Russia’s National Drug Insurance: Healthy Society, Healthy Economy

As Russia faces a declining population and a rise in chronic illness, a new, pharma-focused healthcare system could boost the economy and improve clinical outcomes.
Russia is on the horns of a dilemma. In the 10 years leading up to the recession of 2008–2009, Russia’s economic growth seemed unstoppable, expanding at an average annual rate of 7 percent as oil prices rose and the energy sector thrived. And even since the recession, which led to a sharp drop in GDP in 2009, the economy has quickly rebounded, growing at a healthy 4 to 5 percent in 2011.¹

However, in the past 15 years, Russia’s population has declined nearly 4 percent, which is hardly the recipe for long-term sustainable economic development. According to the latest World Health Organization (WHO) statistics, life expectancy for a Russian male is now 61.8 years and 74.2 years for a female (see figure 1). Russia’s average life expectancy is 20 percent lower than that of most European Union member states—only slightly better than for males in Haiti and Myanmar—and roughly 10 percent below those of comparable emerging countries. Deaths from cancer, cardiovascular disease, and alcohol-related disease have thrown Russia into what the United Nations calls a state of “hypermortality” that is having a grave impact on health, social welfare, and national productivity. Furthermore, continued economic development predicted for the next decade could accelerate these trends as increased wealth and improved quality of life lead to richer diets and less exercise, and exacerbates the risk factors for chronic diseases.

Figure 1

Russia faces serious demographic challenges

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<td>(Index, 1998=100)</td>
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<table>
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<tr>
<th>Mortality causes</th>
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<tr>
<td>Population age 15 and older, 2008</td>
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<tr>
<td>Ischemic heart disease</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
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<tr>
<td>Unintentional injuries</td>
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<tr>
<td>Other</td>
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<table>
<thead>
<tr>
<th>Life expectancy</th>
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<tbody>
<tr>
<td>2009</td>
</tr>
<tr>
<td>Russia</td>
</tr>
<tr>
<td>Brazil</td>
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<tr>
<td>China</td>
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<td>Turkey</td>
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<td>UK</td>
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<td>Germany</td>
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<td>France</td>
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<tr>
<td>Canada</td>
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<tr>
<td>Spain</td>
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Source: Economist Intelligence Unit, World Health Organization

¹ Growth rates refer to GDP growth in constant rubles.
However, the major causes of death in Russia are largely preventable and treatable, which means that this population trend is avoidable. The problem is that the nation’s healthcare system is ill-equipped to deal with the sharp increase in incidence of chronic disease. Russia has neither the sustained level of investment in resources and infrastructure to provide its citizens with timely access to affordable, high-quality healthcare, nor a cohesive healthcare policy that rewards longer-term changes in behavior.

As we know by observing other countries, effective healthcare systems are both possible and affordable. For Russia, such a healthcare system would present the government with a golden opportunity to provide a social and economic breakthrough for its people.

Russia’s healthcare system is ill-equipped to deal with the **sharp increase in incidence of chronic disease.**

Russia is not alone in its problems, and the lessons learned from the country’s current dilemma are instructive for countries seeking to reshape healthcare policy as a way to drive and support sustainable economic development. In this paper, we examine a major aspect of the healthcare policy debate taking place in Russia today—national drug insurance (NDI).

**A Vision for National Drug Insurance**

While some drug coverage already exists in Russia, the system is plagued by many issues, including low funding levels, relatively late disease intervention in the clinical pathway, high copayments that discourage treatment compliance, and the possibility to choose a cash payout without having to purchase any medicine. Generally speaking, Russia’s drug system treats coverage as a cost to be controlled rather than a cost-effective investment in social wellbeing. Furthermore, the quality and safety profiles of medicine on the Russian market is unclear—by some accounts, as much as 15 percent of medicine in Russia is counterfeit—so treatment variability for the same disease is high.

With this in mind, A.T. Kearney recently examined roughly 20 NDI schemes around the world. We consulted with health policy and health economics experts to identify best practices that maximize the benefits of drug coverage and contribute to the development of a healthy, viable domestic pharmaceutical industry. In the course of our work, we also conferred with primary Russian stakeholders at the federal and regional levels.

