

Payments for Health Care in New EU Member States

*What opportunities for greater
access to innovative products?*

*“New Health for the New Europe”, Prague
Symposium September 4-5, 2004*

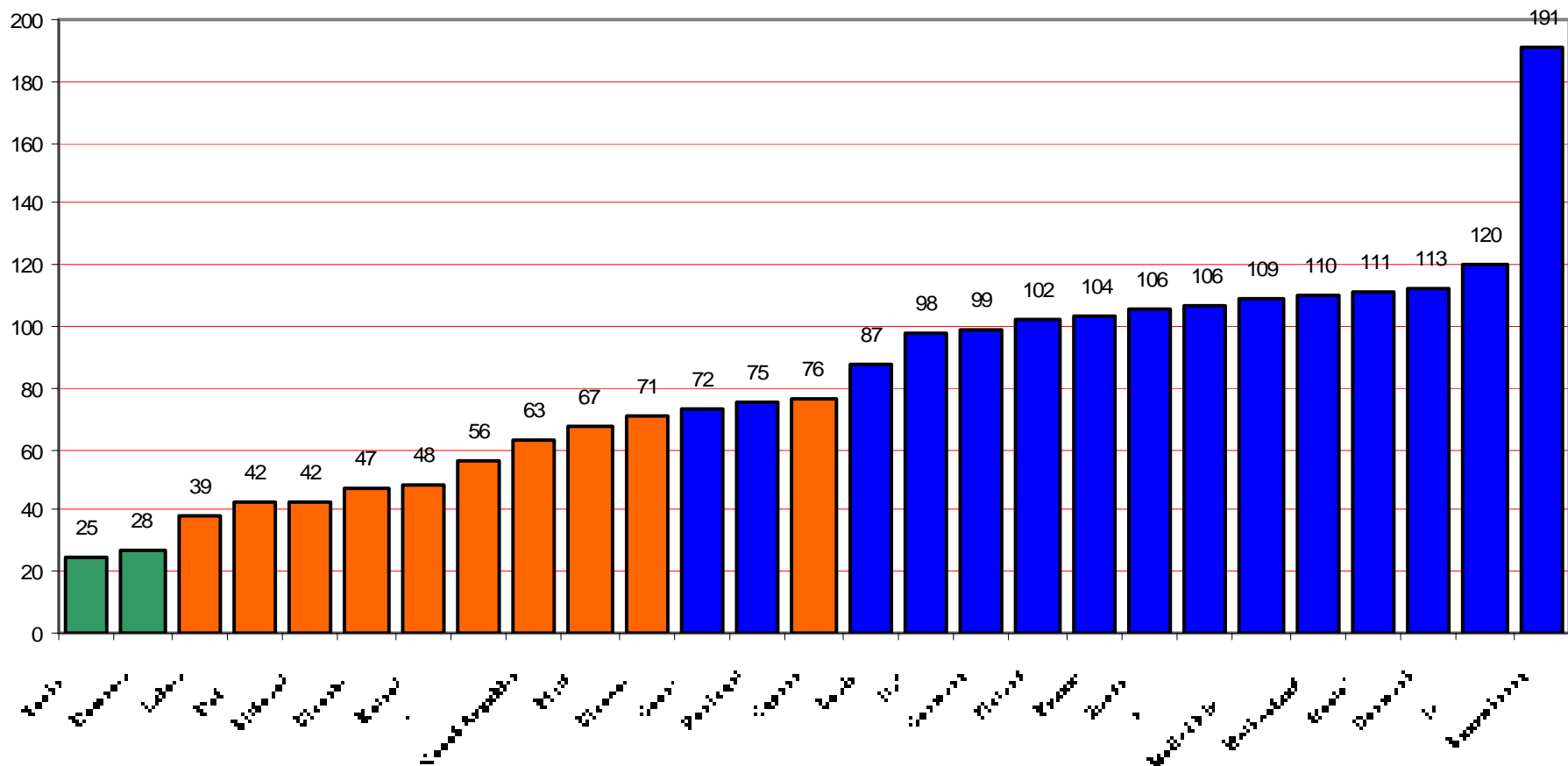
Helena R Brus, Merck & Co. Inc, USA

Outline

- Economic and health gap
- Financing of health care
- Private payments for health care
- Informal payments
- Payments for medicines
- Policy implications

Based on selected examples

Economic gap: accession countries are less wealthy than the established EU – as measured in PPS in 2003



Health Care Gap

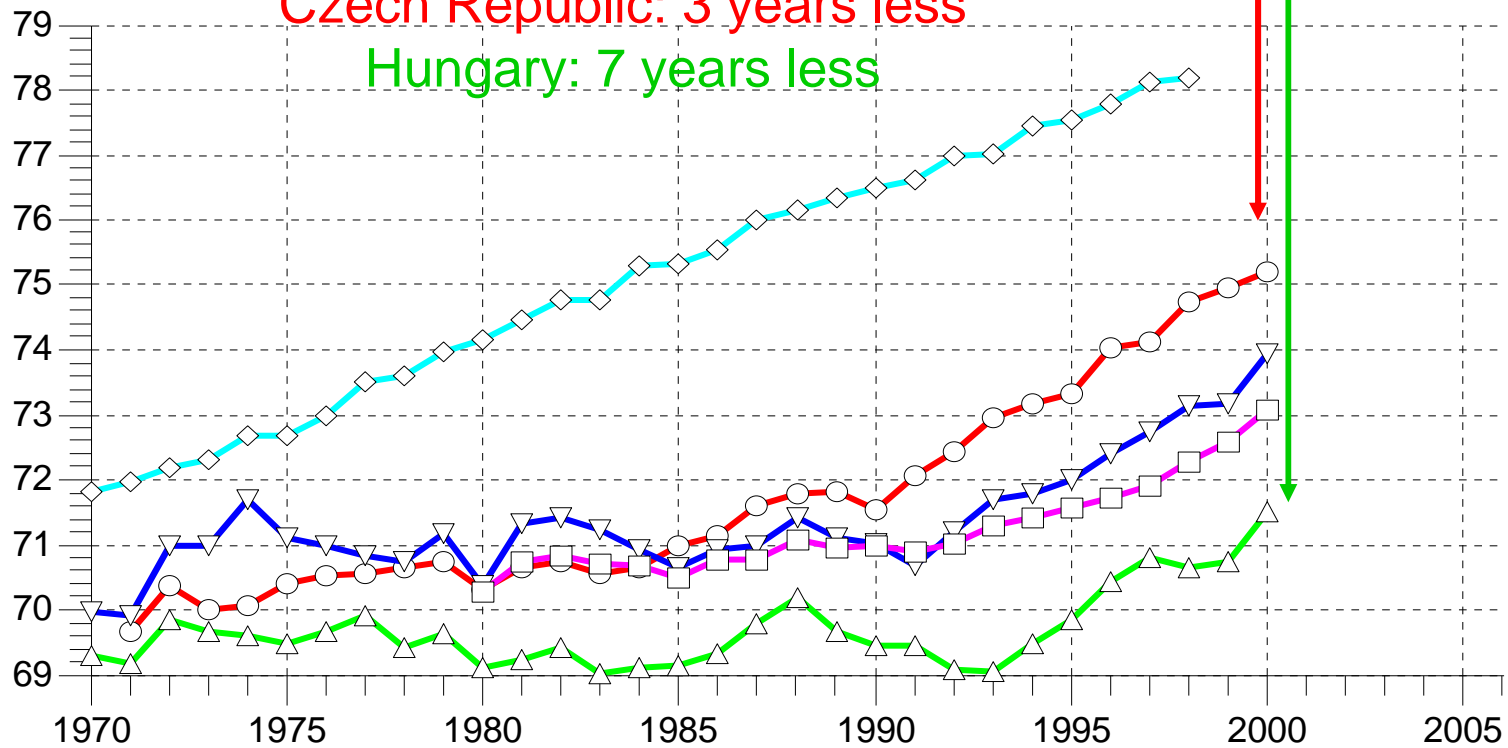
- Shorter life expectancy
- Higher toll from diseases of the circulatory system
- High cancer mortality relative to incidence
- Low absolute per capita expenditure on health
- Low relative and absolute level of public expenditure

