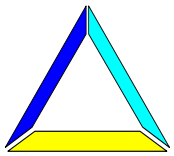
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U8

First steps of reforming public health care: improve efficiency and get the private sector involved

Executive Summary

The current Ukrainian health care system is highly inefficient and delivers dismal results. The present structure of health care is heavily based on most expensive health care providers – namely hospitals and specialists. The role of primary care and general practitioners remains negligible. Furthermore the health care budget is allocated towards existing infrastructure and not according to actual performance and services delivered to patients. Hence, no incentives for improving efficiency and structural change are in place. The current debate suggests increasing the financing of the present system. However, this will not improve the situation. We propose instead to change the incentives for health care providers and to introduce market type relationships into the system without changing its main feature, the predominant tax financing and public ownership of health care provision. In particular we argue to **switch the budget allocation to a fee for service** base and **introduce case mix funding**. The **management** of health care providers shall be granted **independence** and be given **commercial incentives**. Barriers to competition between private and public suppliers of health care should be removed. Policy makers shall develop **benchmarks for measuring the performance** of and to **introduce yardstick competition** among the health care providers. Such measures would increase the efficiency of the health system and attract private investment to the sector.

1. Introduction

Since many years Ukrainian policy makers are discussing health care reforms. Until recently the debate was mostly focussed on increasing financing of the existing system. Ukrainian health care is predominantly tax financed and provided by public institutions, while the performance of the system is dismal. Politicians were debating the introduction of a mandatory medical insurance as part of the social taxation of wages. However, almost no attention was paid to the inefficiency of the present system. In our view a reform sequence starting with the introduction of a mandatory medical insurance in order to substantially increase funds injected into an inefficient system would mostly stimulate rent seeking and create vested interest groups, which later would block any structural reforms. Shortly afterwards the health system would experience again significant "under-financing".[1]

We argue instead that any health care reform requires some basic structural changes to be successful. In the rest of the paper we provide an overview of the current situation of health care provision in Ukraine, followed by a discussion of how an ideal type efficient tax financed health care sector would look like. From that analysis we derive policy recommendations for Ukraine.

2. Current situation of health care provision in Ukraine

The organization and structure of health care provision still follows the Soviet "Semashko-model", which is typically characterized by:

- A relatively small proportion of GDP dedicated to health care;
- Centralized and inequitable allocation of resources;
- Lack of response to local needs and disease patterns;
- The under-development of primary care services, inadequate referral and the overemphasis on hospital-based inpatient services;
- Inequality in health care provision among regions and different social groups;

[1] Such was the development of events for example in the Czech Republic. See also http://www.medicover.com and http://www.healthreform.cz

- A poor managerial capacity within the health care system and the lack of health care workforce with competencies in policy development and management;
- Poor attention paid to preventive measures.

Health care provision in Ukraine is not in line with standards of the WHO, as most health care is provided not at a primary level, but at the tertiary level in hospitals, i.e. as inpatient and specialized care. The structure of Ukrainian health care provision resembles an inverted pyramid. In comparison, there are 5.74 hospitals per 100.000 of population in Ukraine, which is more than twice higher than 2.75 hospitals per 100.000 of population in the new EU-member countries (EU-10). Primary health care units are extremely underdeveloped in Ukraine with only 13.8 per 100.000 of population, while the respective number for the EU-10 is 105.8, or seven times higher (see table 1). The number of physicians with 300 per 100.000 inhabitants is slightly higher in Ukraine than in EU-10 with 278. Hence most physicians are working at (public) hospitals. The number of general practitioners is 28 per 100.000 inhabitants, which is by 2 times lower in comparison to the EU-10 with 64 per 100.000 population. In Ukraine patients often refer to general practitioners only with the aim to receive a sickness leave documents, which the person is obliged to present at the working place. The role of the primary care remains extremely underdeveloped and public hospitals continue to be the most important health care providers. At the same time the length of stay in hospital is in Ukraine significantly longer and the bed occupancy rates higher than in EU countries.

While the numbers of public hospitals, specialized health personnel and hospital beds remain relatively large they vary significantly across regions. The number of hospitals, hospital beds and health personnel has been decreased by administrative closures, mostly due to lack of financing resources and decline in population. However, the number of hospitals, beds and staff personnel is still defined by an Order of the Ministry of Health Care. Hence, funds are allocated administratively to finance the existing health care facilities.

