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Feasibility study for the introduction of mandatory health insurance in Uzbekistan



Uzbekistan

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FEASIBILITY STUDY FOR THE INTRODUCTION OF MANDATORY HEALTH INSURANCE IN UZBEKISTAN

Abstract

Uzbekistan has decided to introduce mandatory health insurance (MHI) to move towards universal health coverage. This feasibility study assesses the impact of potential revenue sources to expand the fiscal space for health under MHI. Using population, employment and economic data, it projects three scenarios of the potential public revenue mix for health. Scenario 1 projects that in 2025, 620 000 som per capita will be available for health from general taxation. Scenario 2 projects revenues from general taxation combined with a 2% payroll tax to add 35 000 som per capita (5.4% of total public funding for health). Scenario 3 doubles the payroll tax to 4% and adds 52 000 som per capita (7.7% of total public funding for health). It concludes that general taxation offers the most effective way to support progress towards universal health coverage, and a payroll tax would generate limited additional resources, be inconsistent with the objectives of the 2019 income tax and social security contribution reform, and risk harming the labour market. Instead, Uzbekistan can seek complementary revenue streams from alternatives (e.g. sin taxes), and further expand fiscal space for health through focusing on efficiency gains in the service delivery system.

Keywords

HEALTHCARE FINANCING
HEALTH SYSTEMS
REVENUE MIX FOR HEALTH
FISCAL SPACE FOR HEALTH
UZBEKISTAN

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Abbreviations

CIS	Commonwealth of Independent States
GDP	gross domestic product
GGHE	general government health expenditure
MHI	mandatory health insurance
NHS	national health service
OECD	Organisation for Economic Co-operation and Development



Executive summary

Uzbekistan is introducing a transformative reform programme to improve its health system. The Concept of Health System Reform of the Republic of Uzbekistan was approved by Presidential Decree No. 5590 in December 2018. A central policy area of the Concept is introducing mandatory health insurance (MHI) to ensure full population coverage of essential health services and pharmaceuticals.

The Decree stipulates a technical feasibility study to assess the funding mix options of the proposed MHI. The discussion about options is a response to the stated aspiration in the Concept to expand fiscal space for health, including through increased public financing. This study is based on reflections of the potential impact of alternative revenue sources to advance the following four economic, social and health policy objectives.

1. Support progress towards universal health coverage.
2. Generate additional revenues for the health system in accordance with the indicators set by the Concept.
3. Be consistent with other policy documents, including those on tax evolution and employment.
4. Impact favourably on the labour market.

Three scenarios have been established to frame revenue projections up to 2025. In the first (baseline) scenario, general taxation continues to be the sole base of public funding, with government funding increasing from its current 2.9% to 5% of gross domestic product by 2025. The second scenario builds on financial resources that can potentially become available from 2021 with the introduction of a hypothetical 2% payroll tax contribution levied on the salary bill, plus a fixed contribution rate from individual entrepreneurs and continued allocation of general taxes from the state budget. Finally, the third scenario has the same construction as scenario 2, but with contribution rates twice as high, providing higher potential revenue. Scenarios 2 and 3 have potential negative consequences for the labour market built into the projections.

In all three scenarios, projections for government health spending show large increases in available resources for health; this is due to the expected increase in the percentage of general taxes allocated to health, regardless of whether an earmarked payroll tax is introduced. These results are driven by the stipulation in the Presidential Decree to increase government health funding to introduce MHI. In 2025, the projected available public funding for health is 620 000 som per capita from general government budget resources (scenario 1). The additional revenue for health from a payroll-based contribution is projected to be 35 000 som per capita in the scenario with a 2% salary-based contribution rate, and 52 000 som per capita in the scenario with a 4% contribution rate. The share of the payroll tax in the total public funding mix in 2025 would be 5.4% and 7.7% respectively.

There are considerable fiscal and labour market risks with introducing a new payroll tax. Uzbekistan has low unemployment but has seen formal employment numbers decrease in recent years. The 2019 income tax and social security contribution reform is designed

to enhance economic growth by increasing the formal labour force participation through lowering taxes on salaries. The new income tax scale is simplified, reduces labour costs and, more significantly, removes disincentives for qualified staff to register income. An earmarked payroll tax for health is inconsistent with this recent tax reform.

The feasibility study concludes that:

- general taxation offers the most effective way to pool funds and risks, to redistribute resources in an equitable manner and to support progress towards universal health coverage;
- the additional resources generated by a compulsory payroll contribution are limited and would not substantially increase the ability to fund MHI beyond what budget resources collected through general taxation can do;
- introducing a payroll tax would be inconsistent with the objectives of the 2019 income tax and social security contribution reform; and
- introducing a payroll tax risks harming the labour market and the overall fiscal situation, and must be seen in a broader public finance and economic growth perspective.

The feasibility study recommends to:

- expand reliance on general taxation within an agreed medium-term budget framework to ensure predictability and not introduce the payroll tax;
- seek complementary financial resources for health by developing health-promoting tax policies for undesirable and environmentally costly consumption, such as tobacco, alcohol and fossil fuels; and
- focus on efficiency gains in the service delivery system to expand fiscal space by introducing modern clinical and professional managerial practices underpinned by strong digitalization and performance monitoring to use limited resources more efficiently.