Health Gap – Life Expectancy

Shorter life expectancy than in EU15:

Czech Republic: 3 years less

Hungary: 7 years less



—○— Czech Republic

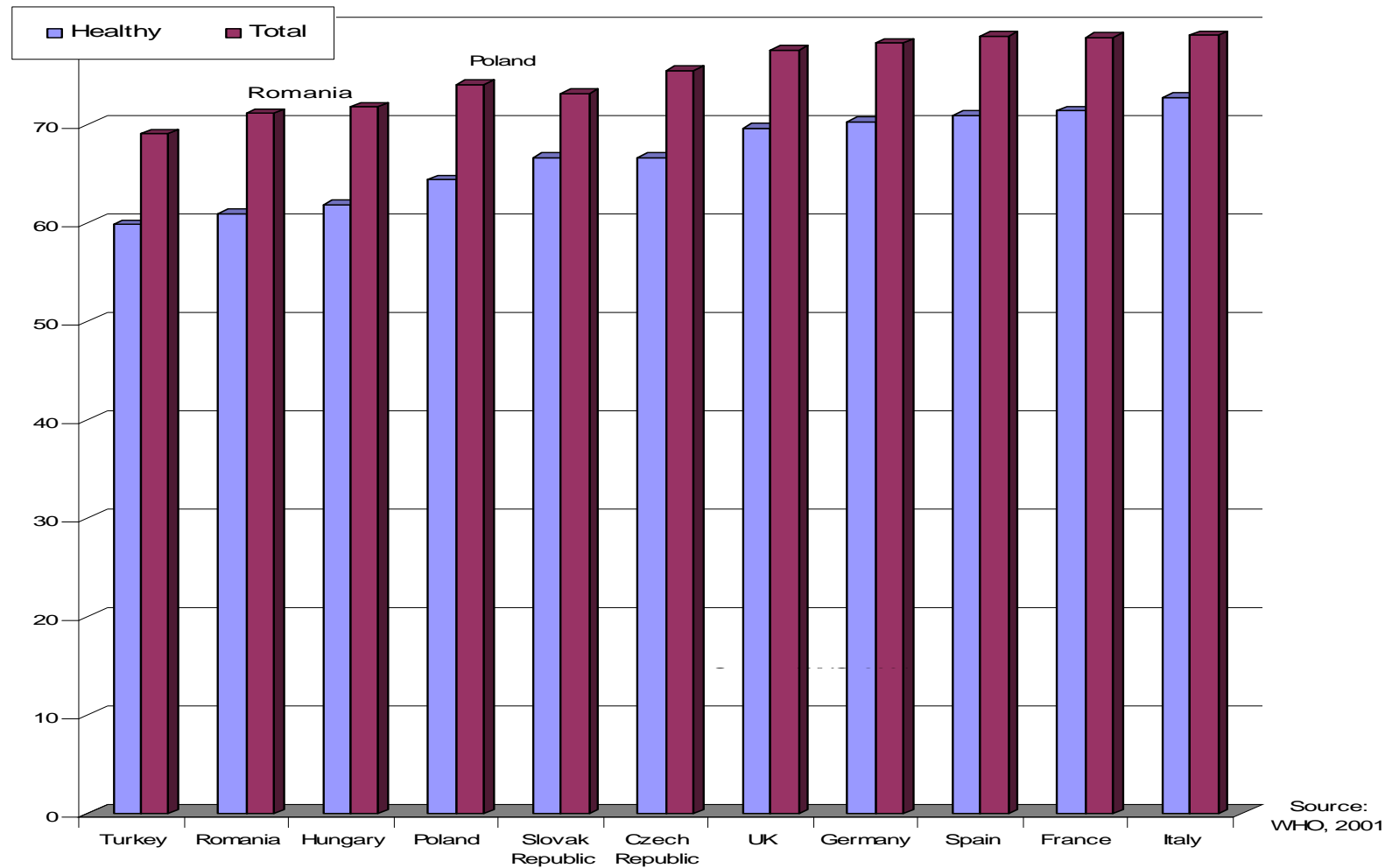
—△— Hungary

—▽— Poland

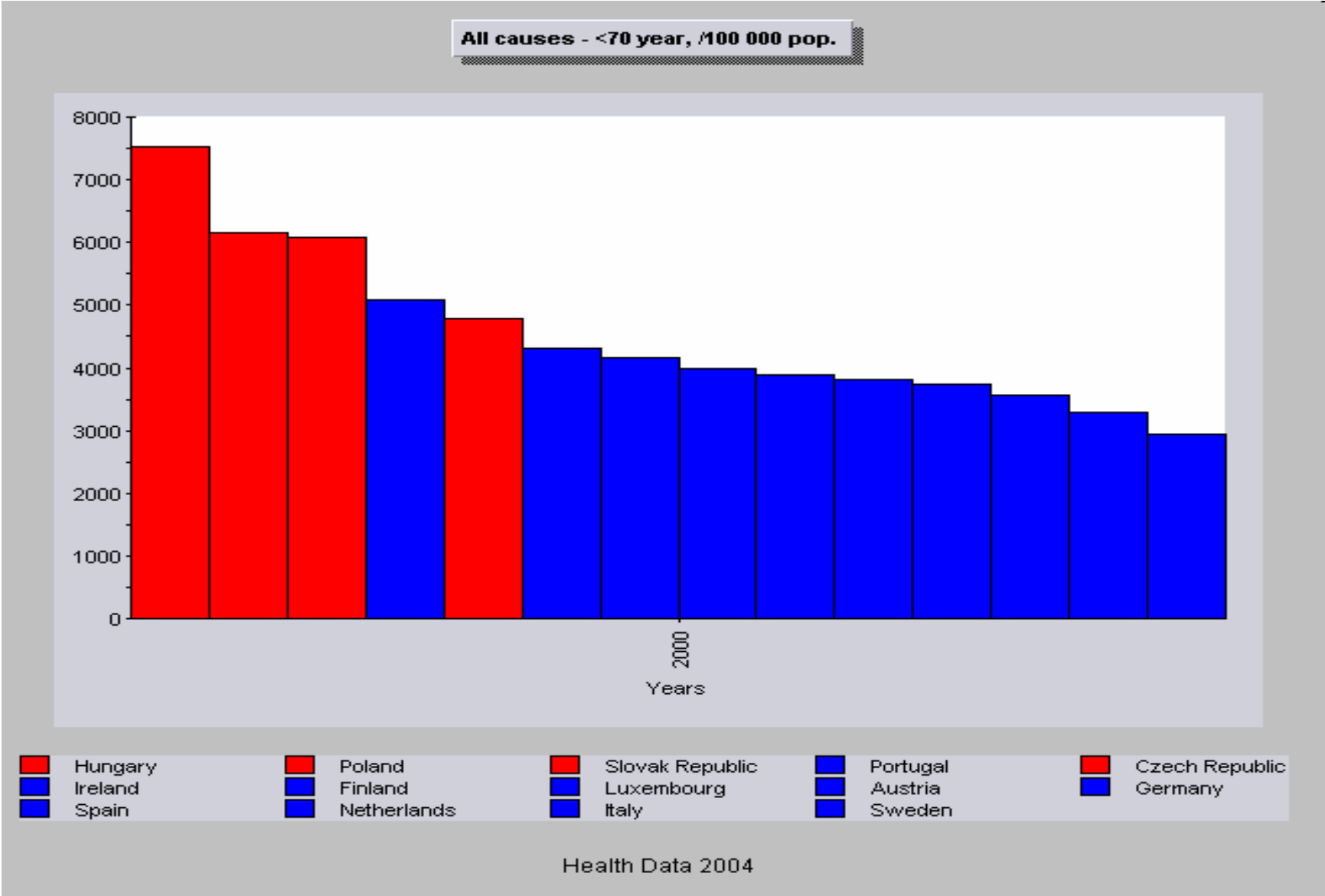
—◇— EU average

—□— CEE average

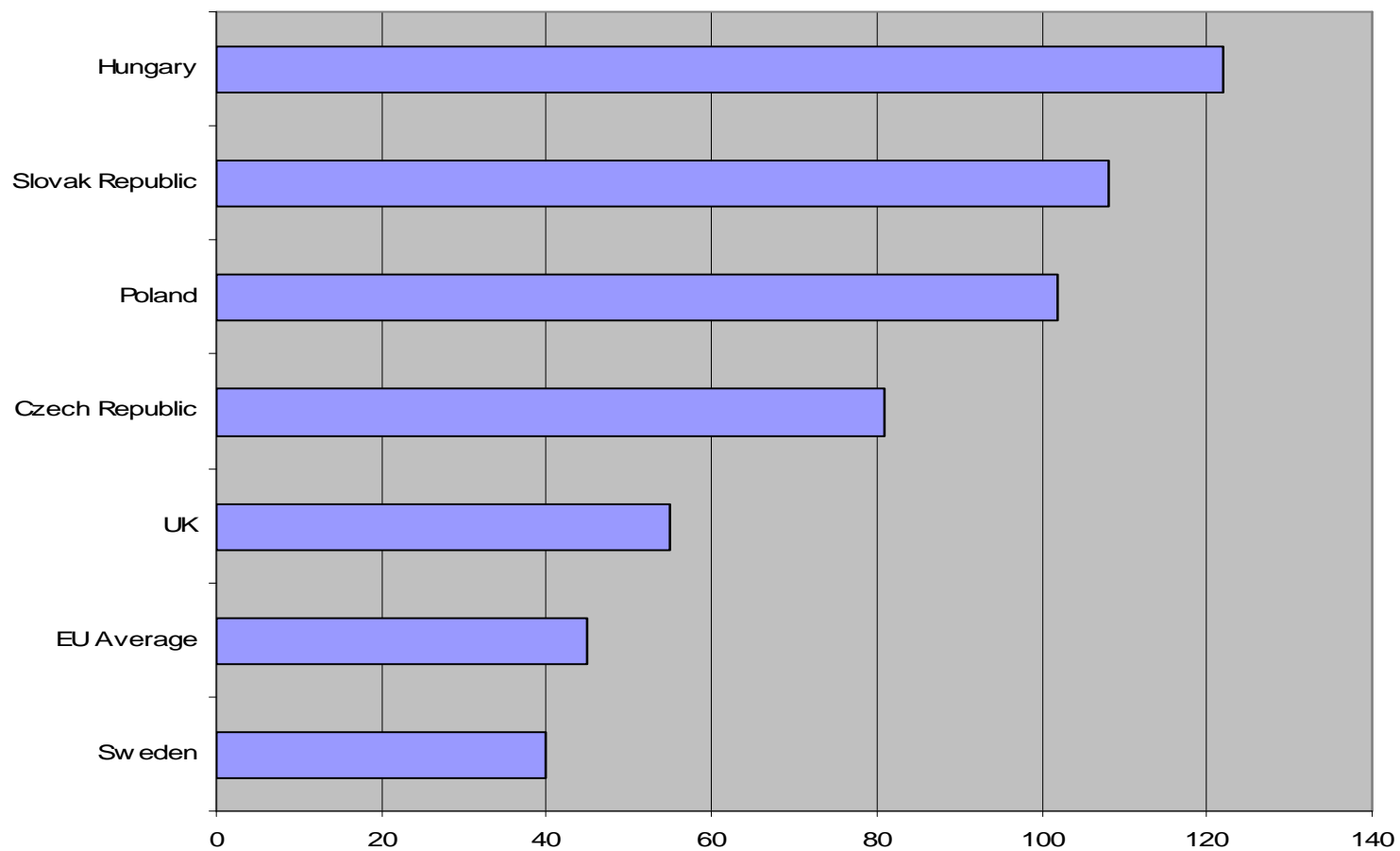
Life expectancy is also lower when adjusted for healthy (disability free) years, 2001



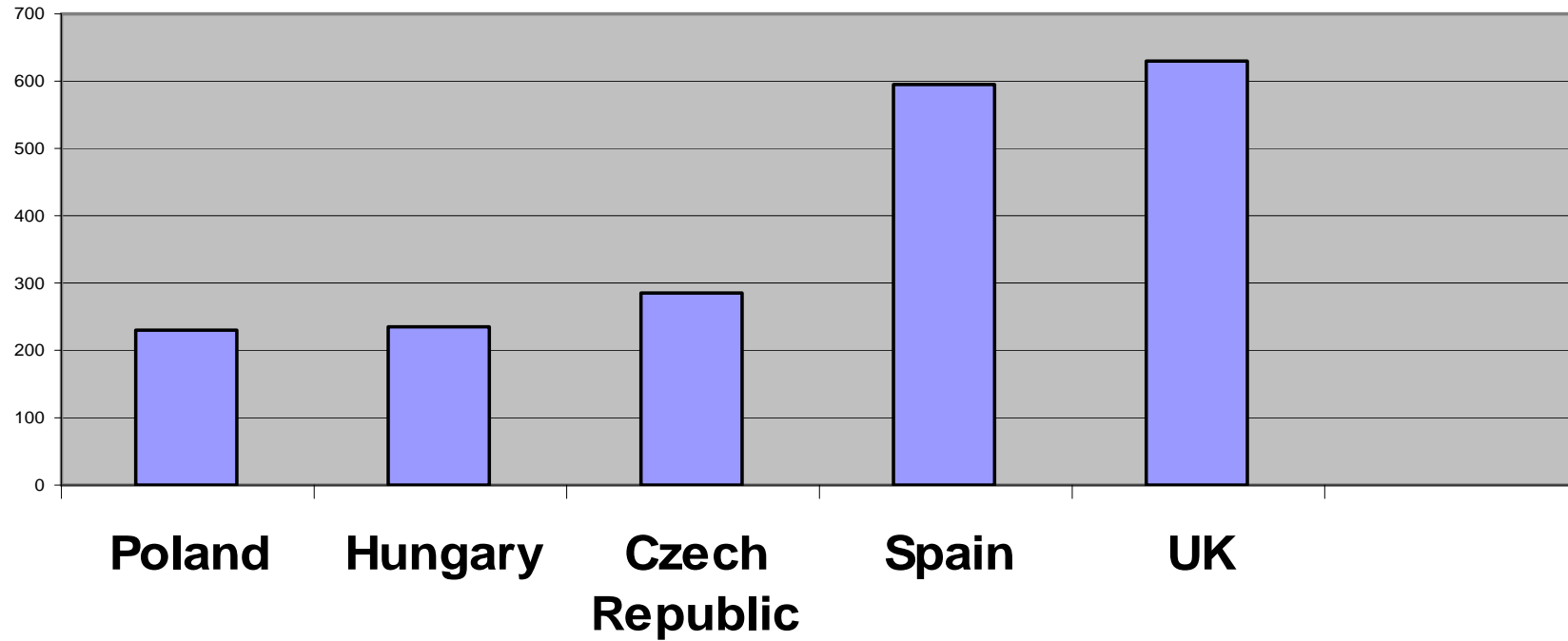
Overall - health problems are more severe than in the EU15



Higher burden of circulatory system diseases (based on standardized death rates)

