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# Universal Medical Savings Accounts

**Consumerizing Medicare to End Waiting Lists and Improve Service**


By Dennis Owens and Peter Holle

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Universal Medical Savings Accounts – Consumerizing Medicare to End Waiting Lists and Improve Service



Cover photo: An image from the Singapore Government's website outlining its system of medical savings accounts. See http://www.gov.sg/moh/mohiss/hlthfin.html

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# UNIVERSAL MEDICAL SAVINGS ACCOUNTS

## CONSUMERIZING MEDICARE TO END WAITING LISTS AND IMPROVE SERVICE

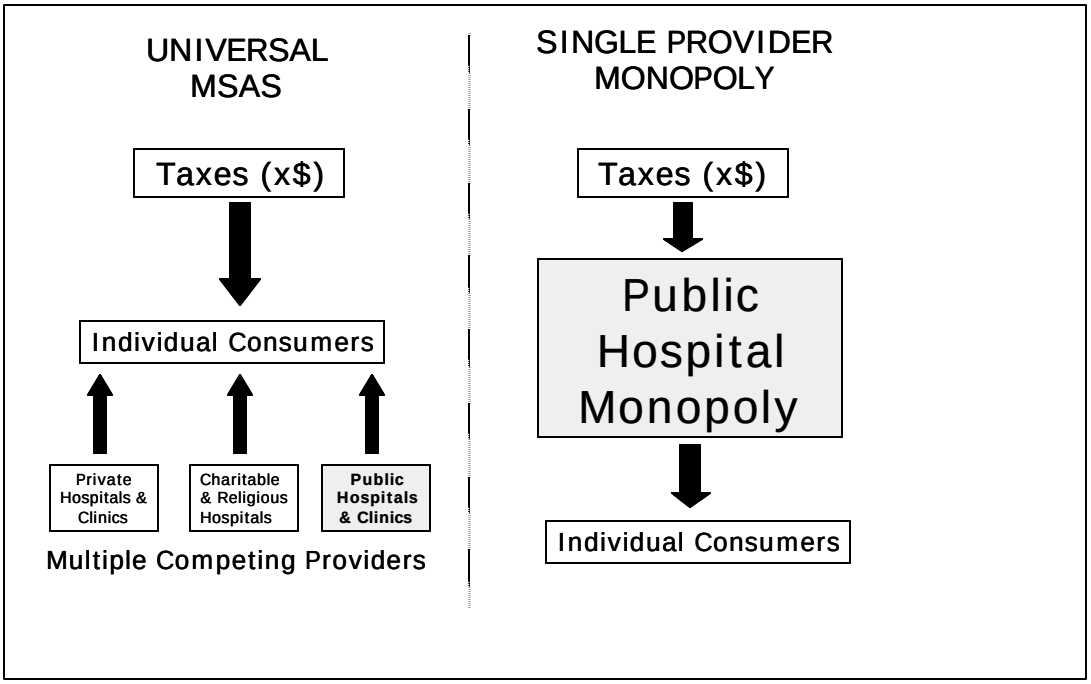
### Executive Summary

Canada's Medicare system is progressively deteriorating. It faces recurrent crises in its present form despite a continuous, decades-long allocation of more tax resources. At the same time, Canadians clearly want to assure guaranteed, universal access to medical services. A new Medicare model has the potential to retain universality, restore service levels, control costs and introduce transparency and accountability to the system. That model, Universal Medical Savings Accounts (UMSAs), allocates existing public funding directly to individual citizen-consumers of health-care services.

Currently, federal and provincial governments underwrite Medicare budgets through a complex system of block grants to medical authorities. With UMSAs, the same money would be divided up among individual health-care consumers, each of whom would receive it in the form of credits deposited to a dedicated health-care account. With the exception of a mandatory requirement to purchase insurance coverage for long-term and catastrophic care, spending from the account would be controlled by the account-holder. Hospitals, clinics and doctors would charge patients for services rendered, with payments made from individual UMSAs. Any money left in the UMSA would remain the property of the account-holder.

**HOW UMSAS WORK**

- At the beginning of each fiscal year, health authorities would deposit each citizen's share of the Medicare budget into a dedicated bank account in that person's name. Each account-holder would gain access to those funds through an electronic debit card.
- Withdrawals from the account would be allowed only to pay for health-care services.
- Minor, non-catastrophic events requiring a visit to a clinic or doctor would be paid by direct electronic debit from an individual's or family's UMSA.
- Individuals would cover themselves against catastrophic events by purchasing insurance from competing companies.
- Money not spent would be rolled over and left to accumulate tax-free over the account-holder's lifetime until the fund reached some pre-determined amount sufficient to create an income stream that would cover future medical emergencies (i.e. $200,000).
- Ownership of the funds belong to the consumer and his or her estate.
- Special cases, the small minority who run out of funds or have special needs, are accommodated separately with extra government assistance.



**ADVANTAGES OF UMSAs**
Using the Frontier Centre's three criteria of high-performance public policy, UMSAs score high:

**1. TRANSPARENCY – clear measurement of costs and results**

- **A public healthcare commitment visible to all** – Few people understand how much the government spends on health care per family in the present system. Under an MSA system, public spending becomes highly visible to all. Based on recent expenditures, a family of four in Manitoba or Saskatchewan would receive between $6,000 and $7,000.
- **Consumers rewarded for not over-using services** – Individuals benefit personally because they keep funds not spent on unnecessary use of health-care resources. Society benefits from a more efficient use of capital, which frees it up for use elsewhere.
- **Consumer choice channels use of resources —** Prices provide valuable information on costs and benefits, thereby enabling providers and consumers to make rational decisions without political involvement.

2. **NEUTRALITY – no bias towards a particular delivery mode**

- **Universality preserved** -- Universal publicly funded access remains in place. The government still funds health care but no longer directly provides it. There is no bias towards a particular process — in other words, the system is neutral.
- **Incentives for efficiency** -- A decentralized, customer-sensitive system that reflects the decisions of millions of consumers replaces a less flexible single-provider monopoly. Competition creates pressure to contain costs, increase quality and offer timely service. Consumers now drive what the system produces.
- **New technology** -- The freedom to shop weeds out services and facilities that fail to please consumers, who vote with their MSA funds by patronizing those which do. MSA debit cards facilitate automated billing through low transaction costs. This reduces administrative overheads while providing customers with useful information on their health-care purchases.

3. **SEPARATION – elected officials involved in setting policy, not operations and administration**

- **Politician separated from operations** -- The task of elected officials is simplified. Resources are no longer allocated politically through a centrally planned system that has too little information to accommodate the complete range of individual healthcare needs and desires. Elected officials withdraw from haphazard involvement in the operation and design of the delivery system. Separating public financing from private production allows the emergence of a framework within which flexibility in process and delivery methods maximizes outcomes.
- **Capital released for public endowment** -- Government ownership is no longer required in a decentralized, competitive system in which the public financing function has been separated from production decisions. Billions of dollars in hospital assets can be transferred to charitable organizations or sold to doctor groups or insurance companies. The proceeds endow a public fund that helps low-income groups and special hardship cases purchase health-care services. Lower taxes and a higher living standard follow this release of capital.

| | **UNIVERSAL MSA** | **SINGLE-PROVIDER PUBLIC MONOPOLY** |
|---|---|---|
| **TRANSPARENCY** | **High** | **Low** |
| Information for directing resources | Prices regulate supply and demand | Waiting lists regulate demand |
| Incentive for not over-consuming | Consumer keeps money not spent | Over-consumption paid for by system |
| Citizen knows public commitment | Amount transferred to UMSA visible | Few understand how much is spent |
| **NEUTRALITY** | **High** | **Low** |
| Universality preserved | Equal public funding for all consumers | Funding provided to single-provider system |
| Incentives for efficiency | Effective suppliers expand, deficient ones close | Administrative "efficiencies" lead to service cuts and excessive centralization |
| New technology | Competing suppliers use technology to attract customers | Low technology levels by developed-world standards |
| **SEPARATION** | **High** | **Low** |
| Politicians separated from operations | Politicians involved only in broad policy decisions on service quality and payment system | Politicians frequently involved in management and facilities decisions where they have little or no expertise |
| Capital released for public endowment | Facilities can be sold to competing suppliers, releasing billions for other uses | Substantial capital investment remains tied up in government-owned facilities |

## CREATING POSITIVE INCENTIVES FOR BETTER HEALTH CARE

UMSAs not only motivate consumers to use the health-care system intelligently by letting them keep the money they haven't spent, but they also reward providers for delivering services efficiently and effectively. Providers would design insurance plans to encourage healthier lifestyle choices (e.g., discounts for non-smokers) that would ultimately lower costs. MSAs, if permitted a degree of flexibility, offer policy makers another lever to encourage better community-wide outcomes. For example, items like exercise-club memberships could be paid through individual accounts.

## WILL A CONSUMER-CONTROLLED SYSTEM WORK?

Medical Savings Accounts have proven successful in the few instances where they have been tried.

Several American corporations offer coverage to their employees through their own private MSAs. Hundreds of employee groups have enjoyed cost savings that range from 12% to 40%. Individual control over resources has produced high levels of personal satisfaction.

Singapore introduced a system of MSAs in three stages, starting in 1984. Since then, the city-state has reduced its national spending on health care to a third of Canada's rate. Yet facilities are state-of-the-art, service is quick and standards are high. Singapore boasts a life expectancy of 77 years and a thriving economy.

## IMPORTANT QUESTIONS AND ANSWERS

**Q: Wouldn't the Universal Medical Saving Accounts system mean the privatization of Medicare?**

**A:** Since the MSA model maintains public funding at present levels, there is no change in the tax-funded public commitment to health care. The MSA model will not function without giving consumers the ability to choose between competing providers. To achieve this, the government would transfer or sell the facilities it owns to interested parties, including health-care professionals, doctor groups, insurance companies and charitable organizations. Health services would, in this practical sense, be necessarily privatized.