BACKGROUND

The health reform agenda

Uzbekistan has decided to embark on a substantial reform programme to improve its health system. The Concept of Health System Reform of the Republic of Uzbekistan was approved by Presidential Decree No. 5590 in December 2018.¹ The overall objectives of the reform are to improve the health status of the population by means of universal coverage of health services and to improve the availability of high-quality health care services across the country. The reform Concept underlines disease prevention and focuses on conditions with the highest burden of illness, equitable distribution of resources and access to health care, financial protection of the population and increased efficiency of the system by clarifying benefit entitlements and shifting funding of services from passive allocation of resources to active purchasing of services. A central policy area of the Concept is implementing MHI, which is an important tool to ensure full population coverage of essential health services and pharmaceuticals.

The health financing strategy to support the objectives of the Concept was developed through a carefully crafted process. An interministerial working group carried out the problem analysis and identified the major components of health financing reform. Its multisectoral nature with representatives of the Ministries of Economy and Industry, Finance, and Health and medical organizations was essential for connecting health financing reforms to other critical functions for greater policy coherence. Then, a group of local consultants drafted the strategic directions in health financing in close collaboration with the Ministries of Economy and Industry, Finance and Health. WHO provided technical assistance during the whole process in the form of webinars, country missions and revisions of relevant documents. An earlier draft of this feasibility study informed the suggested funding mix of the MHI. The health financing strategy was discussed and approved at the high-level policy dialogue in April 2019 with consensus on major strategic directions. Guided by the health financing strategy, the government will soon finalize a law on MHI and regulation of a state-guaranteed benefit package.

¹ The Concept is in Appendix 1 of the Presidential Decree of the Republic of Uzbekistan, December 2018 No. UP-5590.

Fiscal situation and funding of the health system

Similar to other central Asian and eastern European countries, overall financial resources for health in Uzbekistan are scarce. Uzbekistan spent 2.9% of GDP on the health sector,² just above the average for the 12 neighbouring countries of the former Commonwealth of Independent States (CIS), but well below the 6.5% average of high-income countries³ (of the Organisation for Economic Co-operation and Development (OECD)). The 2.9% share of GDP translates to 197 international dollars (power purchasing parity) on health per capita, less than a tenth of the absolute amount spent in the highest income countries of the world. This necessitates making the most use of these resources, i.e. creating an efficient system and reaching patients with the highest need. In the long term, a growing economy will create more resources and, with strong socioeconomic development, the health status of the population will improve. In the short and medium-term, Uzbekistan needs to define priorities within the available economic envelope.

General government spending is low compared to most middle- and high-income countries. Two factors make up the general government health expenditure as a share of GDP: government spending as a share of GDP and the amount of these public funds devoted to health. The first factor (horizontal axis, Fig. 1) reflects the government's ability to collect public resources from taxes and other public revenue. This in turn is dependent on the structure of the economy, explicit public policy and, to a large extent, on how formal the economy is, i.e. how much economic activity takes place in the officially registered economy. Uzbekistan's government expenditure share of GDP is 31.8%, just below the CIS average of 33.2%.² It is also considerably lower than most high-income countries in western Europe and Asia, which have larger government spending as a share of the overall economy. Economic development and improved tax collection will create greater fiscal space to fund public commitments in order to support socially sustainable development.

The priority to health as reflected in spending numbers is on par with the highest health-spending neighbouring countries, but much lower than in high-income countries and the ambition in the President's Decree. The other determining factor for health expenditure relative to GDP is how much of government expenditure, i.e. available public resources, is spent on health. Uzbekistan has increased its priority to health during several years. In 2016, 9.2% of government resources were allocated to health, and this number has increased considerably since then.⁴ This compares well with other CIS countries, but is much lower than

