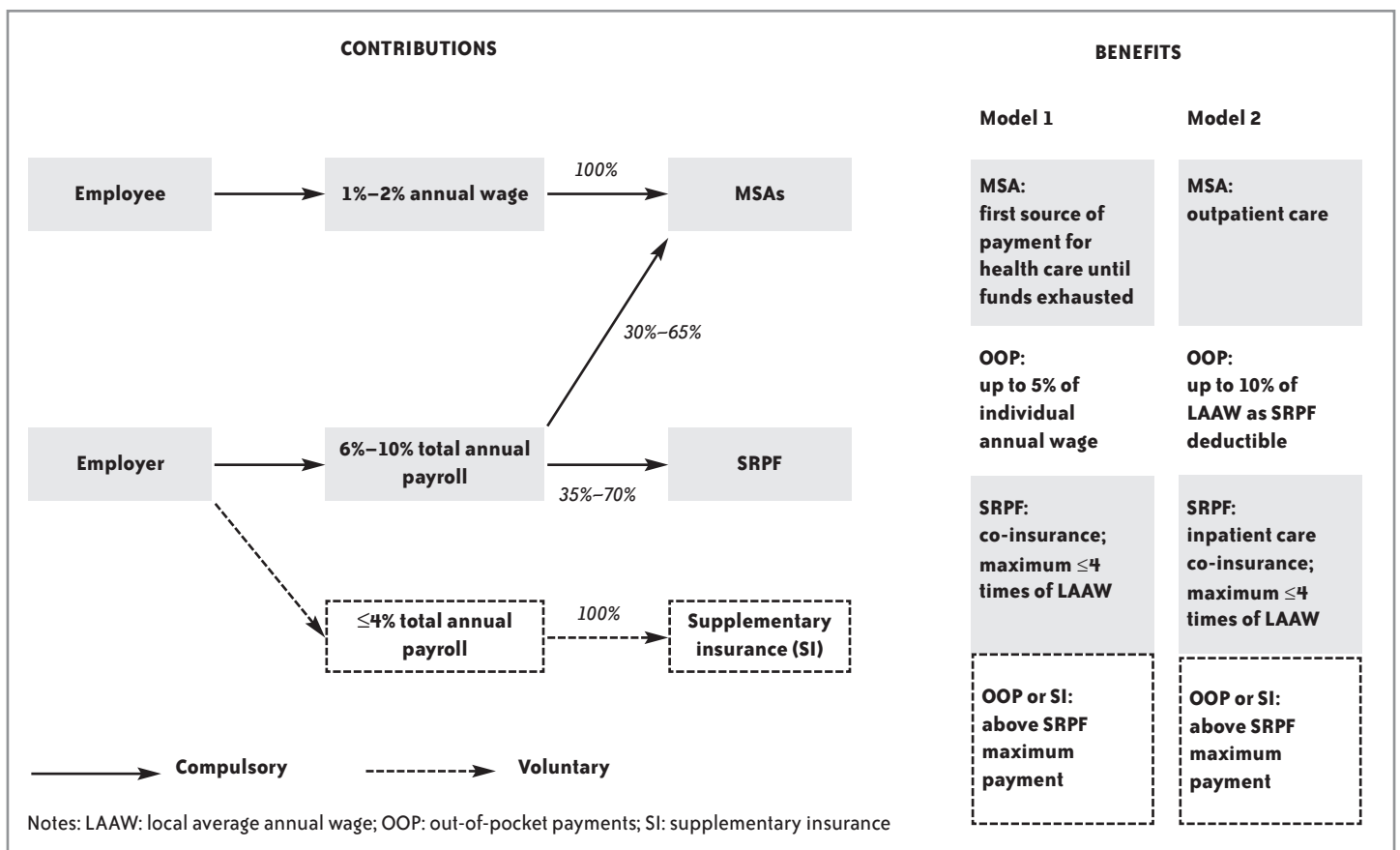
implemented compulsory medical savings accounts (MSAs) in every city following initial pilot projects in 58 cities between 1995 and 1996. MSAs, in combination with a city-wide social risk pooling fund (SRPF), are used to finance the government-run Urban Employee Basic Medical Insurance System (UEBMI), which aims to replace the GIS and LIS and to provide basic health insurance for all urban employees and retirees at an affordable cost.* Although the official policy is that the UEBMI will supplant the two other insurance schemes and gradually extend coverage to uninsured urban employees,

a general lack of enforcement means that many government organizations and state-owned enterprises continue to offer the GIS and LIS to their employees because the benefits are higher and costs lower than the UEBMI.