Our analysis of drug-coverage models is structured around three linchpins critical to a proper balance between economic and health priorities: coverage and eligibility, structure and funding, and controls and incentives (see figure 2 on page 4). We also examined how certain aspects of the overall health system and its economics influence NDIs’ sustainability and effectiveness in terms of health outcomes.
Our findings helped us define the contours of a best-practice NDI scheme for Russia. That model features, among other characteristics:

**Coverage and eligibility.** A federally approved minimum formulary balances essential drugs, chronic care, and innovative new therapies. It includes tiered patient participation in drug costs—initially up to 50 percent but moving progressively to 20 to 30 percent—with full exemptions for those who cannot afford to contribute, and with hospital products free at the point of delivery. And the right to receive federal contributions to drug purchases as a cash payment is discontinued.

**A best-practice NDI scheme would improve medical outcomes, create a more productive workforce and create sustainable economic development.**

**Structure and funding.** A competitive market for supplementary insurance covers patient copayments, with clear accountability for drug budgets and funding flows at the federal and regional levels.
Controls and incentives. Electronic medicine tracking is established in accordance with future European Union standards. New ambulatory-care incentives focus on early diagnosis and treatment of chronic diseases, recognizing that medicine is an investment that helps avoid future costs. High levels of automation ensure real-time monitoring of activity, efficient claims processing, and swift reimbursement.

A model designed in accordance with these principles would not only improve medical outcomes, create a more productive workforce, and, potentially, create sustainable economic development, but it would also lay the groundwork for an innovative domestic pharmaceutical industry (see figure 3).

Figure 3
Practices from other markets can illuminate the path for Russia

Key areas of the program

Coverage and eligibility

- Deliver universal coverage
- Ensure patient participation in ambulatory drug costs (~20%-50%)—must not limit access to care
- Provide protection for those unable to pay
- Arrange for free medicine in hospital settings

Structure and funding

- Integrate medicine and health services funding
- Require mandatory contributions; no opt-outs
- Create comprehensive national formulary
- Ensure federal accountability for minimum standards; allow regional flexibility to address needs

Controls and incentives

- Enforce medical practices; ensure thorough supply chain tracking
- Invest in chronic care pathways
- Adhere to best-practice clinical guidelines and monitoring
- Create incentives for innovation (for example, transparency in pricing and reimbursements)

Source: A.T. Kearney analysis

In the following sections, we examine in greater detail some of the best practices we found and the implications for the design of an NDI scheme for the Russian market.

Coverage and Eligibility

Any rational payer in a health system is seeking to maximize its return on healthcare and medicines spending. Following this logic, and considering the finite nature of financial resources, a payer should naturally seek to fund those treatments, interventions, and medicine that generate the greatest health benefit for an insured population. While developing countries such as China and Mexico provide coverage in line with the WHO’s essential drugs list, European
nations such as Germany and Sweden tend to provide broader medicine coverage, including innovative drugs that offer significant improvements in quality and standard of care. Generally, funds spent on drugs that prevent disease and manage chronic illnesses—starting relatively early in the clinical pathway—provide more “bang for the buck” than money spent managing conditions that have reached the acute stage (see figure 4).

Determining which population segments to include in a drug-insurance scheme, and whether their participation is voluntary or compulsory, is another major aspect of the coverage and eligibility debate. In this respect, basic social concepts of fairness and equality come into play, as do considerations of how to create a risk pool balanced enough to make premiums—whatever their source—affordable to all people and to the system as a whole, with healthy citizens helping to finance the sick. Turkey, Spain, and France, for example, require all their citizens to pay into national public health insurance, while Australia offers its residents a private-coverage option in lieu of enrolling in the public plan. Most health-system experts consider compulsory healthcare and drug coverage under state-run programs, with no potential for opt-out, to be the most appropriate way to fund the provision of medicine.

Another consideration is the degree to which insured patients are obligated to share in the cost of their prescription drug purchases through out-of-pocket deductibles or copayments. While some copayments can be a sensible way to encourage responsible behaviors, the system must be designed so not to discourage drug usage for critical illnesses that, if left untreated, would lead to more severe health problems (and considerably higher social expense elsewhere in the system). It is particularly important that copayment systems be designed to enable the poor and disadvantaged, who tend to suffer more from chronic diseases, to access medicine.