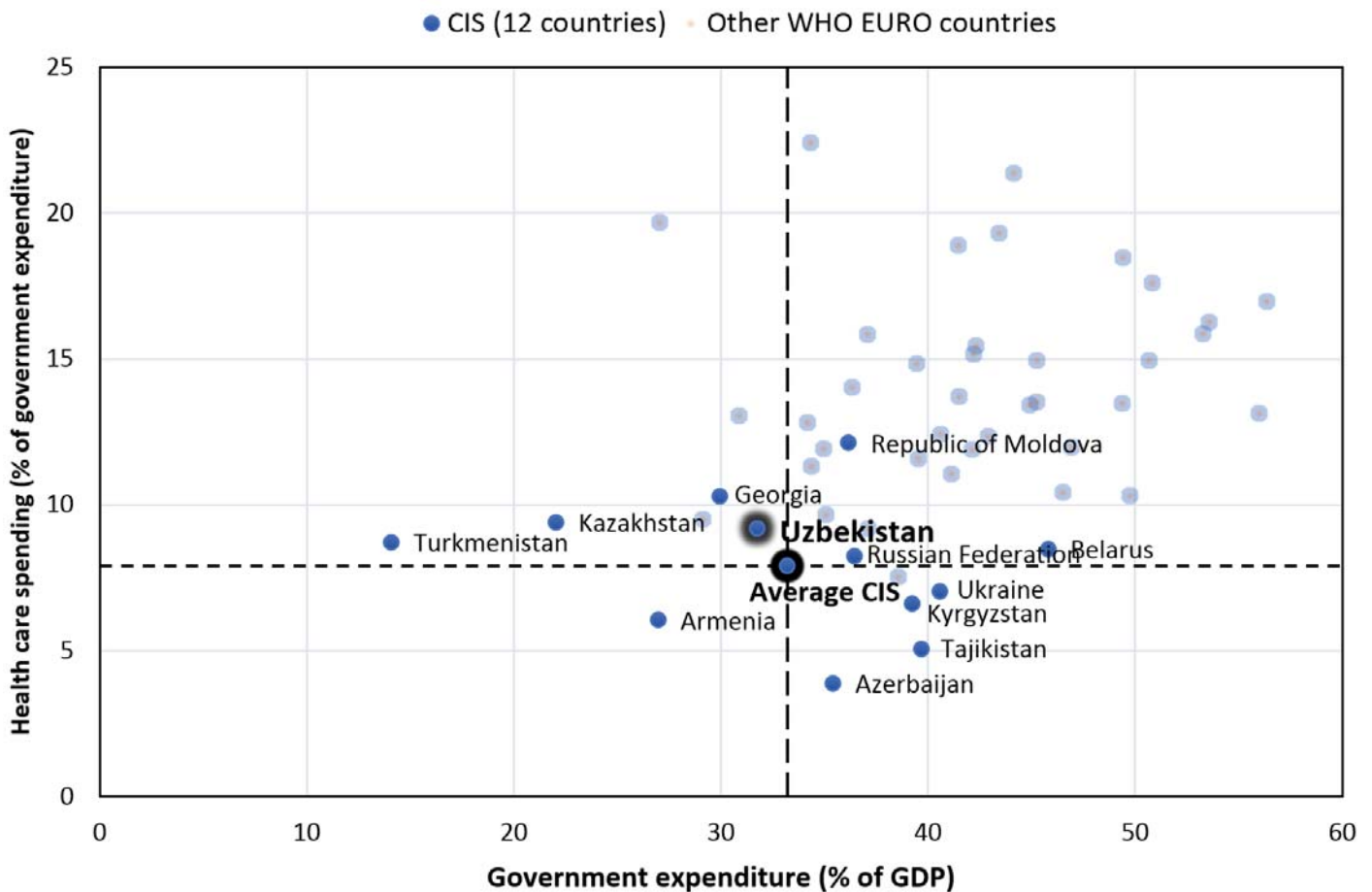
² Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (<http://apps.who.int/nha/database/Select/Indicators/en>, accessed 12 August 2019).

³ OECD. Health at a Glance 2017: OECD Indicators. Paris: OECD Publishing; 2017 (http://dx.doi.org/10.1787/health_glance-2017-en, accessed 5 September 2019).

⁴ This 2016 number is lower than the official budget share allocated to health in Uzbekistan. Data in Fig. 1 are based on the System of Health Accounts' definitions of health care boundaries, which are often different than national sector budgets.

most high-income countries (Fig. 1). The target number in the Presidential Decree of 15.4%, which was reached in 2018 according to national budget data, has brought Uzbekistan's priority to health closer to countries in western Europe and high-income countries in central Asia, and substantially increased resources for health.

Fig. 1. Health care spending and government expenditure in Uzbekistan, 12 neighbouring countries and other countries in the WHO European Region, 2016



Source: Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (<http://apps.who.int/nha/database/Select/Indicators/en>, accessed 12 August 2019).

Although no amount of health spending might be considered enough, Uzbekistan's ambition to increase government spending on health is well founded. In addition to much needed efficiency gains and more explicit priorities, increasing public funding for health will enable Uzbekistan to increase access to services, reduce financial burden and improve health outcomes. In this context, the following chapter provides an analysis of three options to fund the envisioned MHI, given the current structure of the economy and labour market.

Purpose and guiding principles of this study

Presidential Decree No. 5590 stipulates that a technical feasibility study is to be conducted in preparation for drafting legislation on MHI, with technical support from WHO and international financial institutions. To build a solid base for the design of MHI and inform the drafting of a MHI law, the objective of the feasibility study was to assess the funding mix options of the proposed MHI mechanism.

The assessment is based on reflections of the potential impact of alternative revenue sources to advance economic, social and health policy objectives.

1. Support progress towards universal health coverage.
2. Generate additional revenues for the health system in accordance with the indicators set by the Concept.
3. Be consistent with other policy documents, including those on tax evolution and employment.
4. Impact favourably on the labour market.

To reach the highest possible attainment of these objectives, the study rests on two fundamental and universally recognized guiding principles.

First, **universal population coverage** of basic health services is the most effective way to deliver health promotion and prevention of illness and creates the most efficient health system in matching resources with care needs. A prerequisite for achieving this is reaching all population groups, including vulnerable and low-income people most prone to a low health status. Therefore, an important starting point of the feasibility study is Uzbekistan's ambition to provide a state-guaranteed benefit package to all, regardless of age or employment status, and to build the most efficient system possible. The basis for universal entitlement to health services in the study is therefore citizenship plus permanent residency, in accordance with the drafted law on MHI.