Table 1:

Comparison of health indicators for Ukraine and other countries*

	Ukraine	EU-25	EU-15	EU-10	CIS	European Region
Hospitals per 100,000	**5.74**	3.23	3.26	**2.75**	6.14	4.3
Primary health care units per 100,000	**13.82**			**105.89**	17.49	31.21
Hospital beds per 100,000	881.08	610.44	599.55	660.8	908.86	738.32
Acute care hospital beds per 100,000	716.7	414.88	399.3	520.04	785.88	532.66
Physicians per 100,000	**300.64**	343.44	356.32	**278.36**	373.91	352.58
Physicians per 100 hospital beds	34.12	56.26	59.43	42.12	41.14	47.75
General practitioners (PP) per 100,000	**28.86**	98.62	102.45	**64.13**	24.49	65.93
Dentists (PP) per 100,000	40.63	61.77	65.51	43.11	31.52	49.66
Pharmacists (PP) per 100,000	46.74	77.66	81.4	59.57	19.99	52.91
Nurses (PP) per 100,000	776.26	779.34	817.84	641.68	790.98	688.51
Midwives (PP) per 100,000	51.43	28.53		44.98	54.21	40.29
In-patient care admissions per 100	20.51	18.53	18.38	19.5	19.8	19.04
Acute care hospital admissions per 100	19.56	17.98	17.87	20.3	19.77	18.31
Inpatient surgical procedures per year, per 100,000	5248.79	7193.44	7158.17	7638.5	5067.01	6761.58
Average length of stay, all hospitals	14.2	9.52	9.74	8.71	13.83	11.11
Average length of stay, acute care hospitals only	12.1	6.77	6.87	7.54	12.08	9.32
Bed occupancy rate in %, acute care hospitals only	90.4	76.91	77.59	72.6	85.88	80.11
Outpatient contacts per person per year	10.4	6.63	6.31	8.38	8.7	7.45
Health personnel graduated:						
Physicians graduated per 100,000	14.45	9.06	8.86	9.27	11.99	10.21
Nurses graduated per 100,000	22.78	26.49	24.79	37.95	37.99	31.74
Midwives graduated per 100,000	4.14	1.28		0.7	4.65	3.58
Pharmacists graduated per 100,000	1.74	3.2	3.37	2.28	2.98	3.39
Dentists graduated per 100,000	3.1	1.76	1.61	2.22	2.01	1.95

Note: the data is provided for last available year, usually for 2002-2003. For groups of countries the data is population-weighted averages. EU stands for the 25 Member States of the European Union; EU-15 - the 15 Member States of the European Union prior to 1 May 2004; EU-10 - the 10 new Member States of the European Union from 1 May 2004; CIS - the 12 countries of Commonwealth of Independent States; European Region - the 52 countries in the WHO European Region.

Source: The European health for all database (HFA-DB)

Most health care institutions are publicly owned and financed from central and local fiscal expenditures. While over the years public health care spending increased in nominal terms, spending measured as a share of GDP and per capita remained rather constant (Table A1 in Annex) and low by international comparison (see Charts in Annex). With low levels of public funding of health care patients are

increasingly forced to pay privately in order to circumvent the inadequacy and unresponsiveness of the health system.[2] Anecdotic evidence suggests wide spread corruption in the health sector. The WHO estimates that in 2001 private health care expenditures - mostly informal out-pocket payments - accounted to nearly 30% of total health care spending in Ukraine, while the coverage with private medical insurances remains negligible. Thus, poor people, in particular in rural areas, are excluded from adequate health care services.

Public spending is directed towards financing of existing institutions, staff, services, i.e. the status quo in health care. Around 50% of public health care funds are devoted to wage payments (see Table 2), while wage levels in the health care sector remains among the lowest. Wages are usually not connected to the quality, quantity and type of services provided. Little less than 30% of the health care budget is spent for purchases of goods, materials and services; roughly 10% are foreseen for utilities. Capital expenditures constituted in 2003 around 9.4% of total health care expenditures, of which 70% were used as an investment into equipment and purchase of durable goods (see Table A2 in the Annex). Due to rather low public investment the replacement of old infrastructure and equipment is very slow. According to the WHO in most health facilities the replacement ratio is about 2%.[3] Only 0.8% of the consolidated health care budget were spent in 2003 for R&D programs.