### Figure 4

**Basic drugs tend to be more cost-effective**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Medicine</th>
<th>Economic impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special management</td>
<td>Death-postponing or orphan drugs</td>
<td>Usually not cost-effective</td>
</tr>
<tr>
<td></td>
<td>High-cost drugs</td>
<td></td>
</tr>
<tr>
<td>Enhanced management</td>
<td>Chronic care • Second-generation technology • Second line</td>
<td>Economically justified in certain situations based on quality metrics</td>
</tr>
<tr>
<td>Core management</td>
<td>Chronic care • First-generation technology • Generics</td>
<td></td>
</tr>
<tr>
<td>Disease prevention</td>
<td>Essential lifesaving</td>
<td>High returns to health system and economic productivity</td>
</tr>
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Source: A.T. Kearney analysis
Many countries apply tiered discount systems based on therapeutic indications and the ability to pay (see figure 5). For example, Spain recently enacted reforms that require its insured population to pay between 40 and 60 percent of the cost of prescription drugs dispensed outside of the hospital setting, depending on family income and number of children, although copayments are limited to 10 percent and capped at €2.69 (roughly $3.50) for drugs used in the long-term treatment of chronic conditions such as high blood pressure, high cholesterol, or diabetes. Pensioners have to pay 10 percent of the cost of medicine, up to a monthly limit of either €8 or €18 ($10 or $23, respectively), depending on income. In France, patients who suffer from a number of long-term disorders, severe disabling conditions, or multiple illnesses are exempt from copayments, subject to approval by a medical inspector. Turkey provides full drug insurance to three socially vulnerable groups: those who earn less than one-third of the minimum wage, pensioners, and patients diagnosed with chronic diseases.

### Figure 5
**Copayment plans vary significantly by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Copayment covers</th>
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<tbody>
<tr>
<td><strong>Canada</strong></td>
<td>Quarterly drug insurance deductible, which is based on patient’s income (patient pays pharmacist fees)</td>
</tr>
<tr>
<td><strong>France</strong></td>
<td>25% of drug cost in most instances; varies by drug class</td>
</tr>
</tbody>
</table>
| **Germany** | Drugs included on negative lists  
Minimum of €5 and maximum of €10 per prescription (patient pays price difference of brand drug versus generic) |
| **Spain**   | 40%-60% of drug cost for active population  
10% of drug cost for most pensioners, with monthly limit of either €8 or €18  
10% for chronic diseases, with cap of €2.69 per prescription |
| **Turkey**  | 20% of drug cost for employed patients and their relatives  
10% of drug cost for retirees                                                                                           |
| **United Kingdom** | £7.65 per prescription (exemptions for patients who are over age 60 and under age 16; receive government support; or have certain diseases, including cancer, diabetes, and epilepsy |

Source: A.T. Kearney analysis

Setting copayments at a level that optimizes financial participation and patient access to care is crucial. Many best-practice examples of multi-tier copayment structures exist, incorporating large differentials designed to create clear incentives for lower-tier use. Consider, for instance, medicine for which there is strong evidence of effectiveness when prescribed early, such as those used to treat diabetes and hypertension. Such medicines can have the lowest copayments in a multi-tier structure, thereby encouraging earlier uptake and treatment adherence while reducing longer-term healthcare costs. Managed-care plans in the United States, for example, are finding that they need targeted copayment reductions to encourage effective care in certain long-term conditions such as type 2 diabetes.

Drawing on our examination of international markets, then, we recommend that Russia establish a national medicine formulary that covers not only essential drugs but also medicine that manages chronic diseases. Participation in the system should be compulsory.

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2 Pensioners with annual income greater than €100,000 must pay 60 percent of the cost of medicine, up to a monthly cap of €60. Retirees receiving the minimum pension and long-term unemployed who no longer receive subsidies, are exempt from copayments.
for the entire population, not only to build a viable risk pool but also to ensure that everyone has a stake in its success. At first, a 50 percent copayment level seems reasonable in a country whose citizens are accustomed to bearing the full cost of medication—maintaining exemptions for children and veterans, and possibly a 20 percent copayment for pregnant women and patients diagnosed with the top 10 diseases.