**Q: What about people who overspend their UMSAs before the year is up and are left with nothing in the account?**

**A:** They tend not to. Since account-holders keep whatever they don't spend, they have a powerful incentive to husband the resource carefully. A special policy can be designed for the small minority who "fall through the cracks". These costs would be covered by an endowment fund formed from the sale of facilities that would be part of the government's complete or partial relinquishing of direct monopoly ownership.

**Q: What happens to the money that accumulates in the UMSA when an individual dies?**

**A:** Since the funds do not belong to the government, but to the individual healthcare consumer, they would remain the property of that individual's estate. They would be passed on to the heirs of that estate, likely their children.

**Q: Will any accumulated funds not spent on health care services earn interest in the name of the consumer?**

**A:** Canadians are familiar with the concept of registered retirement savings plans where the government defers taxes on compounded growth and earnings to RRSP holders to save for their retirement. The UMSA system would be like the RRSP where companies compete with different financial products to maximize the returns to individual account holders.

**Q: Wouldn't the return of individual billing create more administrative overhead?**

**A:** This may have been the case in the past, but electronic debit cards and technology are rapidly driving down transaction costs. A shift to a universal MSA system would take advantage of this development. Even if changing the single-payer system resulted in slightly higher transaction costs, the savings in consumption and from increased efficiency in the use of resources would more than compensate for them.

**Q: One argument in favour of the single-provider model is that it saves unnecessary spending on billing administration. Won't a publicly funded competing-supplier system just waste money?**

**A:** This ignores the role accounting systems play in providing valuable information about production costs. Before it collapsed, the centrally planned Soviet economy "saved money" by neglecting to bother with accounting systems that tracked costs. Prices and costs provide the information that guides decisions in a competitive environment. Without them, no supplier can make rational pricing decisions.

**Q: Isn't health care too important to allow the profit motive in hospitals and clinics?**

**A:** Many groups have an ideological problem with the concept of profits. Lacking any sophisticated understanding of how markets work, they fail to understand that profits provide information that signals to the market place what services consumers are seeking. They automatically direct the use of resources towards the desired activities and services. High profits in particular markets will attract new entrants, expanding supply and reducing prices. Low profits and losses signal the opposite. Facilities that garner higher profits than others will do so because they offer more timely service of a higher quality. That creates a powerful incentive for providers to do their best.

**Q: Wouldn't insurance companies try to gouge consumers for long-term and catastrophic coverage?**

**A:** The best policy would be to maximize competition by not restricting or encumbering entry into the health-care market. Competition among multiple providers in a market worth billions of dollars would prevent price gouging. To allay this concern, the government could allow each citizen a choice: Do you want to have an MSA that belongs to you, or do you want to remain in the current system? American companies that have allowed employees to stay with their existing managed-care plans or to use MSAs have found that, within a short time, large majorities opt for the latter.

**Q: How much would comprehensive insurance coverage for extraordinary medical expenses cost?**

**A:** It would depend on the age of the account holder and the size of the deductible. One estimate of the cost, calculated by using recent rates for equivalent insurance now available in the United States, assumes a $1,000 deductible:

**Estimated Cost of Catastrophic Insurance Coverage**

| Demographic Status | Insurance Premium* | MSA Resources** | Balance |
|---|---|---|---|
| Single male, aged 25 | $ 298 | $ 1,750 | $ 1,452 |
| Single female, aged 25 | 633 | 1,750 | 1,117 |
| Male and female, aged 35, with two children | 1,825 | 3,500 | 1,675 |
| Male and female, aged 55 | 1,537 | 3,500 | 1,963 |

* Insurance premiums from: *Healthy Incentives: Canadian Health Reform in an International Context,* the Fraser Institute, 1996
** Based on $1750 per person per year or $7,000 per family of four

In each case, the size of the premiums leaves more than enough in the MSA accounts to cover the cost of deductibles and out-of-pocket payments for minor health expenses.

**Q: How do you prevent insurance companies from cherry-picking low risk customers?**

**A:** You make it a condition of participating in the huge new market that they have to accept all applicants. The resultant higher level of risk would require slightly higher rates, which would socialize the expense of covering higher-cost patients over the entire market.

**Q: Would UMSA holders have to restrict their spending to government-approved facilities and methods?**

**A:** The best policy would allow as much latitude as possible. A wide body of evidence supports the value of many therapies now regarded as "alternative medicine". Consumer choice— millions of people judging their worth instead of a few regulators — allows the market to determine their effectiveness. That promotes much greater innovation in solving health problems. The government would have to set minimum quality-control standards, as it does in many other industries. It would have the power to delist any providers who failed to meet its criteria, making them ineligible for MSA dollars.

**Q: What would happen to waiting lists?**

**A:** They would disappear. Waiting lists appear when the demand for services exceeds the supply in a system without prices. Since resources are not unlimited, the excess demand translates into shortages and line-ups. In an MSA system consumers control the money formerly spent by government on them. They would purchase services in line with their needs and desires. Providers would price their services to best attract customers. As in any normal market, prices would rise as demand increased. This would attract new suppliers. Supply would expand and prices would adjust downwards. The price mechanism furnishes us the signals we need to balance supply with demand—the dynamic that is missing in our present single-provider system

**Q: Wouldn't UMSAs create a two-tier system in which wealthier people could ensure better service by paying more?**

**A:** We have a two-tier system now, one in which only those with deep pockets can seek care outside the country. People with fewer resources have no choice but to rely on the service offered by a single provider. MSAs would expand their choices by allowing them to spend their resources wherever they wished.

**Q: What would happen to publicly owned facilities?**

**A:** In an UMSA system the government still finances health care but is no longer the sole producer. To facilitate the emergence of a competitive market, the government would curtail its direct ownership of facilities. In order to maximize competition, billions of dollars in assets would be sold or transferred to as wide a range of providers as possible. These would include insurance companies, groups of doctors and other health professionals as well as charitable and religious organizations with a history of humanitarian involvement. The capital released would be deployed into an endowment fund to provide an income stream to support special cases that fell through the cracks.

The government may choose to continue to own selected facilities and operate a dual system that would theoretically provide a "window" on the industry. To maintain neutrality, however, it would need to create a level playing field for all providers by charging public facilities the same capital costs and taxes that competing private suppliers would face.

**Q: What risk is there that huge American conglomerates could buy up Canada's health care facilities if they were put up for sale**?

**A:** The best policy from an efficiency and consumer viewpoint is to maximize competition in the healthcare marketplace. Therefore policy makers should refrain from any attempts to extensively micro-manage the healthcare services market. That said, our government can specify who were eligible first buyers and also sell the facilities in modules which were small enough to be competitively bid on by Canadian providers.

**Q: Are there any MSAs that have been put in place that were not successful?**

**A:** No, none that we are aware of.

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**Introduction**

The ideal of universal health care is a noble one. Similarly benevolent intentions underlie the effort in our society to eradicate hunger and homelessness. As a culture, we believe that no person should be without the means to meet basic needs. But good intentions need to be implemented intelligently.

The institution we have established in Canada to guarantee universal access to medical care no longer works. The older our Medicare program gets, the worse it performs. There are some who still insist that the problems in the system don't exist, but year after year the evidence mounts that they are very real and getting worse over time. This failure has produced devastating consequences for countless thousands of Canadians who have suffered extended illness, additional pain and suffering and, in many cases, needless death because the procedures they required were not available in a timely manner. Certainly, the system no longer provides the level of service it once did.

Why are these things happening? What is wrong with Medicare? Can it be fixed? These questions are complicated, but they have answers.

What lies at the core of the problem is the structure of Medicare. The elements that have led to its deteriorating performance are:

- **Zero Price.** When any good is treated as free, it becomes subject to what economists call "infinitely elastic demand". People stampede the medical system and make claims on its resources that are impossible to meet. No amount of money can cope with this demand because it is open-ended and progressive. It has been described in non-economic terms as the "tragedy of the commons".
- **Monopoly.** The single-provider system we adopted to manage Medicare may be administratively more efficient, but it brings with it a great deal of unwanted baggage. Whenever an industry has been effectively monopolized, or even cartelized, it stops responding to its consumers as customers. Its culture becomes prone to what is known in public choice economics as "provider capture." It begins to internalize, and its actions serve the interests of those who run the system at the expense of the interests of its clients.
- **Lack of Separation.** A common feature of failed public policy, this means that the governments which provide the funds for health care are the same parties who administer them. Serving both roles creates an inherent conflict of interest. Whose preferences will prevail at budget time, those who are responsible for fiscal efficiency or those who are responsible for delivering needed services?
- **Lack of Transparency.** Without the information that prices contain, neither governments nor health-care workers nor patients have a clear idea about the costs of their behaviour. They cannot, therefore, perform even the most elementary cost-benefit calculations. They cannot deploy scarce resources intelligently.
- **Politicization.** Because Medicare is a government program, it is subject to political cycles rather than ones dictated by supply and demand. Budgets are constructed and amended in response to electoral rhythms rather than market ones. Policy advocated with votes in mind is later reversed by subsequent administrations that have a different

fix on things or cater to particular groups. Spending on highly visible projects surges in the run-up to elections, and cutbacks crush the system after the new government is safely installed.

These policy flaws are by no means unavoidable. We can do away with the features of the system that have given rise to them and still ensure universal access. Another model has the potential to guarantee medical care to every Canadian and at the same time to shake out most of the problems that now bedevil the public.

The system is Medical Savings Accounts (MSAs). Instead of governments administering our health-care system, they simply provide the funds. Instead of directing those funds through global budgets to departments and treatment facilities, they send them to each citizen in the form of a health-care savings account dedicated to paying medical expenses. The amount in the account would be the average amount governments now spend per capita for health care. (A more complicated model might make appropriate adjustments to accommodate demographic realities such as age. However, the point of this report is to keep the discussion as basic as possible.) The account holder would be required to use as much as half of the money to purchase insurance for long-term and catastrophic care. The balance would defray day-to-day medical expenses. Any amount left in the account at the end of a year would be retained and remain the property of the account holder.