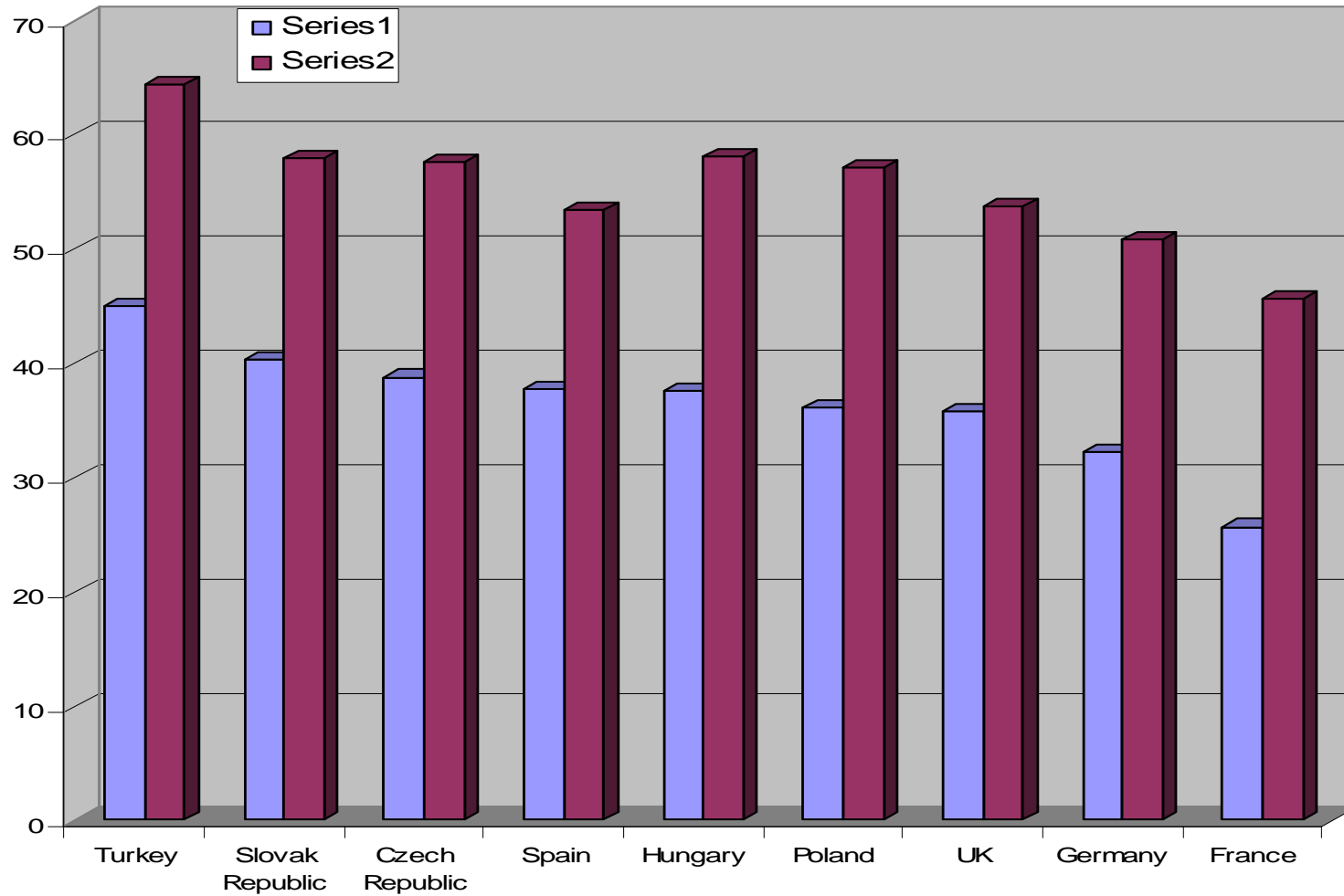


Lower use of statins (per 1000 Inhabitants in volume terms)



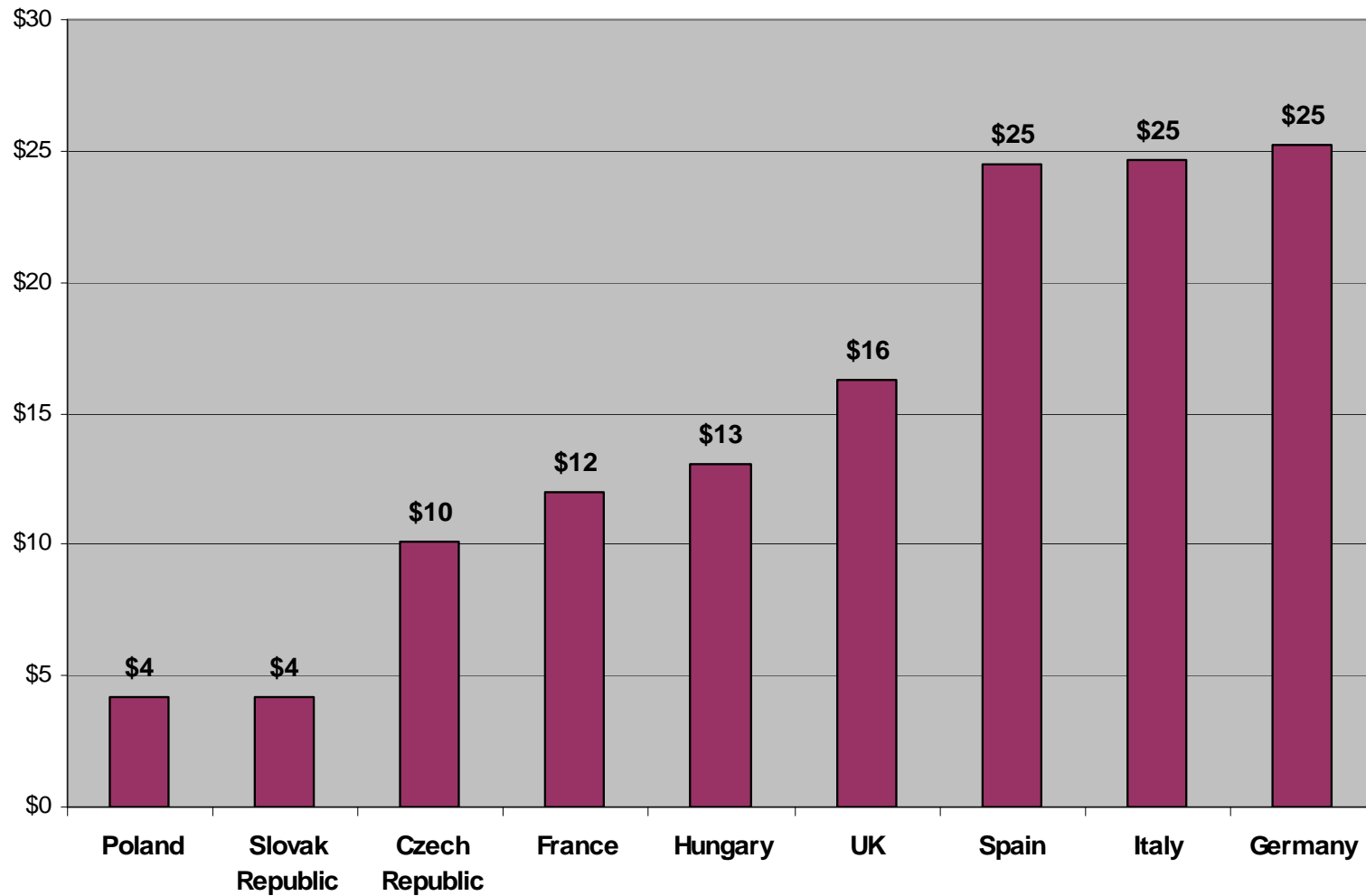
Higher cancer mortality

Breast (1) and Colorectal (2)
Ranking, OECD 2000



Much lower use of anti-cancer drugs (on sales per capita basis)

Anti-cancers + Immunomodulators
Sales per capita in US\$ in 2003

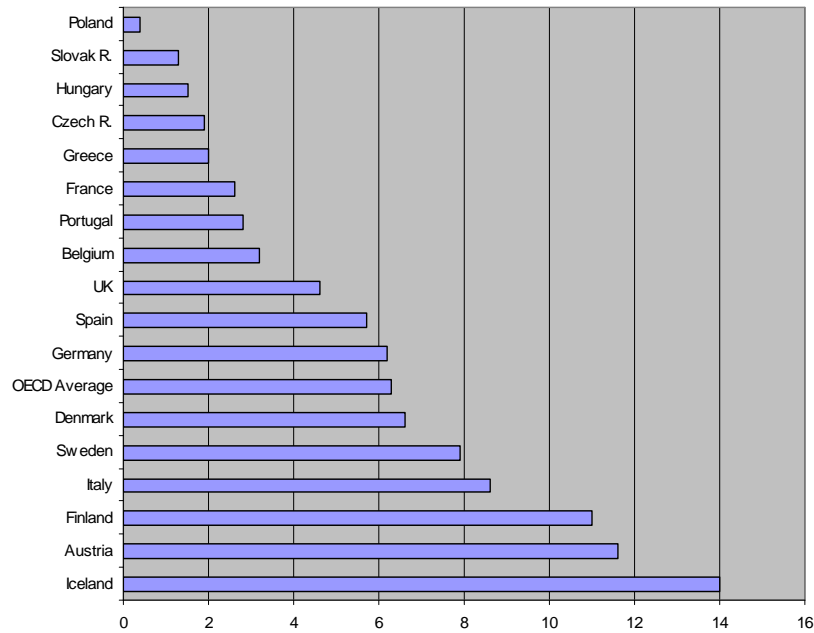


Structural problems – inheritance of the past (compared to EU 15)

