The World Health Report
HEALTH SYSTEMS FINANCING
The path to universal coverage

Technical Brief Series - Brief No 7

MEDICAL SAVINGS ACCOUNTS

WHAT ARE MEDICAL SAVINGS ACCOUNTS?

Medical Savings Accounts (MSAs) are a relatively new mechanism for financing health care. The key feature of MSAs is that they are personalized savings accounts earmarked for health care. Individuals or households accumulate savings for the majority or the full cost of care which is paid directly to providers (physicians, hospitals, pharmacists) at the time of consumption, much like the purchase of other goods or services.

As such, MSAs do not pool the financial risks of poor health across individuals but rather within a person's lifetime (saving in advance for future expenditures). Aside from this feature, there are important variations in how MSAs are implemented across countries. These arise in the rate and nature of contributions (i.e. mandatory or voluntary), the mix with supplementary insurance and pre-existing financing mechanisms, and the extent of government stewardship in the health sector. Accordingly, the performance of MSAs depends on their design and the context of their implementation. Where MSAs exist they often play a relatively limited role, supplementing other health financing mechanisms.

WHY MEDICAL SAVINGS ACCOUNTS?

MSAs have been featured in policy discussions for nearly two decades and recently implemented in a handful of countries, i.e. Singapore in 1984, South Africa in 1994, China in 1995, and the United States (US) in 1996. Policy makers commonly consider introducing MSAs for one or more of the following objectives:

- to control consumption and costs,
- to mobilize additional resources for health, and
- to extend financial protection in countries without a universal or comprehensive system of health coverage.

HOW DO MSAS CONTROL CONSUMPTION AND COSTS?

By holding individuals more financially responsible for health care costs, MSAs raise consumers' awareness of the price and quality of health care. Consumers would therefore demand fewer services and seek more cost-effective services (i.e. largest health gain for the least cost). MSAs are further seen to reduce costs given the absence of expensive administrative practices associated with other financing mechanisms, e.g. billing, processing and checking claims. The ability of MSAs to control consumption and costs has, however, been difficult to distinguish from concurrent policy initiatives and/or the existence of other health financing mechanisms. For example, MSAs in Singapore and China were introduced alongside supply-side regulations and policies changing provider payment methods. Furthermore, cost reductions may simply be a shifting of costs from the government

to individuals. The mixed policy environment raises questions over the root of escalating health care costs and the ability of MSAs to contain costs. Lastly, some evidence of improper use of MSA funds and the decreased use of necessary care indicate the need to factor in administrative costs to monitor misuse and adverse secondary effects.

HOW DO MSAS MOBILIZE RESOURCES?

The ability of MSAs to raise additional funding for health depends on rules for the saving and withdrawal of funds. The amount of resources ultimately raised by MSAs will be a function of whether contributions are compulsory or voluntary, sourced by individuals and/or employers, encouraged by incentives such as tax exemption, and established rates and/or limits. Regular savings are also dependant on a formal labour sector and a high employment rate. The accumulation of savings is further influenced by criteria for the withdrawal of funds. Withdrawals can be restricted to a sole individual (as opposed to all household members), by type of medical intervention, or a set amount per day or intervention. Resource mobilization by MSAs must also be looked at in a wider context. Overall resources raised by MSAs may be insignificant in the wider mix of total health financing and even negated if the government share of total health spending decreases following their introduction.

HOW DO MSAS EXTEND FINANCIAL PROTECTION?

MSAs are argued to reduce the number of uninsured by offering an accessible alternative to pay for health care in countries that currently lack a universal or comprehensive system of health coverage. For example, MSAs in South Africa and the US were expected to be a more affordable alternative to individual private health insurance coverage, especially for the lower-income groups, self-employed or those working for a small employer. The reality is more complex. MSA enrolment in the US did not grow as targeted, due to lack of information and demand. On the other hand, MSAs in have had more success in South Africa as a result of the deregulation of private insurance. MSAs pose equity risks as they are unable to ensure access and even exacerbate barriers to access health care among vulnerable groups. In Singapore, the poor and elderly were unable to access care until the government created safety nets. In South Africa, the voluntary nature and the tax incentives of MSAs attracted the young, wealthy and healthy individuals while the older, poorer and unhealthier individuals relied on traditional private insurance. As a result, insurance premiums increased, causing some to be no longer able to afford coverage. To rebuild financial protection, the government introduced regulation and risk adjustment in 2000.

KEY ISSUES FOR POLICY MAKERS

The performance of MSAs depends on its design and the context of implementation. Key design features are linked to the objective of MSAs and conducive contexts are similar to those for other financing mechanisms. MSAs are more likely to be successful in countries with strong government stewardship, an extensive and formal labour force, and high levels of earnings and savings, combined with policy tools addressing supply-side cost drivers.

Government stewardship is required to ensure that the objectives of MSAs (efficiency, resource mobilization and increased financial protection) are met and equity risks avoided. Policy makers should consider the following questions: What is at the root of

escalating healthcare costs? Will individuals be able to adequately save to access care? If not, will insurance for rare but high cost events and/or safety nets for the vulnerable adequately ensure access to needed health services? If there are other pre-existing financing mechanisms, such as private health insurance, will there be negative cross-over effects? The answers to these questions will help in the design of national health financing systems where MSAs could have their place. Taking into account the experimental nature of MSA implementation to-date and evidence suggesting limited ability to reduce costs and a risk to equity goals, their role is best seen as a supplement to health financing mechanisms that distribute more effectively the financial risk among the population at large.

FURTHER READING:

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- Maynard, A. & Dixon A. (2002). Private health insurance and medical savings accounts. In Mossialos, E., et al (eds). Funding health care: options for Europe. Buckingham, Open University Press.