The main advantage of the MSA model is that it restores prices to medical care. Hospitals, clinics and doctors would charge their patients fees. The patients have the freedom to take their health-care dollars wherever they feel they would receive the best care at the best price. The MSA model cures the dysfunctions listed above, except for the last. Since governments pay the money in the accounts, the potential to diddle with the amount still exists. In practice, MSAs achieve such substantial cost savings that that danger becomes moot.

What about those people who are imprudent and spend their funds foolishly? In fact, when they or their estates get to keep the unspent funds, they tend not to. Individual consumers who control MSAs ration themselves much more effectively than any bureaucratic protocols that restrict access. No doubt, a few will slip through the cracks and spend their money unwisely. But the financial advantages of MSAs are so overwhelming that it is comparatively easy to put up safety nets to catch the exceptions rather than to operate a whole system based on that fear.

MSAs also confer a singular advantage on political officeholders: they defuse a terribly contentious issue. MPs and MLAs no longer have to take embarrassing trips through crowded emergency rooms and hospital corridors; nor do they face heat from outraged electors who have been denied service.

This happened because MSAs over time bring medical supply in line with demand. Those jurisdictions that have implemented the model find that it eliminates the need for restrictions on access to control runaway costs. The features that Canadians used to expect in their health system – high quality, prompt service – return as consumers regain control of their system.

Those who object to any changes in Medicare on principle ought to remember the reasons why we set up the system in the first place. The goal was always to provide good medical service to everyone. The current model is not meeting that goal. If they are serious about meeting it, they should look at MSAs.

**A Short History of Medicare**

In the 19th century, political philosophies rose up in Western Europe that called for expanded government services and social programs of all sorts. The movements that these philosophies inspired had their expression in Canada, notably through the Co-operative Commonwealth Federation and its successor, the New Democratic Party. These organizations provided the most effective lobby for universal provision of health care by governments, whose previous role had been mostly limited to providing medical care for the poor.[1]

Governments were already heavily involved in public health projects of all types, and this became the bridge for the first experiment in universal state provision. In 1916, the Municipal Doctors' Scheme in Sarnia, Saskatchewan extended the services of public health doctors, already on public salary, to all residents of the town. Other towns in other provinces soon imitated the system. The Great Depression brought increased political pressure for health protection for the poor and unemployed, and prepayment and insurance plans sponsored by medical and hospital associations proliferated in every province.[2]

The first national political platform that contained universal health insurance was offered by the Liberal Party under Mackenzie King in 1919, but it was never implemented. In 1945, a federal-provincial conference on post-war reconstruction drafted a health-care bill based on Britain's National Health System. It called for patients to register with physicians who would be paid a capitation fee — a flat-rate payment set by a government commission for each person in their practice. Ontario and Québec objected to the plan because the British North America Act had made jurisdiction over health care a provincial responsibility, and it was abandoned.[3]

The federal government was successful in passing the Hospital Construction Grants Program in 1948, which provided total funding for the construction of all new hospitals in Canada. Universal hospital insurance plans also spread throughout the provinces, which began to ask Ottawa to help fund all the new beds. By 1961, the federal government was paying half of the hospital operating costs. In 1964, the Hall Commission recommended this funding formula be extended to physician services.[4]

The Hall Commission's report contained the first version of what has come to be known as the Five Principles that govern Medicare. The funding from Ottawa, as codified in *The Medical Care Act of 1966*, was tied to provincial compliance with these conditions. In order to qualify, the provincial insurance plans had to be **universal** and cover all residents, to be **portable** from province to province, to be **comprehensive** in their coverage of all necessary medical services, and (what appears to be a fatal flaw) to be **publicly administered** as non-profit programs. All provinces eventually agreed to the arrangements and joined. In 1984, the federal government passed the *Canada Health Act,* which added a fifth feature — that Medicare be **accessible**, without user fees for hospitals or extra billing by doctors.[5]

Although these five conditions have never been fully satisfied – the failure to implement them has been extensively documented[6] – the federal government is adamant about enforcement, especially of the rules on accessibility. Other provinces have received the same treatment to a lesser degree, but Alberta has provided the most public demonstration of the painful consequences of breaking the rules.[7] The federal government's longstanding payments to the provinces form an integral part of their health budgets, and most provinces cannot afford to lose the cash.

The refusal to legitimize any private providers who bill patients beyond the rate paid by Medicare enforces the monopoly status of Canada's public health-care providers. What is so extraordinary about this rigorous enforcement of the rules is that it is unknown in other countries with socialized medicine. "Canada is the only nation in the Organization for Economic Co-operation and Development [the industrialized countries] that refuses to permit private competition over a broad range of health care. Britain, creator of the National Health Service, has always allowed private medicine to exist alongside public care."[8]

Ideological purity may be on Canada's side, but the federal government's intransigence on the Five Principles means that the collapse of Medicare has been all the swifter and more harmful. Private alternatives in other countries with universal health-care programs serve as a release valve on a pressure cooker, allowing stress on public facilities an outlet.

Late in 1998, the president of the Ontario Medical Association summarized the effects:

> By severely restricting the nature of healthcare delivery by the provinces, and using the hammer of reduced federal transfer payments, the Canada Health Act directly and indirectly has been a barrier to the quality of health care that we, as doctors, can deliver to our patients. The Canada Health Act has stifled innovation, experimentation and flexibility in creating both better alternative delivery methods and funding options.[9]

**The Collapse of Access**

The media have aired and published volumes of anecdotal evidence of the lack of quality and timeliness Canadians experience under Medicare. In his book, *Code Blue: Reviving Canada's Health Care System,*[10] David Gratzer movingly described dozens of case histories in which individual lives ended earlier than they should have, or in which waiting in queues for medical attention inflicted pain, suffering and loss of income on patients.

The full impact of the decline, however, requires a more systematic treatment. That has been provided by the Fraser Institute, which started to document the consequences of the Five Principles in 1990. Its annual series, *Waiting Your Turn: Hospital Waiting Lists in Canada,*[11] provides a snapshot of the delays that face Canadians trying to obtain critical treatment.

Although the findings are disturbing enough in themselves, the cumulative effect as one reviews the growing problem from year to year is even more alarming. Across Canada, for instance, hundreds of patients with cancer wait many weeks past what their doctors consider to be medically safe waiting periods for radiation and chemotherapy. Since untreated cancer spreads and becomes ever more life-threatening, it is clear that under Medicare we are playing a dangerous game with lives.

As part of its data collection, the Fraser series asks doctors to estimate what they regard as "reasonable" waiting times for a variety of medical services and compares those opinions with actual waiting times. As the chart below indicates, the spread between those times has increased substantially:

**Canada – Actual vs. reasonable waits from specialist to treatment, 1994 to 1998**[12]

| Year | Median Reasonable Waiting Times | Median Actual Waiting Times | Difference |
|---|---|---|---|
| 1998 | 4.3 weeks | 7.3 weeks | 3.0 weeks |
| 1997 | 4.2 weeks | 6.8 weeks | 2.6 weeks |
| 1996 | 5.4 weeks | 6.2 weeks | 0.8 weeks |
| 1995 | 5.4 weeks | 5.7 weeks | 0.3 weeks |
| 1994 | 5.2 weeks | 5.8 weeks | 0.6 weeks |

Source: The Fraser Institute, annual waiting list survey, 1995 to 1999

These data compare real waiting times with "reasonable" waiting times to describe the period between seeing a specialist and receiving treatment. But Canadians wait a lot longer than that in total, when you measure the time between first contact with a family doctor and treatment. The waiting time from referral by a general practitioner to actual medical therapy in Canada was 13.3 weeks in 1998, an increase of four weeks over 1993.[13] In other words, Canadian patients who need specialized treatment must wait over three months on average from the onset of symptoms before they can have it.

In short, denial of access is increasing year by year. Data on the pervasiveness of "hallway medicine" has not been formally gathered, but anecdotal reports are not reassuring. Wholesale closure of hospitals and the reduction of acute care bed space over the last decade have received wide media coverage.

The consequence has been a deep and growing public dissatisfaction with the state of our health-care system. An opinion poll conducted by the Harvard University School of Public Health in the fall of 1998 showed that 56% of respondents believed that Medicare does "some good things, but fundamental changes are needed." Another 23% said the system needs to be completely rebuilt. The same survey in 1988 had 56% of Canadians saying the system worked well and needed only minor changes; that number had dropped to only 10% a decade later.[14]

Other polls support this data. One of them asked the public, "Who is more responsible for the decline in Canada's health care system?" The response from 55% was "the government," which they believe has caused the Medicare crisis through budget cuts.[15]

The most alarming contradiction that emerges from Medicare-style monopolies is that restrictions in access disproportionately affect the most vulnerable. Affluent, connected people can queue-jump or seek treatment in other countries. But "[w]hen health care is rationed, the principal victims are the poor, the elderly, racial minorities and rural residents."[16]

**What Cuts?**

Cuts in federal health transfer payments to the provinces are usually cited as the cause of the growing crisis in access. But these cuts have been minor ones. Except for the year

1995, the provinces have replaced that money and added more from their own revenue sources:

**Canada's Health Expenditures by Source of Finance (1996 Dollars)[17]**
**(In Billions)**

| Year | Provinces | Annual Change | Transfer Payments | Annual Change | Public Sector* | Annual Change |
|---|---|---|---|---|---|---|
| 1995 | $48.8 | –0.2% | N/A** | +1.7% | $52.7 | –0.3% |
| 1996 | $49.0 | +0.6% | $24.2 | N/A** | $52.9 | +0.3% |
| 1997 | $49.9 | +1.7% | $25.6 | +5.5% | $53.8 | +2.4% |
| 1998 | $51.9 | +4.0% | $25.1 | –1.8% | $55.8 | +3.7% |

Source: The Canadian Institute for Health Information
* The total of public sector spending includes other, direct health spending by the federal government and municipalities.
** The federal government changed its funding formulas in 1996, so the CIHI's data for 1995 is not comparable.