Second, in order to strategically allocate resources according to needs, and to avoid fragmentation in administration and service provision, effective **pooling of funds** from different sources is necessary. Creating one national pool of funds for the purpose of health thereby supports an efficient use of resources.

Methodology and data sources

Data from the State Committee of the Republic of Uzbekistan on Statistics (current GDP, population size, birth and mortality rates, number of employees in legal entities and their salary), the Asian Development Bank (on GDP growth rates) and the Ministry of Labour and Social Protection of Population (economically active population, number of individual entrepreneurs) and the Presidential Decree/Concept indicators (general government health expenditure (GGHE) as a percentage of GDP) were used to quantify three scenarios of a future public revenue mix for health. No official data were available on the current government revenue mix or on the income of formal sector employees beyond those in legal entities (see Annex 1).

A number of assumptions have been made for the estimates in the scenarios. The level of GDP and the projections in the Concept are used as starting points for the calculations. The Concept presents a basic indicator package for both health outcome objectives and health financing, among them the share of government health expenditure to GDP, which is projected to grow from 2.9% in 2017 to 5.0% in 2025. This growth is used for the projection of government resources in this study (see Annex 1 for all variables and data points used). For the projection of labour income until 2025, the salary bill per employee is assumed to grow with GDP, and the number of formally employed are assumed to grow with the increase in population. The base year used is 2017 with data from official statistics and all Uzbek som expressed in constant 2017 prices. Because a new payroll tax will most probably have a negative impact on the formal labour market and tax payment compliance, scenarios 2 and 3 are adjusted based on assumptions about the level of evasion of formal sector salary payments (see Annex 1 for adjustment rates). This could be, for example, paying part of salaries outside the official payment system or compensating work by other means than salary payments. The larger the contribution rate, the higher is the risk of evasion. The evasion rate is assumed to decrease over time, as the economy matures and tax collection improves.





REVENUE OPTIONS

Public funding is essential to move towards universal health coverage. The two main sources of public funds for health can be described as (i) revenue from general taxation and (ii) payroll tax contributions. Usually, mainly general taxation-funded health care systems are referred to as national health service (NHS) systems and mainly payroll tax-funded systems are referred to as social health insurance systems; however, internationally, the revenue mix has become less relevant for the distinction between an NHS and MHI and for institutional arrangements of health care systems.

General taxation is non-earmarked government revenues of all administrative levels: local, regional and national. It has a variety of sources, such as taxes from labour income, capital, corporate profit, consumption (value-added tax) and trade, and revenues from sales of government assets. The mix of taxes and other revenue depends on individual country circumstances and a country's ability to collect specific types of taxes. Low-income countries tend to rely on taxes that are easier to collect – such as import and export duties – while high-income countries typically can rely on a broader spectrum of revenue sources. The relative advantages of general taxation-funded health systems include: good opportunities to design a progressive revenue base, low dependency on labour market development, low administrative costs and a high degree of political accountability through regular legislative budget processes. A perceived weakness of general tax-funded health systems is that the health sector competes for funds with other publicly funded sectors.

Payroll taxes are earmarked payments based on the salary bill and tax only employment-based economic activity. Payroll taxes can be levied on employers and employees. With payroll taxes, health funding becomes largely dependent on the formal labour income in the country. Payroll taxes increase labour costs and thus have a negative impact on employment and on economic growth. Several European countries including Czechia, France, Germany, Hungary, Lithuania, the Netherlands and Slovakia have in recent years significantly reduced payroll taxes for health in their revenue mix, replacing them with more broadly based general taxation. Additionally, payroll tax collections are particularly problematic where a large share of employment is less regular (e.g. agriculture) and informal. Collection of payroll taxes is not effective in such cases, and more broadly based taxes not related to employment are needed to distribute the burden over a wider range of economic activity. The design of a benefit package for contributors and non-contributors becomes an important issue in systems financed by payroll taxes and is usually a source of inequality.

Three scenarios of a future public revenue mix for health

A MHI system provides full population coverage of publicly funded health services. This chapter describes three potential scenarios for the revenue mix options of MHI in Uzbekistan.

Scenario 1 | (baseline) describes the public financial resources available if general taxation continues to be the sole base of public funding, with a gradual increase of GGHE to GDP reaching 5% in 2025. This scenario is based on stipulations of this effect in the Concept of Health System Reform of the Republic of Uzbekistan approved by Presidential Decree No. 5590.

Scenario 2 | estimates resources that can potentially become available in 2021 with the introduction of a hypothetical 2% payroll tax contribution levied on the salary bill, plus a fixed contribution rate from individual entrepreneurs and continued allocation of general taxes from the state budget.

Scenario 3 | has the same construction as scenario 2 but with contribution rates twice as high, providing higher potential revenue but also potentially more severe consequences for the labour market. Hence, it estimates resources that can potentially become available with the introduction of a hypothetical 4% payroll tax contribution rate levied on the salary bill, a fixed flat contribution rate from individual entrepreneurs and continued allocation of general taxes from the state budget.