Table 2
Structure of the consolidated health care spending according to economic budget classification in 2000-2003

	Wages (with payroll)		**Utilities payment**		**Purchase of goods, materials and services**		**Capital expenditures**		**Other**	
	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE
2000	2.48	50.76	0.56	11.40	1.32	26.96	0.33	6.81	0.20	4.06
2001	3.26	50.45	0.59	9.16	1.76	27.25	0.49	7.59	0.36	5.55
2002	4.10	54.45	0.65	8.67	2.07	27.52	0.56	7.46	0.14	1.89
2003	5.10	52.57	0.80	8.20	2.67	27.47	0.91	9.42	0.23	2.34

Source: State Treasure Reports for 2000 – 2005, Ministry of Finance Budget Reports

[2] Many hospitals are not well equipped, and most are poorly supplied with diagnostic materials, drugs, etc.

[3] Lekhan V., Rudiy V., Nolte E., *Health Care Sector in Transition: Ukraine*, 2004, the World Health Organization Regional Office for Europe.

At present, health care providers (HCPs) administer broad budgets, where funds are allocated not to the provided services, but to the existing facilities. In such a system patients are seen as a cost factor and an item of spending, where each additional patient and treatment cuts into the budget. HCPs have few incentives to become more productive since this has no impact on the budget or salary of employees.

Patient's choice and competition between health care providers (HCP's) are both absent because of barriers to competition like the administrative 'catch-up' principle that directs patients for receiving "free" medical services at the public clinic/ hospital at their official place of residence. Furthermore, private HCP are prohibited by regulation to issue sickness leave documents to be accepted by the employer of the patient. Many restrictions prevent the market entry of private HCP, like the prohibition to use strong anesthetics. The competition for private patient payments is distorted further by specialists working in the public funded HCP using tax-financed equipment for earning additional private (shadow) income through undercutting market prices.

The lack of competition and management autonomy creates weak incentives for public HCP to deliver high qualitative medical services efficiently. Therefore, at the moment the allocation of funds for financing health care is not efficient, investments remain low, and restructuring of the sector is hampered with too much health care provided at the second and third pillar of the system.

In the next section we will develop an ideal type tax financed health care system.

3. An ideal health care model for Ukraine

Reform experience in countries with tax-financed health care systems demonstrates that the introduction of market-type relationships and elements of competition into public health care systems leads to significant improvements of services supplied with higher quality at more affordable costs.[4]

[4] For a detailed discussion of various reforms and country cases see for example: Melitta Jakab, Alexander Preker, Aprli Harding, and Loraine Hawkins. The introduction of Market Forces in the Public Hospital Sector. Worldbank, June 2002

As discussed above, hospitals are among the most problematic institutions of the Ukrainian health care sector, remaining in oversupply while being at the same time the most cost intensive form of health care delivery. Administrative closures of hospitals have been often politicized and do not provide incentives for the remaining hospitals to pursue better management. Hence we will pay in the rest of this section special attention to hospitals, while describing how an ideal health care model for Ukraine would be like.

3.1 Payments for services delivered to patients

Any efficient allocation of budget resources in a tax financed health care system depends on the simple principle of payments for actual treatments and services delivered to patients, instead of financing existing public infrastructure. Such an approach ensures a stronger position of patients *vis-à-vis* and turns them into "consumers of health services", while the income of HCP would depend on patient's choice and recommendation. The type of treatments and services eligible for compensation and the price of both are specified in a health care catalogue issued by the government (MoH). The more patients a HCP attracts through quality services, the higher its revenues are. At the same time reducing costs and increasing efficiency becomes a priority for management, since it directly affects the hospital's budget. Such an approach requires independent budgets for each HCP.

3.2 Independent and commercially oriented management of HCP

Independent management teams with commercial orientation are more efficiently operating hospitals and other HCP. The government could contract out the management of hospitals to independent profit oriented management companies or trusts, while the hospitals would remain in public ownership. For such measures a wide range of options for private sector participation (also known as public-private partnerships - PPP) is available, from short-term service and management contracts (1-5 years) to medium term lease contracts (10-15 years).[5] In cases where the

[5] A brief but excellent overview of various options and models for public hospitals is provided in Public Policy for the Private Sector: Public Hospitals: Options for Reform trough Public-Private Partnerships. World Bank Group, private sector and Infrastructure Network, Note Number 241, January 2002.

management company or trust is not fulfilling its contract obligations or is going bankrupt, the hospital remaining in public ownership would be given to another operator. The terms and conditions of such PPPs need to be specified for each case. Another option is the outright privatization of hospitals.