**Structure and funding.** The first question when it comes to funding is to what extent medicine and healthcare coverage can be managed separately. Medicine, of course, cannot be treated as a mere consumer good, nor should the use of medicine be considered optional. Rather, medicine is one more instrument in the disease-treatment toolbox—although perhaps the one most frequently used, most accessible to the patient, and, hence, the one whose cost payers fear is most likely to spiral out of control. Consequently, is it preferable to combine monies to pay for medicine and health service coverage, or is it better public policy to fund each separately?

A comparative review reveals models at both ends of the spectrum. Canada, for example, distinguishes between funding of health services and medicine, with the latter financed through separate insurance plans (both public and private). On the other hand, Turkey—similar to most models in Western Europe—uses the same revenue source to fund both, although spending for each is budgeted separately.

Integrating the funding of both avoids perverse incentives to favor one at the expense of the other, which tends to lead to poorer overall health outcomes and higher costs. In short, joint funding allows the system to manage the “whole patient.” Nonetheless, even in integrated systems, spending on medicine is always under threat from cost-containment measures because it is easy to get at, and it avoids more politically difficult decisions such as cuts in services, staffing, or facilities. To avoid the diversion of funds to less efficient areas, drug spending is best protected through earmarked allocations.

A second major issue to consider when examining structure and funding is the respective roles of private and public insurers. In countries such as France, where high per-capita medicine consumption causes drug copayments to add up quickly, private drug insurance markets thrive, helping to ensure that patient access to medicine does not suffer. In other systems, the role of private insurance is largely limited to covering secondary care.

The final issue is structural, namely the extent of government centralization necessary to fund and administer the drug insurance program. Again, successful examples can be found across the continuum. France exercises strong national control over nearly every aspect of the drug-insurance system, with the regions’ role limited to administration. Spain combines strong regional administration with a basic framework of national controls: marketing authorizations, value assessments, and pricing are the prerogative of the central government, while regional governments oversee medicine budgets, formularies, and administration. It should be noted, however, that decentralization of health insurance in Spain seems to have reached its limits, and much of the public debate now revolves around the need to ensure greater uniformity across the country. Canada, which also has a federal structure, has likewise propitiated a more regional approach. As in Spain, this arrangement has become increasingly divisive, given the high variations in coverage and patient participation in costs between rich and poor provinces. Federal authorities are crucial to ensuring that minimum universal standards are set and that risk-equalization funding mechanisms are in place. Whichever model is chosen, clear accountability is vital.

Our recommendation to Russia is, first, that healthcare and medicine be jointly financed, with funding for the latter protected through specific appropriations. Second, while the emergence
of a vibrant private health-and-medicine insurance market in Russia would be desirable, those
who choose to purchase such insurance should not be allowed to opt out of the public system.
Third, marketing authorizations, pricing and reimbursement decisions, value assessments,
and definition of the minimum formulary should be conducted at the federal level. Regional
governments could be allowed to participate in administering medicine and managing the
budget, but they should not be allowed to overrule—or undermine—federal decisions.

Controls and incentives. All of the markets we reviewed have a comprehensive framework of
controls and incentives to drive cost-effective, quality prescribing and to assure patient safety.
At a basic level, authorities must be able to guarantee that medicine is safe and that patients are
protected from predatory pricing if they are required to make major out-of-pocket contributions
to the cost of their drugs.

Counterfeit drugs are rampant in many parts of the world, as are drugs made with suspect
raw materials or using methods that fail to conform to good manufacturing practice (GMP).
Supply-chain integrity is crucial to protecting consumers from unscrupulous profiteers.

Implementation in Russia will require
a shift to a longer-term emphasis on the
prevention, early detection, and timely
management of chronic diseases.