Current status

MSAs and the SRPF are implemented at city level under central government guidelines. A wide diversity exists in the contribution levels and the uses of MSAs and the SRPF across cities (Figure 1). Contributions are made by employees and employers, with total employee con-

Figure 1: The diverse contribution and benefit structure of MSAs and the SRPF in China



* The problem of health protection in rural areas is the subject of separate reforms.

Table 1: MSAs and SRPF contributions to total health expenditure (THE) in China, 2006 (billion Yuan)

| | MSAs | SRPF | UEBMI |
|----------------------------|---------------|----------------|----------------|
| Revenue | 70.6 | 104.1 | 174.7 |
| (% of THE) | (7.2%) | (10.6%) | (17.7%) |
| Expenditure | 56 | 71.7 | 127.7 |
| (% of THE) | (5.7%) | (7.3%) | (13.0%) |
| Accumulated Savings | 67.5 | 107.7 | 175.2 |
| (% of THE) | (6.9%) | (10.9%) | (17.8%) |

Source: Ministry of Human Resources and Social Security of China and the National Bureau of Statistics of China, *The Statistic bulletin of labour and social security development, 2007*.

tributions and a proportion of employer contributions going to individual MSAs; the remaining employer contributions go to the SRPF. Depending on the model chosen, funds in MSAs are used either as the first source of payment for all health care or to pay only for outpatient care.

The SRPF is used either to pay for health care expenditures above a deductible, or for inpatient care and some predefined chronic diseases. Apart from a high deductible equivalent to 5–10% of individual earnings or the local average annual wage, the SRPF has complex co-insurance requirements. The benefits it covers are also capped at the equivalent of four times the local average annual wage. Expenditures above the SRPF maximum reimbursement level must be paid out-of-pocket or through supplementary health insurance. The government uses tax incentives to encourage employers to buy supplementary coverage from commercial insurance or from city social insurance bureaus but the tax incentive is capped at less than 4% of the total annual payroll.

UEBMI insured employees are allowed to choose between two and four hospitals to receive care and to buy medications on the national and local essential drug lists from designated pharmacies using MSA funds. At city level the Social Insurance Bureau (SIB) is responsible for operating the UEBMI and paying designated hospitals and pharmacies. After insured employees obtain health care services using their MSA cards, the SIB reim-

burses the providers. UEBMI deficits are covered by city governments.

In 2007, UEBMI covered 180.2 million urban employees and retirees, over 13% of the Chinese population.¹ Most beneficiaries were enrolled in the previous GIS and LIS schemes and MSAs have been established for the majority of them. However, the extension of MSAs to all targeted employees (both those previously insured and those uninsured) has proven difficult due to adverse selection resulting from a lack of enforcement.² As a result, the UEBMI and GIS/LIS coexist in many cities and some employees from financially poor enterprises are covered by the UEBMI without MSAs to encourage the enrolment of their employers. By the end of 2007, 31 million migrant workers were also included in the UEBMI without MSAs.

Table 1 illustrates the contributions that MSAs and the SRPF have made to total health expenditure in China. In 2006 payments from MSAs and the SRPF contributed to 5.7% and 7.3% of total health expenditure respectively and the accumulated savings in MSAs and SRPF amounted to 6.9% and 10.9% of total health expenditure respectively.

According to data from the Ministry of Human Resources and Social Security, the UEBMI's total cumulative savings (about 40% in MSAs and 60% in SRPF) have exceeded its annual expenditure every year since 2001; and in 2006 for the first time savings also exceeded total contributions. The surprisingly high level of

savings in the SRPF may reflect the fact that SIBs and local governments have become too risk averse and have attempted to avoid deficits by various measures, including increasing patient cost sharing and placing restrictions on insured patients and hospitals providing services. Given that the basic medical insurance benefit package is so limited and that insured individuals still bear a rather high financial burden, it is questionable whether such large savings are reasonable or represent an efficient way of using UEBMI resources.