The average annual rate of growth in health-care spending in Canada was 11.1% between 1975 and 1991. That declined to 2.5% between 1991 and 1996 but bounced back up in the years 1997 and 1998, largely due to increases in provincial government spending.[18] The cuts to health spending in recent years have not been as substantial as reported in the popular press. Rather, what has been cut is the rate of annual increase. Fewer tax dollars have been committed to health than would have been if annual increases above 10% had been maintained, but that rate is fiscally unacceptable and impossible to accommodate forever. Should we attempt to do so when the annual economic growth rate averages below 3%, we would eventually be spending government budgets on nothing else but health care.

The data on spending reveal that, in terms of a national commitment to better health care, Canadians were comparatively better off without the monopoly. Before Medicare, Canada spent more of its GDP on health care than the United States did. In 1960, the respective figures were 5.5% and 5.3% of GDP. By 1992, the U.S. had nearly tripled that, to 14%, while Canada's medical spending merely doubled, to 10.2%.[19] Further, the public sector's participation in paying health-care costs escalated in both Canada and the United States at about the same rate. In 1960, the respective figures were 42.7% and 24.5%. By 1992, governments in the two countries were underwriting health-care at rates of 72.2% and 45.7%.[20] Americans were heading in the same direction, at about the same speed.

The precipitous decline in standards, despite continued, if more modest, increases in funding, indicates that the problem lies elsewhere.

**Zero Price**

A better explanation for increasing shortages under Medicare is the fact that services are delivered to health-care consumers as free goods.

A convenient illustration of the operation of markets without prices is the operation of "food banks" in Canadian cities. Each year, the director of Winnipeg Harvest – a worthwhile effort to supplement the diets of the poor by seeking and distributing food from donors – publicly declares that poverty is increasing at an exponential rate. His estimate depends on annual increases in demand experienced by his food bank, as measured by the number of people who register to receive assistance. His alarms vary, but they are usually expressed in a

mathematical form— that demand has doubled or tripled or quadrupled. But objective measures of poverty in Winnipeg, primarily increases in rates of receiving social assistance, reflect no such explosion. The director perceives poverty as rising because the food is given away. The only cost to potential applicants is the social stigma they risk by queuing up for a handout. So the list of recipients grows.

Merchants have used giveaways or loss leaders to attract customers since commerce began. This marketing device is based on the theory that more customers will patronize their establishments if they rush in to obtain the free or cheaper goods, and that they might stick around to buy something else, something on which the merchant can realize a profit. People respond to lower prices with considerable energy, and to zero price with an eagerness close to mania.

When Medicare first started in 1968, most provincial governments folded the plan into existing medical plans. These arrangements at first included modest premiums everyone was expected to pay. After a hospital stay or a visit to a clinic, patients would receive a mailed notice from the medical plan that announced how much it had paid out on their behalf. One by one, the provinces, starting with Saskatchewan, began to waive the requirement of premiums and eventually decided to save the expense of notifying patients about the cost of their services. These actions allowed consumers to disregard costs and flood the system.

Economist Åke Blomqvist has summarized the dynamic between prices and consumers:

> [The supply-demand model] describes a process through which no single individual or agency decides how much of a given good or service is going to be produced in the society. Instead there is a *market* for it where consumers are free to buy as much of it as they please, at a given price, and suppliers can put as much up for sale as they please. If the total quantity demanded exceeds the quantity supplied, tendencies towards shortages may develop and consumers may begin bidding up prices in order to be able to get as much as they want, or, more realistically, producers may find that they can raise prices and still be able to sell as much as they want. In either case, the "market price" will begin to rise.
>
> Consumers, finding the good or service more expensive, will tend to demand a smaller quantity at a higher price. Producers will find it more profitable to produce and will increase production, and if at a higher price the profits on invested capital become higher in this particular industry than others, new investment will take place and new firms may enter the market. The decrease in quantity demanded and increase in quantity supplied will tend to wipe out the excess demand, and "in equilibrium", the market price will be such that the quantity demanded by consumers matches the amount offered by producers, and the profitability of firms in this industry is about the same as in others.[21]

Under zero-price Medicare, this equilibrium can never be established. Health care becomes a creature of "infinitely elastic demand", with potential patients flooding into waiting rooms and emergency wards. This heightened demand can never be met at a price of zero, and the supply can never become large enough to satisfy all the demand.

Indeed, some have claimed that the explosion in demand for medical services in Canada predates Medicare, that it started when the federal government started to pay half the costs for hospital construction. The number of hospital beds in the country rose by 34% between 1960 and 1970, while the Canadian population only increased by 19%.[22] Even entities such

as provincial governments responded rationally when federal largesse reduced the price of new facilities by 50%.

The same disconnection between prices and consumption may be the root cause of runaway heath-care costs in the United States. Typical American health-care consumers, covered by Medicaid/Medicare or by insurance provided as part of an employment package, pay only five cents out of every dollar spent on their behalf for hospital care, nineteen cents out of every dollar billed by doctors, and twenty-four cents out of every dollar spent on health care in general.[23] As much as 95% of total U.S. health-care costs are paid by third parties, not by the patient[24], and 56% of American health-care spending comes from tax dollars.[25]

In 1974, the U.S. government commissioned the RAND organization to measure the effects of price on health-care consumption and on overall health outcomes. The study, conducted over eight years, set up control groups with different levels of user fees and quantified the results. When the group whose out-of-pocket expenses were zero was compared with those who had to pay a $1,000 deductible, the RAND Health Insurance Experiment found that those who faced a zero price used medical services 28% more often, visited a doctor 67% more often and were admitted to hospitals 30% more often. Overall, costs for the zero-price group were 45% higher than those with a high deductible.[26] Were the health outcomes of the zero -price group superior? Not at all. "Those with the free-care plan used far more services. At far greater expense, without improving their overall health. In addition, there was no significant difference between the two groups in the risk of dying or measures of pain and worry."[27]

A miniature version of the RAND work took place in Saskatchewan thirty years ago. Between 1968 and 1971, the province imposed modest user fees. These amounted to $1.50 for each visit to the doctor, $2.00 for home visits or trips to an emergency room, $2.50 per day for the first 30 days spent in hospital and $1.50 a day for the next 60 days. Although the results were not as startling as those found in the RAND experiment – the co-payments amounted to only a third of actual costs – overall use by patients declined by more than 7%. Since those on welfare were exempted from the fees, it was possible to compare rates of growth in the demand for medical services. Those who had to pay a small user fee used medical services an average of 4% less than those who had to pay nothing.[28]

Another study of the effect of prices on health-care use was conducted in California, where some Medicaid recipients were required to pay one dollar for the first two visits to a doctor in a calendar month. Those who paid nothing visited the doctor 8% more than those who paid just a small part of the cost.[29] "The bottom line: people do consume more health care when they are spending other people's money."[30]

Zero price may be an attractive position in terms of social policy, but its economic effects over time are destructive.

**Monopoly**

"A monopoly is an enterprise that is the only seller of a good or service."[31] "In practice, monopoly frequently, if not generally, arises from government support. . . ."[32]

With Medicare, there seem to be multiple sellers because the provincial governments deliver services. But the Five Principles of the Canada Health Act bind the transactions so completely with uniform conditions that competition is effectively forbidden. In terms of economic position, the Medicare system functions as a single seller of health-care insurance because Canadians are not allowed to purchase the coverage it offers from any other party.

Another paradox lies in the fact that the transactions are not direct acts of exchange. Payment is indirect, through taxes, and the tax collector is many layers of government away from the actual delivery of services. But the forced nature of the payment reinforces Medicare's monopoly in much the same way that school taxes push parents towards the public system. Why pay twice? Payment has also been extracted in advance, to create a captive market of all except those who can afford to seek care outside the country.

The decision to structure Medicare as a monopoly has had effects that are both far-reaching and --- paradoxically -- little understood. Although consumers do retain a limited ability to shop between doctors and hospitals, terms and conditions at these facilities are for the most part identical. Because their funding arrives whether or not they provide good service, health-care workers have no direct incentive to satisfy their clients or to innovate to provide better service. One physician puts it this way:

> Hospitals receive periodic block payments from government, a method known as global funding. Instead of getting paid for the service they provide to individual patients, they get their money in lump sums at agreed-upon intervals. Each year there is a negotiating process where the hospital argues that it deserves more money than last year, and government negotiators argue that the hospital can get by with less. In these debates the needs of individual patients are of peripheral interest, and the end result is usually a saw-off between the two negotiating teams with a figure in the middle being agreed upon as the funding for the hospital for the next year. The government is all-powerful in these negotiations. . . .
>
> Global funding promotes inefficiency and bureaucratic waste. An example of this occurred [at my hospital] in Vancouver when wards were closed to "save money". Usually within a few weeks the vacant wards were converted into offices for newly hired bureaucrats and their staff. Similarly, most large hospitals in B.C. routinely close beds and operating rooms in the summer and at other times in order to "save money". This occurs in spite of the fact that hundreds of patients are waiting for urgent services. The result? Taxpayer dollars are poured into maintaining the hospital edifice, while casting aside the needs of the patients it is funded to serve. In another twist on this bizarre scene, most surgeons who 20 years ago had operating room times totaling up to 20 or more hours per week, are now restricted to absurd schedules of as little as 5 or 6 hour per week. . . [A]nd of course the backlog of patients requiring surgery grows daily.[33]

Another consequence of global budgeting is the "spend it or lose it" syndrome. "If a hospital has money left over at the end of a fiscal year, the amount is taken off the following year's grant. In other words, hospitals are encouraged to be wasteful."[34] The system creates "no financial incentive for hospitals to serve patients efficiently. If anything, such budgets create a disincentive – a well-run hospital that serves patients in a timely and cost-effective manner will see more patients, not more money."[35]

Medical facilities in Canada don't have to satisfy their customers. They are paid regardless of performance. "You can't have innovation if you don't have markets. And you can't have markets if you don't have customers. And you can't have customers in the ordinary sense in a monopoly."[36] "[M]onopoly providers determine what information is available to measure their own performance."[37]

Medicare's monopoly opens the door to "provider capture". Large monopolies tend to be sitting ducks for union leaders when wages, benefits and working conditions are negotiated.

