Unclassified **ECO/WKP(2006)66**

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

15-Jan-2007

English text only

ECONOMICS DEPARTMENT

ECO/WKP(2006)66
Unclassified

HEALTHCARE REFORM IN RUSSIA: PROBLEMS AND PROSPECTS

ECONOMICS DEPARTMENT WORKING PAPERS No. 538

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JT03220416

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ABSTRACT/RÉSUMÉ

Healthcare Reform in Russia: Problems and Prospects

This paper examines the prospects for reform of Russia's healthcare system. It begins by exploring a number of fundamental imbalances that characterise the current half-reformed system of healthcare provision before going on to assess the government's plans for going ahead with healthcare reform over the medium term. The challenges it faces include strengthening primary care provision and reducing the current over-reliance on tertiary care; restructuring the incentives facing healthcare providers; and completing the reform of the system of mandatory medical insurance.

This paper relates to the *OECD Economic Survey of the Russian Federation 2006* (www.oecd.org/eco/surveys/russia).

JEL classification: I11, I12, I18

Keywords: Russia; healthcare; health insurance; competition; primary care; hospitalisation; pharmaceuticals; single payer;

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La reforme du système de santé en Russie: problèmes et perspectives

La présente étude analyse les perspectives de réforme du système de santé en Russie. Il commence par explorer un certain nombre de déséquilibres fondamentaux qui caractérisent le système actuel, en état de semi-réforme, avant de passer en revue les projets du gouvernement à moyen terme. Les principaux enjeux sont de renforcer les soins primaires et réduire le recours excessif aux soins tertiaires, de réexaminer les incitations auxquelles font face les prestataires de soins et de mener à son terme la réforme de l'assurance-maladie obligatoire.

Ce Document de travail se rapporte à *l'Étude économique de l'OCDE de la Fédération de Russie 2006* (www.oecd.org/eco/etudes/russie).

Classification JEL: I11, I12, I18

Mots clés: Russie; système de santé; assurance-maladie; compétition; soins primaires; hospitalisation; produits pharmaceutiques; payeur unique;

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Healthcare Reform in Russia: Problems and Prospects

by

William Tompson[1]

1. Since 1991, the centrepiece of healthcare reform in the Russian Federation has been the transition from an integrated, hierarchical model of healthcare provision to a more decentralised, contested and insurance-based system of public healthcare. That transition is still unfinished. The initial steps were taken in 1991–93, but little was done in the decade that followed to complete the process, and it is this that accounts for many of the problems facing Russia's healthcare system. The recent reinvigoration of healthcare policy is thus a welcome development, for it is critical that Russia act decisively and systematically to complete the healthcare reforms begun over a decade ago. This paper examines the problems associated with the half-reformed state of Russia's public healthcare system before considering the steps that must be taken to bring the reform to completion. It begins by placing healthcare reform in its larger policy and institutional context, before proceeding to outline the structural imbalances and incentive problems that affect the system, largely as a result of the incomplete reforms of the early 1990s. This is followed by an analysis of the steps that need to be taken to address these problems.

The context of healthcare reform

Healthcare reform must be addressed in the larger context of Russia's health and mortality crisis

2. Russia continues to struggle with a health and mortality crisis. The deterioration in basic indicators of health and human welfare that began in the Soviet period and accelerated after the Soviet collapse has yet to be overcome. Recent economic growth seems to have had little impact on key indicators of human welfare (Table 1). Life expectancy at birth has failed to recover, having fallen sharply (mainly for men) in the 1990s. Mortality rates have fallen only slightly and remain at levels unseen for decades. The share of deaths induced by infectious diseases, which are traditionally related to living standards, is also high for a country at Russia's level of development, and the incidence of tuberculosis and other "poverty-related illnesses" remains high, although viral hepatitis infection rates have fallen. This is not to suggest that there has been no improvement in recent years: while life expectancy overall has not yet risen much from the lows of the 1990s, there has been a significant rise in the average life expectancy of persons diagnosed with chronic illnesses over the last five years. This suggests that the economic recovery and rising healthcare expenditure are having a positive impact on healthcare provision. Nevertheless, the overall picture remains extremely grim.

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1. The author works in the Country Studies Branch of the OECD Economics Department. This paper draws on material originally prepared for the *OECD Economic Survey of the Russian Federation*, which was discussed in the OECD's Economic and Development Review Committee on 25 September 2006 and published in November 2006. The author is grateful to the many Russian and western officials, experts and businessmen, too numerous to list here by name, who discussed healthcare issues with the *Survey* team. He is also indebted to colleagues in the Economics Department, in particular Val Koromzay, Andrew Dean, Andreas Woergoetter and Christian Gianella for useful discussions, comments, and drafting suggestions. Elizabeth Docteur, Jeremy Hurst and Maria Hofmarcher-Holzhackerof the OECD Directorate for Employment, Labour and Social Affairs also provided valuable feedback on an early draft. Special thanks go to Corinne Chanteloup for technical assistance, and to Susan Gascard, Sylvie Ricordeau and Sheila McNally for secretarial assistance.

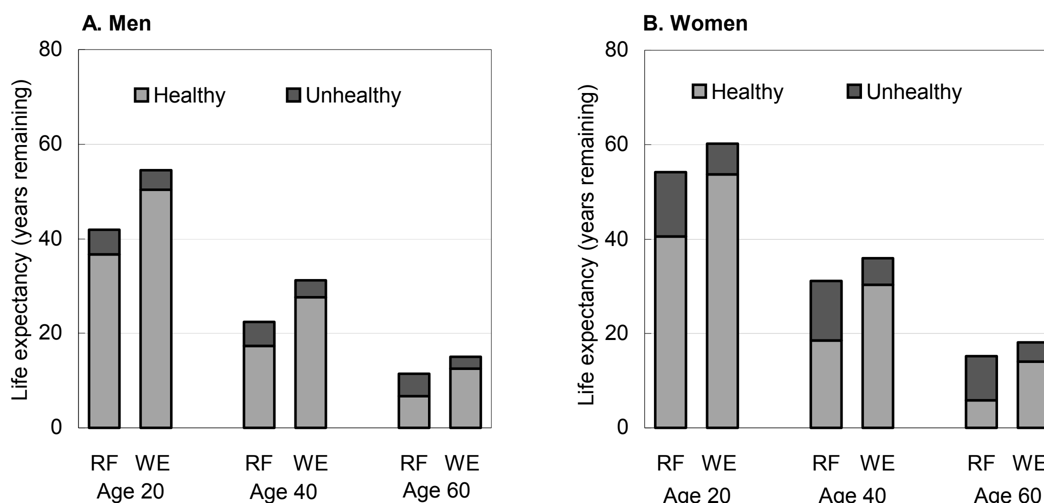
Table 1. Selected health and demographic indicators

	1990	1995	2000	2001	2002	2003	2004
Life expectancy at birth (years)	69.2	64.5	65.4	65.2	65.0	64.9	65.2
• Men	63.7	58.1	59.1	58.9	58.7	58.6	58.9
• Women	74.3	71.6	72.3	72.2	71.9	71.9	72.3
Death rate (/1000)	11.2	15.0	15.3	15.6	16.2	16.4	16.0
Death from circulatory diseases (/100 000)	137.1	225.0	205.0	211.2	227.9	246.7	249.6
Death from respiratory diseases (/100 000)	18.9	38.7	35.4	35.5	39.2	42.2	40.8
Death from diseases of the digestive tract (/100 000)	15.4	35.7	31.8	35.3	40.0	45.9	49.0
Death from infectious and parasitic disease (/100 000)	11.5	25.0	31.2	30.5	32.0	32.8	33.0
Deaths from alcohol poisoning (/100 000)	15.6	41.6	34.0	36.4	39.5	40.5	38.5
Suicides (/100 000)	33.9	56.4	49.8	50.2	47.9	44.5	42.4
Murders (/100 000)	21.4	44.4	38.0	39.0	40.2	37.9	35.6
Tuberculosis cases (/100 000)	34.2	57.8	89.8	87.8	85.5	82.7	83.3
Hepatitis cases (/100 000)	226.7	166.8	163.3	181.4	123.2	97.7	99.1

Note: Data on death rates by cause of death are for the working-age population only.
Source: Federal Service for State Statistics.

3. One of Russia's biggest problems is that it is not only average life expectancy that is exceptionally low for a country at its level of development – *healthy* life expectancy is very low as well (Figure 1). Russians above the age of 40 are far less likely to be healthy than citizens of Western or Central Europe, and the gap is particularly large for Russian women: their average life expectancy at any given age is higher than that of Russian men, but they also tend to spend much more of their lives in ill health.[2]

Figure 1. Life expectancy and healthy life expectancy at different ages
The Russian Federation (RF) and Western Europe (WE), 2002



2. Healthy life expectancy for Russian women is actually *lower* at age 65 than it is for men, even though their life expectancy is almost four years longer.

Source: Andreev *et al.* (2003).

4. Poor health and high levels of preventable, premature death entail enormous human and economic costs. They also pose a threat to economic development as a result of both their long-term impact on secular trends in labour supply and their more immediate economic costs, which include productivity losses, reductions in household income and early exit from the labour force. Moreover, the impact of the health crisis is socially regressive: both the likelihood of chronic illness and the probability that illness leads to early retirement are negatively correlated with income.[3] This points to the need for a broad-based effort to tackle Russia's health and mortality crisis, a central part of which must involve a reform of the healthcare system itself.

5. Few would argue that the roots of this crisis are entirely, or even primarily, to be found in the state of the healthcare system. Indeed, some studies find little evidence of a link between health and mortality outcomes and access to healthcare in Russia.[4] High levels of mortality and morbidity reflect many other factors, including environmental degradation, unhealthy diets and high levels of tobacco and alcohol consumption (particularly among men), high levels of traffic-related fatalities and a sharp rise in murders and suicides.[5] Nevertheless, the evidence suggests that access to quality medical care has declined for much of the population since 1990 and that this aggravates Russia's health problems. Thus, while this paper focuses on the reform of the healthcare system itself – *i.e.* on the delivery of medical services to the population – it should be emphasised that reform of the healthcare system will be insufficient to tackle Russia's health and mortality crisis. Healthcare reform must be undertaken as part of a broader programme of *health* reform, involving a range of policies that extend far beyond the bounds of healthcare delivery, encompassing such issues as: reform of the public health system,[6] greater emphasis on health education and promotion, increased efforts to combat the spread of HIV/AIDS,[7] more effective environmental protection, and steps to reduce Russia's exceptionally high road-death rates.[8] While these problems are beyond the scope of this paper, it is important to recognise that the success of healthcare reform will depend to a significant extent on the success of other measures aimed at improving health and mortality outcomes, particularly those aimed at changing lifestyles.

6. At present, Russia spends a lower share of GDP on healthcare than most OECD countries (Figure 2), although its health expenditure-to-GDP ratio is fairly typical for a middle-income country.[9] In contrast to many OECD countries, cost-control problems are not (yet) at the centre of the reform debate. Indeed, Russia probably needs to spend more on healthcare than it currently does, and the major long-term drivers

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3. On Russia, see World Bank (2005a); Suhrcke (2005). With respect to the impact of epidemic diseases on economic performance, see Bell and Gersbach (2004).

4. Brainerd and Cutler (2005).

5. For a detailed recent analysis of Russia's mortality crisis and possible solutions, see World Bank (2005a). On the economic and human costs, see also Suhrcke (2005).

6. The public health (*san-epid*) system inherited from the Soviet era has decayed substantially since 1990, as a result of under-funding and fragmentation, but there is still much here on which to build in creating a modern public health system (Tragakesand Lessof, 2003).