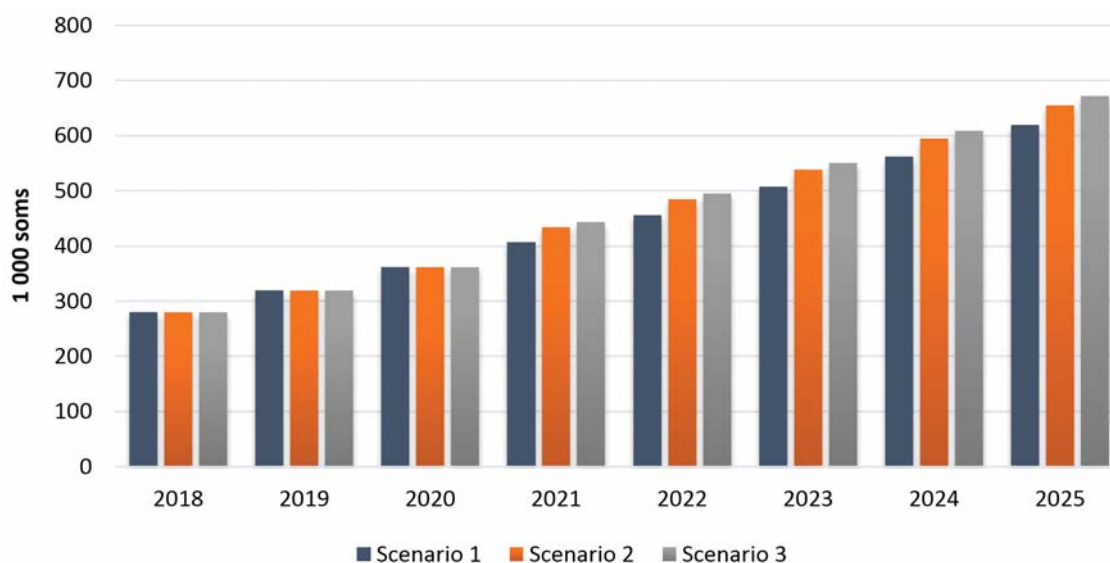
Table 1. Contribution rates for the three scenarios

Scenario	Payroll tax introduced 2021 (%)	Contribution from individual entrepreneurs*
1. Revenues from general taxation, no payroll tax	0	0.0
2. Revenues from general taxation, 2% payroll tax for those on taxable payroll and a one-time payment of 0.5 times the official monthly minimum salary per individual entrepreneur as of 2021	2	0.5
3. Revenues from general taxation, 4% payroll tax for those on taxable payroll and a one-time payment of the official monthly minimum salary per individual entrepreneur as of 2021	4	1.0

*as a multiple of the official monthly minimum salary

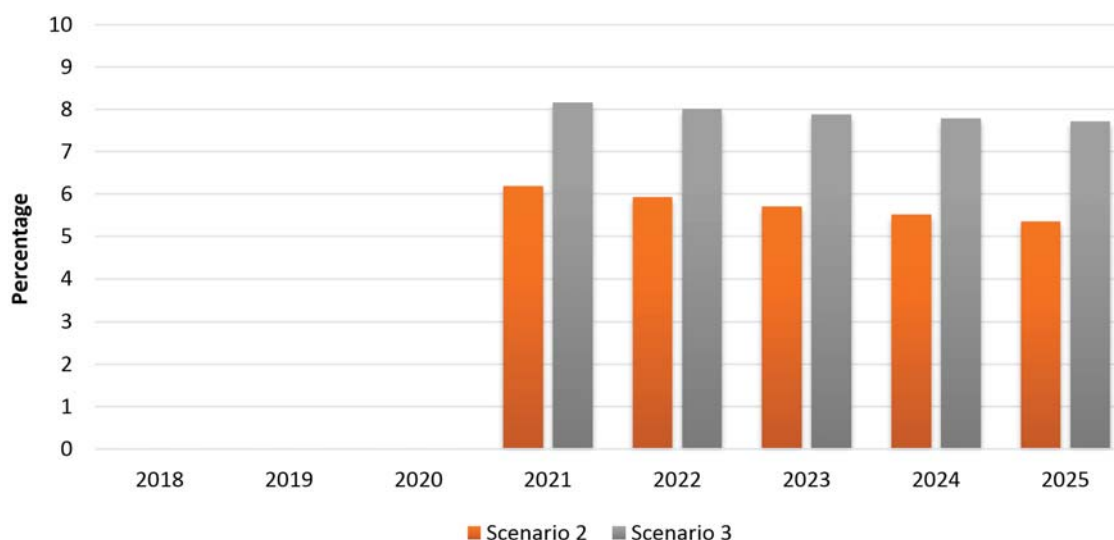
In all three scenarios in this feasibility study, projections for government health spending show large increases in available resources for health, regardless of whether an earmarked payroll tax is introduced or not. In scenario 1, the general government budget for MHI is projected to grow from 280 000 som per capita in 2018 to 620 000 som per capita in 2025 (Fig. 2, scenario 1). This growth is driven by two factors: general economic development (GDP growth) and the government's ambition to increase health funding, as expressed in the Concept.