Proof of that is provided by the large wage gap that has opened between health-care workers and their equivalents in the private sector:

**Wage Comparisons Between Union Workers in Vancouver Hospitals and Hotels[38] (April 1, 1995)**

| Worker | Hospital Wage Rates | Hotel Wage Rates |
|---|---|---|
| Laundry Aide | $16.67 | $12.40 |
| Storekeeper | $17.46 | $12.83 |
| Maintenance Worker | $18.04 | $13.89 |
| Groundskeeper | $19.21 | $13.71 |
| Electrician | $24.58 | $15.08 |
| Plumber | $23.88 | $15.21 |
| Painter | $21.83 | $13.37 |

Source: *Healthy Incentives: Canadian Health Reform in an International Context,* the Fraser Institute

The economist who reported these figures also calculated how much difference the differential would make in the budget of one large urban hospital. In one year, the wage gap for that facility alone created an extra $5.4 million in staff costs, 4% of the hospital's total annual spending. When extrapolated to the whole province, the difference came to $115million per year.[39]

Monopoly provision of Medicare does bring lower administrative costs. The elimination of billing represents a significant saving. "The per capita cost of insurance overhead under the Canadian system, wherein provinces operate 'single payer' insurance systems, is approximately one fifth the per capita cost in the United States where private health insurance is the norm."[40]

Defenders of Medicare are quick to point to this administrative advantage. Do these savings compensate for the higher costs implicit in monopoly provision, let alone the lack of customer focus and the loss of incentives to dispense care effectively and efficiently? Among OECD countries, only the United States and Germany incur administrative overheads larger than 5% of total health spending (the figure for Canada is 1.3%).[41] That would indicate that administrative savings might not be the most important factor to consider.

**Lack of Separation**

"There is a serious conflict of interest in health care in Canada because the state is purchaser, provider and regulator of virtually all medical services."[42] When budgets must be allocated, the oversight needed to evaluate the wisdom of those decisions comes from the same people who made the decisions in the first place. This is not a formula for good public policy.

The difficulty in accountability arises because the mixed roles of the monopoly provider pull it in different directions. Ideally, resource allocation will be flexible enough to respond to real health needs in the community, but measuring and meeting those needs may conflict with the desire of centralized administrators to control costs. Efforts by administrators to perform their task of fiscal oversight may result in the cancellation of program spending deemed necessary by their partners on the delivery side of the equation. "Purchasing and providing are two very different functions. The purchaser of a service is concerned with its

cost, the need it satisfies. The provider is financially dependent on satisfying the demands of the purchaser."[43]

A low level of accountability for results follows directly from this lack of separation. "[D]octors, hospitals and regional health authorities have few incentives to maximize value for money (best service or product at the most reasonable cost). . . [P]rovincial health departments typically fund hospitals and regional health authorities in Canada whether they meet budget targets or not."[44] Working under multiple layers of authority, "managers cannot free themselves from meddling by politicians in health care administration. The result of this rigidity and confused accountability is the inability of line managers to bring about change, solve problems, or seize the leadership in providing better care for patients or value for money."[45]

Governments in Britain and New Zealand have attempted to create separation of these different roles by establishing "internal markets". This approach is also described as "managed competition".

In New Zealand, a special, independent purchasing authority was created to represent the consuming public and to purchase services on their behalf from competing suppliers.[46] Great Britain used a more complex formula, as described by the OECD:

> The central idea that underpins the new [National Health Service] is the distinction between the purchaser and the provider of hospital and community health services. The providers compete with one another to provide such services by means of contracts with purchasers of health services. There are two kinds of purchaser. First and largest are the District Health Commissions (DHCs) who operate under a budget. The reforms recast their role from one of organising and providing hospital care to selecting the services required to meet those needs and then contracting with various service providers. . . .
>
> The second type of purchaser is the fundholder; self-employed primary care doctors (normally in group practices with at least 7,000 patients) who manage a budget which they must use to secure a defined range of hospital and primary care services for their patients. The fundholder's practice receives a transfer of roughly one-fifth of the per-capita costs of hospital and community health services to purchase a variety of services and products. . . . Since GP fundholders "compete" with DHCs and private insurers . . . (with the areas of competition being defined by health-care regulation), the purchasing side of the market is now subject to some competitive pressures.[47]

Similar plans are under discussion in the Canadian provinces. In Britain they have had a salutary effect: "Since a hospital's budget now depends in large part on contracts with GP fundholders . . . hospitals must be more responsive to doctors' (and patients') requests for quality and cost-effectiveness in order to remain financially viable. In return, doctors are more acutely aware of hospital costs since they themselves must now operate within a budget constraint. At the same time, extension of capitation-based funding (in which money follows the patient) . . . makes it easier to change GPs, and this strengthens the incentive for the GP to meet the demands of his or her patient."[48]

Creating internal markets improved "efficiency, consumer choice, resource allocation and information analysis in the UK health care sector".[49] But it has by no means achieved the degree of separation required to accomplish neutrality in pricing. "Internal markets introduce competitiveness but fall short in reducing excess demand."[50]

**Lack of Transparency**

Medicare-style programs have difficulty functioning in the long run because reliable information on costs is difficult, if not impossible, to obtain without the clarity achieved by market prices. In properly functioning markets, profits provide valuable information about successful outcomes. Those vendors who best serve the needs of consumers attract more customers and earn higher returns.

When this dynamic is removed, objective performance measurement suffers. "The health services produced and their cost are determined by countless decisions made by individual providers, governments and consumers."[51] Prices make up the body of "information regarding the clinical and economic effectiveness of specific health technologies, health programs and policies, as well as information describing the actual performance of the health care system. . . Not surprisingly, inadequate information results in inefficient methods of producing services, inefficient organization of health care and poor coordination of services. In addition, some services are overused and others underused."[52]

The Atlantic Institute for Market Studies has described the frustrating lack of transparency in Medicare:

> Health care is the largest public spending programme in government. Yet we do not possess the information, or even the ability to gather the information, that would allow us to assess the performance of the current system, let alone evaluate the realistic alternatives. Moreover, the monopoly structure of the system deprives patients of choice, also removing many of the incentives for providers and administrators to gather information on how the system performs.
>
> Efforts to overcome these disincentives within the Medicare system have proven ineffective to date. No Canadian jurisdiction is able to provide either systematic, regular and reliable information linking health outcomes with health care activities, or regular and reliable information about access to care.
>
> . . . Consumer choice in a competitive environment rewards providers that provide information on their access and results, since they win clients if they can demonstrate superior performance. Patient decisions would be made based on the information available and an assessment of the quality of that information.[53]

Complex bureaucracies have evolved to ferret out the information lost through the abandonment of markets. Without the clear knowledge of needs afforded by the process of supply and demand, they cannot perform this function effectively. All allocations of resources require decisions about opportunity costs: if money is spent on A, it cannot also be spent on B or C. In the absence of prices or consumer choice as methods to direct these decisions, administrators must make them in the dark.

**Politicization**

Canadians are all too familiar with the political wrangling that is the consequence of operating a complex industry with blinders on. One economist summed it up in this manner:

> In general, . . . it might be characterized as a system of bureaucratic and political wrangling, with considerable resources being devoted to the study of principles of

> 'efficient health planning'. Again Canadian experience provides plenty of evidence of the sorts of things one can expect if the system moves further in a centralized direction: proposals by the government to enforce uniform hospital bed/population ratios or physician/population ratios, met by considerable opposition from the localities and organizations involved; acrimonious bargaining regarding physician fee schedules, involving threats by doctors to opt out of public insurance schemes and counter-threats by governments to put physicians on salary; and increasingly vocal complaints by doctors of government interference with the practice of medicine for purposes of cost-cutting.[54]

Political decision-making has made a shambles of a health-care system that once ranked as the best in the world. The issue of the size of nursing staffs, for instance, has come full circle through recent political cycles. When cutting costs came into vogue a decade ago, registered nurses were laid off, and new graduates had to leave for the United States to find work. Training of licensed practical nurses stopped altogether, and those already employed were cashiered. More recently, alarms have sounded over an impending shortage. Recruiters are bringing in replacement RNs from the Philippines and LPN courses have been brought back.

The supply of hospital beds has also fallen hostage to politics:

> [S]ome provincial ministries have made energetic attempts in the last few years to slow down the increase in the cost of hospital systems. These attempts have taken the form of proposals to close down some of the smaller, high-cost hospitals and of strict limitations on expenditures for expansion or the addition of new services and equipment at others, as well as general pressure on hospital managers to keep down the rate of increase in operating costs. The effectiveness of the provincial governments in controlling operating costs through general pressure on hospital managers is probably reduced by the absence of direct financial incentives: an efficient manager will presumably receive an encouraging pat on the head, and may be indirectly rewarded by having his requests for expansion or additional equipment treated with more favour than a less efficient one, but he has no *guarantee* that the money he saves will in fact revert to his hospital. Conversely, less efficient managers or managers of hospitals which are inherently uneconomical . . .may not be compelled to cut back if they can convince the ministry that their case merits special consideration. . . . Under those circumstances, it is unavoidable that many decisions in the ministry will be heavily influenced by political factors. . . .[55]

Britain's National Health Service was recently caught up in a reversal of political fortune. Efforts by the Conservative Party to create internal markets (as described above) were opposed by the Labour Party.[56] Before taking power, the Labourites vowed to abolish GP fundholding. Since taking power, however, they have rethought their policy. But the danger that the NHS would have to undergo another wrenching reorganization based on the fickleness of electoral fortune was clearly real. Huge industries like health care need to be insulated from the caprices of temporary officeholders.

### Medical Savings Accounts

The problems of zero price, monopoly, lack of separation and transparency, and political diddling can mostly be solved by a consumer-based policy model known as Medical Savings Accounts (MSAs). Variations on this system abound, but they have a basic feature in common: they redirect spending power to consumers.

MSAs started to receive serious and widespread consideration as a way out of the health-care muddle about ten years ago. Most of the discussion has taken place in the United States, where several private organizations have adopted them as replacements for traditional medical benefit packages. As we shall see, most of these plans remove third parties from the process of spending health-care dollars. But they still rely on a combination of contributions from employers and employees.