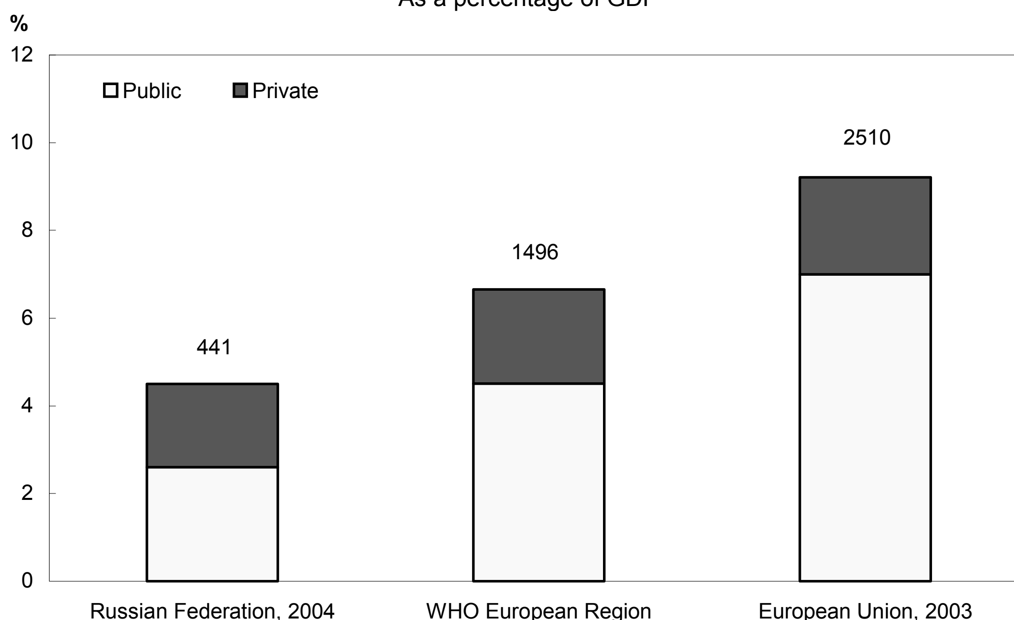
7. HIV/AIDS is not by any means among the leading causes of high mortality at present, but Russia is now experiencing one of the fastest-growing HIV/AIDS epidemics in the world. The long-term consequences of failing to address this issue speedily are potentially catastrophic; see UNDP (2004).

8. ECMT (2006) finds that Russia has the highest road-death rate in Europe.

9. In 2002, Russia ranked slightly below the median among CIS countries in terms of public health spending as a share of GDP.

of healthcare spending – rising incomes,[10] technological change and demographic change – all point to a significant long-term rise in healthcare expenditure. The impact of demography will be particularly important. The Russian population is ageing fast: the proportion of the population above the age of 60 is projected to rise from 17% in 2005 to 31% by 2050.[11] Since healthcare spending per capita on pensioners (women over 55 and men over 60) is typically estimated to be roughly triple the level for working-age adults and double the level for children,[12] the system will come under enormous pressure as the population ages unless the *healthy* life expectancy (HLE) of Russians increases. Russian women, in particular, tend to suffer much more ill health than either Russian men or western women, and the gap increases with age.[13] This is one reason why the success of reform of the healthcare system will depend on broader initiatives aimed at improving Russians' health. Unless healthy life expectancy increases, the system risks becoming overburdened by a rapidly ageing, increasingly ill population.

Figure 2. Health care spending
As a percentage of GDP



Note: The figures above columns represent per capita healthcare spending, US$ PPP.
Source: WHO, Federal Service for State Statistics, OECD calculations.

7. At the same time, it is clear that Russian healthcare expenditure is poorly allocated and inefficiently administered. There is an urgent need to alter the structure of healthcare spending, while simultaneously enhancing efficiency. The authorities are committed to increasing healthcare expenditure

10. In both OECD and emerging market economies, healthcare expenditure exhibits a tendency to rise faster than real GDP.

11. Russia's population is greying rapidly despite low levels of life expectancy at birth (LEB): this is because the fall in LEB reflects elevated mortality rates in all decades of life; as Russians grow older, the gap between Russian and western levels of life expectancy falls.

12. These estimates are based on insurance company figures on expenditures *via* the system of mandatory medical insurance. Comprehensive data on the breakdown of all public healthcare spending by age group are not available.

13. Although female LEB exceeded male LEB in Russia by 13.2 years in 2003, Andreev *et al.* (2003) estimate that the gap in *HLE* at the age of 20 was just 3.9 years and falling. Above the age of 65, Russian men have lower life expectancy but higher HLE than Russian women.

substantially over the medium term, but rising expenditure in the absence of reform may not deliver higher quality or wider access to the population – it could simply create quasi-rents for healthcare providers.[14] It is therefore critical that increasing healthcare expenditure be accompanied by both structural reforms designed to improve the efficiency and effectiveness of the healthcare system itself and by a broader programme of health reform.

The Russian healthcare system today is the product of an unfinished reform

8. The Soviet healthcare system was centralised, integrated, hierarchically organised and wholly financed from general government revenues. Healthcare services were (in principle, at least) provided free to all citizens, and all health personnel were state employees. The system placed enormous emphasis on the control of epidemics and infectious diseases. This contributed to the development of a large and effective public health (*san-epid*) network, but the determination to isolate infected persons also led to over-provision of hospital beds, which contributed over time to an imbalance in the overall structure of healthcare provision. On the whole, the Soviet system tended to neglect primary care, apart from public health, and to place too much emphasis on specialist and hospital care. Low prestige and poor pay reduced the quality of entrants into the primary-care sector and also encouraged the *de facto* privatisation of services *via* moonlighting or the levying of informal charges for supposedly free services. Despite these weaknesses, this integrated "Semashko model" achieved considerable success during the Soviet period in dealing with infectious diseases such as tuberculosis, typhoid fever and typhus. However, it tended to neglect non-communicable diseases and proved ill equipped to deal with the demographic and epidemiological shifts of the post-war period, which witnessed a steady rise in chronic non-communicable diseases. Thus, during the 1960s and 1970s, the decades-long improvement in life expectancy and health indicators stalled and, in some cases, went into reverse.[15] Moreover, by 1991, many of the strengths of the Semashko model had been eroded as a result of underinvestment in general and declining resources for prevention in particular. Despite a doubling in the number of hospital beds and doctors per capita between 1950 and 1980, the quality of care was in decline by the early 1980s (Schroeder and Denton, 1982).

9. Faced with these problems, the Russian authorities opted in the early 1990s to make the transition to an insurance-based system. Their aim was to preserve the established principle of free provision – Article 41 of the 1993 constitution confirms a citizen's right to healthcare and medical assistance free of charge – while restructuring the system to make it more efficient and more responsive to actual needs.[16] The first law on medical insurance in the Russian Federation was adopted in 1991 and led to the creation of a Federal Fund for Mandatory Medical Insurance (FFOMS), as well as territorial funds in each of Russia's constituent regions. The mandatory medical insurance (OMS) system was intended to promote both efficiency and patient choice by enabling patients to choose among competing medical insurance companies, which, in turn, would act as informed buyers of medical services.[17] Thus, OMS funds would be channelled to healthcare providers *via* (public or private) insurance companies which would have incentives both to work for better patient care (in order to attract clients) and to press providers for greater efficiency (to hold down costs). Healthcare providers would have to compete for the custom of insurers, who would contract with them to purchase healthcare services. The introduction of this purchaser–provider

14. Docteur and Oxley (2003) observe that the market failures typically associated with healthcare mean that this risk is high.

15. For details, see Brainerd and Cutler (2005); also Wheatcroft (1999) and Feshbach and Friendly (1995).

16. Greater efficiency and greater flexibility in responding to changing needs were among the major reasons for the decision to undertake a similar reform of health insurance in the Netherlands (Bertens and Bultman, 2003).

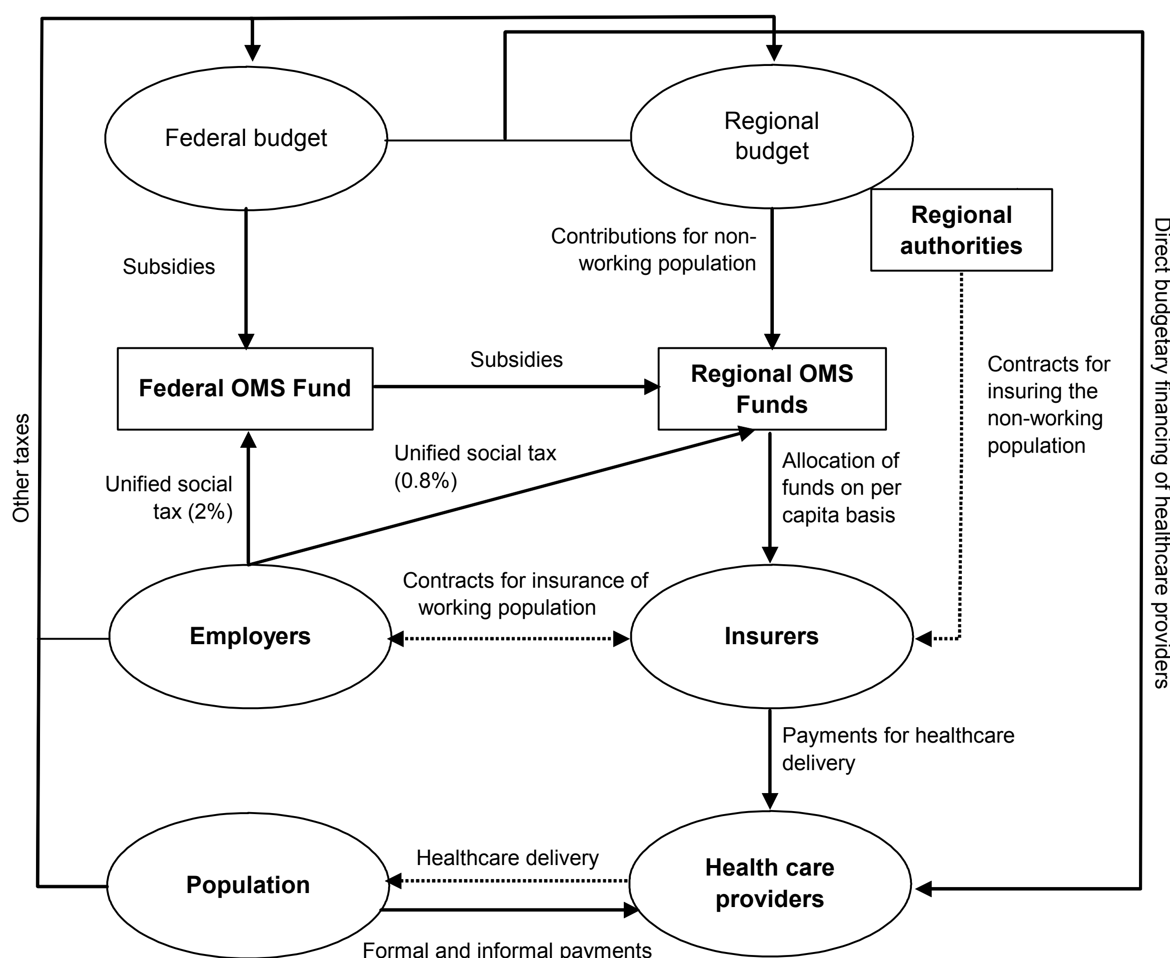
17. A number of OECD countries, including Germany, the Netherlands and Belgium, also allow competition among insurers within the framework of public health insurance schemes.

split was also expected to help facilitate the restructuring of care, as resources would migrate to where there was greatest demand, allowing for a reduction in excess capacity in the hospital sector and stimulating the development of primary care. Finally, it was intended that insurance contributions would supplement budget revenues and thus help to maintain adequate levels of healthcare funding. Unfortunately, none of this has worked out as planned. The resulting system is overly complex and very inefficient (Figure 3). It has little in common with the model envisaged by the reformers. This is chiefly a result of the failure to resolve problems with financing, competition and micro-level incentives.

10. Despite the intention of shifting to an insurance-based system, federal and regional budgets still administer about 60% of public healthcare expenditure. The remainder goes through the OMS system. OMS was initially financed chiefly *via* dedicated employers' contributions to regional OMS funds, a system that led to considerable differences in the level of OMS income across regions and failed to generate sufficient revenues to finance the system's commitments. After the introduction of the unified social tax (ESN) in 2001, the OMS system received ESN revenues equal to a 3.6% rate of payroll tax – 3.4% to regional OMS funds and 0.2% to the FFOMS. This left the system as a whole under-financed and left the FFOMS without significant resources to help equalise healthcare finance across regions. Inter-regional disparities could only be addressed *via* the various regional-support programmes operating under the federal budget. However, inter-budgetary transfers went to regional *budgets*, not regional OMS funds, and most regions chose not to transfer them to the OMS system. Indeed, since the transfers were not earmarked for healthcare, these funds were often directed to other purposes. When the ESN was cut in 2005, OMS income from the tax fell to the equivalent of a 2.8% payroll tax rate – 2.0% to the regional funds and 0.8% to the FFOMS. The cut in income, amounting to an estimated RUB 16.0bn in 2005,[18] thus coincided with some recentralisation of OMS resources, but its main impact was to reinforce the role of the budget in direct healthcare finance. As will be seen below, the combination of budgetary and OMS financial channels presents healthcare providers with conflicting incentives.