Most developed markets have high-quality standards and tough supply controls. Mexico, Brazil,
China, and many other countries, on the other hand, continue to struggle with falsifications or
drugs of dubious quality that endanger public health. Considering the stakes, GMP must be
strictly enforced, and drugs must be systematically tracked throughout the supply chain. This is in
the best interests of patients and for the development of a competitive domestic pharmaceutical
industry. European markets will be progressively implementing two-dimensional data matrix
barcoding—with a unique encrypted code for each pack—to track products at every step in the
supply chain. Given the complex nature of Russia’s pharmaceutical supply chain, compounded
by the problem of counterfeits, authorities will be best served by adopting similar standards.

Patients also need to be protected from price exploitation by distribution channels. The
overwhelming majority of the best-practice markets we examined either set nationally
approved prices or establish maximum prices. In addition, margins and markups at each
stage of the supply chain, at both the wholesale and pharmacy levels, are often either fixed
or capped to ensure transparent pricing throughout. The dispensing of expensive drugs is
increasingly restricted to hospital settings as a means of keeping their costs under control.

Moving beyond the basics, the current focus for most of the best-practice systems we examined
is the enactment of clinical guidelines. More than ever, payers and health administrators are
balancing limited resources against rising social demands, and they are pressing for providers
to adopt consistent best practices to ensure the most effective use of resources. In relation to
drugs, the main trend is to manage their appropriate use at each stage of the patient pathway
so that innovative products are used when there is evidence of their effectiveness, and cheaper
alternatives are favored over more expensive options when both would provide the same
outcome. Clinical guidelines, however, should not just reflect cost priorities, but also the patient’s right to high standards of care. Clinicians should have the flexibility to exercise their judgment where there is a clear patient interest.

Of course, what isn’t measured doesn’t get done, as the saying goes, and no control system can work without a well-designed, well-oiled information and performance-management system that offers a transparent view into how money is being spent. Spain and France lead the pack in terms of how they capture and report information on drug prescription and dispensation, and how they track funds. Best practices include electronic patient eligibility cards (such as Turkey’s “green card” or France’s Carte Vitale) and automated, near real-time fund flows between payers, the pharmacy network, and patients, thus minimizing administrative costs.

For Russia—and particularly for the safety of its citizens—the enforcement of GMP and the implementation of EU-compliant medicine tracking are vital steps. Medicine should be priced at a sufficiently attractive level to encourage the development of a local supply base, and channel margins should be regulated to avoid abuses. Furthermore, establishing federal clinical guidelines (with regional modification, if needed) can make sure that the right drugs are used at the best time in the patient pathway. Lastly, instituting patient eligibility cards and electronic financing systems can enable swift payment and ensure transparent funding.

Balancing Health and Economic Priorities

As we noted previously, experience shows that an NDI strategy can contribute significantly to national productivity over a relatively short timeframe—provided that drugs are seen as an investment and not a cost, and funding is targeted at addressing chronic illnesses. Moreover, as Russia’s own Pharma 2020 strategy already acknowledges, a new approach to medicine coverage presents a significant opportunity for the Russian government to look beyond the immediate healthcare benefits of NDI and seize the opportunity to transform the prospects of domestic pharmaceutical research and production by creating an attractive market that can attract quality investment.

For Russia, it might be tempting for the government to look at its industrial policy separately from its approach to drug coverage, where budget optimization may be the main goal, but the two are clearly interdependent. The competition for quality investment is truly global in nature, starting with academic powerhouses on the U.S. east and west coasts and going around the globe to new life-sciences hubs springing up around Shanghai, Singapore, and near Hyderabad, India. But the interdependency goes further. The development of a viable and sustainable medical research industry in Russia requires scientists and clinicians with experience on the cutting edge of treatment. Increasingly, clinical trials are designed to make head-to-head comparisons, so having a sufficient number of patients treated according to the current standards of care will be essential to attracting investment in clinical research. As the United Kingdom has learned to its regret, a pure focus on cost effectiveness not only can run counter to the best interests of patients, but also lead to deterioration in a location’s attractiveness as an investment destination as clinical professions become increasingly “de-skilled.”