Impact and prospects

With MSAs and the SRPF much of the responsibility for health care has been shifted from the government and employers to employees. The key issues associated with MSAs in China include:

- limited risk pooling due to MSAs results in a low level of benefits and a complicated multiple tier system without a safety net;
- the impact of MSAs on the use of health care and cost control are mixed: while evidence suggests that there has been some reduction in the use of expensive, unnecessary and even necessary health care due to increased cost awareness among MSA holders, there is also widespread evidence of the misuse of MSAs for purposes other than those specified by the UEBMI, especially when savings are accumulated;³
- high administrative costs with low efficacy have led SIBs in many cities to leave MSAs unmonitored and unmanaged, allowing MSAs to operate as ordinary savings accounts for insured employees;⁴
- MSAs have worsened inequity in health care financing and use among UEBMI's insured employees.⁵

In a report on health care system reforms, the Ministry of Health acknowledged the defects of the UEBMI with regard to MSAs and was not optimistic about the insurance scheme's continuance.⁶

In recent years, critics have called for the removal of MSAs from the UEBMI.⁷

However, supporters argue that MSAs are still needed to provide incentives to encourage greater enrolment of employees in the UEBMI and more effective use of health care. They propose extending the coverage and functions of MSAs to include family members, or to allow MSAs to be used for prevention and health promotion purposes, or to buy supplementary health insurance coverage. However, the possibility of family MSAs has been ruled out by the government which recently decided to establish a separate basic medical insurance scheme to cover urban uninsured citizens. None of these proposals confront the issues of supplier induced demand and the perverse incentives which fossilize inefficient supply-side behaviour.

It seems more likely that in the near future MSAs will continue to be used alongside the SRPF under the UEBMI. It is even possible that the functions of MSAs may be extended as has happened

already in some cities. However, the continuing challenges will be how to ensure that MSAs enhance efficiency and equitable risk protection. The fate of MSAs in China will depend mainly on the decisions taken by local governments.

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Key international developments in medical savings accounts, 1970–2008

| | |
|-------|--|
| 1970s | MSAs begin to be discussed in the United States in the context of private health insurance markets and moral hazard |
| 1980s | Compulsory MSAs (Medisave) established in Singapore as a separate branch of the Central Provident Fund amid government concerns over rising health care costs and a need for greater cost-sharing (1984) |
| | De-regulation of the private health insurance market in South Africa which covers approximately 15% of the population: abolition of community rating, giving insurers greater freedom in designing and pricing benefit packages (1988) |
| 1990s | Medishield, a voluntary and supplementary health insurance scheme, established in Singapore to provide cover for catastrophic illness and hospital expenses (1990) |
| | Further private health insurance de-regulation in South Africa: abolition of minimum benefits (1993) |
| | MSAs established in South Africa as a means of promoting individual responsibility and controlling costs by making consumers more cost conscious (1994) |
| | Clinton administration in the United States introduces the Health Insurance Portability and Accountability Act (HIPAA) with a limited pilot of MSAs among self-employed people and small businesses (1996) |
| | MSAs established in urban areas of China following pilot schemes in 58 cities. MSAs are twinned with a social risk pooling fund (SRPF) to form the Urban Employee Basic Medical Insurance System (UEBMI) (1998) |
| 2000s | Eldersshield, a further voluntary, supplementary health insurance scheme, established in Singapore to provide long-term care for older people needing assistance with daily living activities (2002) |
| | HSAs established in the United States as part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The HSAs need to be combined with high-deductible health plans (2003) |
| | Tax incentives expanded to boost the voluntary take-up of HSAs in the United States (2006) |
| | MSAs considered in Central and Eastern European countries such as Lithuania (2008) |

2008 Summer School

Hospital re-engineering: new roles tasks and structures



Coinciding with its 10th Anniversary, the European Observatory on Health Systems and Policies, in collaboration with the Veneto Region, organized its second Summer School programme on 3rd–8th August 2008.