18. Estimate of the FFOMS in Taranov (2005).

Figure 3. Financing public healthcare in the Russian Federation, 2005



Source: Adapted from Shishkin (2006).

11. Nor did the OMS system emerge as an additional source of healthcare finance. Instead of supplementing budget revenues, OMS contributions largely offset the impact of reductions in budgetary spending on healthcare. Healthcare spending fell in both absolute terms and as a share of regional budgetary expenditure.[19] In the circumstances, a contraction of funding in absolute terms was probably inevitable, as all public budgets were under severe strain in the 1990s, but it is likely that the reduction in the healthcare *share* of budgetary expenditure reflected the authorities' awareness that the OMS system had created a cushion for offsetting cuts in healthcare spending. Nevertheless, public health expenditure held up better than social spending in other fields during the 1990s, thanks chiefly to OMS revenues.[20]

12. In most regions, the OMS system is characterised by a lack of competition. Although there are more than 300 private insurers and numerous public ones in the market, real competition for patients is rare. In principle, individuals have the right to choose their insurers, but this right is difficult to exercise in

19. It fell from around 15% in 1995 to just under 12% in 2001 before recovering to 13–14% (Rosstat, 2006).

20. At its lowest point, healthcare spending was down about one-third from 1991 levels in real terms, whereas social spending in some other areas fell by half.

practice even where competing insurers are present. This leaves most patients with little or no effective choice of insurer – and, in many places, no choice of healthcare provider either.[21] As a rule, it is not the individual who chooses the insurer in any case; his employer does so. Thus, where real competition among insurers exists, it is often competition for employers, not patients, and many managers are motivated by concerns other than the quality of care procured for their employees. Employers frequently opt for "pocket" insurance companies, which they control. There are also reports of corruption in the selection process, with competition taking the form of "competing" kickbacks to managers.

13. The insurance companies themselves have failed to develop as active, informed purchasers of healthcare services. Most are passive intermediaries, making money by simply channelling funds from regional OMS funds to healthcare providers, for which they are allowed to claim reimbursement of administration costs; in 2004, these costs averaged around 3.1% of the payments processed. In the event of overspending on healthcare for their clients, insurers are generally reimbursed by regional OMS funds, so they have little incentive to plan for anticipated care volumes or organise the purchase of care efficiently.[22] In short, health insurers are not risk-bearers, which raises questions about their entire *raison d'être*. These problems are not unique to Russia. World Bank (2005b) observes that insurers have tended to play a passive role in reformed healthcare systems in Central Europe and the Baltic States, and OECD (2005a) draws attention to the passivity of private health insurers even in the OECD area. As will be seen, the reasons for this passivity are much the same across the region: a combination of weak incentives for insurers, provider resistance to the introduction of a new source of influence over healthcare decision-making, and regulatory restrictions intended to serve equity goals or other social policy aims.

14. While insurers do sometimes act to uphold patients' rights *ex post* when patient–provider conflicts arise,[23] they have neither the incentives nor the capacities to press actively for better-quality provision or greater efficiency *ex ante*. In some regions, branches of the regional OMS funds themselves perform the role of insurer. Many regional authorities long opposed the involvement of private insurers in the OMS system: as late as 2004, 19 regions still relied entirely on regional OMS funds to perform this role, as against only 47 in which insurance companies were the only OMS insurers – the insurers and the territorial OMS funds shared this role in the remaining 23.[24]

15. The impact of healthcare reform has varied widely across the country, because regional and local authorities have a very important role in healthcare policy. The vast majority of public healthcare institutions are owned and operated by municipalities (Table 2).[25] The federal level consists primarily of specialised institutions subordinated directly to the Ministry of Health and Social Development and the parallel healthcare systems still operated separately by some federal ministries and departments, the most important being that of the Ministry of Defence.[26] While the regions control only a small proportion of

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21. Of course, there is no link, in principle, between choice of insurer and choice of primary care provider. However, in many places, choice of the latter is either very limited or determined *via* the insurer.

22. See Bertens and Bultman (2003) on similar inefficiencies that arose in the Netherlands owing to reimbursement of sickness funds' expenses from a single central fund.

23. The FFOMS estimates that around 70% of such conflicts are resolved in favour of the patient.

24. IISP (2005).

25. Although private provision has been developing in Russia since 1991, the healthcare sector is still overwhelmingly public. Non-state healthcare providers in 2004 accounted for just 0.6% of hospital beds, 2.7% of outpatient capacity and 6.2% of healthcare employment (Rosstat, 2006). These data include staff of church-affiliated and other non-state, non-commercial organisations.

26. Such parallel systems account for around 15% of outpatient facilities and 6% of inpatient. Most ministerial systems offer secondary care only in outpatient settings. The Ministry of Defence is the major exception.

medical institutions, these are typically the most important establishments in the area, and the regions' power over municipal budgets ensures that they play a key role in overseeing municipal clinics and hospitals. Moreover, nearly all healthcare expenditure that is channelled through the OMS system is administered by regional OMS funds; the FFOMS spends very little of it directly.

Table 2. Structure of healthcare provision by level of government, 2004
% of total

	Federal	Regional	Municipal
Outpatient care			
Outpatient clinics	1.5	17.3	81.2
Physicians in outpatient clinics	2.5	35.4	62.1
Inpatient facilities			
Hospitals	2.6	19.8	77.6
Hospital beds	4.7	30.6	64.7
Physicians in hospitals	5.6	26.2	68.2

Source: RF Ministry of Health and Social Development.

16. The regions are thus key players in healthcare provision. While this allows for experimentation and adaptation of systems to local conditions, it makes for a certain fragmentation of regulatory practices and also gives rise to considerable inter-regional inequalities. If healthcare expenditures are deflated by regional consumer price indexes, there is an eight-fold difference between the highest- and lowest-spending regions. In view of the guarantee set out in Article 41 of the Constitution, these inter-regional differences raise constitutional as well as efficiency issues. In some areas, to be sure, regional experimentation could yield valuable results: as will be seen, regions are already exploring a wide variety of approaches to policy-making, management and financing, and the best practices of the most innovative regions are beginning to spread. However, it is important to ensure that the system remains a coherent whole, in the interests of both equity and efficiency.

The need for healthcare reform

The semi-reformed state of the healthcare system aggravates its underlying structural imbalances

17. The Russian healthcare system today is characterised by a number of fundamental imbalances. The first is between *commitments and resources*. In principle, the constitutional right to medical care is given substance in a range of free services defined in the so-called Guaranteed Package Programme, administered jointly by the regions and the federal centre. Arrangements introduced in the late 1990s provide for the involvement of the federal and regional governments and OMS funds in planning provision and matching commitments to free healthcare with available resources. The Guaranteed Package Programme is also intended to facilitate a shift in provision away from inpatient care and towards greater outpatient care (see below). Under the programme, the federal government sets utilisation targets which define the minimum package of services for the regions and also serve as targets for this restructuring process. The regions are obliged to develop territorial programmes complying with the minimum norms set by the federal centre but may also include additional free services.

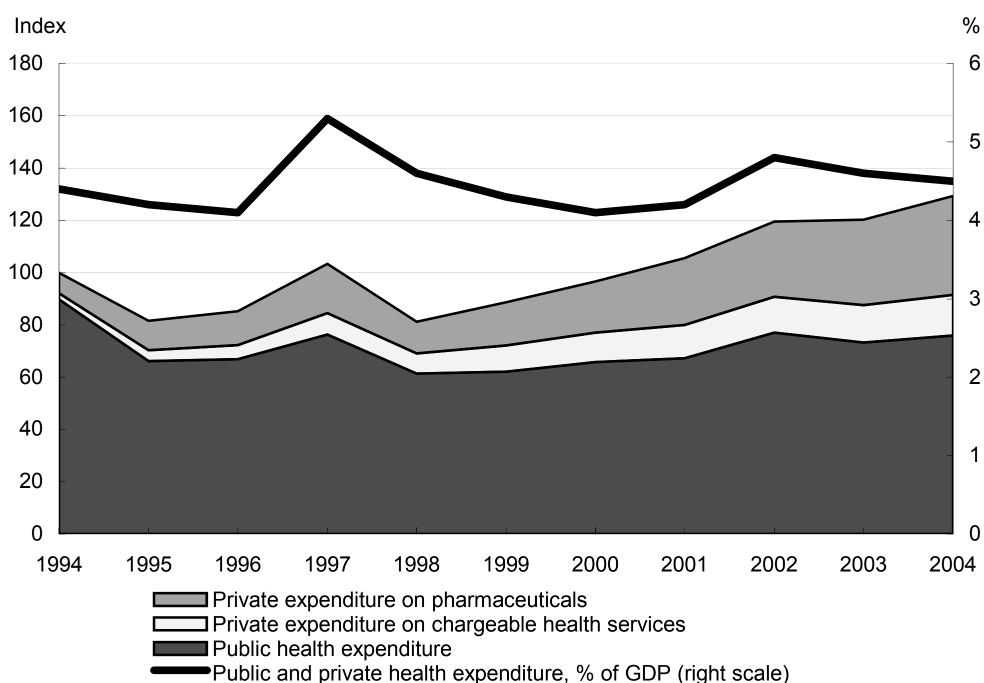
18. Similar guarantees have been adopted in many OECD countries in order to specify patients' rights or protections within the healthcare system and to ensure access to a specific set of services.[27] Docteur and Oxley (2003) note that such guarantees can provide incentives for those parties responsible for

27. For example, Sweden adopted a revised Guarantee for Medical Treatment in 1997, and Austria a patient's charter in 1999. Many US states also have patients' "bills of rights".

a patient's rights to take appropriate action. However, the Russian package (Annex 5.1) is actually quite extensive for a country that spends a relatively low share of GDP on healthcare, and in practice, the available resources are insufficient to cover the guaranteed package. Households finance a good deal of medical care that is supposed to be free; the household share of total health expenditure has risen rapidly, roughly quadrupling in the decade to 2004 (Figure 4).[28]

19. Shishkin (2004) gives a lower-bound estimate of the cost of financing the full programme of state guarantees in 2002 at RUB 348.3bn (3.6% of GDP). The actual cost would probably have been somewhat higher. Yet *total* state expenditure in 2002 – including construction, equipment procurement and other activities not directly concerned with financing guaranteed services – amounted to just RUB 324bn. In 2004, financing of the state-guaranteed package reached an average level of 81.8% nation-wide, although this figure conceals significant regional variations.[29] Only nine regions, accounting for 12.8% of the population, achieved full financing of the guaranteed package.[30] There are particularly severe shortfalls in the provision of high-tech medical procedures: the Ministry of Health and Social Development estimates that in 2005, the system covered around 10% of the demand for coronary angiography and heart-valve replacement, about 7% of the demand for joint replacements and roughly 35% of the demand for treatment of congenital heart defects.

Figure 4. Public and private health expenditure



Source: Federal Service for State Statistics; Shishkin (2006).

28. Not all household payments are "informal". Healthcare institutions can offer paid medical services. This should not extend to guaranteed services but it often does.

29. See IISP (2005); and Shishkin *et al*. (2005). A regional programme for state-guaranteed care is elaborated for each region, on the basis of an assessment of expected care needs.

30. Tyumen', Rostov, Chuvashiya, Lipetsk, Novosibirsk, Jewish AO, Udmurtiya, KhMAO and Sverdlovsk. A few of these regions actually exceed 100% provision, offering more extensive guaranteed packages.

20. As will be seen, there is a need to revisit some of the guarantees themselves, but the gap between commitments and resources largely reflects the low level of public healthcare spending. This is a problem common to many transition economies: the gap between extensive guarantees and limited means has given rise to financial strains and significant informal payments for what are supposed to be free services in many Central European countries.[31] Rosstat estimates that households spent RUB 53bn on medical services in 2002, as against RUB 120bn on medicines. On the basis of survey data, Shishkin (2004) estimates that informal payments to providers added another RUB 22bn to the former figure.[32] Whether formal or informal, the increasing role of payments by households to state healthcare providers implies that access to the public healthcare system is becoming significantly more unequal, notwithstanding the provisions of Article 41 of the constitution.

