

# The Changing Dynamics in Healthcare Funding

Keiron Sparrowhawk, Morgan Long, Priyanka Patel, Janice Watch; PriceSpective www.pricerspective.com

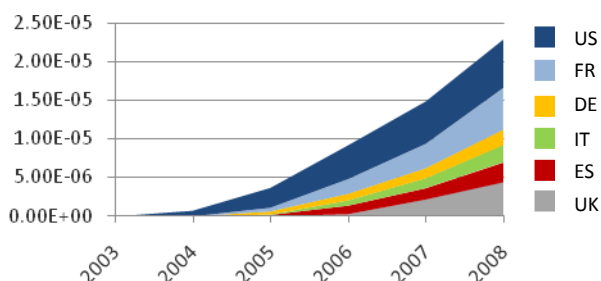
The US can be broadly defined as having three sources of funding (private insurance, out-of-pocket funding and public funding through Medicare/Medicaid). This funding triangle can lead to varying degrees of inequality in the healthcare system. Meanwhile, European markets generally fund healthcare either through statutory health insurance schemes or by the government with very little being paid for directly by the patient. However, as governments consider how to meet their growing healthcare needs in a global recession, many will look towards a combination of cost reduction and finding new funding sources. This scramble to fund healthcare services will open markets to ideas once thought off-limits: just as the US starts moving towards universal care, some European markets, such as the UK, are considering the idea of supplemental, private provision of healthcare.

## 1. Introduction

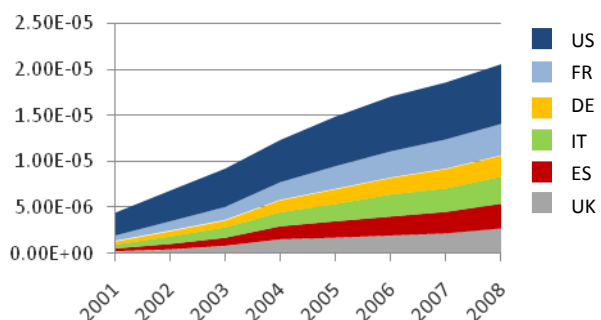
There is general consensus that the quality of healthcare in a country correlates to the level of funding. However, high levels of spending do not necessarily lead to equity of access across the entire population.

The US spends a greater proportion of its GDP on healthcare (~18%) than the EU (average ~10%) and, in comparison, US patients have quicker and better access to innovative, more expensive therapies. Comparative unit sales of novel oncology and rheumatoid arthritis (RA) agents across markets are a striking example of this paradox (Figures 1 and 2).<sup>1,2</sup>

**Figure 1. Sales of a high cost monoclonal antibody indicated in oncology in the US and EU5 (Annual Unit Sales per Capita)**



**Figure 2. Sales of a high cost monoclonal antibody indicated for RA in the US and EU5 (Annual Unit Sales per Capita)**



However, the US faces several problems:

- Lack of equity where the non-insured or under-insured have poor access to healthcare
- An inefficient system where 30 cents on the dollar are spent on administration
- A Congressional Budget Office projection that spending on healthcare will rise to 28.3% GDP in 2050<sup>3</sup>

In the EU, equity is generally assured, and compared to the US, Europe uses its resources more efficiently.

However, Europe faces its own problems:

- Overall lack of funding provision and budget deficits in many countries
- Access to newer therapies is highly restricted in many markets

Given these problems it is our contention that:

- The level of healthcare funding a country can sustain is linked to the number of major funding sources
- Efficient use of healthcare funding is required to ensure equity of access
- Healthcare provision and funding in the US and EU are evolving such that the structure of the systems is becoming more similar

**Figure 3. The six major markets are moving to a more diverse funding matrix and will begin to resemble each other**



<sup>1</sup> Congressional Budget Office Analysis: *The Long-Term Economic Effects of Some Alternative Budget Policies*, May 19 2008.

<sup>2</sup> IMS sales data

<sup>3</sup> Congressional Budget Office Analysis: *The Long-Term Economic Effects of Some Alternative Budget Policies*, May 19 2008.