64 participants from 25 countries met in Venice on the island of San Servolo to learn, debate and exchange ideas on the new roles of hospitals.

Covering all areas of hospitals' functions and organization, sessions looked at hospital reengineering, planning and management of health services, reconfiguring hospital structure and financing, regulation, governance and collaboration. Participants also attended an afternoon presentation by the representative of the WHO Regional Office in Venice on the use of economic evidence in health care.

During the week participants were actively involved in discussions and worked in sub-groups on various case studies, drawing on their own experience and knowledge acquired during the course. A key finding that contextualized all of the lively debates on the development of hospital infrastructure is that there is no standard solution that is applicable to the diversity of European health care systems.

With a strong focus on the evidence base, many of the sessions joined theory with practice. Reinhard Busse's session on patient safety was illustrated with the example of hospital reform in Serbia over the past five years. A discussion on the importance of top-level hospital leadership as well as collaborative approaches between chief executives and clinical teams was underlined by the reconstruction of Maasland Hospital (The Netherlands). And underlining the centrality of quality-driven strategies for hospital services, Niek Klazinga discussed a number of such strategies in place in European hospitals. Moreover, the problem of centralization of care was a core issue in Nigel Edward's presentation, which illustrated the pros and cons of centralized and decentralized systems through the Spanish organization of hospitals.

Martin McKee's session on the evolution of hospitals stressed the current-day role of hospitals not only as treatment settings but also as places for training and research

that interact with the wider community, playing a major role in local economies. Emphasizing the theme further, Josep Figueras focused on the need to shift perceptions of modern hospitals, seeing them not as the source of large health expenditures but rather as good economic investments for health care systems. Although the financing and provision of health care services are Member State responsibilities, Nick Fahey of the European Commission highlighted the need to pinpoint more precisely the potential wealth-generating capabilities of good health for societies. He also outlined several mechanisms undertaken at international and EU level that foster collaboration between hospitals: cooperation frameworks through cross border healthcare, Structural Funds investment assisting with health infrastructure, OECD indicators monitoring the scene and international benchmarking.

Other session leaders stressed the need for agreed definitions of hospitals before embarking on re-engineering their structure (Pascal Garel); the importance of assessing hospital processes, particularly with regard to patient care and safety, as well as organizational characteristics (Nigel Edwards); the need for diverse hospital financing instruments to demonstrate their efficiency, effectiveness, relevance, and sustainability (Barrie Dowdeswell); understanding the target population in order to deliver effective hospital services (Antonio Duran); appropriate and effective regulation of the hospital sector (Reinhard Busse); and the value of collaboration between hospitals and the wider community, especially patient and consumer groups, to promote the appropriate use of services and better patient outcomes (Jeni Bremner). The newly proposed European Commission initiative for a directive on patients' rights to cross-border care was also discussed in the context of patient involvement in community settings.



World Health Organization
Regional Office for Europe



Government of Belgium



Government of Finland



Government of Greece



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Veneto Region of Italy



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World Bank



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FORTHCOMING STUDY

Private health insurance and medical savings accounts: lessons from international experience

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For equity and efficiency reasons, many countries aspire to provide publicly-financed health care on a universal basis. However, levels of public finance are often low in poorer countries and may be perceived as unsustainably high in richer countries, prompting interest in private forms of pre-payment. In recent years the role of private health insurance and medical savings accounts (MSAs) in financing health care has emerged as a key policy issue in different parts of the world.

This book focuses on the history, politics and performance of markets for private health insurance and MSAs in a wide range of countries. It examines the origins and development of these markets, their relationship with the publicly-financed part of the health care system and the evolution and effects of public policy. Using a country case study approach, the aim is to draw policy lessons by considering financing mechanisms in the context in which they are situated.

Because financing mechanisms are functions of historical, political and institutional factors, an understanding of context can help to explain why markets for private health insurance and MSAs exist in a particular form, behave in particular ways and result in particular outcomes.

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