Fig. 2. Projected public expenditure on health per capita



In scenarios 2 and 3, the additional resources generated by a compulsory payroll contribution are limited and would not substantially increase the ability to fund MHI, beyond what budget resources collected through general taxation can do. Scenario 2 introduces in 2021 a 2% payroll-based compulsory contribution (and a one-time payment of 0.5 times the official monthly minimum salary per individual entrepreneur) for health, and the contribution from this additional revenue source is projected to be 35 000 som per capita in 2025. The additional revenue is projected to be 52 000 som per capita in 2025 with scenario 3 and the 4% contribution rate. Thus, the revenue mix of the MHI will be heavily reliant on budget resources generated by general taxation, also after a potential introduction of a payroll contribution. In these projections, the revenue collected with a payroll tax can potentially represent 6.2% or 8.2% of government spending on health in 2021, depending on the contribution rate applied. However, the relative contribution of the payroll tax will gradually decrease thereafter, projected to be 5.4% and 7.7% in 2025 (Fig. 3). The anticipated gradual decrease in the evasion rate of payroll collection (due to improved compliance with the payroll contribution) results in a higher relative share of payroll funding over time. However, this is more than offset by the Concept’s anticipated increase in general government budget resources for health.

Fig. 3. Projected potential payroll contributions’ share of total government health spending





THE RECENT TAX REFORM AND IMPACT ON THE LABOUR MARKET

Uzbekistan has low unemployment but has seen formal employment numbers decline and is struggling to formalize its economy. Introduction of the new payroll tax poses a potential risk for further deterioration of formal labour participation and for compliance with the tax legislation. The working-age population in Uzbekistan was estimated at 18.6 million people in 2017.⁵ The official unemployment rate is low (5.8%), and so is most probably also the share of the population seeking jobs without being officially registered as such. However, Uzbekistan has large agricultural and small trade sectors, in which the working population participates based on barter and cash payments, with no registered income. Also in other sectors, formal labour participation rates and compliance with income tax legislation are challenges. According to the International Monetary Fund, the formal sector employment rate decreased from 38% to 26% between 2000 and 2018.⁶

Introducing a new payroll tax for health would be inconsistent with the 2019 income tax and social security contribution reform, which is designed to enhance economic growth by increasing the formal labour force participation. The reform ultimately intends to increase public revenue by a larger and wider revenue base for taxation. Until 2018, Uzbekistan had a progressive, four-bracket income tax from 0% for those who earn the official monthly minimum salary, with additional up to 22% on income above 10 times the monthly minimum salary. In addition, an 8% social security contribution to the pension fund is applied to all income. Employers paid a 15% or 25% social security contribution (depending on corporate status), of which all but 0.2% was a pension fund contribution (Table 2). From January 2019, Uzbekistan has a 12% flat-rate income tax on all income, of which 0.1% is designated for the individual pension fund but with no additional social security contribution for the employee. Employers' social security contributions are only reduced marginally from 15% to 12% and only for non-budgetary institutions and institutions with less than 50% state capital.

⁵ Open Data [online database]. Tashkent: State Committee of the Republic of Uzbekistan on Statistics; 2019 (<https://stat.uz/en/open-data>, accessed 12 August 2019).

⁶ Republic of Uzbekistan: 2019 Article IV Consultation – Press Release and Staff Report. Washington (DC): International Monetary Fund; 2019 (Country Report No. 19/129; <https://www.imf.org/en/Publications/CR/Issues/2019/05/09/Republic-of-Uzbekistan-2019-Article-IV-Consultation-Press-Release-and-Staff-Report-46884>, accessed 12 August 2019).

Table 2. Tax rates on personal income

Income Prior to 2019	Tax rate
Income \leq minimum salary ^a	0%
Minimum salary < income \leq 5 times the minimum salary	7.5% on the amount exceeding the minimum salary
5 times the minimum salary < income \leq 10 times the minimum salary	Additional 16.5% on the amount exceeding 5 times the minimum salary
Income > 10 times the minimum salary	Additional 22.5% on the amount exceeding 10 times the minimum salary
After 1 January 2019	
All labour income	12% ^b

^a Official monthly minimum salary.

^b Income tax exemption up to four times the minimum salary is applicable for specific groups, e.g. single parents.

Source: Постановление Президента Республики Узбекистан от 29 декабря 2017 г. № ПП-3454 «О прогнозе основных макроэкономических показателей и параметрах государственного бюджета Республики Узбекистан на 2018 год». [Decree of the President of the Republic of Uzbekistan of 29 December 2017 No. PP-3454 "On the forecast of the main macroeconomic indicators and parameters of the state budget of the Republic of Uzbekistan for 2018"].

The new income tax scale is simplified, reduces labour costs and, more significantly, removes disincentives for qualified staff to register income. The reform also simplifies tax collection and compliance monitoring, both intended to support economic development. However, it increases the relative tax burden on low-income people, by removing the progressive structure of the previous tax scheme. This can have consequences for social cohesion and the ability to redistribute resources in society. This is a deliberate policy choice to support economic development, which many transition economies have taken over the last two decades. In Uzbekistan, the reform should also be seen in the light of the broader market reforms and other efforts to boost economic development in the country. Introduction of the new payroll tax would increase labour costs and thus would have a negative impact on employment and on economic growth.