Today all European countries use mixed owned but socially responsible health care delivery systems. For example Sweden put in 1998 all hospitals (except emergencies) on the market, while the universal tax financed health care system was maintained. As a result there are now more than 200 small and medium-sized health care suppliers, which successfully replaced the previous monopoly supplier. Among them are many that were created by nurses who were unhappy with poor working conditions and mediocre salaries and who used the opportunity to set up their own businesses. The nurses' union in Sweden actively supported the new businesses and even created an institution to support new forms of entrepreneurship. In Sweden the new suppliers are to be found mostly at the primary and secondary health care provision level operating local health care centers, general practitioners' clinics and centers specializing in postnatal care as well as laboratories and psychiatric clinics. The largest private HCP operator "Praktikertjänst" is in fact a cooperative owned by doctors, nurses, psychiatrists, dentists, physiotherapists and support staff. [6]

Another advantage of the changes is that since competition began in the area of nursing care, salaries increased significantly. This is a crucial element in hiring and keeping skilled and motivated staff. A remuneration system based on performance rather than age or years of service also encourages medical staff to be more productive in the private companies that have applied it.[7]

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http://rru.worldbank.org/Documents/PublicPolicyJournal/241Taylo-010802.pdf

[6] Hjertqvist, Johan, Turning to the private sector in health care: The Swedish example, Montreal Economic Institute, Economic Note October 2003. http://www.opas.org.br/servico/Arquivos/Destaque963.pdf

[7] Lofgren, Ragnar, The Swedish Health Care System: Recent Reforms, Problems, and Opportunities, Vancouver, Fraser Institute, Public Policy Sources Number 59, July 2002, p.43.

3.3 Case mix funding of HCP

In order to guarantee equal access to the health care system for all patients the compensation of services for "dominant" suppliers like hospitals is based upon numbers and types of patients treated and not upon the resources used, what ensures a specific minimum variety of services. Such a "Case mix funding" that resources are used effectively, and healthcare is kept affordable, while taking into account the wide spectrum of disease conditions, their varying degrees of severity, and significant patient variables such as age and gender. The Case mix system is adjustable to changing local needs and disease patterns.

3.4 Benchmarking performance

Benchmarks are a valuable tool for evaluating the quality of HCP managements. Benchmarks allow policy-makers and patients to compare the performance of different HCP and are used for assuring cost and quality control, detect waste of resources and promote cost-reducing innovations among the different HCP's. There are two basic methods of establishing benchmarks and comparing the performance, either through expert opinion as it is used for example in the Star Fund Rating in the United Kingdom, or frontier analysis methods, used, for instance, in Australia.

The UK Star Fund Rating:[8] The Star Fund Rating in the UK is annually conducted by an expert panel with the attempt to assess the management, provision and quality of public health services and, thus, serves as an important tool for concentrating management attention on key strategic priorities and national targets as well as facilitates accountability to patients and the public.[9]

Frontier analysis method:[10] Different to rating systems based on expert opinion frontier (productivity) analysis methods deliver benchmarks that reflect best-

[8] The detailed description is available at http://www.nhs.uk/england/default.aspx and http://www.healthcarecommission.org.uk/Homepage/fs/en

[9] Annually health trusts are awarded the 'stars', which indicate how well they are doing in relation to the main targets set by the government, as well as other broader measures of performance.

[10] The discussions see: Mortimer D., Peacock S. *Hospital Efficiency Measurement: Simple Ratios vs. Frontier Methods*, 2002, WP 135, Center for Health Program Evaluation; Webster R., Kennedy S., Johnson L., *Comparing Techniques for Measuring the Efficiency and Productivity of Australian Private Hospitals*, 1998, WP 98/3, Econometric and Applied Studies; Staat M., Hammerschmidt M., *Benchmarking the Health Sector in*

practices employed in the health care sector and efficiency scores which indicate deviations between observed and potential performance of individual HCP.[11] The efficiency scores in the frontier analysis are calculated based on the inputs and outputs of hospital's activity,[12] hence more objective performance rankings are obtained by using frontier analysis methods. The estimation results also provide information about how individual hospitals should vary their inputs and outputs to achieve a performance comparable to that of the best ones.

