World Health Organization

European Region

Health financing system assessment

Tajikistan 2023

Health Financing Progress Matrix

Funded by
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Abstract
This report provides a concise summary of the Health Financing Progress Matrix (HFPM) assessment in Tajikistan, identifying strengths and weaknesses in the current health financing system as well as those areas of health financing which need to be addressed in order to drive progress towards universal health coverage (UHC). Findings are presented in several different summary tables, based on the seven assessment areas and the 19 desirable attributes of health financing. By focusing both on the current situation as well as priority directions for future reforms, this report provides a prioritized agenda for analytical work and related technical support. The latest information on Tajikistan's performance in terms of UHC and key health expenditure indicators are also presented. Detailed responses to individual questions are available on the WHO HFPM database of country assessments, or upon request.

Keywords: HEALTHCARE FINANCING, PUBLIC EXPENDITURES, TAJIKISTAN, UNIVERSAL HEALTH COVERAGE

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Abbreviations

Decree 600	Government Decree 600 "About the procedure for the provision of medical services to citizens of the Republic of Tajikistan by facilities of the government health care system", December 2, 2008
DPT3	Diphtheria, Tetanus Toxoid and Pertussis Vaccine (third dose)
DRS	districts of republican subordination
HBS	household budgetary survey
HFPM	Health Financing Progress Matrix
IEG	Interagency Expert Group
Ministry of Health	Ministry of Health and Social Protection of the Population of the Republic of Tajikistan
MTEF	Medium-Term Public Expenditure Framework
NCD	noncommunicable disease
NHA	National Health Accounts
OOP	out-of-pocket
PHC	primary health care
SDG	Sustainable Development Goal
SGBP	State Guaranteed Benefits Program
UHC	universal health coverage

Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system[1]. The assessment builds on an extensive body of conceptual and empirical work and crystallizes "what matters in health financing for universal health coverage" (UHC) into nineteen desirable attributes, which form the basis of the assessment.

This report identifies areas of strength and weakness within Tajikistan's current health financing system, in relation to desirable attributes. Based on this, the report recommends adjustments to health financing policy, specific to the context of Tajikistan, which will then help to accelerate progress towards comprehensive UHC.

The qualitative nature of this analysis, together with supporting quantitative metrics, allows almost real-time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress of the development and implementation of health financing policies. Country assessments are implemented in four phases, as outlined in Fig. 1. Given that no primary research is required, assessments can be implemented within a relatively short time period.

Fig. 1. The four phases of HFPM implementation

Source: Country assessment guide: the health financing progress matrix, Geneva: World Health Organization; 2020 (*11*)

1 Health financing progress matrix [website]. In: WHO/Health Systems Governance and Financing. Geneva: World Health Organization; 2023 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix, accessed 26 June 2023).

Phase 2 of HFPM consists of two stages of analysis.

- Stage 1 involves mapping of the health financing landscape; consisting of a description of the key health coverage scheme(s) in a country. For each, key design elements are mapped, such as the basis for entitlement, benefits and the payment provider mechanisms, which provides an initial picture of the extent of fragmentation in the health system.

- Stage 2 undertakes a detailed assessment, based on the answers to 33 questions concerning health financing policy. Each question explores one or more desirable attribute of health financing, and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using HFPM findings and recommendations to feed into policy processes, including the development of new health financing strategies, the review of existing strategies, and the routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Methodology and timeline

The principal investigator for this assessment was Dr Farrukh Egamov, Health Financing Expert and member of an Interagency Expert Group (IEG) established under the Ministry of Finance of the Republic of Tajikistan. The main objective of the IEG is to provide technical support to the Ministry of Finance and the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan (Ministry of Health) in regard to health financing reforms through the analysis and assessment of the health financing system in the Republic of Tajikistan. The IEG has good health financing experience and works closely with both the Ministry of Health and development partners. During the Health Financing Progress Matrix (HFPM) data collection process, the IEG used the guidelines provided and additional technical assistance was provided by WHO experts.

Stage 1. Dr Egamov collected the data and produced the tables describing key characteristics of the health financing system in Tajikistan. Mr Wilkens and Ms Goroshko reviewed and provided comments and ratings.

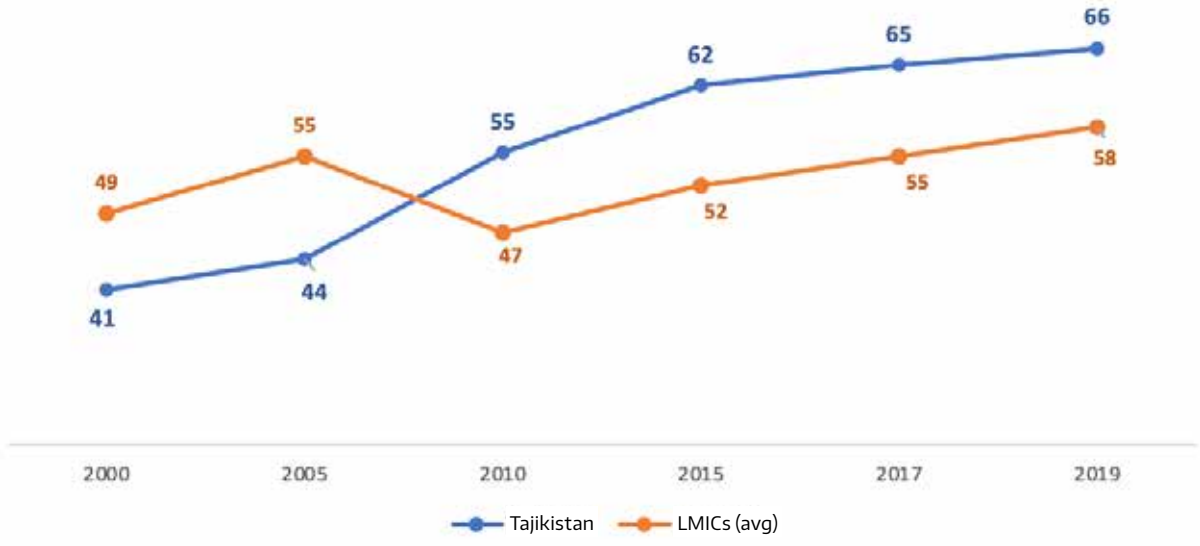
Stage 2. Dr Kirvalidze drafted responses to matrix questions across the seven assessment areas and by 19 desirable attributes of health financing. Together with Mr Egamov, assessment levels were reviewed and a consensus was reached. A final draft was shared with the WHO Health Financing team for review. Ms Goroshko addressed changes and comments made by the WHO team.