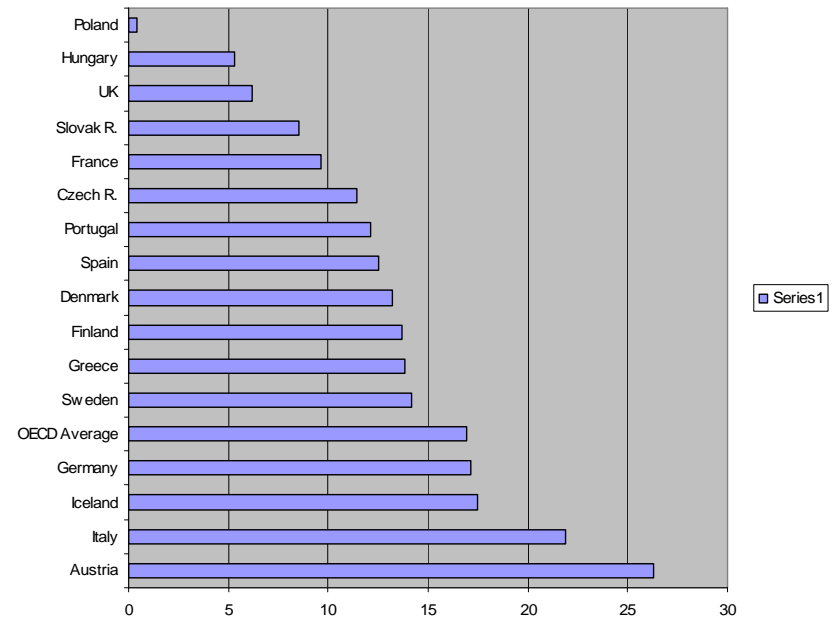
- Relatively high number of hospital beds
- Relatively low number of doctors
- Low socioeconomic status of health professionals
- Insufficient prevention, undeveloped screening – especially in view of high cancer and cardiovascular mortality
- Lack of modern infrastructure, equipment, and efficacious treatments