While establishing benchmarks by experts is rather easy, it can only subjectively take into account tendencies and best practices in health care provision. Frontier methods are technically more difficult but if properly implemented the deliver more insights. A recent publication demonstrates that such frontier methods can be applied successfully also in Ukraine[13].

3.5 Benchmark regulation and yardstick competition

Benchmarks and frontier estimations are providing policy makers with insights and information about best practices and efficiency in health care provision. However, efficient practices cannot spill over across HCP through direct competition, because even if all administrative barriers are removed, competition is still limited by various natural barriers such as regional segregations, scale effects etc. Therefore, the improvement of firm level performance needs to be coordinated by an independent regulator, which simulates competition by comparing firm level benchmarks and ordering efficiency-enhancing measures. Through this so-called "Yardstick Competition" would ensure fair (cost covering) and quality-oriented price setting, productivity growth, and efficiency-driven operation of HCPs.

Germany – an Application of Data Envelopment Analysis, 2000, Institute for market-Oriented management; Jian W., *Estimation of Hospital Cost Functions and Efficiency Measurement: an Overview*, WP 2001-07, China Center for Economic Research, etc.

[11] The data envelopment analysis (DEA) and stochastic frontier analysis (SFA) are advocated as statistical tools for measuring global indices of efficiency.

[12] ibid.

[13] Pilyavsky A, Aaronson W, Golubchikov M. Comparative Efficiency of Tertiary Care Hospitals in Ukraine. The European Journal of Health Economics [Supp.1] 2002; 3(54): 23-30.

To ensure the success of such regulation the independence and credibility of the public regulator will be of critical importance. The regulator should be independent from HCP and policy makers in order to avoid conflict of interest potentially arising from the fact that the public sector is shareholder and regulator at the same time.

The realization of such an ideal model of public health care provision in Ukraine would mean improved quality and more services provided to the patients, while maintaining access to the system for all social groups.

4. A reform framework for public health care provision – policy recommendations

We argued in the "Strategy for Reforming the Social Security System in Ukraine",[14] that reforms in the health care sector should start with a separation of health care policy, budget execution and management of health care institutions. The role of the Ministry of Health (MoH) would be to develop standards and framework conditions for the operation of the health care sector.

We suggest to introduce a public medical fund, which would execute the funds allocated to health care, thus, insulating the health budget execution from political considerations. The role of the public medical fund would be to process the information, check what treatments where delivered and compensate the health care providers for their services.

Of utmost importance is to switch the health budget allocation to payments for actual treatments and services delivered to patients. The more patients a HCP attracts through quality services, the higher its revenues are. By doing so, reducing costs and increasing efficiency becomes a priority for management, since it directly affects the hospital's budget.

The Government of Ukraine should specify property rights in health care and liberalize and commercialize the management of health care providers.

[14] See: IER/GAG 'Towards Higher Standards of Living: An Economic Agenda for Ukraine', December 2004, for health care see especially pages 24-26, http://www.ier.kiev.ua/English/books_eng.cgi

Remove all barriers to competition between different providers of health care in order to increase efficiency of allocation of scarce resources and quality of health service provision. Competition among HCPs would also lead to higher valuation of skilled and motivated staff resulting in higher salaries. A remuneration system based on performance rather than age and years of service would encourage health personnel to be more productive. Switching to such system would also set incentives for providing medical services in the countryside and villages, what would significantly improve current situation. Sweden's recent experience shows that it is possible to increase the efficiency of a mixed health care system by means of market mechanisms while maintaining universal care and tax financing.[15]

In a final step introduce benchmarking regulation and yardstick competition among hospital management teams. That would allow the implementation of best-practices in the sector. This, along with the creation of incentives for equitable care provision, will promote efficient provision of quality health services in Ukraine.