Companies seeking to invest and build a presence in Russia—or any market, for that matter—must trust that their investment will be safeguarded through rigorously enforced industrial-property laws and anti-counterfeiting measures that protect patents and revenues. Profit reforms, together with incentives for R&D and other investments, are important steps that both emerging and
developed countries have effectively used to build local pharmaceutical industries (see sidebar: Ireland: Building a Thriving Pharmaceutical Industry). Mexico and Turkey, for example, have introduced data exclusivity laws that protect against the duplication of patented medicines. Brazil has reduced tax rates on pharmaceutical manufacturing, and the United Kingdom has profit allowances for pharma investments. Turkey also offers tax exemptions on R&D expenses and income-tax reductions for employees to encourage investment in pharmaceutical R&D.

Challenges to Implementation

The principles we’ve outlined can guide the creation of an expanded Russian NDI scheme that builds on the solid foundations of existing territorial funds, using them as the basis for an integrated health-and-medicine fund in ambulatory settings to better manage total patient costs. However, implementing broader drug coverage will require additional funding that cannot be covered by simply making the system more efficient—indeed, Russia’s per-capita spending on medicine lags other comparable economies. This issue must be tackled head-on (see figure 6).

Ireland: Building a Thriving Pharmaceutical Industry

Ireland is a good example of how a well-thought-out industrial policy can lead to a vibrant pharma-ceutical industry. Over the past 20 years, Ireland has made a concerted effort to develop a local pharmaceutical industry and attract inward investment, lowering its corporate tax rate to a flat 12.5 percent and investing in education to create a pool of highly qualified scientific and medical specialists. Through these policies, Ireland has become a leading net exporter of medicine globally, with the pharmaceutical industry accounting for more than half of Irish exports in 2008 and contributing 11 percent to GDP. Between 1990 and 2003, jobs in the industry grew 10 percent annually, and by 2008 two out of every five pharmaceutical jobs created in Europe were located in Ireland. Today, eight of the 10 top pharma companies have Irish facilities, and five of the top 12 drugs are manufactured in Ireland (including Lipitor, Enbrel, and Remicade). Pharmaceutical industry investments in Ireland in the past 10 years alone amount to more than €7 billion.
While any number of options—including employer contributions, wealth taxes, or so-called sin taxes on alcohol and tobacco—could be developed to cover funding needs in the medium and long term, initial pump-priming will be needed to get the new drug-insurance scheme going. In line with other resource-rich countries such as Norway, which has used its oil wealth to help build a highly developed welfare state, Russia might also consider letting sovereign wealth funding play a significant role in financing NDI.

Implementation in Russia will require resolving several contentious and complicated issues about how to shift from a near-term focus on curing diseases and protecting the frail to a longer-term emphasis on the prevention, early detection, and timely management of chronic diseases. Specifically, Russia will need to:

- Develop a system to cap copayments at a level that neither discourages patients from seeking treatment for chronic diseases nor denies citizens access to the medicine they need
- Find the proper balance between innovation, affordability, and health outcomes through a combination of reference prices and clinical guidelines, in concert with pharmaceutical manufacturers operating in the Russian market
- Provide the control mechanisms and tools necessary to protect the system from runaway spending and ensure the transparency of financial flows, even in the face of universal coverage

An advanced NDI model for Russia is no pipe dream—it’s not even a luxury. It’s only a question of setting the right goals and finding the social commitment and tenacity to meet them.

Resolving these thorny issues will require broad stakeholder consensus, encompassing numerous public and private agents: the presidential administration, the Ministry of Health, the territorial funds for obligatory medical insurance, physicians, pharmacies, providers of vital drugs, pharmaceutical distributors, and patients, to name just a few.

A good way to build this consensus while also tuning best practices to the practicalities of the Russian market, is to test different aspects of the NDI concept through a series of proof-of-concept pilots. Given the huge geographic, economic, and political variations across Russia, any new system will need to be tested in a cross-section of regions and probably in urban and rural areas.

There are major questions in each of the categories:

**Coverage and eligibility.** How will different copayment levels and formulas influence patient access? What exceptions or limits should be established to guarantee basic fairness and equity for the socially disadvantaged? What is the tradeoff between short-term drug reimbursement costs and potential longer-term healthcare costs?

**Structure and funding.** What is the likely budget impact of a nationwide universal NDI? What are the associated resourcing and service requirements? For example, what managerial and
administrative personnel will be needed to run the system? How willing are employers to contribute to funding the NDI?