Lagging medical technology : MRI and CT Scanners

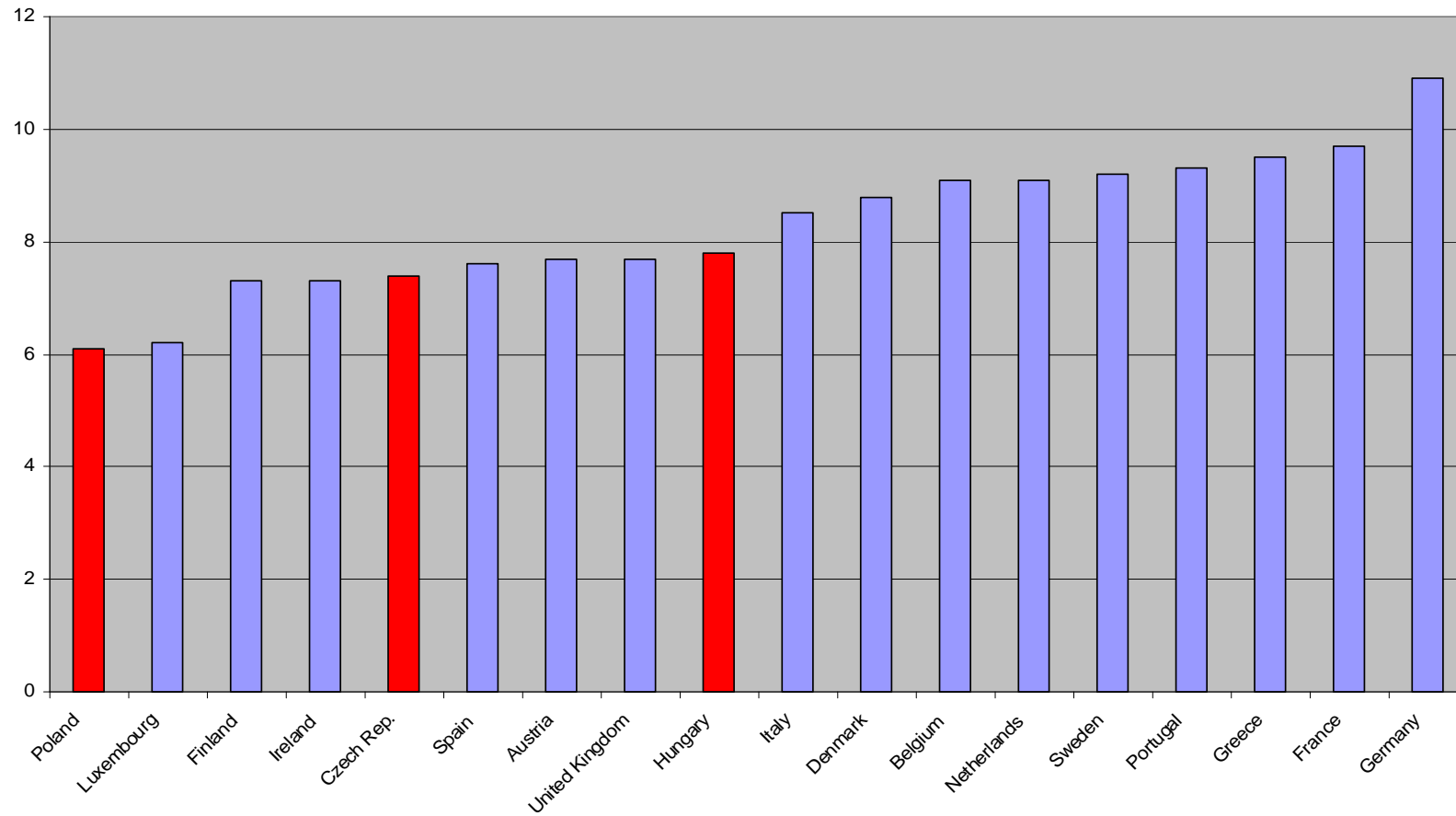
MR/Million, Selected OECD, 2001



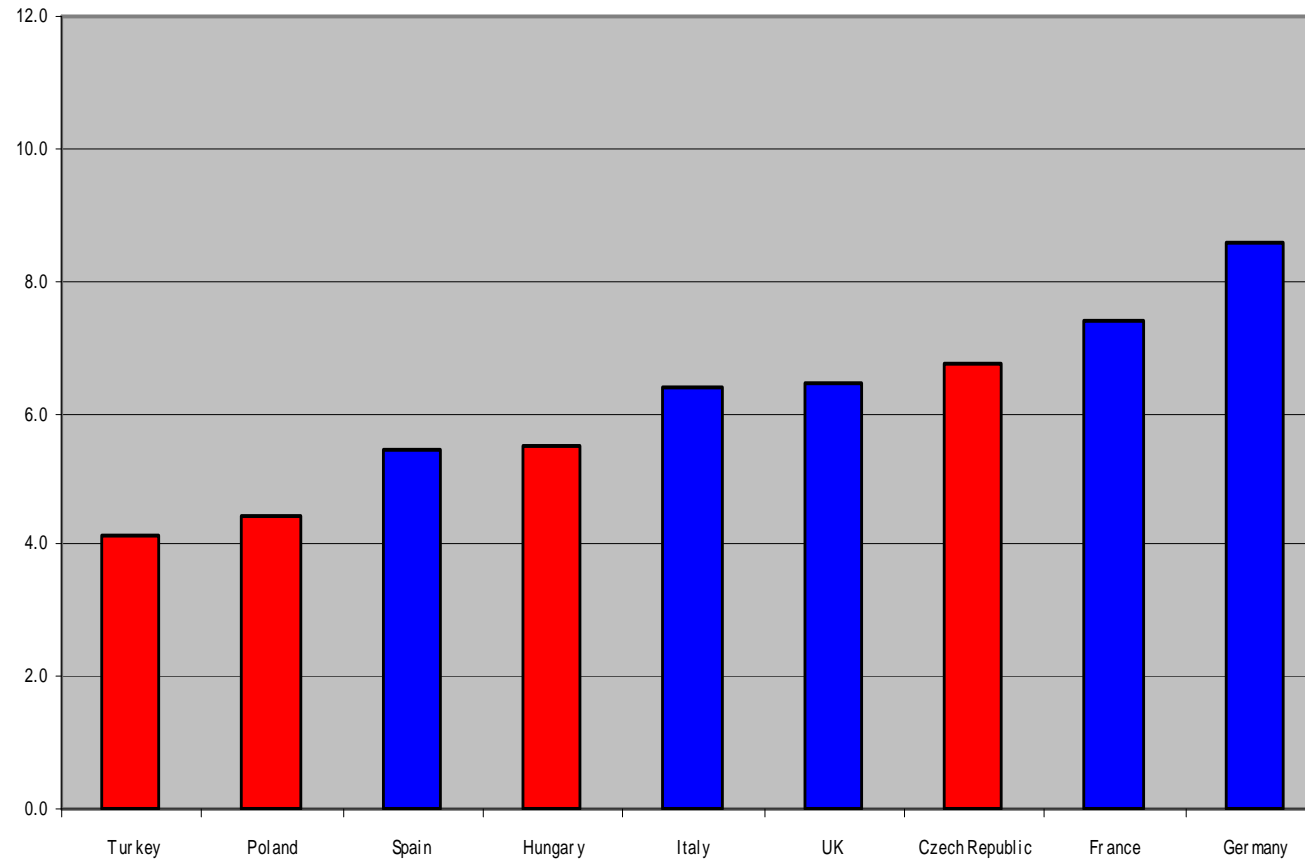
CT Scanner/Million, Selected OECD, 2001