ALTERNATIVE FISCAL SPACE

With limited potential resources from salary-based contributions, increased fiscal space for health can be achieved by means of a wide range of other policies. The three scenarios with projections of potentially available public resources for health until the year 2025 show that the additional resources generated by a compulsory payroll contribution are limited and would not substantially increase the funding of the MHI, beyond what general taxation resources can do. The main reason for this is the small share of the population working in the formal sector and the relatively low levels of officially registered income.

Therefore, it is useful to consider alternative strategies for expanding the revenue base of the MHI. To assess the large set of options to expand public financial resources for health, it is useful to frame the analysis in the following five principal policy areas.⁷

1 | Economic growth

With increased wealth, more resources are available in society, hence also for health. Uzbekistan has experienced strong economic growth over the last decade, and has an elaborated and to a large extent already implemented agenda for enhancing this further. Uzbekistan spent 2.9% of GDP (government funding) on health in 2016.² With this share of GDP spent on health by the government, each percentage point of GDP growth equates to approximately 133 billion som per year, or 4000 som per capita in increased health spending.

2 | Increased government revenue

With economic growth, Uzbekistan is likely to follow higher-income countries and increase public resources, through a more formalized economy, broader tax base and improved tax payment compliance. Concrete fiscal policies can also impact on the ability to develop a larger government in financial terms. Tax policies that can be implemented without evading the tax base and at the same time protect vulnerable people should be in focus. The 5% health spending as a share of GDP and 15.4% health spending as a share of general government expenditure expressed in the President's Decree will require much larger public spending, also with higher priority to health.

⁷ The five policy areas presented here are modified after a framework presented in Tandon A, Cashin C. Assessing Public Expenditure on Health from a Fiscal Space Perspective. Washington (DC): World Bank; 2010 (Health, Nutrition and Population (HNP) Discussion Paper).

3 | Government priority to health

Within the general government envelope, health can be given greater priority. The increase to 15.4% health spending as a share of general government expenditure anticipated in the President's Decree is a strong commitment to health and will bring Uzbekistan on par with high-income countries. Protecting this ambition in the budget formulation process over the coming years is an investment in the health system.

4 | Complementary revenue for health

Taxes on socially undesirable consumption, so-called sin taxes, have the potential to serve as complementary revenue for health. When compared to western European countries, most of these taxes are considerably lower in Uzbekistan and neighbouring countries. Increasing taxes on consumption of goods such as alcohol, tobacco, petrol and others makes good sense from both a public health and economic perspective. In some countries, for example in the Philippines, sin taxes have provided for substantial additional revenue.⁸

5 | Health sector efficiency gains

Creating and collecting more resources is a long-term effort, which is immensely dependent on other sectors in society, and other line ministries than the Ministry of Health. Instead of only striving to enlarge the envelope of available resources, a complementary strategy is to use available resources more efficiently. OECD has estimated that wasteful spending represents up to 20% of health expenditure in high-income countries.⁹ In Uzbekistan, with a legacy of an extensive hospital sector, whose resources would buy more health gains if used in outpatient settings, this number is likely to be even larger.

Any of these pillars for fiscal space can on its own generate substantial resources. They can each be analysed separately to estimate their potential effectiveness in generating resources. However, they are not mutually exclusive alternatives, but must rather be seen as parts of comprehensive reform.

⁸ "Sin Tax" expands health coverage in the Philippines. In: WHO [website]. Geneva: World Health Organization; 2015 (<https://www.who.int/features/2015/ncd-philippines/en/>, accessed 12 August 2019).

⁹ OECD. Tackling wasteful spending on health. Paris: OECD Publishing; 2017 (<https://doi.org/10.1787/9789264266414-en>, accessed 12 August 2019).

CONCLUSIONS AND RECOMMENDATIONS

Based on the findings of this feasibility study, the most effective revenue option to fund MHI in Uzbekistan is to expand reliance on general taxation and focus on efficiency gains without introducing a payroll tax.

This feasibility study shows that the additional resources generated by a compulsory payroll contribution are limited and would not substantially increase the ability to fund MHI, beyond what budget resources collected through general taxation can do. In 2025, the additional revenue for health from a payroll-based contribution would give a projected 35 000 som per capita, in addition to the projected 620 000 som per capita from general government budget resources, in the scenario with a 2% salary based contribution rate, and 52 000 som in the scenario with a 4% contribution rate. The share of the payroll tax in the total public funding mix would in 2025 be 5.4% and 7.7% respectively. The main reasons for this low share of the funding mix are the small share of the population working in the formal sector, and the relatively low levels of officially registered income. The scenario projections also show that even if it is assumed that compliance with the payroll tax will increase in the years after implementation, the share of this revenue will decrease. This is because of the anticipated increase in public funding for health, as expressed in the Presidential decree.

Introducing a payroll tax earmarked for health risks affecting the labour market and the overall fiscal situation negatively, and must be seen in a broader public finance and economic growth perspective. No single revenue collection mechanism stands on its own. Of particular relevance is the newly implemented tax reform, with a substantially simplified and lowered tax scheme. This was specifically implemented in 2019 to incentivize economic growth and formal labour market participation. Introducing a new payroll tax partly reverses this reform. The revenue mix choices also demonstrate how income tax, social security, and other public finance policy areas, have to balance several objectives across different sectors in government. Introducing a payroll contribution earmarked for health is beyond the health sector policy domain and must be seen in the broader reform agenda.