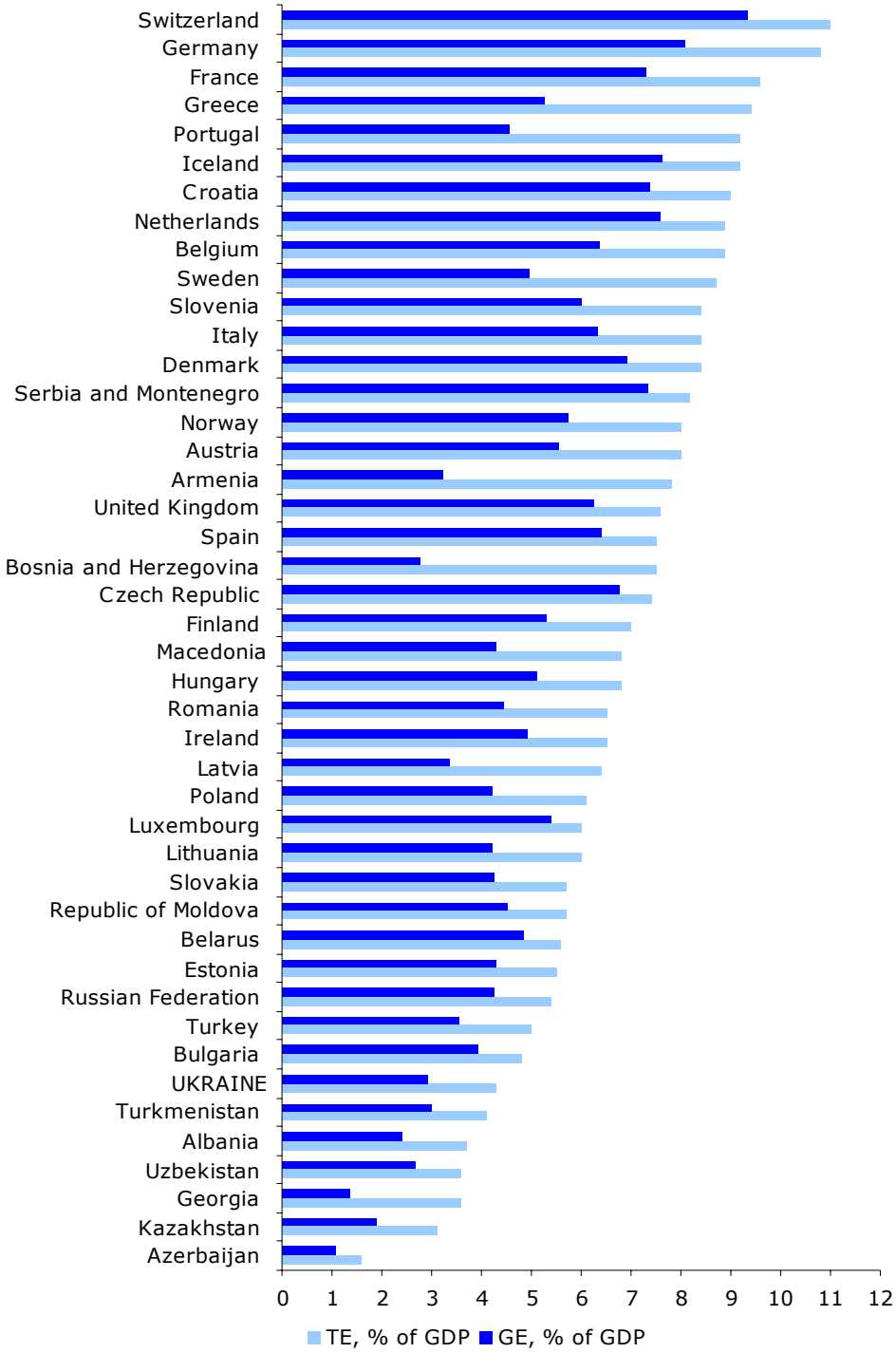
Authors: LH, SB Lector: FP

Kyiv, 8th of July 2005

[15] Hjertqvist, Johan, Turning to the private sector in health care: The Swedish example, Montreal Economic Institute, Economic Note October 2003. http://www.opas.org.br/servico/Arquivos/Destaque963.pdf

Annex:

Chart 1: Total expenditure on health as % of GDP, 2001

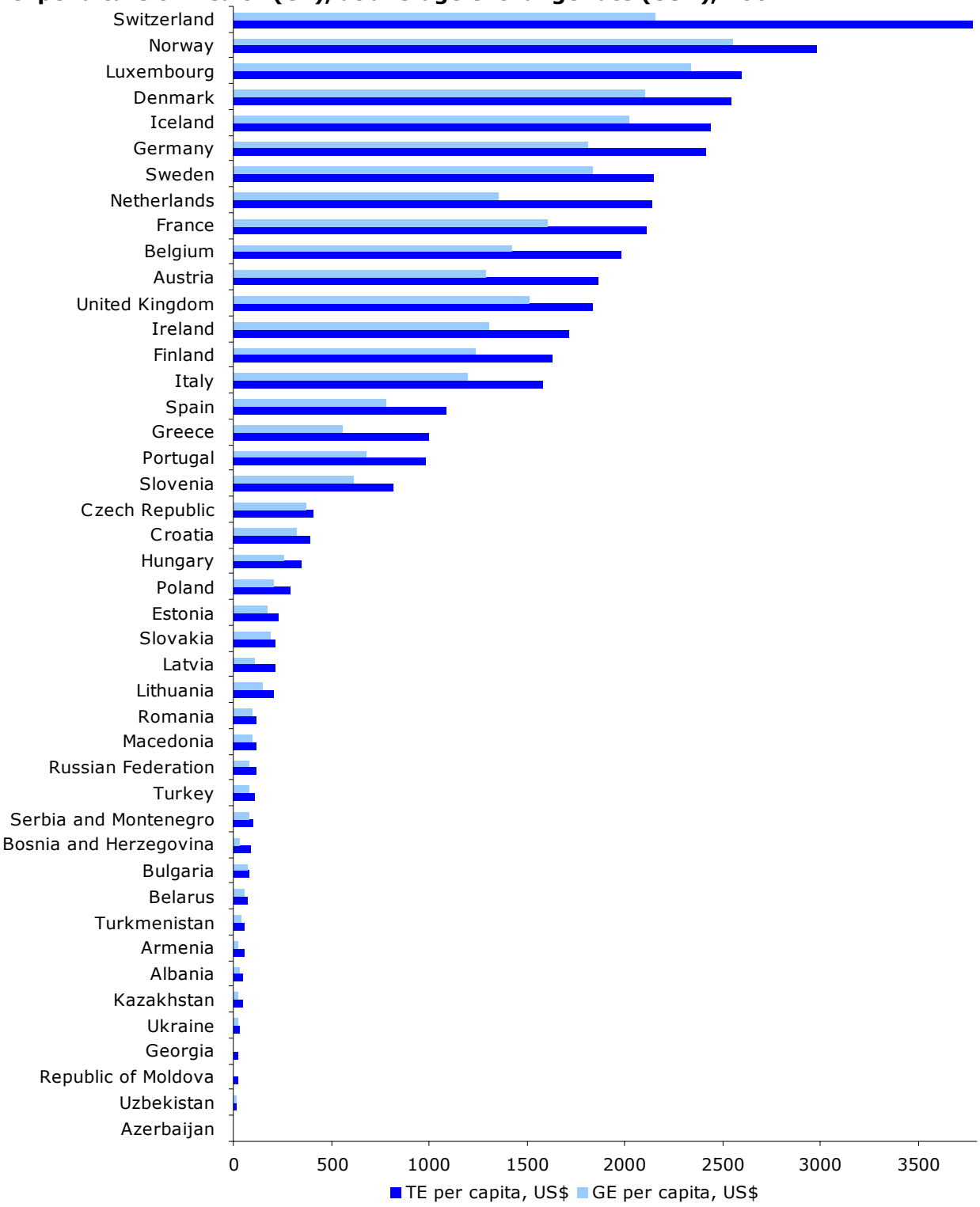


Source: World Health Organization

TE - Total health expenditure is the sum of Public Health Expenditure and Private Health Expenditure.

GE - Public Health Expenditure (general government expenditure) is the sum of outlays on health paid for by taxes, social security contributions and external resources (without double-counting the government transfers to social security and extra-budgetary funds).

Chart 2: Per capita total expenditure on health (TE) and per capita government expenditure on health (GE), at average exchange rate (USD), 2001



Source: World Health Organization

Table A1:
Annual health care expenditures in 2000-2005

	CB HCE			SB HCE		LB HCE	
	bn UAH	% GDP	UAH per capita	bn UAH	% GDP	bn UAH	% GDP
2000	4.89	2.87	99.92	0.72	0.42	4.17	2.45
2001	6.46	3.16	133.33	1.33	0.65	5.13	2.51
2002	7.54	3.34	157.03	1.58	0.70	5.96	2.64
2003	9.71	3.63	203.86	2.35	0.88	7.36	2.75
2004	11.81	3.41	249.72	3.51	1.01	8.30	2.40
2005	13.71	3.15	292.39	3.34	0.77	10.37	2.38

Note: CB – Consolidated fiscal expenditures, SB – Central fiscal expenditures, LB – Local fiscal expenditures, HCE – health care expenditures. The amount of GDP for 2004 is a preliminary figure, for 2005 the GDP is taken at the level of UAH 436 bn, as it is foreseen in the Budget 2005 assumptions.