## 2. *The Changing Dynamics in Healthcare Funding*

The US broadly funds healthcare through three main sources (2007)<sup>4</sup>:

1. Private insurance provided to individuals or en-mass as part of an employment contract (41%)
2. Patient out-of-pocket funding (13%)
3. Public funding through Medicare/Medicaid obtained via federal and state taxes (46%)

This “funding triangle” enables the US to devote a higher proportion of its GDP to healthcare than other countries, but there are still problems of inequality of access within the healthcare system.

Alternatively, European countries fund healthcare by public means through statutory health insurance or direct taxation. There is limited private or direct patient funding.

However, as governments worldwide devise strategies to meet their growing healthcare needs, they are seeking ways to use their funds more efficiently as well as establishing new funding sources. This will open governments to ideas once thought off-limits. For example, in some areas the US is moving towards universal care, whereas European markets are considering the idea of supplemental, private provision of healthcare or encouraging higher patient co-pays.

To better understand the question of how healthcare funding is evolving, this analysis reviews key policy changes that have been introduced or considered. This research suggests that while the US is at a critical point in addressing the inefficiency and inequality in its healthcare system, European markets have reached a financial threshold (ceiling) in terms of the cost of providing equitable care to all patients.

## 3. *Addressing Inequality in America*

### *Expanding Coverage at the Federal Level*

In 2006, introduction of Medicare Part D added \$40.5 billion in government expenditure to subsidize private plans for enrollees prescription drug costs based on a standard capitated payment.<sup>5</sup> This plan marked a significant shift in the provision of prescription pharmaceuticals in the US from private to public funding.

President Obama’s planned healthcare reforms will increase government funding through a combination of increasing federal programs and novel federal subsidies. This will dramatically increase coverage for the uninsured and make healthcare more affordable for those in the lowest income brackets. Key features of the reform include a government run, subsidized healthcare plan that will compete with private agencies, undefined expansion of Medicaid and the State

Children's Health Insurance Program (CHIP) and a mandate for the government to subsidize catastrophic healthcare costs incurred by employers.

### *At the States' Initiation*

Several states have also increased the public contribution to healthcare. Most notably, the 2006 Massachusetts Health Care Reform Law (MHCRL) expanded local funding by providing publically subsidized private insurance to individuals and families who were not eligible for existing state subsidized programs or employer sponsored coverage. The act included a mandate that every state citizen must pay for healthcare at a level decided by the state, making Massachusetts the first and, to date, only state to mandate universal healthcare. However, current costs are now ballooning because expected efficiencies did not materialize, and the state's health costs have increased 42% since 2006.<sup>6</sup>

Other states attempting to address inequality in healthcare include California, Hawaii, Iowa, Maryland, Minnesota, Missouri, New Jersey, New Mexico, Ohio and Wisconsin; in 2008 or 2009 each has introduced legislation similar to MHCRL, but proposed reforms have not been enacted. Additionally, since 2007, 36 states have expanded Medicaid eligibility and increased public expenditure for healthcare.

### *The Way Forward in America*

While it is clear that America is taking strides to increase inequalities in healthcare coverage by expanding public expenditure, Massachusetts reforms suggest that broad sweeping plans to address the uninsured require careful consideration if costs are not to spiral. Some may conclude from this that direct provision of healthcare (as in Europe) may be a more efficient means of administration.

## 4. *Addressing the Lack of Funding in Europe*

Europe is also poised for a change in the relationship between private insurance and the statutory public system. European markets struggle to adequately fund new, expensive therapies while maintaining universal care programs. Public healthcare systems are facing chronic deficits and cost containment policies have had a limited impact. EU governments are investigating reforms that would shift some responsibilities from public to private institutions or even individuals.

### *France*

To address a deficit in its healthcare system, France has de-listed many drugs and has sought to increase the use of generics. France is now the third largest generic market in Europe after the UK and Germany.<sup>7</sup>

A centralized public health insurance system (*Regime Generale*) provides healthcare for most of the French

<sup>4</sup> Hartman et al. *National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998*. Health Affairs Vol. 28 No.1 pp 246-261.

<sup>5</sup> IBID.

<sup>6</sup> Sack, Kevin. *Massachusetts Faces Costs of Big Health Care Plan*. New York Times, March 15 2009.