To have resources relative to the economy that is in line with high-income countries, Uzbekistan needs to allocate more public resources to health. A comparison of overall public funding of health with other countries in the region, shows that Uzbekistan is very similar to other CIS countries, but spends much less on health than high income countries. Both the government expenditure share of GDP and the priority to health within this government envelope are very close to the average of neighbouring countries. The Presidential Decree however, clearly expresses an ambition to change this, with a stronger public commitment to the health sector. This enables adequate funding of a MHI, and brings Uzbekistan to a level of health funding as share of the economy similar to high-income countries.

Important areas of health promotion and health system efficiency should be seen as avenues for generating more resources to the health sector. Complementary resources can be found in developing health promoting tax policies for undesirable and environmentally costly consumption, such as tobacco, alcohol, and fossil fuels. Inevitably, Uzbekistan needs to progress on efficiency gains in the service delivery system, where large savings can be achieved without losing medical quality and effectiveness. These resources can then be reallocated to health services, which generate more value. The potential of these strategies should be further explored in follow ups to this feasibility study.

ANNEX 1.

DATA AND DATA SOURCES FOR THE FEASIBILITY STUDY'S THREE SCENARIOS¹⁰

Variables	2017	2018	2019	2020	2021
GDP (in constant 2017 prices, billions of som)	302 537	317 966	334 501	352 898	372 308
Real GDP growth (%)	4.5%	5.1%	5.2%	5.5%	5.5%
GGHE (% of GDP)	2.9%	2.9%	3.2%	3.5%	3.8%
GGHE (% of general government expenditure)	14.9%	15.4%	15.4%	15.4%	15.4%
Population (thousands)	32 654	32 955	33 532	34 119	34 716
Economically active population in the formal sector (thousands)	4 636	4 602	4 694	4 777	4 860
Number of employees in legal entities on taxable payroll (thousands)	2 581	2 605	2 650	2 697	2 744
Evasion rate with 2% payroll tax; percentage of non-complying employees	–	–	–	–	20%
Evasion rate with 4% payroll tax; percentage of non-complying employees	–	–	–	–	45%
Annual average salary/person (thousands of som) in legal entities	17 438	18 328	19 281	20 341	21 460
Average annual salary/person (thousands of som) of other employees in the formal sector	The income is assumed to be considerably lower than for the group working in legal entities, not meeting tax payment thresholds.				

¹⁰ Data provided by MOH at the time of development of the feasibility study might slightly differ from the later published official Uzbekistan state statistics. Figures on 2020 and onwards do not include COVID-19 impact.

	2022	2023	2024	2025	Sources and assumptions
	392 784	414 388	437 179	461 224	2017, 2018: NSC; 2019–2025 estimates based on real GDP growth forecast by the Asian Development Bank
	5.5%	5.5%	5.5%	5.5%	Asian Development Bank, 2017 and 2018 measured, 2019 and 2020 estimates, 2020 projected rate applied for subsequent years
	4.1%	4.4%	4.7%	5.0%	As per indicators for 2018 and 2025 in the Concept, Annex #1 to the Presidential Decree, 2019–2024 based on a linear trend
	15.4%	15.4%	15.4%	15.4%	2017, 2018: actual data; 2019–2025: 15.4% in accordance with the Concept indicators
	35 324	35 942	36 571	37 211	2017, 2018: NSC; 2019–2025 projections based on 2.25% birth rate and 0.5% mortality rate
	4 945	5 032	5 120	5 209	2017–2018: Ministry of Labour and Social Protection of Population; 2019–2025 projected with the ratio of economically active in the formal sector in 2018 to the total population (excluding individual entrepreneurs (IEs), small-scale farmers, farm labourers and others not on the payroll)
	2 792	2 841	2 890	2 941	2017: NSC; 2018–2025 projected with population growth (excluding IEs, small-scale farmers, farm labourers and others not on the payroll).
	19%	18%	17%	16%	Assumption about the share of employed people who move to the informal sector or by other means avoid contributing
	43%	41%	39%	37%	Assumption about the share of employed people who move to the informal sector or by other means avoid contributing
	22 640	23 886	25 199	26 585	2017: NSC, projected to grow with GDP

Variables	2017	2018	2019	2020	2021
Number of IEs (thousands)	934	330	336	342	348
Evasion rate of IEs with 0.5 times the minimum salary contribution (%)	–	–	–	–	25%
Evasion rate of IEs with 1 times the minimum salary contribution (%)	–	–	–	–	50%
Minimum salary (thousands of som)	184	194	204	215	227

IEs: individual entrepreneurs; NSC: State Committee of the Republic of Uzbekistan on Statistics.

	2022	2023	2024	2025	Sources and assumptions
	354	360	367	373	2018 data from Ministry of Labour and Social Protection of Population; forecast from 2019–2025 based on current ratio (2018) of employees and IEs
	24%	23%	22%	21%	Assumes a larger share of IEs can move into the informal sector compared to the employment group
	48%	46%	44%	42%	Assumes a larger share of IEs can move into the informal sector compared to the employment group
	239	252	266	281	The minimum salary introduced on 15 July 2018 is used as base data, growth projection based on GDP



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