Source: State Treasure Reports for 2000 – 2005, Derzhkomstat, IER calculations

Table A2:
Economic classification of consolidated health care expenditures in 2000-2003

	2000		2001		2002		2003	
	UAH m	%	UAH m	%	UAH m	%	UAH m	%
Total	**4888.22**	**100.00**	**6238.90**	**100.00**	**7537.91**	**100.00**	**9708.16**	**100.00**
Current expenditures	**4512.80**	**92.30**	**5748.46**	**92.10**	**6975.67**	**92.50**	**8793.68**	**90.58**
Expenditures for goods and services	**4461.61**	**91.30**	**5682.84**	**91.10**	**6908.24**	**91.60**	**8676.02**	**89.37**
Wages of budget employees	1808.01	37.00	2388.56	38.30	3018.55	40.00	3770.77	38.84
Payroll tax	673.02	13.80	870.85	14.00	1086.04	14.40	1332.42	13.72
Purchase of goods, materials and services	1317.98	27.00	1760.74	28.20	2074.71	27.50	2667.28	27.47
Payment for business trips	9.53	0.20	18.06	0.30	24.98	0.30	34.33	0.35
Payment for utility services and electricity	557.39	11.40	591.62	9.50	653.76	8.70	795.71	8.20
Heating	*259.63*	*5.30*	*245.47*	*3.90*	*263.91*	*3.50*	*311.14*	*3.20*
Water supply	*83.48*	*1.70*	*90.71*	*1.50*	*101.96*	*1.40*	*130.73*	*1.35*
Electricity	*141.04*	*2.90*	*172.30*	*2.80*	*193.73*	*2.60*	*239.82*	*2.47*
Gas	*38.15*	*0.80*	*35.98*	*0.60*	*42.06*	*0.60*	*49.80*	*0.51*
Other communal services and electricity	*35.10*	*0.70*	*47.15*	*0.80*	*52.09*	*0.70*	*64.23*	*0.66*
R&D	95.68	2.00	53.01	0.80	50.20	0.70	75.51	0.78
Interest payments on liabilities	**0.09**	**0.00**	**0.11**	**0.00**	**0.00**	**0.00**	**0.31**	**0.00**
Subsidies and current transfers	**51.11**	**1.00**	**65.51**	**1.10**	**67.43**	**0.90**	**117.35**	**1.21**
Subsidies and current transfers to enterprises	8.81	0.20	19.74	0.30	15.18	0.20	28.82	0.30
Current transfers to population	41.81	0.90	45.10	0.70	51.84	0.70	88.53	0.91
Capital expenditures	**333.11**	**6.80**	**490.38**	**7.90**	**562.25**	**7.50**	**914.48**	**9.42**
Acquisition of fixed assets	**331.30**	**6.80**	**481.52**	**7.70**	**559.82**	**7.40**	**910.80**	**9.38**
Purchase of equipment and of durable goods	209.61	4.30	290.99	4.70	347.47	4.60	644.09	6.63
Capital construction	5.85	0.10	11.17	0.20	21.22	0.30	5.71	0.06
Capital repair	115.85	2.40	179.35	2.90	191.13	2.50	260.99	2.69
Purchase of land	**0.05**	**0.00**	**8.40**	**0.10**	**0.42**	**0.00**	**0.44**	**0.00**
Capital transfers	**1.76**	**0.00**	**0.46**	**0.00**	**2.00**	**0.00**	**3.24**	**0.03**
Capital transfers to enterprises	1.76	0.00	0.45	0.00	2.00	0.00	3.24	0.03
Capital transfers to population	0.00	0.00	0.01	0.00	-	-	-	-
Crediting	**0.08**	**0.00**	**0.03**	**0.00**	**0.00**	**0.00**	-	**-**
Payments to the budget	**42.22**	**0.90**	**-**	**-**	**-**	**-**	**-**	**-**

Source: the Ministry of Finance