21. The largest share of household spending on healthcare is devoted to pharmaceuticals, and the gap between commitments and resources is particularly stark when it comes to financing pharmaceuticals provision. Like almost all OECD countries, Russia tries to hold down rising pharmaceutical costs *via* a combination of cost-sharing and regulation. Drugs are in theory provided to hospital patients free of charge, but outpatients must pay for them – an arrangement which creates incentives for unnecessary hospitalisation. In practice, however, informal cost-sharing is pervasive in the hospital sector: it is estimated that around 80% of inpatients still have to pay part of the cost of their medicines. Apart from a few centrally supplied drugs related to public health needs (*e.g.* insulin and vaccines), hospitals generally have to buy medicines on commercial terms from their budgets, which are limited. This, combined with ineffective enforcement of controls on wholesale and retail mark-ups, means that drugs available on the market are often unavailable to hospital patients unless they can pay.[33] It is reckoned that a substantial proportion of the demand for medicines in Russia simply goes unmet.[34]

22. The reliance on formal and informal cost-sharing with respect to pharmaceuticals provision underlies the unusually large household share in total healthcare expenditures in Russia, because pharmaceuticals themselves account for an exceptionally large share of Russian health expenditure. Household expenditure on drugs accounts for around 30% of total healthcare spending in Russia, as against an average of just under 12% in OECD countries. It is not clear what proportion of *public* health spending is devoted to pharmaceuticals in Russia, because such expenditure is channelled through multiple budgets and various levels of the OMS system, and comprehensive data are not available. However, the Ministry of Health estimated in 2002 that drugs and other medical supplies accounted for around 17–20% of total public health spending.[35] If this proportion held in 2004, then total pharmaceutical spending in Russia would have reached around 40% of all healthcare expenditure, as compared with an OECD average of 18%. This is not entirely surprising, since the pharmaceuticals share of health spending tends to be strongly negatively correlated with both per capita health spending and per capita GDP. In a country like Russia, this largely reflects heavy reliance on pharmaceuticals imports, which are expensive relative to locally

31. World Bank (2005b:117).

32. Shishkin also finds significant regional variations in the scale and structure of household healthcare spending. Surveys yield widely varying estimates of the prevalence of household spending for medical care, though all find that it is relatively common, especially for outpatient and dental care; see Balabanova *et al*. (2004), Feeley *et al*. (2001), Belyaeva (2001a and 2001b), IISP (2003) and Shishkin *et al*. (2004). See also the Russian estimates yielded by the Russia Longitudinal Monitoring Survey, available at http://www.cpc.unc.edu/rlms/.

33. Wholesale mark-ups are limited to 25% of the manufacturer's price and retail mark-ups to 30% of the wholesale price, but actual mark-ups are often in the 120–200% range. See Tragakes and Lessof (2003).

34. Tragakes and Lessoff (2003).

35. Specifically, the ministry estimated that this item accounted for 20.3% of OMS spending, 28.9% of federal spending on health and 14.3% of the health expenditure of consolidated regional budgets.

supplied goods and services.[36] The high share of spending on pharmaceuticals may also reflect an ingrained cultural expectation, left over from the Soviet period, that any consultation with a physician will result in a prescription.[37]

23. The second major imbalance is between *the structure of provision and health needs*. The Russian healthcare system still reflects the tendency of the Semashko model to rely too much on specialist treatment and hospitalisation. Hospital stays are too common and too long, on average, and primary care remains seriously under-developed, both quantitatively and qualitatively (Table 3). While there has been some evolution away from this approach, progress has been slow: Starodubov (2005) reports that the share of healthcare expenditure devoted to in-patient services fell by only two percentage points over the preceding decade, and Russia still spends about twice as much on stationary care as on outpatient services, compared with the roughly equal shares typically found in OECD countries.[38] Only about 30% of Russian physicians work in outpatient care settings, and roughly 60% of these are specialists. While some of these specialists are paediatricians in what might effectively be described as family practice, the bulk of the burden of primary care falls on the 12% of physicians who work in district polyclinics. Historically, moreover, primary care has been the least prestigious and least remunerated field of medicine, and the reputation of ordinary primary care physicians – *terapevty*, in Russian parlance – is low in the eyes of both the profession and the population. The government has tried to rectify this by training physicians for two new specialisms – general practitioner (GP) and family practitioner[39] – but few have yet been trained. Many physicians insist that the GPs' training is inadequate, and the population still tends to confuse them with *terapevty*.

Table 3. Indicators of resource use in the health sector, 2004

	Russian Federation	WHO European region	European Union
Physicians per 100 000 population	484.0	352.4	347.1
of which			
General practitioners	22.5	65.8	98.9
Nurses per 100 000 population	798.7	670.0	731.2
Hospital beds per 100 000 population	1125.0	691.3	591.6
Average length of stay, all hospitals	14.2	11.1	9.5

Source: Federal Service for State Statistics, WHO; European Union data on physician numbers are for 2003.

36. Indeed, the low price elasticity of demand for medicines contributed to a sharp jump in real household spending on pharmaceuticals after the 1998 rouble devaluation, even as real incomes fell sharply. While Russia's pharmaceutical industry has recovered somewhat from the output collapse of the 1990s, the country's revealed comparative disadvantage in medicines and pharmaceutical products has grown somewhat since 1998.

37. Tragakes and Lessof (2003); Karnitski (1997); Hovhannisyan *et al*. (2001).

38. World Bank (2004) reports that 64% of healthcare spending in Russia in 2001 was devoted to inpatient care. See also OECD (2005b:73). The average OECD member state devoted 31% of healthcare spending to inpatient care and 34% to outpatient, with the balance being devoted to medical goods, collective services and other items. However, it is important to note that the OECD figures for inpatient care exclude most long-term care for the elderly and disabled. Including this would raise the OECD average to about 37% of spending. There are, moreover, wide divergences among OECD systems in the inpatient/outpatient balance.

39. Whereas in international terminology, the terms "general practitioner" and "family practitioner" are synonymous, they refer to distinct groups in Russia. A general practitioner (GP) covers all specialties for adults except gynaecology. He/she does not cover paediatrics either. A family practitioner, by contrast, is effectively a GP who is also qualified to cover gynaecology and paediatrics. As a result, GPs are often confused with *terapevty* in the public mind. The Ministry of Health and Social Development favours training GPs as family practitioners – *i.e.* covering all the above-mentioned specialisms.

24. The potential benefits of a stronger primary care system are considerable, particularly when it comes to prevention and early diagnosis. WHO (2004) draws attention to the growing body of empirical work suggesting that greater emphasis on primary services is associated with better health outcomes, higher patient satisfaction, reduced expenditure and greater equity/access, particularly in middle- and lower-income countries.[40] Weakness at the primary care level results in over-referral of patients to specialists. In Russia, an estimated 35% of primary care consultations result in specialist referrals, around 5–10 times the rate typical of OECD countries. Patients often press actively for referrals, because they have no faith in their local district polyclinics, while *terapevty* and other primary care staff tend to over-refer owing to the weaknesses in their own training and, in many cases, the incentives for over-referral that some remuneration schemes create (see below). Moreover, the 35% referral rate actually *understates* the extent of reliance on specialist treatment, since ordinary Russians often bypass primary care providers altogether and approach specialists directly.

25. Yet while there is clearly a need to shift resources away from tertiary, and towards primary, care, healthcare restructuring is *not* primarily about bed closures, and bed closures can only follow provision of alternative, more appropriate services, medical facilities and forms of social support. This is particularly true of any attempt to reduce over-hospitalisation. Many patients, particularly elderly patients, are hospitalised for long periods simply because they cannot manage alone and there are no alternative care arrangements available. This highlights the need to address the problem of long-term care in conjunction with the restructuring of the healthcare sector.[41] The government's medium-term reform programme recognises this need, anticipating a significant, albeit gradual, increase in the number of non-hospital long-term care beds available. Starodubov (2005) points out that Russia's size and sometimes poor transportation networks mean that closures in rural areas and small towns must be managed carefully, if access to care for their populations is not to be compromised. He notes a tendency in some regions to "rationalise" bed provision at the expense of such areas.

26. Not surprisingly, given the above, there is also a substantial gap between *expectations and outcomes*. This is reflected in survey data showing that 60–70% of Russians are dissatisfied with their country's healthcare system. Only 11–13% express satisfaction with it, although just over a quarter express confidence that they can get good-quality medical care for themselves and their families. The latter figure suggests that a significant minority of the population believe that they can secure what they need from the system despite its defects. Retrospective evaluations are more positive still: of those who state that they have recently undergone some sort of medical treatment, roughly half report having found it satisfactory. Unfortunately, around half also declared it unsatisfactory.[42]

27. The above-listed problems notwithstanding, Russia's healthcare reforms have brought some benefits. First, as noted above, the OMS system helped to maintain healthcare spending levels in the 1990s, even if OMS contributions did end up replacing, rather than supplementing, budgetary funds. Secondly, the creation of OMS marked the first steps towards a purchaser–provider separation, which, in turn, has helped to make funding less dependent on supplier interests and to focus greater attention on questions of cost and efficiency. It has also spurred the development of clinical protocols and medical-economic standards similar to those adopted in some OECD countries in an effort to increase healthcare providers' accountability for healthcare quality (Docteur and Oxley, 2003). In a small but growing number of regions, such standards are also being used in an effort to devise more rational tariff structures and methods of payment. Nevertheless, healthcare reform could hardly be called a major success. The unfinished transition

40. In some cases, however, such an emphasis can raise costs by exposing previously unmet needs.

41. According to WHO data, Russia has one of the lowest ratios of nursing and elderly care home beds per head of population in the European region.

42. See FOM (2006); Levada-Tsentr (2005); and VTsIOM (2003).

to insurance-based medicine has left the country with an exceptionally complex system of mandatory medical insurance that has achieved few of the reformers' aims and that, despite its name, actually has relatively little in common with a system of medical insurance.

28. This unfinished OMS reform also constitutes one of the reasons for the very limited shift in the structure of provision. The reformers of the early 1990s focused their attention on the reform of healthcare finance, believing that if financial arrangements were properly restructured, then financial pressures would bring about the kind of broader restructuring of provision that the sector needed. In the event, reform of healthcare finance stalled, and the basic structure of the system remained largely unchanged as a result. This affects not only the provision of current services but also patterns of investment in the sector. Current financing arrangements do little to ensure that capital investment in the sector will be directed towards areas of greatest anticipated need, rather than being use to replace/perpetuate existing facilities and structures. This is a critical issue, given that the healthcare sector's fixed assets are generally very old.[43]

Healthcare providers and insurers face perverse micro-level incentives

29. The half-finished transition to an insurance-based system has left healthcare providers facing a confused system of financing. Direct budgetary expenditure still plays the dominant role in healthcare finance. In 2004, only about 40% of public healthcare spending was executed through the OMS system, although this figure varied widely from region to region. In Komi and Tuva, OMS expenditures in 2004 covered just 16% of public healthcare spending, as against a high of 95% in Samara, the only region in which the OMS share exceeded two-thirds.[44] The authorities aim to raise the nationwide figure to 60% by 2008. At present, the OMS system in most regions tends to reimburse healthcare providers' expenditures on salary, pharmaceuticals, disposables and food for inpatients. The fixed costs of regional and municipal public healthcare facilities are generally covered by regional and municipal budgets, as are services related to severe conditions, such as cancer, and emergency care.

30. While it was never intended that the budget should altogether cease to play a role in healthcare finance, the current mix presents providers with contradictory incentives. The problem is not so much with the *sources* of financing as with the *methods* used to allocate it. Most budget financing is still input-based – it is allocated to facilities and institutions, based largely on size and staffing, with little reference to volumes of care actually provided or forward-looking assessments of need. The OMS portion of providers' income is insufficient to create incentives to focus on outcomes. For example, restructuring an institution in order to better meet patient demand (as reflected in OMS income) can result in a loss of budgetary income (which may be based on staffing ratios, bed numbers, etc). The incentives to resist the restructuring of capacities may also be reinforced by the fact that OMS tariffs for specific services in around three-quarters of regions are partly dependent on the status of the institution, rather than the nature of the procedure.

31. One reason for the limited share of OMS revenues in total public health spending has been the chronic under-financing in many regions of OMS for the non-working population, who are not covered by payroll taxes. This is a major problem: only a little over 40% of insured persons are working, and many of these under-contribute, owing to "grey schemes" for paying wages and salaries. However, regional budget transfers to cover OMS contributions for non-working people sometimes amount to less than 5% of regional OMS funding. In 2002, 24 regions allocated only about RUB 100 per person ($ 3.19 at the average exchange rate for the year) in premia for the non-working population; a further 19 regions spent

43. The Ministry of Health and Social Development estimates that the fixed assets of the healthcare sector were over 58% amortised by end-2004. Amortisation rates for the sector's machinery and equipment had reached 62–64%.