MSAs, however, need not be limited to the private sector. Their most important element has nothing to do with the way the funds are acquired. It has to do with how they are disbursed.

MSAs "are health accounts that are established in conjunction with catastrophic health insurance. They can be set up by individuals, by employers or by the government."[57] They "can induce competition in the medical market place without creating financial barriers to care."[58]

MSAs work because they recognize that ever-escalating costs are mostly driven by patients who act as if they were spending someone else's money. Third-party insurance plans and universal access programs like Medicare discourage the search for the best care at the best cost because neither providers nor consumers have effective incentives to be "smart" shoppers. MSAs reverse the incentives by allowing patients to benefit directly from reduced expenses.

Most MSAs operate in a two-track fashion. Payment for ordinary medical expenses comes directly from each individual's account at the point of service. Extraordinary expenses, such as major surgery, long-term care for chronic illness or catastrophic emergencies, are covered by insurance. Premiums for this insurance are also paid from each person's account.

How does the money arrive in a Medical Savings Account? A number of scenarios is possible:

- The system we use now, where health-care dollars arrive in the government's coffers through taxes and are paid out by bureaucrats. The difference would lie in where the money lands. Instead of going to providers in the form of global budgets, it would be deposited into millions of MSAs.
- A regime of forced contributions, where individuals and/or their employers would be required to pay a percentage of their salaries into MSAs. Presumably, this would be accompanied by a general reduction in tax rates. Those without employment or incomes would set up accounts with money designated for that purpose as part of their support from social service agencies.
- A system of tax credits, analogous to RRSPs, where money deposited into accounts would be deducted from taxes owing to Revenue Canada. Individuals with low or no incomes would receive the tax credits in the same manner as they now do for a variety of other purposes.

Regardless of the method used to open the accounts, the money in them could be used for no purpose other than to pay for health care. The account would be considered each person's private property. Unspent funds would remain there for a specified length of time. They could be withdrawn at the end of each tax year, or they could be left there until the account holder dies and then become part of his or her estate, or they could be withdrawn on a sliding scale over time should the account reach a certain size.

How much money would go into an MSA? Canadians now pay an annual average of about $2,500 each for medical care through a combination of taxes, private insurance premiums and out-of-pocket spending.[59] Setting the minimum MSA amount at that level might be a sensible starting point. Those who wished to pay more into their accounts should be free to do so.

How much would comprehensive insurance coverage for extraordinary medical services cost? Over time, the annual injections of cash would build up into a substantial fund to defray the extra costs associated with aging. In order to compensate for shortfalls at the beginning of an MSA system, the program could be phased in by endowing larger accounts for individuals who suffer from pre-existing maladies or who have reached the age where medical costs escalate. Again, over time, this problem would resolve itself.

Medical Savings Accounts are not simply a theoretical construct. They have been operating in a variety of American organizations and in the city-state of Singapore.

**Private American MSAs**

Several private companies in the United States have used Medical Savings Accounts to pay for the health-care costs of their employees. Depending on how the plan is structured and initial health insurance costs faced by the firm, savings have ranged from 12% to 40%.[60] "Where they have been adopted, MSAs have resulted in lower costs to employers and employees, accumulated savings, and high degrees of employer and employee satisfaction."[61]

Employers buy catastrophic insurance, which is available at a much lower cost than existing comprehensive insurance. The company then deposits the difference into the employee's MSA. If the employee needs more cash for day-to-day medical expenses, he or she is responsible for paying an amount equal to the employer's contribution, after which point the purchased insurance begins coverage.[62] Any money left in the fund at the end of the year remains the property of the employee, although restrictions on how and when the funds may be taken out and used are not uncommon.

Some examples:

- In 1993, the Golden Rule Insurance Company in Indianapolis offered its 1,300 employees a choice between MSAs and their traditional insurance plan. Eventually, 98% of them chose the former. The plan has reduced overall costs by 40%. Employees are allowed to cash out their MSAs at the end of the year, the remainder averaging $1,000. Health costs dropped dramatically as employees began to take an active role in shopping around for less expensive providers. The purchase of preventive care, as opposed to reactive treatment, rose by 26%.[63]
- *Forbes* Magazine offered MSAs to its employees in 1992. "In the first year of the plan, the firm's health costs dropped by 23%, a total of about $400,000."[64] The company paid out $125,000 in bonuses.
- Dominion Resources, a utility holding company, set up an MSA-style plan in 1989. While other American employers have faced annual average increases in health costs of 13% since then, the firm has had zero premium increases.[65]
- In 1994, the United Mine Workers union inaugurated an MSA plan with a $1,000 deductible. In return, members receive a $1,000 bonus at the beginning of the year and get to keep whatever they don't spend.[66]
- Morris County Hospital in Kansas used an MSA plan from 1982 till 1992, when new management changed the policy. During that time, the hospital's own health costs

stabilized at less than 5% of payroll and employee sick time dropped to 1% of payroll. Most hospital employees rolled the money left over in their accounts into retirement plans.[67]

These and many other organizations that have switched to MSAs demonstrate a consistent pattern. Medical Savings Accounts save money by restoring the link between health care and customers.

**Singapore**

Medical Savings Accounts in Singapore have developed as part of a compulsory savings plan called the Central Provident Fund (CPF), which covers about three-quarters of all workers in that country.[68]

All employees must place 40% of their earnings in the Fund, with 22.5% coming from employees and 22.5% coming from employers.[69] Originally established in 1955 to provide retirement benefits, the Fund has expanded in stages to include the cost of health care, as well as insurance, mortgages and higher education. Fund participants can invest up to 40% of their accounts in real estate, Singapore-based company stocks or gold, but are not allowed to invest in bonds or foreign securities.[70] These assets held in these accounts are considered the private property of the individuals who have accumulated them. "The funds may be withdrawn at retirement, in the event of permanent disability, or if the individual emigrates from Singapore. At the fund holder's death, the funds are payable to the individual's heirs."[71]

Singapore introduced its current system of Medical Savings Accounts in three stages:[72]

- The "Medisave" plan started in 1984, as part of the CPF. Depending on age, between six and eight per cent of an employee's salary is placed in the account. Contributions accumulate until the account reaches S$11,000 (about US$8,500), considered enough to cover all but the most catastrophic medical need. Additional payments bleed over into the retirement sector of the CPF.[73] The Medisave portion of MSAs is intended to cover the cost of day-to-day medical expenses and carries certain restrictions on the use of the account. The funds can be used only at approved facilities and exclude outpatient care.
- The "Medishield" component, introduced in 1990, provides long-term catastrophic insurance to pay extraordinary hospital expenses for those under 70 years of age. Premiums are low, ranging from S$12 to S$132 a year, depending on age. A variety of restrictions and limits on coverage keeps the premiums low and guarantees that the plan is used only for new catastrophic medical need.[74]
- The "Medifund" program, begun in 1993, was designed to provide a safety net for those whose needs are not met by Medisave and Medishield. Lower-wage workers, the poor and those who are too old to have built up enough money in their MSAs receive coverage from a special fund underwritten by general government surpluses. The fund started up with S$200million and receives an additional S$100million each year the government runs a surplus. (In Singapore, that means every year.) Payment is decided on a case-by-case basis.[75]

How well do MSAs work in Singapore? These are some of the positives:[76]

- Medical personnel are highly trained and paid salaries equivalent to those of their American counterparts.

- Sophisticated medical technology is utilized at rates comparable to those in Europe or Canada.
- Most patients wait less than 15 minutes for treatment after arrival at a medical facility.
- Hospital admission rates and the average length of stay equal those in the United States and are far less than those in most developed countries.
- Overheads for administration run at less than two per cent. The ratio of caregivers to support personnel comes in at five to one, versus the American standard of two to one.
- Queues are rare, occurring only in a few specialized fields like cataract surgery.
- Singapore has low rates of infant mortality and steadily improving health care in the general population.
- All MSA accounts, at the time of deposit and the time of withdrawal, are tax exempt.
- The system spends only 3.1% of Singapore's GDP, about a third of Canada's outlay.

Are there negatives? Yes, among them:[77]

- The savings system is forced, which means that experimentation with other methods of payment, such as third-party insurance, is not possible.
- The restriction that forbids the use of Medisave funds for outpatient services tilts the patient caseload towards more expensive, hospital-based care. Outpatient treatment is available only at government-run clinics, for a fee.
- Restrictions on coverage make the system complicated and incomprehensive. For instance, only three childbirths per family are covered, and prenatal and postnatal care are not covered at all.
- Depending on their income levels, patients must choose from five classes of hospital service. The lowest category offers only open wards that are not air-conditioned.
- The Singapore government micromanages medical care by limiting the number of physicians, the ratio of specialists to general practitioners and the amount and location of high-technology services.

Despite these shortcomings, Singapore's MSA system has proven that a decentralized structure which allows consumers to control their own funds can offer significant advantages. Its drawbacks are not intrinsic to the market-based model, but rather reflect the desire of its designers to keep costs as low as possible. An MSA system without the restrictions of the Singapore version would in theory cost more, but it there is no intrinsic flaw to prevent retention of the cost-saving incentives.

## A Canadian Model - Universal Medical Savings Accounts

A Medical Savings Account system in Canada would differ in several respects from those discussed above. The Singapore MSA program provides universal coverage and access, but its structure dictates that higher-income people are treated differently from those who lower-income people. Similarly, corporate American MSAs cover only those who work for the companies that have adopted the program.

Universal access, to paraphrase the adage about justice, must not only be done, it must also be seen to be done. Anything less would make an MSA model politically unobtainable. Therefore, the model proposed here for Canada would continue to draw its funding from the tax system. It would retain the salient feature that underpins universality in Medicare, the socialization of the resources necessary to provide health care. Thus, a more apt description of the model described here is Universal Medical Savings Accounts (UMSAs).