<sup>7</sup> *Emerging Generic Drug Markets in Europe*. Espicom. December 2007.

population. Coverage is incomplete but complemented by three private health insurances<sup>8</sup>:

1. The *Mutuelles*, which constitute a majority of the total private insurance market
2. Non-profit provident institutes
3. For-profit insurance companies

The *Mutuelles* sometimes reimburse products not covered by the public system (e.g., Relenza for influenza). Since 1980 the proportion of the population covered by the *Mutuelles* has grown from 68% to 85%.<sup>9</sup> This trend suggests a demand for private health insurance.

### Germany

The German healthcare system (GKV) is characterized by a mix of public and private funding through the statutory health insurance system. About 90% of the total population is insured by 280 competing sick funds, *Krankenkassen* (Ks), with ~10% covered by private health insurance.<sup>10</sup>

Germany's healthcare system is in a state of flux with several, recent reforms introduced to curb rising costs. A notable 2007 mandate increased the Ks's purchasing power and provided authority to negotiate drug discounts directly with manufacturers.<sup>11</sup> Consolidation of the Ks and the growing presence of private health insurance are expected.

### Italy

The Italian National Health Service is financed by statutory, general taxation which guarantees uniform provision of comprehensive healthcare. As long ago as 1994, Italy limited public expenditure on pharmaceuticals and introduced Class C drugs, which are paid entirely by the patient (e.g. SSRIs).<sup>12</sup> From 2001 there has been devolution of fiscal autonomy from the federal healthcare funding body to the 20 regions to ensure more efficient allocation of monetary resources. Some regions have incorporated co-pays to Class A drugs to improve funding and deter waste.

### Spain

Spain offers universal coverage and finance from general taxation, but has a relatively greater reliance on patient out-of-pocket costs compared to other EU5

markets. Additionally, 15% of the Spanish population is now covered by private health insurance.<sup>13</sup>

### UK

Healthcare in the UK is funded through general taxation and national insurance contribution with relatively few copayments. Indeed, contrary to the rest of the EU, Scotland and Wales are removing prescription charges.

The UK created the National Institute for Health and Clinical Excellence (NICE) to help address problems of inequality of access and to improve access to innovative therapies, especially in cancer care. Despite NICE, the UK still faces criticism over these two problems: postcode prescribing and access. The UK has faced international media scrutiny of its limited access to new cancer agents such as Avastin.

This pressure has caused the Government to issue guidance on allowing patients to pay for, or have private insurance to cover, treatments not available on the NHS without forfeiting other NHS services.<sup>14</sup> This announcement marks a significant shift in the mindset of how healthcare provision is considered in the UK and, in the future, should result in an increase in the level of private insurance for drugs in the UK.

## 5. Conclusion

Despite a range of cost containment measures, healthcare systems struggle to fund the rising cost of healthcare. While the US appears set on a course towards a greater reliance on government funded healthcare to solve its problem of inequality of access, European markets are realizing the necessity of additional funding sources to improve access to innovative drugs. In order to stretch budgets to meet growing healthcare needs, the US and major EU markets are moving to a more diverse funding matrix for healthcare and, along the way, will more closely resemble one another.

PriceSpective is a management consulting firm specializing in innovative strategies to identify, capture and communicate value for products portfolios and companies in the biopharmaceutical area.

For further details please contact:  
**Keiron Sparrowhawk, Partner**  
ksparrowhawk@pricespective.com

<sup>8</sup> *Surveying, Assessing and Analysing the Pharmaceutical Sector in the 25 different EU Member States*- Commissioned by European Commission/France; OBIG 2006.

<sup>9</sup> IBID.

<sup>10</sup> IBID.

<sup>11</sup> *Moving toward more sustainable healthcare financing in German; Economics Department Working Paper No.612; OECD 2008.*

<sup>12</sup> *Change in prescribing patterns of general practitioners in Italy before and after the Reform Drug Act; Pharmacy World & Science; Volume 17, Number 5/ September 1995*

<sup>13</sup> *Surveying, Assessing and Analysing the Pharmaceutical Sector in the 25 different EU Member States*- Commissioned by European Commission/Spain; OBIG 2006.

<sup>14</sup> Guidance on NHS patients who wish to pay for additional private care [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_096428](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096428)