44. Shishkin *et al*. (2005:5).

between RUB 100 and RUB 200.[45] Such under-funding can create particular problems in poorer regions, since the issue of contributions for the non-working population is more acute in regions of high unemployment and/or high fertility.[46]

32. In an effort to address shortfalls with respect to the elderly population, the Pension Fund of the Russian Federation (PFRF) in 2003 began to participate in the financing of OMS coverage for pensioners in around a dozen regions. This number grew to 32 in 2004. The PFRF insisted on the maintenance of personal accounts for the pensioners so insured and on the use of specific payment methods to facilitate the monitoring of expenditure and ensure that PFRF funds introduced into the system were not diverted to other purposes. While the PFRF programme has not been formally wound up, it cannot be a complete or permanent solution to the problem, especially given that the pension fund itself faces funding problems over the coming years. Under arrangements put in place in 2005, the regions are now responsible for making contributions to the OMS system on behalf of the non-working population, but they receive subventions from the federal budget and the FFOMS to help pay OMS contributions for children, and the PFRF is – for the time being, at least – still involved in helping to finance healthcare for pensioners.[47]

33. The mixed incentives generated by the combination of budgetary and OMS-based financing are compounded by the variety of formulae used to calculate payments to healthcare providers. Diversity is not, in itself, a problem. No single formula is likely to be appropriate for all forms of medical care. However, some widely used forms of payment generate perverse incentives for healthcare providers. At present no fewer than seven forms of payment are used for outpatient care (Figure 5). These include: financing of budgeted costs by line item, pay per visit, pay per service, pay per case, capitation fees based on assignment of patients, capitation with fundholding, and a points system similar to the Uniform Value Scale used in Germany. Six methods are used to pay for in-patient care (Figure 6): financing of line-item budgets, financing of global budgets, pay per bed-day, pay based on the average cost of treating one ill person, pay per case completed, pay for agreed volumes of care, and reimbursement of actual expenditures. Reliance on line-item budgets, global budgets and actual reimbursement of expenditures often eliminates incentives to economise. The challenge is to shift to forms of payment that align incentives to promote effectiveness *and* efficiency objectives.[48]

34. While matters are improving gradually, fee per outpatient visit is still widely used, as is pay per bed-day in the hospital sector. Both forms of payment tend to incentivise over-treatment, and the former minimises any incentive for primary care providers to focus on prevention.[49] At the opposite end of the

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45. Taranov (2005) notes that this figure in 2004 was as low as 1.4% in one region, which implies a more or less total failure to provide for insurance of non-working people.

46. It does not help that the informal share of wages and salaries is often greater in such regions, so OMS contributions for the *working* population are frequently depressed as well.

47. In 2005, the federal authorities provided RUB 6bn for children's OMS contributions, divided roughly equally between the federal budget and the FFOMS. The regions spent about RUB 13.0bn on contributions for the non-working population, and the PFRF provided around RUB 10.0bn for pensioners (Taranov, 2005:12). However, the extent of the PFRF's future involvement is unclear: no formal decision has been taken to wind up the experiment launched in 2003, but it is hard to see how it can continue indefinitely given the PFRF's financial position and the undesirability of financing healthcare from pensions funding on a permanent basis.

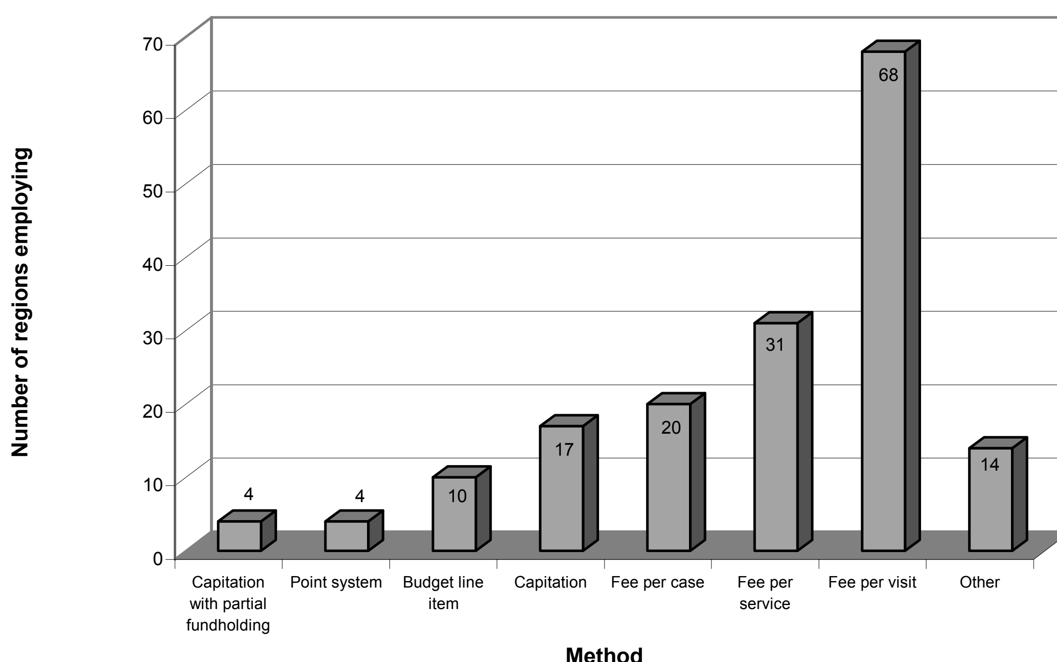
48. Docteur and Oxley (2003) treat "effectiveness" as concerned with health system performance, without regard to cost. Effectiveness reforms may be cost-increasing, -neutral or -decreasing. "Efficiency" refers to the relationship between cost and outcome: efficiency reforms aim at better outcomes for any given amount of healthcare spending.

49. It should be noted that most other widely employed methods of paying for primary care also limit the incentives to focus on prevention. In the hospital sector, reliance on bed-days stimulates such practices as

spectrum, many healthcare workers in outpatient settings have little or no incentive to treat patients at all, since they are employed on fixed salaries and subject to little monitoring of outcomes. As a result, they tend to over-refer patients to more expensive specialist outpatient clinics and/or hospitals – which is often what patients want anyway. In 2004, only four regions employed an element of fundholding in respect of primary care providers.[50] In the hospital sector, only ten regions employed cost-and-volume contracts based on anticipated care needs.

35. The problem here is not a lack of awareness of incentive problems but a lack of administrative capacity: regions tend to adhere to forms of payment that are easier to monitor and administer. For the same reason, the PFRF insisted on personalised accounts and fee-per-visit arrangements in financing its additional support for pensioners: the Fund was concerned above all to ensure that the money it contributed was spent on treating its clients. At times, therefore, there are trade-offs between transparency and efficiency, a fact which highlights the extent to which the authorities' healthcare reform options might be broadened by a successful administrative reform.

Figure 5. Methods of paying for outpatient care through regional OMS funds, 2004

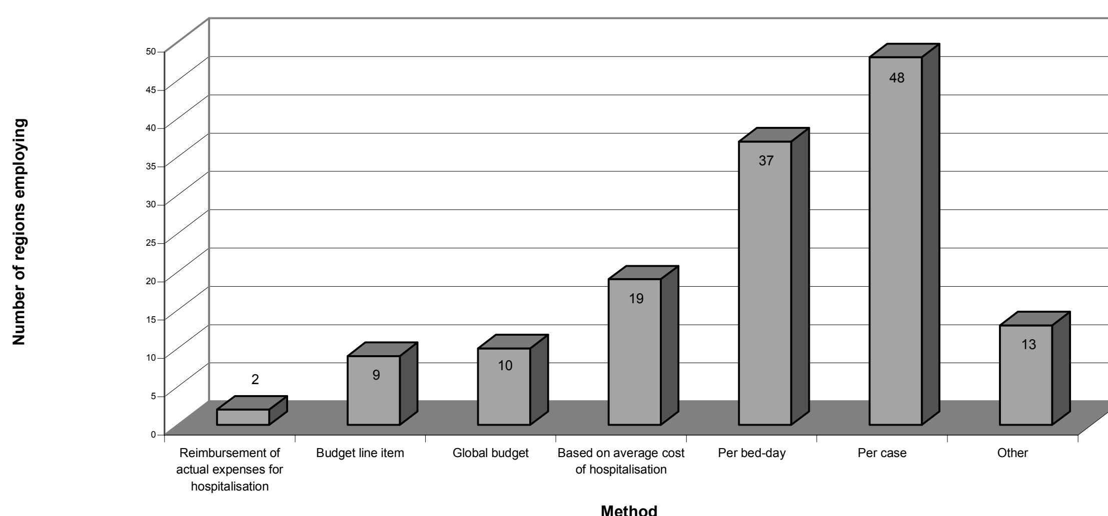


Note: Different methods may be used for different providers in the same region.
Source: IISP (2005).

sending patients home on weekends/holidays without formally discharging them – *i.e.* while recording them officially as being in hospital.

50. Kemerovo, Irkutsk, Samara and Primorskii Krai.

Figure 6. Methods of paying for inpatient care through regional OMS funds, 2004



Note: Different methods may be used for different providers in the same region.
Source: IISP (2005).

The direction of healthcare reform

The government has recently been stepping up its healthcare reform efforts

36. The government is not by any means unaware of the problems just described, and after a long hiatus, the authorities have recently begun trying to reinvigorate healthcare reform. In an effort to accelerate progress on some of the most urgent of its healthcare priorities, the government in late 2005 launched "Priority National Project 'Health'", which is intended to bring about a palpable improvement in the healthcare system during 2006–07. The health project is by far the largest of the four projects undertaken by the government this year. It will channel an additional RUB 208.9 from federal and regional budgets into healthcare during the course of 2006–07, the bulk of which will be spent on increased salaries for primary-care physicians, the creation of 15 new high-tech medical centres and expanded immunisation and disease-prevention efforts (Table 4). This represents a substantial increase in expenditure focused on a limited number of priorities and administered under a high degree of political direction. It should, therefore, have a positive impact on healthcare in Russia. The project also marks a long-overdue resumption of active policy-making in healthcare, following a period in which little was done.

37. The focus on primary care and prevention is particularly welcome, although critics have raised questions about the efficiency of mass immunisation and screening efforts. The high-tech emphasis also makes sense. Although Russia's healthcare system is generally still too biased towards hospitalisation and tertiary specialist care, it is under-resourced when it comes to high technology. Moreover, the investment in building new high-tech medical centres is to complement a shift in the financing of federal health institutions from line-item budgets (so-called *smetnoe* financing) to financing based on tasks performed. The planned introduction of a waiting lists system should increase both transparency and equity when it comes to rationing access to highly specialised medical facilities and procedures. It is also intended that such measures should reduce demand somewhat and ensure that the system's capacities are targeted at those in greatest need. As noted above, the authorities estimate that the healthcare system in 2005 was capable of meeting about 10% of the demand for high-tech medicine. Realisation of the Health project is intended to raise this figure to around 40% within three years.

Table 4. Priority National Project "Health"
Planned federal expenditure, RUB bn

Measure	2006	2007	Total
Increased pay for primary care medical staff	12.8	17.7	30.5
Training of general (family) practice doctors, district therapists and pediatricians	0.2	0.3	0.5
Diagnostic equipment for polyclinics and other outpatient facilities	14.3	15.4	29.7
Upgrading emergency vehicle fleet	3.6	3.9	7.5
Programme of regular immunisation and vaccinations (including flu)	4.2	6.1	10.3
Prevention, diagnosis and treatment of persons infected with HIV-AIDs, hepatitis B and C	3.1	7.7	10.8
Screening of newborns for galactosemia and adrenogential syndrome	0.4	0.5	0.9
Additional prophylactic medical examinations of the working population	2.0	4.0	6.0
Construction of high-tech medical centres	12.6	19.4	32.0
Increased volumes of high-tech medical services	4.1	12.0	16.1
Project overheads	0.6	0.7	1.3
Total	**57.9**	**87.7**	**145.6**

Note: Figures exclude project financing from regional budgets.
Source: Ministry of Health and Social Development.

