

Commentary

**Behind the Ideology and Theory:
What Is the Empirical Evidence for
Medical Savings Accounts?**

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Singapore's Medisave scheme has attracted widespread interest around the globe, due to its innovative ideas and the salesmanship of Singapore's leaders (Kwa 1994; Nichols, Prescott, and Phua 1997; Phua 1997). While countries as different as the United States, South Africa, and China have adopted some of the core ideas of Medisave, its impacts have not been critically examined. The essay "Medical Savings Accounts in Singapore: A Critical Inquiry," by Michael Barr, attempts to partially fill this void and gives a major explanation for this gap—the reticence of the Singapore government to provide complete information about its health system performance. Nonetheless, several major conclusions can be reasonably drawn from the remedial actions taken by the government to correct the Medisave scheme. This commentary provides the economic explanation for Medisave's failure to curb health expenditure, which has led the Singapore government to abandon its reliance on price competition and to demand constraints in an effort to structure its health care system and impose controls on supply and prices. I also point out several irrational and inconsistent features of the Medisave scheme that have caused financial hardship for Singapore's citizens and have adversely affected the cost-effectiveness of its health care system. It's curious why Singapore has not taken action to ameliorate them.

Barr's essay correctly distinguishes the philosophical principles and rhetoric of Medisave from its economic impacts. Under Medisave, patients pay a large portion of medical expenses directly out of pocket, and only

a small portion comes from medical savings accounts. Thus compulsory savings played a very small role in paying for health services, evidenced by the government statistics that show that in 1995 only 8.5 percent of the total national health expenditure came from the savings accounts while 57.7 percent came from patients' direct out-of-pocket payments (Phua 1997). The designs of Medisave and MediShield employ high deductibles, noncoverage of most outpatient services, and a claim amount cap, forcing the patients to pay cash for their health services. To minimize the "moral hazard" arising from health insurance or free health care, Singapore de facto uses patients' demand to impose the budget constraint on the total health spending. Besides forcing the patients to pay directly, Singapore also consciously structures competition between public and private hospitals. Patients are informed of the price differentials in advance whenever possible so patients can make informed decisions between public and private hospitals. This strategy to curb health expenditure inflation failed. In its 1993 White Paper, the government declared that the demand forces could not effectively hold down medical cost inflation; the government had to regulate the health system (Republic of Singapore Ministerial Committee on Health Policy 1993).

In my view, Singapore's experience has made a significant contribution to the global policy debate. Many economists and health professionals have attributed the health cost inflation of the 1970s and 1980s to moral hazard induced by health insurance (Pauly and Goodman 1995; Goodman and Musgrave 1994; Ferrara 1995). If this is so, the remedy is clear and simple—make patients pay directly out of pocket and educate patients to be informed buyers; however, Singapore's well-designed and executed 3Ms scheme could not curb rapid health expenditure inflation. From Singapore, we learned that providers compete by recruiting the best-known physicians with higher pay and by having the most sophisticated expensive technology. Price competition is secondary. Moreover, the market power on the supply side is much greater than the demand side. Providers can induce demand, offsetting the reduction in patient-initiated demand from being uninsured (Hsiao 1995).

Unfortunately, Singapore's evidence was not adequate to alter the beliefs of those Americans who have unfaltering faith in the free market or those who believe the rich should get more favorable tax treatment than the poor. In 1995, the U.S. Congress passed its version of a tax-favored medical savings account scheme (MedPAC 2000). Despite the clear evidence from Singapore, the proponents of the U.S. law argued that greater self-pay by patients would reduce insurance-generated moral

hazard. Patients would demand fewer unnecessary medical services and thus help curb health expenditure inflation. Self-pay would also offer patients greater control over their health care (American Academy of Actuaries 1995).

Singapore's 3Ms plan has some glaring contradictions. Because our health declines as we age and health spending increases accordingly, any compulsory savings scheme based on the principle of self-reliance should ask people to save as much as they can during their working years for their health- and long-term-care costs, particularly the high costs after retirement. However, Medisave caps the balance in the medical savings account to a maximum amount of U.S.\$11,970. This amount is not sufficient to protect the elderly who have serious chronic diseases and need surgery. Moreover, Medisave allows participants to withdraw their medical savings at age fifty-five, leaving only a U.S.\$9,120 balance in the account (Ministry of Health 1998). These features defeat the whole purpose of compelling people to save so that they have the financial means to be responsible for their own health expenses.

Private insurance schemes tend to select healthy people to insure and exclude those who need more health services. Often a nation justifies using a public monopoly to provide health insurance to avoid this risk selection. Public monopoly also pools the risk nationwide. The Singapore government created the MediShield as a public monopoly, insuring its citizens for a part of their catastrophic medical expenses. Yet MediShield adopted the risk selection practices of private insurance schemes by excluding as enrollees persons aged seventy and older and by not covering some expensive services, such as treatments for congenital abnormalities, mental illness, and HIV/AIDS (Central Provident Fund 1999). These restrictions contradict the rationale for using a public monopoly to provide catastrophic insurance and defeat the purpose of insurance. These irrational practices leave those who need risk protection the most without insurance coverage. Those who can't afford to pay have to forgo medical care or plead for public charity.

Lastly, the 3Ms plan create a segmented health care system. Community medicine, primary care, and hospital services are financed from different sources. Consequently, these services are delivered by diverse institutions with little coordination and continuity of care for the patients. In this era, people suffer more from chronic illnesses and disabilities. As the U.K. health system demonstrates, patients benefit the most when health care is organized with community services staffed by community nurses and GPs serving as gatekeepers. Yet Singapore's 3Ms plan has segre-

gated primary care from hospital services, and public from private sector providers. Now three-quarters of the GPs in Singapore are in private fee-for-service practice while 75 percent of hospital services are provided by public facilities. No one is responsible to monitor and follow up on chronically ill and frail patients.

Medisave was derived from the principles of self-reliance and self-responsibility with the government assuring access only to basic services. Translation: people's access to health care depends directly on their ability and willingness to pay. Since humans are endowed with unequal ability, given unequal social support or economic opportunity, it means our incomes are vastly different. Thus, Singaporeans have unequal access to health care. This was a conscious decision made by the government in trading off equity and efficiency. As noted by Barr, the design of Medisave and MediShield exacerbated the inequitable treatment of the most vulnerable population—the poor, low-wage workers, and those with serious chronic illnesses. Meanwhile, Singapore has publicly acknowledged that its demand-side strategy has failed to produce efficiency and contain health cost inflation. Perhaps it is time for Singapore to have an open and thorough examination of its 3Ms plan to assess how well it can serve the needs of its aging population.

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