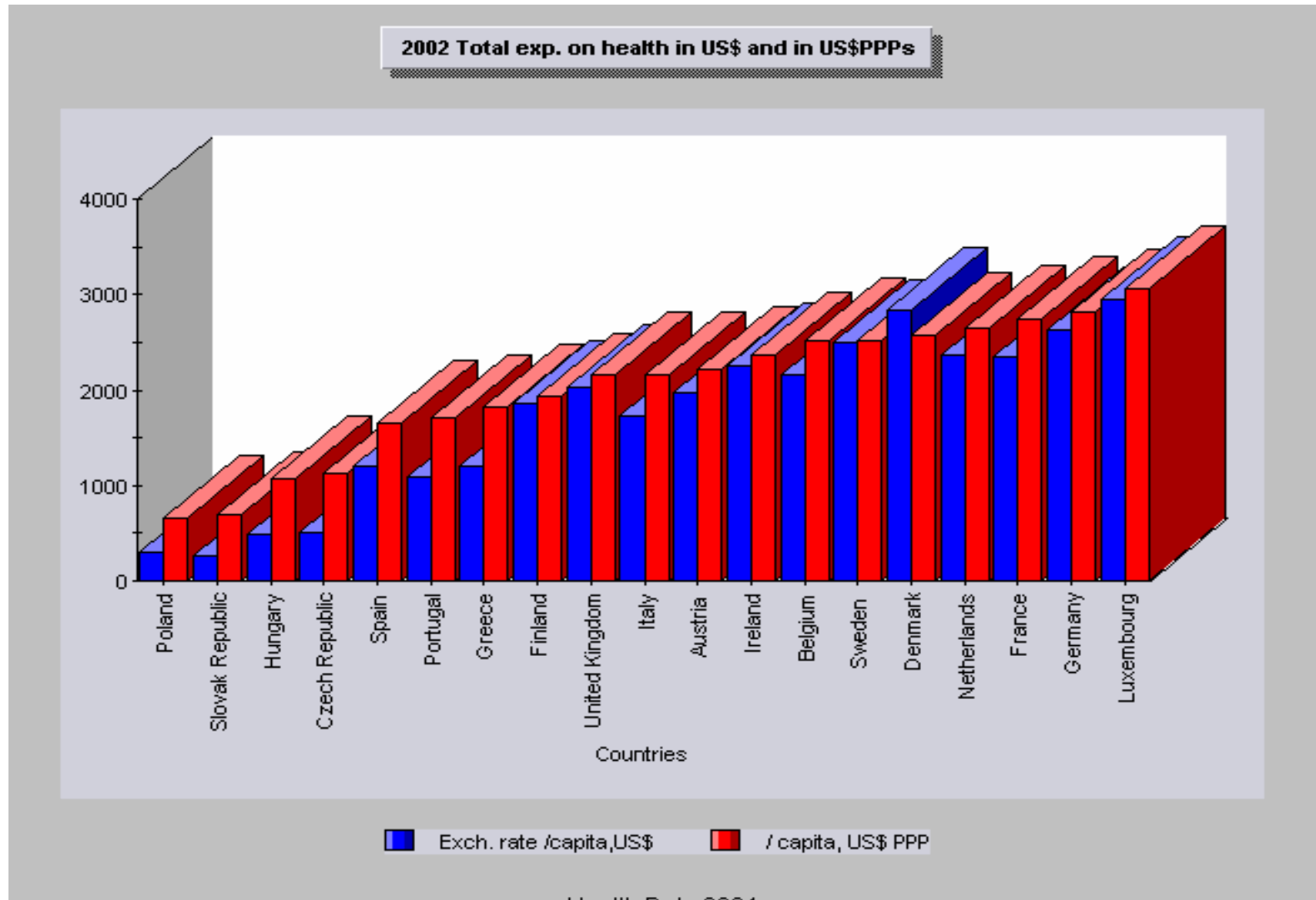
Share of GDP devoted to health care is still lower but growing - 2002 (OECD)



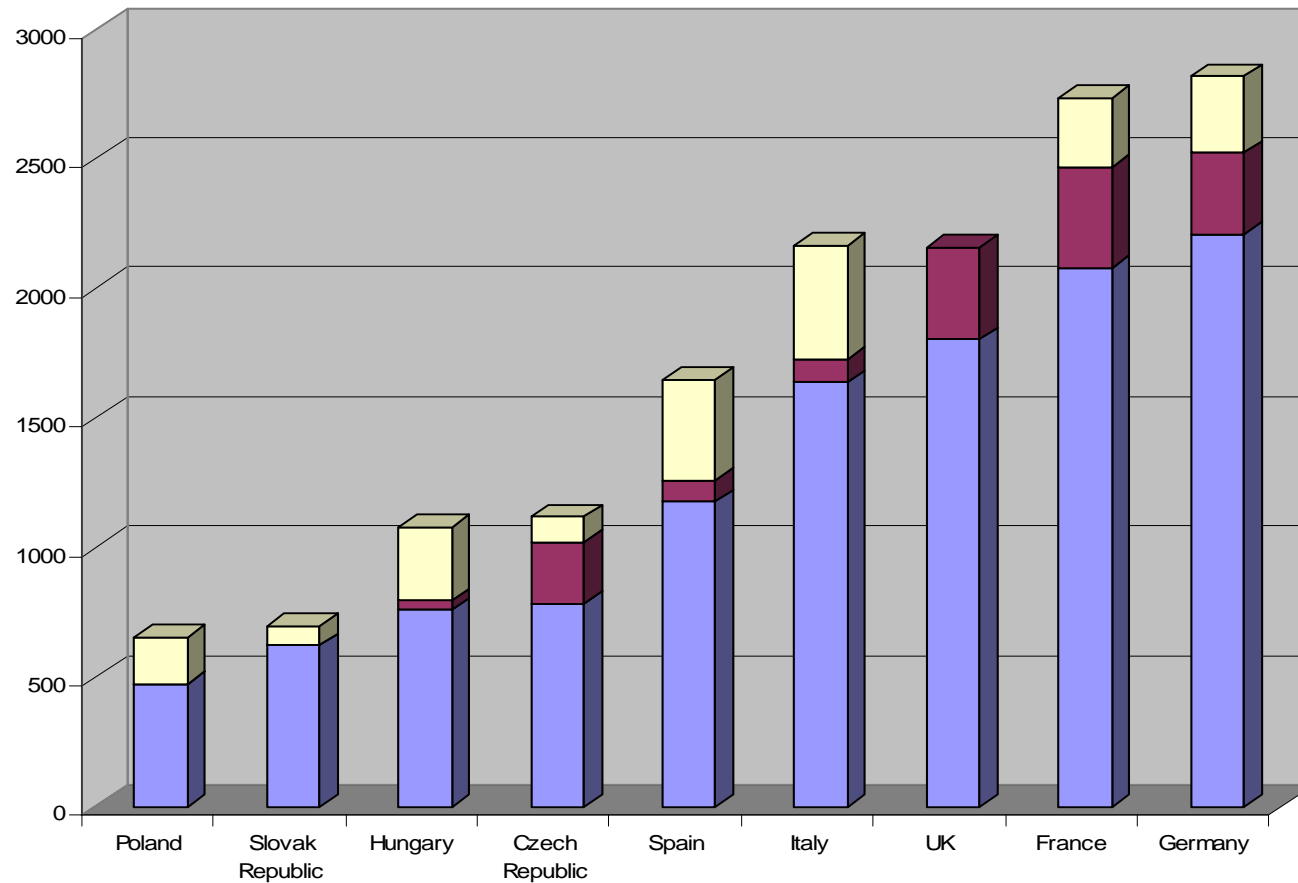
Public expenditure on health care as % of GDP