38. That said, there remain a number of concerns about the design of the health project, not the least of which is its reliance on large spending increases that are in many cases not linked to reforms that address the underlying structural weaknesses of the healthcare system. While the project is meant to give renewed impetus to healthcare reform, it is far from clear that it will do so. Only limited steps towards greater efficiency or changed incentives are planned, and this must be regarded as a missed opportunity, since such reforms would be easier to implement in a context of rapidly increasing resources. Although the federal government has recently undertaken a number of experiments and pilot projects in cooperation with regional and municipal authorities in the field of healthcare reform, there has been no move to address the reform of the guaranteed package programme or the need for greater equity in access to healthcare. Moreover, the risk of large-scale corruption and waste must be regarded as high, given that over half of the expenditures envisaged involve centralised procurement of medicines, equipment, services and construction work. It is not entirely clear how the authorities intend to ensure efficient spending of the funds allocated for such purposes, although they are clearly aware of the challenge: the creation of a Council on the Implementation of National Priority Projects chaired by the President of the Russian Federation is indicative of a high-level determination to monitor the projects closely.

39. The mechanisms used to adjust salaries also raise problems. In principle, salary increases could have been introduced alongside changes in the way primary care medical staff were paid, and this was indeed what some policy-makers envisaged. In practice, however, the necessary changes were probably too complex to introduce quickly, and the authorities determined that salary increases should be implemented as a matter of urgency. Thus, the decision was taken to pay an additional RUB 10 000 per month to the pay of primary care physicians[51] and an additional RUB 5 000 to nurses in primary care facilities from the beginning of 2006 – sums sufficient in many regions to triple or even quintuple their take-home pay. While regions have discretion to introduce changes to remuneration packages when implementing the pay hikes,

51. Including district *terapevty*, district paediatricians, general practitioners and family doctors.

there is little evidence of their doing so.[52] As a result, the large, flat increase in remuneration for primary care staff risks distorting incentives throughout the medical system: early 2006 saw large numbers of specialists and hospital staff, who did not receive the additional increments, being reclassified as primary-care *terapevty*.[53]

The government has recently confirmed its healthcare reform priorities for the period to 2010

40. While many of the specific measures advanced as part of project "Health" are to be commended, it does little to foster the restructuring the system requires. This will remain to be undertaken over a longer period, outside the framework of the project. However, the federal government reaffirmed its commitment to this restructuring in November 2005, when it defined its major goals for healthcare policy to 2010. Among the most important of these are to:

- bring commitments to the population into line with available resources by reforming the guaranteed package mechanism and strengthening its legislative basis;

- make the OMS system genuinely insurance-based;

- shift the structure of provision away from specialist/hospital care and towards greater reliance on integrated primary care; and

- change the remuneration schemes employed in the sector in an effort to restructure providers' incentives.

The challenges posed by these four priorities are examined in the sections that follow.

What can be done to balance commitments and resources?

41. While healthcare spending is expected to go on rising, both in absolute terms and relative to GDP, the balance between commitments and resources cannot be restored merely by increasing the latter. The guaranteed package itself will have to be re-examined. This will involve more than an assessment of what the Russian state can actually afford, although resource constraints will clearly be a critical factor. If the state guarantee is to have any meaning at all, the package must be transparent to both providers and patients, and must provide mechanisms for citizens to assert their rights if the commitments in the package are not met. Ensuring real accountability will require specifying not only *what* medical services are to be provided free of charge, but also by whom and in what setting. If the guarantee is to be effective, a patient's package of guaranteed services should probably be financed from a single source, so as to avoid cost-shifting among different actors. Moreover, clarity about the precise nature of the guarantees should help reduce the incidence of informal payments: patients who are not aware of the benefits to which they are entitled are likely to be more susceptible to requests for additional payments.[54] In the Slovak Republic, which faced a similar problem, the government has established a special office under the auspices of Ministry of Health to which citizens can appeal if they believe they have been charged for service that

52. The subventions in question are transferred not to regional budgets but to regional OMS funds. These, in turn, conclude separate agreements with healthcare providers who conclude additional contracts with their staff, covering the requirements for receiving the additional increments. In practice, these requirements seem to be minimal, so the incentives facing primary care staff have changed little.

53. See *Vedomosti*, 14 February 2006.

54. See the discussion of benefit-package reform in Central Europe in World Bank (2005a:121–22).

should have been free. The office is obliged to investigate such complaints and to take remedial action if necessary.

42. All this implies that the package will have to be very carefully designed, so as to avoid unsustainable commitments and ensure that the new package does not create incentives to choose more expensive state-guaranteed care in preference to cheaper paid services. If the package is poorly conceived, patients in some cases might simply be deterred from availing themselves of cheaper (paid) care at an early stage and may thus end up requiring more expensive (guaranteed) care later on. In others, physicians might come under pressure to "upgrade" patients' care in order to spare them financial hardship. Particular care should be taken not to reduce incentives to seek preventive care. If some reliance on co-payments for treatment or pharmaceuticals is envisaged, for example, these might be lower for those patients whose problems are detected in the course of regular screening or preventive procedures. Finally, the process for designing the package will itself be important, as changes in medical and economic conditions are likely to necessitate regular revisions.[55] The government should thus seek to design a transparent process involving government, medical professionals and representatives of civil society in any revision of the guaranteed package.

43. As and when the authorities tackle the question of matching state guarantees to available resources, they will need to address the need for more effective, equitable mechanisms for holding down pharmaceutical costs. As noted above, pharmaceuticals account for an extremely high share of healthcare expenditure, but *public* pharmaceuticals expenditure remains at relatively modest levels. This is largely the result of widespread informal cost-sharing arrangements. Any serious attempt to give substance to the formal guarantees could result in spiralling public expenditure on pharmaceuticals, unless the guaranteed package is carefully defined and is accompanied by other measures to manage expenditure on drugs. Reform should involve a narrowing of the list of free medications while eliminating the policy of providing inpatient drugs for free and requiring outpatients to purchase them. Since charging for many inpatient drugs is likely to be both undesirable and politically unacceptable, the solution is likely to lie in combining some reimbursement of outpatient drugs with policies to influence their use. Federal and regional governments already compile lists of essential drugs and work to ensure their availability to the most vulnerable groups, but financial constraints mean that even these are often paid for by patients out-of-pocket. Further steps are also needed to reduce the tendency to over-prescribe and to eliminate incentives to prescribe more expensive drugs when there are chemically identical products available at lower prices. Unfortunately, there are still problems with the reliability of generic drugs, so both physicians and patients continue to prefer branded products, a preference that is reinforced by aggressive promotion of brand-name drugs.

44. The "monetisation" of prescription drug benefits in 2005 highlights the potential dangers involved in trying to give real substance to formal guarantees of free provision. The great majority of persons who had previously enjoyed a right to free medicines opted for the cash benefit of RUB 4 200 per annum offered by the government rather than retaining their in-kind entitlement. In many respects, the reform was successful: the funds available were, for the first time in the post-Soviet period, adequate to finance the commitments made to beneficiaries in full, whether in cash or in kind, and the tendering arrangements do appear to have enabled healthcare authorities to procure the needed medicines at relatively low prices. However, the new system stimulated a dramatic increase in prescriptions for benefit recipients in a matter of months. This appears to have been the result of adverse selection: the minority who refused the cash seem – unsurprisingly – to have been those with greatest need for drugs.[56] Since the previous pharmaceuticals benefit regime had suffered from chronic underfinancing and thus left many

55. See Docteur and Oxley (2003:20) and World Bank (2005b:122).

56. There is also a risk that many who made the transition from in-kind to cash benefits have under-estimated the cost of meeting their pharmaceutical needs and may have to go without needed drugs.

eligible persons unable to obtain free or reduced-price pharmaceuticals, the government made substantial additional resources available to finance the programme. This triggered an upsurge in demand among those who had not chosen a cash benefit. The Ministry of Health and Social Development deliberately chose *not* to impose any overall controls on spending on such drugs, because it wished to assess the extent of the real suppressed demand for medicines among the affected groups. However, the sharp upsurge in prescriptions that followed the change highlights the danger of spiralling costs.[57]

How can a restructuring of provision be engineered?

45. The authorities remain committed to changing the distorted structure of provision described above. The government aims over 2004–08 to increase per capita provision of outpatient visits by 11.3%, to increase the provision of services in day-care facilities by 65% (albeit from a low base) and to cut the number of hospital beds by 8.7%. Over the same period, the number of doctors per 1 000 population is to fall by 18.8% and the number of nurses to rise by 8.8%. Popular resistance may make the transition to greater reliance on primary care more difficult than it would otherwise be. As noted above, primary care physicians have not traditionally been held in high regard, so patients often press for hospital referral rather than accept ambulatory care. Pharmaceutical financing arrangements reinforce this preference; changing them would reduce incentives to over-hospitalise. So, too, would improving the state of many primary care facilities: the priority national project's emphasis on investment in equipment and facilities for outpatient establishments thus reflects a real need that must be met if the government is to restructure provision.

46. Above all, however, this restructuring of care will depend on reinvigorating efforts to develop a large, well qualified corps of general practitioners (GPs) capable of providing integrated primary care and of acting as "gatekeepers" responsible for referring patients to secondary and tertiary care providers. GPs remain extraordinarily rare outside a handful of regions. The main exception is Samara, which has worked hard to make this transition. Indeed, Samara, which is home to 2.2% of Russia's population, accounted for an estimated one-third of the country's GPs in 2003 (Tragakes and Lessof, 2003). Moreover, many specialists insist that the overall level of preparation of the new GPs is little better than that once provided for *terapevty*. Whether or not this harsh judgement is warranted, it is clear that most of the handful of GPs who have entered service are finding it difficult to establish themselves in their new roles. Rese *et al*. (2005) find that the development of general practice continues to be hampered by vague legislation regarding its scope and by resistance from specialists and polyclinic managers, who often tend to deploy GPs as *terapevty*, resisting any extension of the GP's role to include such activities as working with social services to provide coordinated care for the elderly and disabled. While some regions, like Kemerovo, are far advanced with respect to the integration of social and medical services, the dominant tendency still seems to be to treat these as separate domains.

47. Tishuk and Schepin (2003) estimate that Russia will need around 90 000 GPs to staff the restructured system; as of early 2003, there were about 2,500. Yet a crash programme to turn out massive numbers of GPs in a short period would merely reinforce concerns about the quality of their preparation. The development of general practice will thus take considerable time and resources. It will also need to proceed in conjunction with the development of methods of payment for primary care that do not create incentives for over-referral or over-treatment. Simply put, primary care staff need incentives to keep their clients healthy. Experiments with fundholding in the late 1980s and early 1990s were not unpromising, and

57. The main constraint involved appears to have been long waiting times for those needing physicians to fill out free prescriptions for them. See IET (2006:336–42) on the introduction of the new system of drug benefits.

some form of weighted capitation with fundholding,[58] such as is used in Samara, could provide the basis for the further development of general practice.

What will it take to complete the transition to competitive insurance-based medicine?

48. With respect to healthcare finance, the government remains committed to completing the creation of a system of mandatory medical insurance that relies on competition among insurers to offer a degree of choice to patients and create real incentives for providers to raise both effectiveness and efficiency. Work on overhauling the OMS system was stepped up in 2003–04, after a hiatus of nearly a decade, and the government is committed to adopting new laws on healthcare, on the OMS system itself and on medical practitioners' professional liability. In addition, the planned legislation on "autonomous institutions" is intended to cover some medical facilities as well. However, progress on all these pieces of legislation has been very slow, and none of them had reached the statute books by mid-2006.

49. In principle, competition among insurers should encourage them to minimise administrative costs and improve services. It should also strengthen healthcare providers' incentives to increase efficiency, at least to the extent that insurers really can engage in selective contracting – the insurers' bargaining position will be weaker where healthcare providers have market power. Competition among providers is thus an important element of the system. However, realising the benefits of competition while maintaining comprehensive coverage and assuring equity in access, is difficult even in developed market economies with mature financial and regulatory institutions.[59] In Russia, with its weak contracting environment and poor state regulatory capacities, the challenges involved will be all the greater.[60]

50. Whatever the final shape of the healthcare system, it will be crucial to do more to empower patients, who currently have little ability to choose, or influence the behaviour of, either their insurers or their healthcare providers – let alone to hold them accountable for the quality of care received. Yet merely giving patients greater rights *vis-à-vis* insurers and healthcare providers will be insufficient – and possibly detrimental – if reform does not take place in the context of a wider effort to educate ordinary Russians and incentivise them to take greater responsibility for their own health. In addition to health education and promotion efforts, this may involve some reliance on formalising some sort of limited co-payments. However, if formalised cost-sharing is not to perpetuate the problems created by widespread informal payments, it will be important to exempt or subsidise the poor and other vulnerable groups. This, in turn, depends on the state's ability to identify members of such groups accurately.