At the beginning of each fiscal year, health authorities would deposit each citizen's share of the Medicare budget into a dedicated bank account in that person's name. Each account-holder would gain access to those funds through an electronic debit card. In the case of dependent children or people who are incapacitated and unable to manage their resources, parents or public or private trustees would be responsible for administering the UMSA.

Withdrawals from the account would be allowed only to pay for health-care services. Minor, non-catastrophic events requiring a visit to a clinic or doctor would be paid by direct electronic debit from an individual's or family's UMSA. Individuals would cover themselves against catastrophic events by purchasing insurance from competing commercial carriers, co-operatives or mutual benefit associations. Money not spent would be rolled over and left to accumulate tax-free over the account-holder's lifetime until the fund reached some pre-determined amount sufficient to create an income stream that would cover future medical emergencies.

**How much would comprehensive insurance coverage for extraordinary medical expenses cost?**

The cost of catastrophic insurance would depend on the age of the account holder and the size of the deductible. One estimate of the cost, calculated by using recent rates for equivalent insurance now available in the United States, assumes a $1,000 deductible:

**Estimated Cost of Catastrophic Insurance Coverage**

| Demographic Status | Insurance Premium* | MSA Resources** | Balance |
|---|---|---|---|
| Single male, aged 25 | $ 298 | $ 1,750 | $ 1,452 |
| Single female, aged 25 | 633 | 1,750 | 1,117 |
| Male and female, aged 35, with two children | 1,825 | 3,500 | 1,675 |
| Male and female, aged 55 | 1,537 | 3,500 | 1,963 |

* Insurance premiums from: *Healthy Incentives: Canadian Health Reform in an International Context,* the Fraser Institute, 1996
** Based on $1750 per person per year or $7,000 per family of four

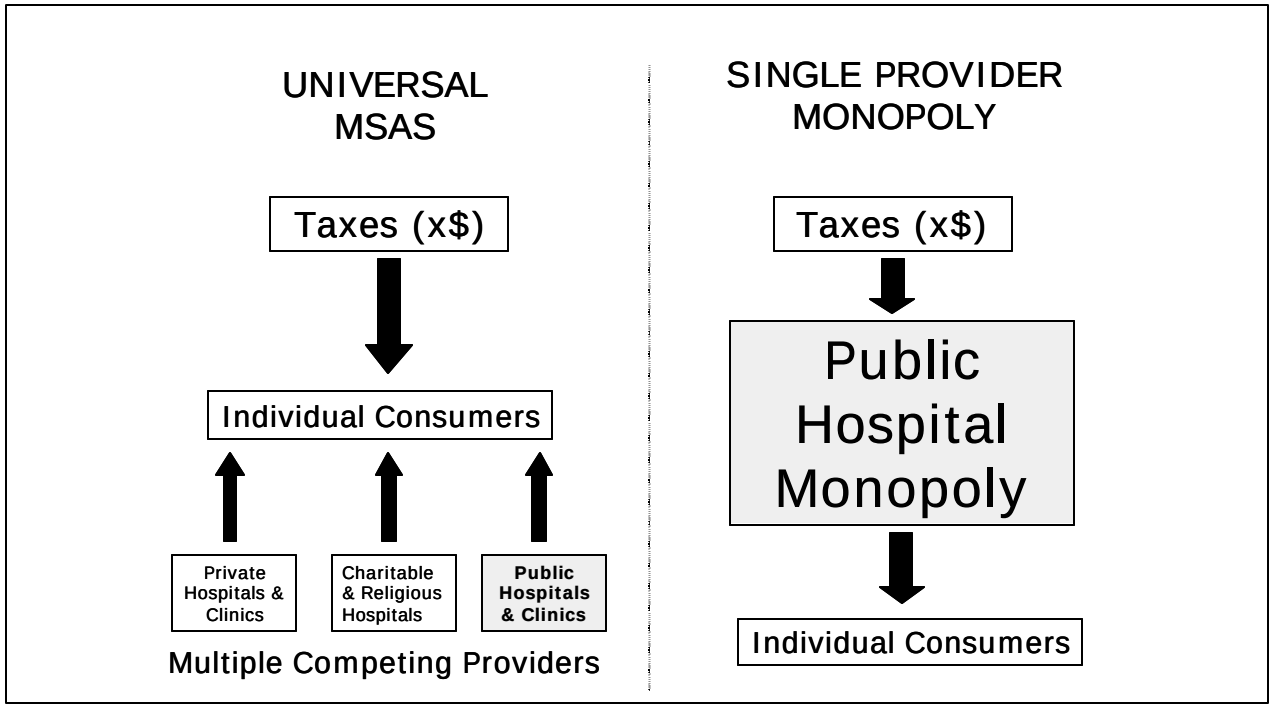
In each case, the size of the premiums leaves more than enough in the MSA accounts to cover the cost of deductibles and out-of-pocket payments for minor health expenses.

What about individuals who overspend their UMSAs before the year is up and are left with nothing in the account? The experience in Singapore and in the United States demonstrates that people tend not to. Since account-holders keep whatever they don't spend, they have a powerful incentive to husband the resource carefully.

**HOW UMSAs WOULD WORK**

- At the beginning of each fiscal year, health authorities would deposit each citizen's share of the Medicare budget into a dedicated bank account in that person's name. Each account-holder would gain access to those funds through an electronic debit card.
- Withdrawals from the account would be allowed only to pay for health-care services.
- Minor, non-catastrophic events requiring a visit to a clinic or doctor would be paid by direct electronic debit from an individual's or family's UMSA.
- Individuals would cover themselves against catastrophic events by purchasing insurance from competing companies.
- Money not spent would be rolled over and left to accumulate tax-free over the account-holder's lifetime until the fund reached some pre-determined amount sufficient to create an income stream that would cover future medical emergencies (i.e. $200,000).
- Special cases, the small minority who run out of funds or have special needs, are accommodated separately with extra government assistance.

No doubt there will be special cases, those who act foolishly, ignore the incentives and run out of money. Further, those with pre-existing conditions that require extraordinary expense may find themselves unable to cope within the limits of their UMSAs. Both these classes of consumers, the small minority who "fall through the cracks," can be accommodated separately through special government assistance. As part of its relinquishment of direct monopoly ownership, the federal and provincial governments would sell facilities such as clinics and hospitals they now directly own. The proceeds from these assets would be directed into an endowment fund dedicated to extending additional coverage to those who needed it.



Although the exact proceeds from such a divestiture of assets cannot be calculated in advance, the public holdings are enormous and diverse. There is no doubt that the money raised would be sufficient to cover any future contingency. Of course, many of the facilities now owned by governments were originally built by private organizations such as religious orders and community-based charities. Where possible, title should revert to these groups.

**Advantages of UMSAs**

UMSAs provide a solution to the structural problems of Medicare.

**Prices**. Because prices are restored to health care, both providers and consumers receive important information about the costs and the benefits of their behaviour, which enables them to make rational decisions. Individuals benefit personally because they keep funds not spent on unnecessary use of health-care resources. Once a cost figure is available to them, health-care providers can make sounder judgments about the value of their activities. Society benefits from a more efficient use of capital, which frees it up for use elsewhere. The health-care economy is allowed to establish equilibrium between supply and demand, so queues for service and waiting lists would eventually disappear.

**Competition**. Hospitals, clinics and medical personnel are no longer guaranteed an automatic income divorced from performance. If they wish to retain their clients, who are now their source of income, they must provide service at least as effectively as other providers. The end of their captive market means that they have strong incentives to upgrade their performance. Making their income depend on customer satisfaction creates a powerful tilt towards continuous improvement, thereby reversing the years of decline under the monopoly. A decentralized, customer-sensitive system that reflects the decisions of millions of consumers replaces a less flexible a sclerotic single provider. Competition creates pressure to contain costs, increase quality and offer timely service. Consumers now drive what the system produces.

**Separation**. Universal publicly funded access remains in place. The government still funds health care but no longer directly provides it. Separating public financing from private production allows the emergence of a framework within which flexibility in process and delivery methods optimizes outcomes. Resources are no longer allocated through a centrally planned system that necessarily runs on too little information to accommodate the complete range of individual health-care needs and desires. Defining a clear split between the purchaser and the provider enables them to clarify their goals, and conflicts of interest are minimized. Health bureaucrats would establish policy guidelines and goals, but operations and administration would become the responsibility of non-governmental / private providers.

**Transparency**. The restoration of prices makes clear measurement of costs and results possible again. Few people understand how much the government spends on health care per family in the present system. Under MSAs, public spending becomes highly visible to all. Based on recent expenditures, a family of four in Canada would receive about $6,500. At present, taxes disappear into an unintelligible void, but with MSAs consumers are able to connect what they pay with what they receive. Even more important: providers can avoid wasteful behaviour because they become clearly aware of the cost of the resources they use to attack medical problems.

**Neutrality.** The task of elected officials is simplified. Elected officials withdraw from haphazard involvement in the design and operation of the health-care system. This removes any bias they may have towards a particular delivery process and makes them

focus on outcomes instead of inputs. The only political haggling that remains under the MSA model is the issue of how much money is placed in accounts annually, but the anticipated reduction in overall misallocation of resources should make this a relatively simple task. The size, quality and effectiveness of the health-care industry would no longer be held hostage to political cycles. These would instead depend on the individual wishes of millions of consumers.

**Conclusion**

Reams of newsprint are annually devoted to discussing the task of refurbishing our health-care system. As Medicare deteriorates, public panic escalates over the poor quality and availability of services. But most of the analysis ignores the central problem, the structural deficiencies of a policy framework that combines zero price, government ownership and political allocation of resources.

Solutions that fail to address this structural failure have no better chance of success than the faulty system we have constructed. As a society, we decided thirty years ago to embrace a system that contained the seeds of its own destruction. We are now reaping its sorry harvest.

Universal Medical Savings Accounts offer a way out, at less cost and at far greater levels of efficiency. We can keep Medicare's ultimate goal, the guarantee of health care to every Canadian. Inside the current policy framework, that goal recedes as the problems mount. Restoring markets through UMSAs will allow us to reach that goal, and to do it quickly.