**Controls and incentives.** What are the barriers and enablers to widespread adoption by pharmacists and clinicians? What is the best payment system to implement at polyclinics and pharmacies to ensure transparency, agility, ease of implementation, scalability, and inter-operability? What technology should be adopted?

Of course, the real test will be whether introducing a new NDI scheme actually improves clinical outcomes and, if so, at what overall cost. Achieving significant improvements in clinical outcomes over the course of a short pilot will be difficult. However, picking the right clinical indicators and metrics could help demonstrate the impact of early drug interventions. For example, a pilot could measure the impact on managing the blood glucose levels of patients with type 2 diabetes. Even over the period of a few months, active glucose management through medication can quickly reduce blood-sugar levels, thereby reducing the patient’s risk of long-term complications such as heart disease, kidney failure, and eye problems. Patients and clinicians could easily monitor blood-sugar levels through devices such as electronic meters to capture daily glucose levels. This could ultimately generate the evidence needed to prove the impact of short-term drug interventions.

### An Evolutionary Process

Testing aspects of a new NDI model and building a consensus for change is merely the first step toward building a best-practice drug-insurance model (see figure 7). Prioritizing the usage of drugs that improve outcomes and increasing access to medicine are crucial in the beginning,

***Figure 7***

**Best-practice NDI** requires a step-by-step approach

<table>
<thead>
<tr>
<th>Basic</th>
<th>Sustainable</th>
<th>Best practice</th>
</tr>
</thead>
</table>
| • Design new coverage model that:  
  - Prioritizes medicine use based on outcomes  
  - Increases access considering ability-to-pay  
  • Increase federal funding cover costs  
  • Develop integrated model to expand ambulatory coverage  
  • Improve operational and tracking controls (such as 2D barcoding system)  
| • Align incentives to focus on health outcomes  
 • Expand coverage to secondary diseases; use cost-effective medicine  
 • Incorporate tiered patient participation in cost of medicine  
 • Further develop exemptions based on income, and clinical and social status criteria  
 • Develop role of pharmacies in identifying high-risk patients and in communicating with polyclinics and medicine-compliance programs  
 • Develop health infrastructure and invest in physician training  
 • Strengthen regional infrastructure and performance management capabilities  
| • Provide comprehensive coverage of medicines and access to innovative medicine  
 • Foment well-developed alternative private insurance options  
 • Establish clear accountability among federal and regional bodies on medicine funds flow  
 • Implement equalization mechanism to redistribute funds across regions  
 • Enact industrial policy and standards  

*NDI is national drug insurance  
Source: A.T. Kearney analysis
as are ramping up federal funding, developing an integrated model to administer expanded ambulatory coverage, and improving operational and tracking controls.

The next stage of development will require Russia to make the system sustainable. At this point, coverage should be extended to include secondary disease priorities and the increased use of cost-effective, innovative medicines. A tiered patient copayment system should be further developed and exemptions applied based on income, clinical, and social criteria. As has occurred in other markets, pharmacies can take a greater role, help identify high-risk patients, communicate with polyclinics, and monitor patient compliance. At the same time, as health infrastructure continues to develop, physician training should be reinforced and regional infrastructure and performance-management capabilities supported. In short, the challenge at this stage will be to align Russia’s overall system incentives to focus on health outcomes.

In the end, Russia can move toward a best-practice stage in which citizens have comprehensive coverage and access to innovative medicine. To do so it will need to ensure that private insurance is well-regulated and well-developed to cover any gaps and complement the system. Additionally, medicine-funding flows will need to be clearly defined and transparent, with equalization mechanisms in place to correct regional inequalities. And, of course, industrial policy and standards will have to reach E.U. levels.

An advanced NDI model for Russia is no pipe dream—it’s not even a luxury. It’s only a question of setting the right goals and finding the social commitment and tenacity to meet them.

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**Authors**

**Per Hong**, partner, Moscow  
per.hong@atkearney.com

**Ayesha Kanji**, consultant, London  
ayesha.kanji@atkearney.com

**Michael Thomas**, partner, London  
michael.thomas@atkearney.com
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<table>
<thead>
<tr>
<th>Americas</th>
<th>Atlanta</th>
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