51. If Russia is to reap the potential benefits of insurance-based medicine, it will be essential to move towards a much greater reliance on OMS-based, rather than budgetary, administration of healthcare finance. While direct budgetary funding may not disappear entirely, it is unlikely that the structure of incentives can be clarified and improved without a move away from the dual financing that healthcare providers now face. This will probably need to be accompanied by an increase in the overall level of healthcare spending, not only because it remains rather low relative to commitments but also because the scope for competition on quality will be limited as long as funding is stretched so thin. Yet with Russia's

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58. Under fundholding arrangements, primary care providers (*e.g.* general practices) receive funds to purchase designated services on behalf of a specified population, typically some hospital services and drugs. Primary care providers are allowed to retain surpluses for practice augmentation, creating an incentive to avoid over-referral and seek low-cost suppliers, but because they compete for clients, primary care providers also have an incentive to seek appropriate, high-quality treatment for their patients.

59. See OECD (2005a), (2004) and (2002); also: Docteur and Oxley (2003:38); and van den Ven *et al.* (2004).

60. The discussion that follows draws on the lessons identified in Sheiman's (2005 and 2006) comparison of the Dutch and Russian reform experiences and his assessment of the prospects for establishing effective competition among insurers in Russia.

low average wages, there must be serious doubts about the wisdom of financing the system wholly out of payroll taxes – increasing OMS revenues by raising the ESN is probably not desirable. A significant degree of reliance on general budget revenues is therefore probably both inevitable and necessary. Indeed, given the degree of inter-regional variation discussed above, a greater role for budgetary *sources* of finance may be needed in the interests of equity: reliance on payroll taxes will leave many poorer regions struggling to meet their obligations even under a streamlined benefits package. However, such budgetary expenditure could and should be *administered via* the OMS system.[61]

52. The authorities will also need to define the possible parameters for competition among insurers, which are currently very limited, since they cannot vary either the benefit package they offer or the rate of contributions. This is a problem common to many countries that have opted for public health insurance: insurers often play a very passive role, despite efforts to foster competition among them, precisely because they face few incentives to hold down costs and are required to offer a pre-determined package at a fixed price. Particularly when the insurance is primary (rather than complementary or supplementary) for some or all of the population, governments understandably wish to regulate in the interests of such objectives as access and equity. However, this limits the scope and incentive for innovation.[62]

53. There should be some scope for competing on *price*, although this will entail the introduction of some form of limited co-payment for either insurance or healthcare services themselves. OECD experience with cost-sharing reforms suggests that modest levels of cost-sharing for specific services have a limited impact on total consumption of care but can reduce unnecessary consultations without compromising access.[63] However, great care must be taken in designing cost-sharing reforms that involve co-payment for services. Such reforms can deter needed primary/preventive care, particularly among the less well off, unless preventive care consultations are exempt.[64] Limited co-payment generally has little impact on non-elective hospitalisation and other high-cost services, for which price-elasticities tend to be low. Cost-sharing on a scale large enough to suppress demand substantially is thus likely to affect access (raising equity concerns), and may have additional social costs. Measures to exempt vulnerable groups from cost-sharing or at least to cap their contributions would entail additional administrative costs and might well mitigate much of the effect of cost-sharing, since, given Russia's income distribution, a very large share of the population would probably have to be protected.[65]

54. This implies that cost-sharing for services should be restricted to certain types of discretionary services and to products for which cheaper substitutes are available. For the most part, this would limit co-payments to the kind of services and products that probably should not be included in the guaranteed package anyway. However, an exception might be made in the case of outpatient pharmaceuticals: a

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61. Hospital investment may remain the major exception to this shift. Many OECD countries still finance hospital investment out of central and regional budgets – even those, like Germany and the Netherlands, that rely on public medical insurance systems similar that which Russia is creating. The main risk here is that separating such investment from hospital operating budgets can lead to hospital over-supply and an increase in the capital-intensity of care if the capital costs are *de facto* free to the hospitals. The United Kingdom and New Zealand have sought to address this problem by introducing capital charges into hospitals' contracting arrangements. See Docteur and Oxley (2003:33).

62. See OECD (2005a); on the eight transition countries that entered the EU in 2004, see World Bank (2005b).

63. See OECD (2004:64) on the German case, and World Bank (2005b:118) on Slovakia's experience.

64. Germany's system of co-payments exempts preventive care consultations and also provides lower fees for people on social assistance. See OECD (2004:64).

65. See Docteur and Oxley (2003): The main impact of cost-sharing on demand will hit ambulatory care and pharmaceuticals. The chances of early diagnosis are likely to be reduced, possibly requiring more expensive treatment later on, and there is a risk that patients will not purchase/take prescribed drugs.

system of tiered co-payments could be introduced alongside the extension of the benefits package to cover outpatient drugs, in order to encourage cost-effective therapeutic choices.[66]

55. On the whole, then, co-payment for insurance is likely to be preferable in respect of services covered by the guaranteed package, at least for time being. One form of co-payment that might make sense would be modelled on the Dutch system, which provides for limited co-payment of insurance contributions rather than co-payment for services. The same co-payment applies to all insurees of a given company.[67] In order to avoid the emergence of a two-tier system in Russia, the maximum size of the permissible co-payment could be capped at 10–15% of the premium. Requiring companies to accept all clients who wish to join, while setting co-payments for all clients at a single level, would help prevent discriminatory screening by insurers: clients would choose insurers based on price, rather than insurers using pricing mechanisms to screen clients. Of course, any shift towards co-payment would be politically sensitive, but surveys suggest that the population is far from uniformly hostile to some form of co-payment (Shishkin, 2004:16), not least because so much formal and informal co-payment already takes place.

56. Steps are also needed to enable insurers to compete with respect to the *package* offered and on the *quality* of services offered. At present, all insurers are required to offer more or less identical coverage under a standard contract. It would probably make sense to insist that all OMS-participating insurers offer a basic minimum package – effectively, the range of services subject to state guarantees – but they should have the freedom to offer packages that include non-guaranteed services, as well as the possibility of offering additional benefits (more comfortable facilities, faster treatment, etc). This, in itself, would facilitate at least some degree of competition on quality. However, real competition in terms of quality would require more selective contracting on the part of insurers. The general tendency at present is for insurers to contract with all providers in a given area. They will need financial and other incentives to change this. This will probably involve more sophisticated contracts with the territorial OMS funds, which tend at present to pay the insurers simple capitation fees, differentiated in most cases only according to age and sex. Since most insurers bear no risk and simply collect fees for transmitting reimbursements from OMS funds to providers, they have no need to press for lower costs or better quality.

57. Closely related to this is the necessity of developing medical insurance companies' own informational, analytical and supplier-assessment capabilities. If they are to play an active role in the system, they will need to be capable of participating in the organisation of healthcare delivery in cooperation with healthcare providers. This would entail their involvement in assessing anticipated care volumes and planning regional programmes. They should have a key role to play in financial innovation in the sector, pressing healthcare providers to adopt more efficient payment mechanisms and supporting organisational and technical innovation. It is critical that insurers become real risk-bearers, capable of planning and managing the risks involved in medical insurance, rather than acting as passive middlemen, as they currently do in most regions. At present, the generally employed practice of retrospective payment for care delivered, combined with OMS reimbursement of cost overruns, gives insurers no incentive to negotiate more efficient contracts with providers. Only when insurers actually profit from better planning of care volumes and more efficient treatment of patients will they have an incentive to begin accumulating data on the most efficient clinical interventions and setting appropriate standards for providers. Ultimately, insurers need to develop the expertise required to assess – and even participate in the development of – so-called clinical-economic standards and clinical protocols.

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66. A tiered co-payment system assigns different levels of co-payment to different drugs. Many might be on a zero-tier (*i.e.* no co-payment) but co-payments for others could be used to encourage cost-effective choices among therapeutic alternatives (*e.g.* by encouraging the use of generic drugs where possible).

67. See OECD (2002:108).

58. While the aim of reform is to ensure that market signals create appropriate incentives for insurers over the longer term, there is much that regional authorities can do in the short-to-medium term. Sheiman (2006) points out that insurers have played a significant role in restructuring healthcare and increasing efficiency in a few regions, like Samara and Kemerovo. Yet the key factor in these cases seems to have been not competition in the market but the readiness of the regional authority to impose more extensive requirements on insurers wishing to handle OMS funds. Of course, regulation and competition are not alternatives here: by imposing more demanding requirements on participating insurers, including reporting requirements, the regional authority may actually be able to *foster* competition. Indeed, the authorities may need to stimulate competition among insurers in many regions. Although some insurers enjoy considerable market power in certain regions, the structure of the OMS insurance market is only part of the problem. In many places, creating real competition will also necessitate some restructuring of healthcare *providers*, to ensure that they do not have market power. Where providers dominate a particular market, the ability of insurers to engage in any kind of selective contracting will be limited. The Dutch experience points to the importance of loosening regulatory and other constraints that restrict supply: freedom to engage in selective contracting will mean little if insurers have little or no choice of provider.[68]

59. A further important step will be the creation of mechanisms that make it easier for individuals to choose their insurers themselves. The agency losses involved in leaving this decision in the hands of employers are substantial. There is no obvious reason why employers should ordinarily make such choices on behalf of their employees when the insurance in question is publicly financed – the Russian situation does not resemble that of a country like the United States, where the employer may be offering healthcare coverage as part of the remuneration package. The temptation for managers is to deal with captive insurers, in order to control the financial flows involved.[69] There may, of course, be a role for employment-based schemes where employers are able to negotiate particularly good packages for their employees, but the "default option" should be individual choice. This will require more than reducing the bureaucratic barriers facing an individual who wishes to change insurers: it will entail a major effort to provide citizens with the information needed to make informed choices. Here, too, the Dutch experience is relevant: as OECD (2002:108) observes, a major reason for relatively weak competition in the Dutch system following the introduction of limited co-payments for insurance was the lack of information made available by insurers to actual and potential clients. Insurers in Russia should be required to present operational plans, justifying particular provider choices, and to report on their performance in forms that were readily accessible to the public and easily comparable across insurance companies.

60. Fostering the emergence of a truly competitive pool of medical insurance organisations capable of playing the role envisaged for them will also make considerable demands on the state. For a start, there is a need for new arrangements for regulating insurance companies in the OMS system. This is probably not a job for the general insurance regulator, Rosstrakhnadzor, alone. The risks facing OMS-participating insurers will be related to their ability to assess care needs and contract efficiently with healthcare providers. There will thus need to be a regulatory authority with medical expertise, which Rosstrakhnadzor lacks, although it may have a role to play in overseeing insurers' management of investment portfolios.

61. A large part of the regulator's task will relate to the prevention of "bad" competition for individual clients. Insurers will naturally want to attract the healthiest (lowest-risk) clients, but if competition is not to undermine equity objectives, then it will be important to ensure that this does not occur.[70] In principle, all insurers should face more or less equal risk, and risk-screening should be

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68. See OECD (2002).

69. Unless managers are taking kickbacks from insurers, as reportedly occurs in some cases.

70. Bertens and Bultman note that the Dutch health insurance reform was necessitated in part by the fact that risk-selection by private insurers destabilised the system of voluntary insurance in the 1980s.

prevented. Such screening can be made more difficult by imposing regulatory and reporting requirements on insurers. In many OECD countries (*e.g.* the Czech Republic, The Netherlands), the authorities simply ban selection, requiring insurers to accept any enrolees at uniform premia. However, some countries have gone further in an effort to minimise the incentives to engage in risk-screening by equalising risk. This is the approach taken in Germany, where the risk-adjustment mechanism compensates health funds for the risks associated with the gender, age, dependents, income and chronic conditions of their clients.[71] The Dutch system also takes account of disabilities as well, and includes a regional factor.[72] Empirical research suggests that personal health history is the best indicator of future healthcare consumption, but the information requirements involved in linking capitation payments to personal history would be enormous. It is likely that a less-than-perfect risk-equalisation formula, coupled with regulations banning selection, would be adequate to minimise "cream-skimming".[73]

Is there scope for regional diversity of approach?