## ADVANTAGES OF UMSAs

Using the Frontier Centre's three criteria of high-performance public policy, UMSAs score high:

1. **TRANSPARENCY – clear measurement of costs and results**
   - **A public healthcare commitment visible to all** – Few people understand how much the government spends on health care per family in the present system. Under UMSAs, public spending becomes highly visible to all. Based on recent expenditures, a family of four in Manitoba or Saskatchewan would receive between $6,000 and $7,000.
   - **Consumers rewarded for not over-using services** – Individuals benefit personally because they keep funds not spent on unnecessary use of health-care resources. Society benefits from a more efficient use of capital, which frees it up for use elsewhere.
   - **Consumer choice channels use of resources —** Prices provide valuable information on costs and benefits, thereby enabling providers and consumers to make rational decisions without political involvement.

2. **NEUTRALITY – no bias towards a particular delivery mode**
   - **Universality preserved** -- Universal publicly funded access remains in place. The government still funds health care but no longer directly provides it. There is no bias towards a particular process — in other words, the system is neutral.
   - **Incentives to efficiency** -- A decentralized, customer-sensitive system that reflects the decisions of millions of consumers replaces an inflexible monopoly. Competition creates pressure to contain costs, increase quality and offer timely service. Consumers now drive what the system produces.
   - **New technology** -- The freedom to shop weeds out services and facilities that fail to please consumers, who vote with their MSA funds by patronizing those which do. MSA debit cards facilitate automated billing through low transaction costs. This reduces administrative overheads while providing customers with useful information on their health-care purchases.

3. **SEPARATION – elected officials involved in setting policy, not operations and administration**
   - **Politician separated from operations** -- The task of elected officials is simplified. Resources are no longer allocated politically through a centrally planned system that has too little information to accommodate the complete range of individual healthcare needs and desires. Elected officials withdraw from haphazard involvement in the operation and design of the delivery system. Separating public financing from private production allows the emergence of a framework within which flexibility in process and delivery methods maximizes outcomes.
   - **Capital released for public endowment** -- Government ownership is no longer required in a decentralized, competitive system in which the public financing function has been separated from production decisions. Billions of dollars in hospital assets can be transferred to charitable organizations or sold to doctor groups or insurance companies. The proceeds endow a public fund that helps low-income groups and special hardship cases purchase health-care services. Lower taxes and a higher living standard follow this release of capital.

| | **UNIVERSAL MSA** | **SINGLE-PROVIDER PUBLIC MONOPOLY** |
|---|---|---|
| | | |
| **TRANSPARENCY** | **High** | **Low** |
| | | |
| Information for directing resources | Prices regulate supply and demand | Waiting lists regulate demand |
| Incentive for not over-consuming | Consumer keeps money not spent | Over-consumption paid for by system |
| Citizen knows public commitment | Amount transferred to UMSA visible | Few understand how much is spent |
| | | |
| **NEUTRALITY** | **High** | **Low** |
| Universality preserved | Equal public funding for all consumers | Funding provided to single-provider system |
| Incentives for efficiency | Effective suppliers expand, deficient ones close | Administrative "efficiencies" lead to service cuts and excessive centralization |
| New technology | Competing suppliers use technology to attract customers | Low technology levels by developed-world standards |
| | | |
| **SEPARATION** | **High** | **Low** |
| Politicians separated from operations | Politicians involved only in broad policy decisions on service quality and payment system | Politicians frequently involved in management and facilities decisions where they have little or no expertise |
| Capital released for public endowment | Facilities can be sold to competing suppliers, releasing billions for other uses | Substantial capital investment remains tied up in government-owned facilities |
| Information for directing resources | Prices regulate supply and demand | Waiting lists regulate demand |

## Endnotes

[1] *Healthy Incentives: Canadian Health Reform in an International Context*, by William McArthur, Cynthia Ramsay and Michael Walker, The Fraser Institute, 1996, p. 112. The authors describe typical pre-Medicare coverage for the poor as taking three forms: philanthropy, social assistance and mutual aid societies. Another form of coverage that they do not mention offered a form of socialization, namely that medical providers could write off uncollected debts from patients as tax losses. This method became more common as our complex tax code developed.
[2] Ibid.
[3] Ibid., p. 113.
[4] Ibid., p. 114.
[5] *Code Blue: Reviving Canada's Health Care System*, by David Gratzer, ECW Press, 1999, p. 66. As McArthur et al. explain, the federal government cannot directly prohibit user fees because health is constitutionally a provincial responsibility. Instead, they simply threaten to reduce payments under the Act dollar for dollar for any money collected by means of user fees or extra billing.
[6] McArthur et al., op. cit., pp. 117-121, and Gratzer, op. cit., pp. 67-68.
[7] "Marleau renews threat to Alberta", by Scott Feschuk, *The Globe and Mail*, November 29, 1994, "Alberta surrenders in clinic battle", by Alanna Mitchell, *The Globe and Mail*, October 12, 1995, and "Alberta gives in to Ottawa on billing", by Brian Laghi, *The Globe and Mail*, May 31, 1996.
[8] "Medicare on the Critical List", by Sydney Sharpe, *The Financial Post Magazine*, May, 1995.
[9] "The real healthcare problem is the Canada Health Act", by Dr. William Orovan, *The Globe and Mail*, November 16, 1998.
[10] Op. cit.
[11] *Waiting Your Turn: Hospital Waiting Lists in Canada (9th Edition)*, by Michael Walker and Martin Zelder, The Fraser Institute, September, 1999.
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[20] *New Directions in Health Care Policy*, op. cit., p. 12.
[21] *The Health Care Business*, by Åke Blomqvist, The Fraser Institute, 1979, pp. 8-9.
[22] McArthur et al., op. cit., p. 114.
[23] *The Perverse Economics of Health Care and How We Can Fix It*, by David R. Henderson, The Hoover Institution, Stanford University, 1994, p. 3.
[24] Gratzer, op. cit., p. 107.
[25] *Congressional Health Care Briefing Book*, the National Center for Policy Analysis, 1995.
[26] *Free for All? Lessons from the RAND Health Insurance Experiment*, by Joseph P. Newhouse and the Insurance Experiment Group, Harvard University Press, 1993, p. 40.
[27] Gratzer, op. cit., pp. 124-125.
[28] *Utilization of Publicly Insured Health Services in Saskatchewan Before, During and After Copayment*, by R. G. Beck and J. M. Horne, *Medical Care*, August, 1980, Vol. XVIII, No. 8.
[29] *Health Care Cost Increases*, by Jack A. Meyer, The American Enterprise Institute, 1979, p. 12.
[30] *Lessons from the Health-Care Defeat: Reform Must Make Economic Sense*, by David R. Henderson, The Center for the Study of American Business, November, 1994, p. 8.
[31] *Monopoly*, by George Stigler, *The Fortune Encyclopedia of Economics*, David R. Henderson (ed.), Warner Books, 1993, p. 399.
[32] *Capitalism and Freedom*, by Milton Friedman, The University of Chicago Press, 1982, p. 28.
[33] "Making Hospitals Work for Patients", by Dr. William McArthur, *The Fraser Forum*, February, 1999.
[34] Gratzer, op. cit., p. 141.

[35] Ibid., p. 142.
[36] Milton Friedman, quoted in *Liberating People for Self-Government,* by Stephen Goldsmith, Heritage Lecture #567, The Heritage Foundation, April 25, 1996.
[37] *Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System,* by Brian Lee Crowley, Dr. David Zitner and Nancy Faraday-Smith, The Atlantic Institute for Market Studies, November, 1999, p. 2.
[38] McArthur et al., op. cit., pp. 154-155.
[39] Ibid., p. 154.
[40] *Operating in the Dark,* op. cit., p. 9.
[41] *New Directions in Health Care Policy,* Health Policy Series No. 7, The Organisation for Economic Co-operation and Development, 1993, p. 32.
[42] McArthur et al., op. cit., p. 167.
[43] Gratzer, op. cit., p. 183.
[44] *Operating in the Dark,* op. cit., p. 21.
[45] *Operating in the Dark,* op. cit., p. 22.
[46] *Healthy Incentives,* op. cit., p. 166.
[47] *New Directions in Health Care Policy,* op. cit., p. 42.
[48] *Who is the Master? A Blueprint for Canadian Health Care Reform,* Institute for Research on Public Policy, 1998.
[49] *Operating in the Dark,* op. cit., p. 28.
[50] *Code Blue,* op. cit., p. 185.
[51] *Limits to Care: Reforming Canada's Health System in an Age of Restraint,* ed. by Åke Blomqvist and David M. Brown, C. D. Howe Institute, 1994. The article cited is *Health Care Reform in Canada: Restructuring the Supply Side,* by Lee Soderstrom, p. 224.
[52] Ibid., pp. 224-225.
[53] *Operating in the Dark,* op. cit., pp. 1-2.
[54] *The Health Care Business,* op. cit., p. 60.
[55] Ibid., p. 97.
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[57] *Medical Savings Accounts: Universal, Accessible, Portable, Comprehensive Health Care for Canadians,* by Cynthia Ramsay, Critical Issues Bulletin, the Fraser Institute, May, 1998, p. 13.
[58] Ibid., p. 12.
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[63] *Code Blue,* op. cit., pp. 190-191.
[64] *Medical Savings Accounts,* by Michael T. Bond, op. cit., p. 11.
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[68] *Patient Power: Solving America's Health Care Crisis,* by John C. Goodman and Gerald L. Musgrave, the Cato Institute, 1992, p. 598.
[69] Ibid., pp. 600-601.
[70] Ibid., p. 598.
[71] Ibid., p. 599.
[72] M*edical Savings Accounts: The Singapore Experience,* by Thomas Massaro and Yu-Ning Wong, the National Center for Policy Analysis, April, 1996.
[73] *Patient Power,* op. cit., p. 602.
[74] *Medical Savings Accounts,* op. cit.
[75] Ibid.
[76] Ibid.

[77] Ibid. These examples are drawn from the NCPA study, but their inclusion in a list of "negatives" is based on analysis by the writers.

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