But the spending is low in absolute terms



Structure and level of financing: public, private insurance, out-of-pocket - 2002



Structure of Financing: Poland

- inadequate public financing
 - Extensive guaranteed basket of services
- inefficient use of significant private financing
 - Inadequate private insurance
 - Large burden of out-of-pocket payments
 - Informal payments

Structure of financing: Czech Republic

- public expenditure closer to EU average
- emerging private insurance
- lower out-of-pocket payments
- low informal payments

Informal payments

- supplement inadequate funding
- contribute to high out-of-pocket payments
- hide the true amount of resources devoted to health care
- distort incentives
- contribute to inequity
- could be formalized?
- trends?

Informal Payments - Study

- Informal Payments -Central and Eastern Europe Health Network (CEEHN) and Harvard School of Public Health in Czech Republic, Hungary, Poland, Romania with the help of MSD in 2002:
 - Jagiellonian University, Krakow, Poland
 - Masaryk University, Brno, Czech Republic
 - Semmelweis University, Budapest, Hungary
- Turkey
 - Hacettepe University

Main findings:

- Formal out-of-pocket payments (OOP) prevail in outpatient care and they are mainly for pharmaceuticals
- Formal OOP were found largest in Hungary
- Informal OOP are mainly associated with episodes of inpatient care, particularly surgery.
- Informal payments were marginal in the Czech Republic, more significant in Hungary, Poland, Romania(41% of OOP) . In Romania they were found to present barrier to access to inpatient care facilities.
- Informal payments in the Turkish study accounted for 25% of OOP. The study exposed equity issues as the poorest category of insureds made informal payments in public in-patient facilities.

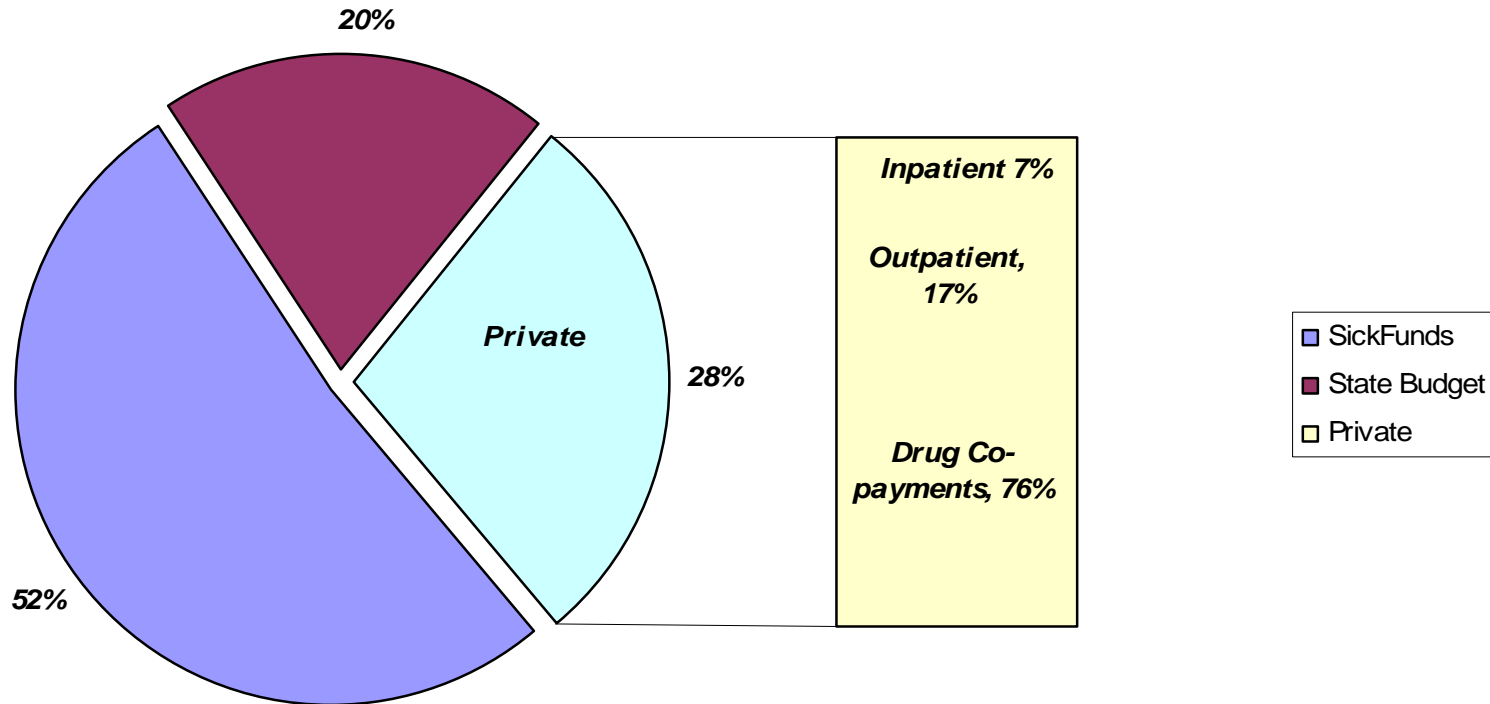
Informal payments - perceptions

- Poland – the Anti-Corruption Program of the Batory Foundation found in 2001 that Poles regard public health as the second most corrupt area of public life (after politicians)
- 61% of patients gave informal payments in the past 10 years, 70% in cash to skip waiting list, guarantee access to hospital treatments. Most payments were to doctors.
- Although the attitudes to OOP were generally negative, the studies detected some willingness to pre-pay a small monthly amount for drugs.

Informal payments – remedies?