62. It is clear from the foregoing that creating real competition among insurers is an enormous challenge, requiring substantial up-front investment in rules, institutions and information. It will make significant demands on the state's administrative and regulatory capacities. If the resulting competition turns out to be weak, the benefits that it generates may be correspondingly limited – and the costs may then outweigh the benefits. Thus, some observers take the view that Russia is unlikely to be able to create a well-functioning, competitive insurance system in the foreseeable future and that the resources such an effort would require should be directed elsewhere.[74] However, as noted above, conditions vary widely from region to region. In a few, like Samara, the OMS system seems to work well. In most it does not, but whether it is better to opt for another model or to improve the OMS framework depends in part on regional conditions and capacities, as well as on regional authorities' own commitment to making the system work.

63. At least one Russian region is already moving towards an alternative approach: a single-payer model. In Leningrad Oblast, the regional OMS fund is now responsible for paying healthcare providers, and the insurers' role has been reduced to secondary functions concerned with quality assurance. Leningrad's move highlights one of the potential benefits of Russia's federal structure: there may be scope for varying the role of insurers across regions. The federal authorities themselves might therefore seek to stimulate enter into discussion with regions about possible pilot projects involving different variants of healthcare reform. If the authorities in a given region are not ready and willing to make a sustained push to complete the creation of an insurance-based system and to commit the resources needed to achieve this end, then they might well be better off considering another model. Given where Russia now stands with respect to healthcare reform, the single-payer model might well be a logical alternative for some regions. The essential condition that must be preserved is equal access: within the limits of the guaranteed package, persons with equal need should receive equal treatment, and individuals who require medical assistance outside the regions where they are registered for OMS should not have problems securing it.

64. In principle, a single-payer model should allow for a reduction in administrative costs and would eliminate some of the potential problems with competitive insurance identified above, such as risk screening. Greater pooling of financial resources and risk would arguably be more economically efficient and more equitable. In addition, the single-payer model would preserve the basic purchaser–provider split introduced in the early 1990s, which should certainly be retained. Moreover, regional OMS funds, operating as single payers, should have the market power required to negotiate from a position of strength

71. OECD (2004).

72. Bertens and Bultman (2003).

73. Cf van de Ven *et al*. (2003).

74. Sheiman (2005) inclines to this view.

when concluding contracts with healthcare providers. The funds would need to be able to refuse to contract with providers whose services or quality of care was deemed unsatisfactory. However, it would be a mistake to see the single-payer model as a simple panacea, not least because it would leave the state in the role of both sole provider and sole buyer of healthcare services, raising the risk that the purchaser–provider split would mean less in practice than on paper. The key would be to define the OMS funds' tasks in such a way as to present regional OMS managers with incentives to act in the best interests of the patients they represent, pursuing both efficiency and quality of care. This would not be easy: in the absence of competition and the profit motive, other means would have to be found to motivate and monitor the managers of both regional OMS funds and healthcare providers; the inclusion of some sort of performance criteria in managerial contracts might help, although the criteria would have to be carefully calibrated if they were not to lead to undesirable distortions of managerial behaviour.

65. Ultimately, any mechanism for quality assurance that does not ensure providers' accountability to consumers is likely to involve very large agency losses. Any shift to a single-payer model would therefore necessitate the development of mechanisms to ensure greater competition in the provision of healthcare services. Unable to choose their insurers, patients would have to be given greater freedom to choose primary healthcare providers at least, whether public or private, even if this freedom were constrained by the power of the OMS funds to refuse to contract with providers whose services were deemed unacceptable.

How can the problem of micro-level incentives be resolved?

66. It would in any case be a mistake to see the choice between an insurance-based model and a single-payer system as the only important question connected with healthcare finance. Whichever model of financing is preferred, much will have to be done to change methods of payment to healthcare providers and, where possible, to foster competition among them. Indeed, it may well be that changing the micro-level incentives confronting healthcare providers will matter more than the question of competition among insurers. With respect to primary care providers, the challenge is to avoid the extremes of under-treatment and over-referral, on the one hand, and over-treatment on the other. Practitioners should be motivated to pay attention to patient preferences and to keep patients healthy.[75]

67. There is room for experimentation here, and Russia's federal system allows ample scope for just that, but the most promising approach is likely to involve some form of weighted capitation fees for primary care. However, such a system could create incentives to screen potential patients if the capitation weights were poorly devised. At the very least, there would need to be restrictions on primary practitioners' ability to turn away patients who wished to register with them, but more sophisticated capitation weights would reduce incentives to screen and thereby also reduce the need to rely on regulation. Current practice varies: most regions used capitation weights that take account of age and gender, and a fair number include place of residence, but other criteria are little used. Given the role envisaged for primary care providers as gatekeepers, an element of fundholding would probably be desirable at some point, particularly if outpatient specialist care is organised on a fee-for-service basis, as is common in OECD countries. The risk of supply-induced demand is high, and it would be important for GPs to have the incentives and authority to limit it. However, the transition to fundholding will take a long time, since it depends directly on the strengthening of primary care in general and the development of a corps of well qualified GPs in particular. The gatekeeping/fundholding role should not be imposed on providers who are not yet equipped to provide good, integrated primary care.

68. In the hospital sector, there is a clear need for more active purchasing/contracting by payers – whether they are private insurers or regional OMS funds. This implies a significant reduction in the

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75. Docteur and Oxley (2003:29).

hospital sector's reliance on direct budgetary funding (whether line-item budgets or block grants), as well as a decisive move away from bed-day payments. Payment per service risks over-treatment, which may be less acute in the case of payment per treated case, but both systems will necessitate other forms of expenditure controls. In OECD countries, hospital-payment systems are increasingly organised around diagnostic-related groups (DRGs). Fees in such systems are set prospectively according to diagnosed medical conditions and standardised treatment costs. Different pathologies are grouped into homogeneous cost groups and average costs of treatment are estimated. A provider then receives a lump-sum payment for treating a patient; the size of the payment depends on the group to which the patient is assigned. Prices are set administratively for each category. A minority of Russian regions have, in fact, developed systems of clinical-statistical groups (KSGs) along these lines; some are quite elaborate, while others are still rudimentary, but most regions have yet to adopt such an approach.[76]

69. Docteur and Oxley (2003:32) observe that systems like this help ensure that resources are allocated on the basis of output and can give purchasers some control over the intensity of treatment. Hospitals face incentives to reduce costs and to reorient their provision to address changes in demand. Though increasingly popular in OECD countries, such approaches are not unproblematic. Prices have to be set to reflect actual cost structures and need to be adjusted regularly as practice patterns change: without an effective system of quality-control and good prices, DRGs can simply creative incentives to reduce the quality of care in the interests of cost-reduction. Moreover, prospective cost-and-volume contracts can reduce the incentives for hospitals that engage in both preventive care and treatment to pay sufficient attention to the former.[77] Care must also be taken to prevent providers from "bumping" patients into higher-cost categories. Some sort of risk-sharing in the event of cost-overruns must also be agreed, since providers will try to avoid high-risk patients if they must bear the risk of cost overruns arising from exceptionally expensive cases. Finally, care must be taken to control costs globally, lest output increases lead to excessive spending across the system.

Conclusion

70. The government's medium-term priorities for healthcare reform reflect well the major problems affecting Russia's healthcare system, and its recent efforts to revitalise the healthcare reform process are to be commended. However, implementing the complex and ambitious agenda the government has set for itself will not be easy. Healthcare is an area in which reform will of necessity proceed relatively slowly. It will take time to develop new capacities, particularly in the field of human resources. In pursuing the kind of restructuring outlined in this paper, great care must be taken to minimise the risks of disruption to the healthcare system. Different strands of reform need to proceed in tandem, so as to ensure that rules, institutions and incentives are coherent, and that resources are adequate to support the development of new activities and forms of care. However, these concerns should not be seen as grounds for delay. On the contrary, they all point to the conclusion that healthcare reform will be a long and complex process. The longer it is put off, the greater the risk that it will eventually be undertaken precipitously and executed in haste in response to a crisis in the system.

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76. In a comprehensive study of the organisation of regional healthcare systems in Russia, Shishkin *et al.* (2005) find that five regions had highly developed KSG systems in 2004 (with 270 or more KSGs defined) and a further nine had elaborated systems of medico-economic standards (MESs). Another nine regions had limited systems of KSGs or MESs (under 100 groups or standards), while 61 had none.

77. OECD (2004:67).

Box 1. Recommendations on healthcare reform

Reform of the healthcare system must be undertaken as part of a much broader drive to improve health and mortality outcomes, encompassing reform of the public health system, improved health education and promotion, and increased efforts to reduce deaths arising from external causes, such as environmental degradation and unsafe roads. Nevertheless, there is much that can be done to improve the delivery of medical services to the population. Moreover, reforms can help ensure that the increases in healthcare expenditure, which Russia needs, are used to best effect.

Resolving the mismatch between commitments and resources

- While raising public healthcare spending, revise the guaranteed benefits package to bring formal commitments into line with available resources, dropping those guarantees that create perverse incentives or are likely to prove financially unsustainable.
- Create mechanisms to enable citizens to take effective action, at reasonable cost, if the commitments made in the revised guarantee package are not met.
- Establish a framework for regular, transparent review and revision of the guaranteed package in light of medical, technological and economic change.

Strengthening the OMS system

- End the "two-channel" budget–insurance system of financing healthcare and ensure that the great bulk of healthcare spending takes place *via* the OMS system, if necessary by channelling most budgetary resources through OMS funds.
- Create mechanisms to make it easier for individuals to assess the relative performance of medical insurers and to choose their own insurers.
- Strengthen the regulatory framework governing the activities of medical insurers in the OMS system, imposing greater demands on them to play an active role, while simultaneously expanding their freedom to compete with one another. It is critical that they be made risk-bearers.
- Encourage pilot projects in the regions with respect to OMS reform, including, where appropriate, experiments involving a single-payer system.

Reducing uneconomic hospitalisation and specialist care

- Build on the current push to increase investment in primary care in order to establish a long-term, coordinated effort to strengthen the training of primary care physicians (GPs) and to provide them with practice settings that favour the provision of integrated primary care.
- Shift away from cost-reimbursement or capacity-based methods of financing healthcare establishments in favour of more efficient methods, such as cost-and-volume contracts.
- Experiment with fundholding and other methods of remuneration for primary care providers that enhance their incentives to keep patients healthy or to treat them on an outpatient basis where possible.

Pharmaceuticals provision

- Eliminate the inpatient/outpatient distinction in determining eligibility for free medicines and restructure the arrangements governing access to free medicines, emphasising proven efficacy, safety and cost-effectiveness – with particular stress on the added value of new or especially expensive drugs. A tiered system of co-payments may have a role to play here.
- Continue efforts to promote more rational drug prescription *via* the development and application of more sophisticated drug formularies and treatment guidelines.

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ANNEX 5.A1

The Guaranteed Package Programme

The Guaranteed Package Programme stipulates that the following services are to be provided by the budget:

- emergency care;
- ambulatory, polyclinic and hospital care provided to patients with socially significant diseases, including: skin and venereal diseases, tuberculosis, AIDS, mental problems and drug addiction;
- pregnancy and delivery abnormalities;
- some types of conditions of children and infants;
- systematic monitoring of healthy children (*dispanserizatsiya*);
- specialised pharmaceutical care and prostheses; and
- some other types of expensive medical care, including high-tech procedures.

Free services to be covered by the OMS funds include:

- ambulatory, polyclinic and hospital care provided to patients with contagious and parasitic diseases, excluding venereal diseases, tuberculosis and AIDS;
- cancer, endocrine system diseases, skin diseases;
- nutritional abnormalities and nervous system diseases;
- blood diseases, immune system pathology, heart and circulatory diseases;
- eye, ear and respiratory diseases;
- pathologies of the digestive system, all types of injuries and poisonings;
- bone and muscle diseases;
- some types of inborn adult pathology; and
- some other diseases.

Some services are explicitly excluded from the guaranteed package, specifically:

- cosmetic surgery;
- homeopathic, alternative, or “non-professional” therapies offered by practitioners with no medical qualification (although some regions do allow territorial OMS funds to finance such therapies);
- dental services, with the exception of basic provision for children, veterans and some other groups;
- medical prostheses including dentures (except for veterans and other specified groups);
- rehabilitation or convalescence in institutions other than those approved by the Ministry of Health;
- educational activities and health promotion literature from non-Ministry of Health-approved health centres; and
- pharmaceuticals for outpatients.

Medical staff are empowered to determine the most appropriate treatment and may refuse to provide treatments demanded by patients who have referred themselves.

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