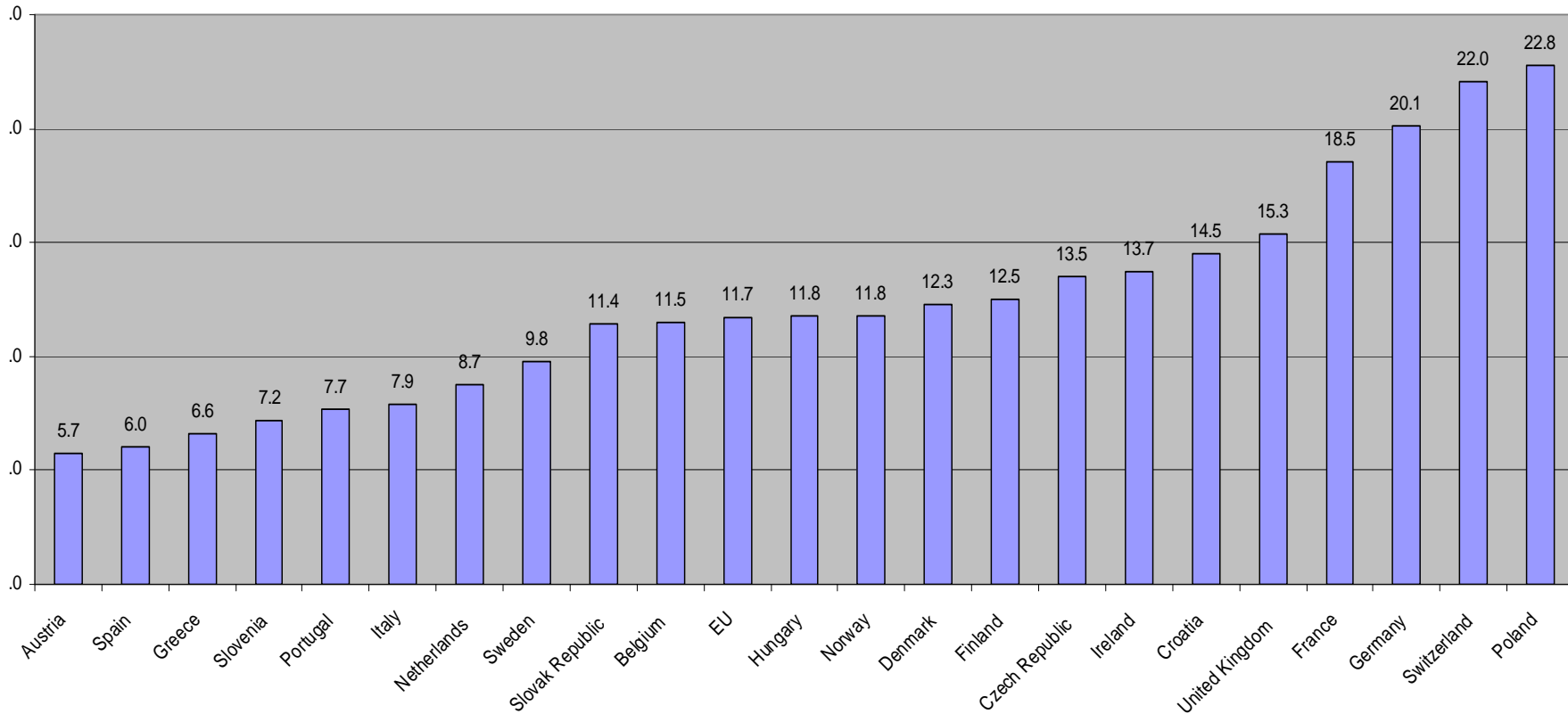
- Reforms of remuneration of physicians
- Defined basket of guaranteed services by the state
- Voluntary private insurance
- Effective control of financial procedures in the hospitals

Private spending in Poland



With limited outlays on medicines, large share is spent on non-Rx pharma (e.g., Poland)

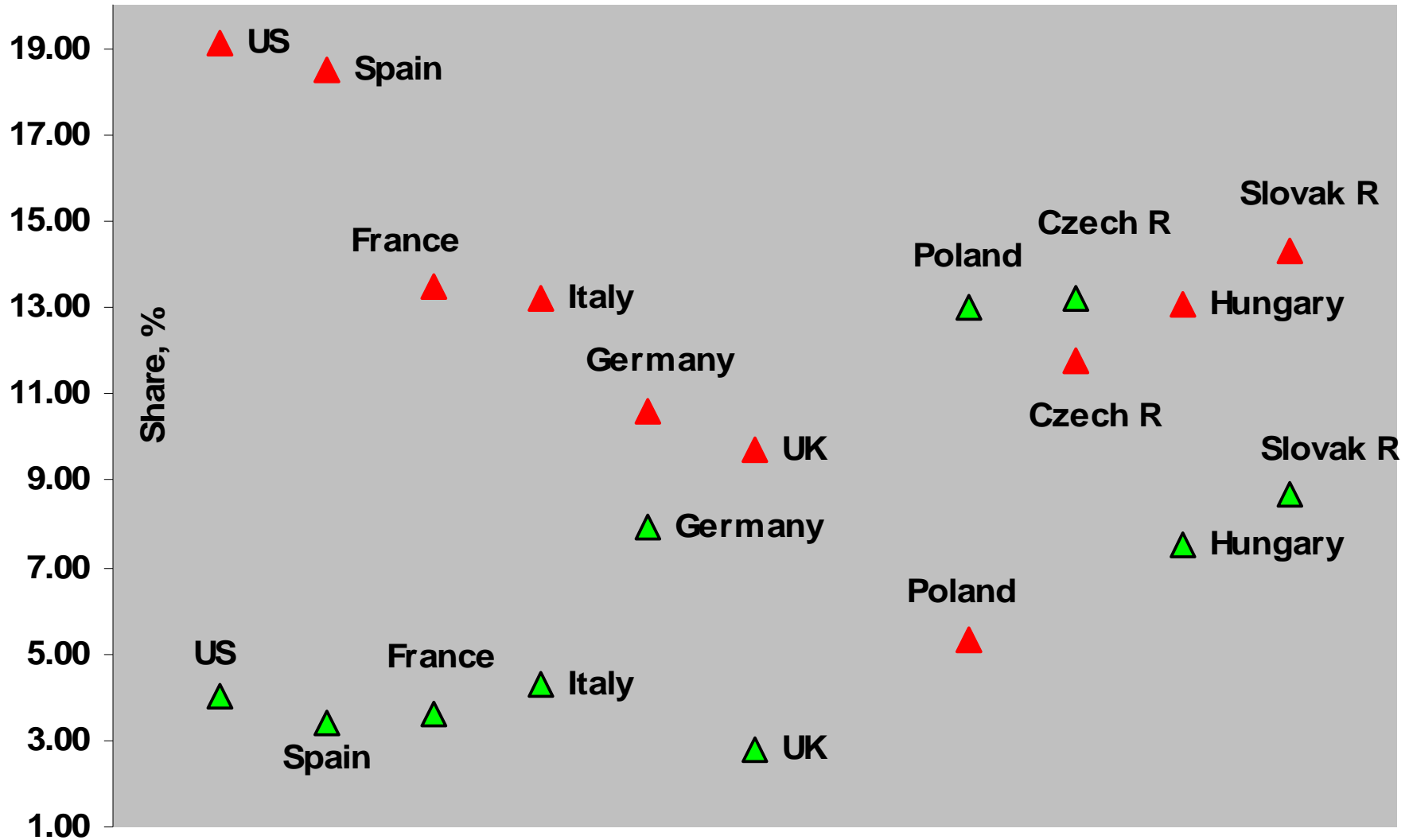
Non-prescription medicines market (1) as a percentage of the total pharmaceutical market at retail prices - 2002



Within Rx products, there is probably more room for more rational expenditure

- Branded generics seem to take a large share that could be allocated to original innovative products
- In some countries, e.g. Poland, no new innovative products were admitted to reimbursement since 1998

New Product Introduction(1999-2003)



What role for the private sector?

- Large out-of-pocket expenditure - what prospects for private voluntary insurance?
- Different findings (Poland):
 - Skepticism as in “Social Diagnosis”, 2003 or
 - Optimism according to PENTOR survey in Poland
 - 70% willing to co-pay for medical care (July 2003)

Large co-payments for pharmaceuticals – Rx and non-Rx

- What prospects for reimbursement reforms?
- Polish report on drug management, June 2004 (Expert Group, School of Business, Warsaw Politechnic)

Reimbursement reforms

- Transparent system
- Reimbursement based on evidence
- Information to patients and doctors
- More effective competition – current price controls favor higher-price branded generics
- Rational co-payments for most, subsidy for the poorest
- Effective access to important new drugs