Two external reviewers (Mr Mathivet and Dr Kirvalidze) reviewed the interim report completed by the principal investigator. A double-blind review process was employed whereby each reviewer independently proposed scores for each assessment question using the HFPM external review spreadsheets. A consensus meeting was then held with the principal investigator and the two external reviewers to discuss the scores and reach consensus. Final scores were shared with the team. Dr Kirvalidze drafted the HFPM summary report by grouping findings around desirable attributes, as per HFPM methodology. The summary report was edited by WHO health financing experts, and priority areas were identified for a summary report which will be published jointly by the Ministry of Health and WHO.

Tajikistan universal health coverage performance

Sustainable Development Goal (SDG) indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases (NCDs) and service capacity and access *(1)*. The service coverage index is a score between 0 and 100, which in Tajikistan has increased from 41 in 2000 to 66 in 2019 (Fig. 2).

Fig. 2. Service coverage index trend in Tajikistan, 2000–2019



Source: World Health Organization, 2023 *(1)*.

Note: LMIC include Angola, Algeria, Bangladesh, Benin, Bhutan, Bolivia, Cabo Verde, Cambodia, Cameroon, Comoros, Congo, Rep., Côte d'Ivoire, Djibouti, Egypt, Arab Rep., Eswatini, Ghana, Guinea, Haiti, Jordan, India, Iran, Kenya, Kiribati, Kyrgyz Republic, Lao PDR, Lebanon, Lesotho, Mauritania, Micronesia, Fed. Sts., Mongolia, Morocco, Myanmar, Nepal, Nicaragua, Nigeria, Pakistan, Philippines, Samoa, São Tomé and Principe, Senegal, Solomon Islands, Sri Lanka, Tanzania, Tajikistan, Timor-Leste, Tunisia, Ukraine, Uzbekistan, Vanuatu, Vietnam, Zambia, Zimbabwe.

For some components of the service coverage index, such as the quantity of antenatal care visits, or the coverage of the Diphtheria, Tetanus Toxoid and Pertussis Vaccine (third dose; DTP3), it is possible to obtain disaggregated information. Fig. 3 shows how inequalities in access have decreased over time.

Fig. 3A. Antenatal care by quintile in 2017

Antenatal care +4 visits

National average (2017): 64.6%				
Value by quintile – 2017				
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
45.0%	55.4%	65.0%	73.3%	82.0%

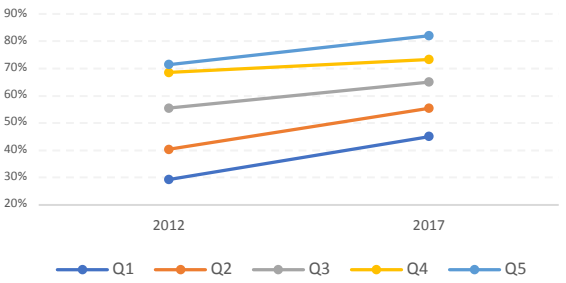
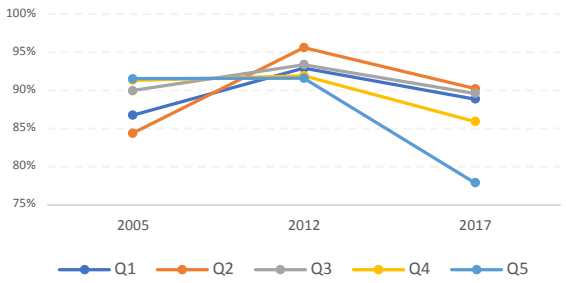


Fig. 3B. DPT3 coverage by quintile in 2017

DTP3 coverage 1 year

National average (2017): 87.1%				
Value by quintile – 2017				
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
88.9%	90.2%	89.6%	85.9%	77.9%



Source: World Health Organization, 2023 *(2)*.

Note: Q stands for quintile, each quintile represents 20% of population based on the level of income

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending. With technical support from WHO, Tajikistan is currently undertaking the analysis of key financial protection indicators, including incidences of catastrophic and impoverishing expenditures, and drivers of these expenditures.

Findings and key recommended actions by assessment area

The information below summarizes key recommended actions that are important for Tajikistan in making further progress towards universal health coverage (UHC). All recommendations are based on conclusions generated in this assessment, as well as supported by evidence on initiatives that have worked well in other countries, as summarized in the desirable attributes of health financing system in the Health Financing Progress Matrix (HFPM) background paper.

Summary of findings and key recommended actions

Assessment area	Summary findings	Status
Policy process and governance	Tajikistan's national policies related to health financing are outlined in the Strategy on Health Care of Population of the Republic of Tajikistan up to 2030 *(3)*. This document outlines major reform components in all aspects related to the country's health system. However, implementation remains slow. In addition, the use of evidence and data to inform current health financing policy development is limited. It is recommended that Tajikistan develops policies to make shifts in the following directions: • improving coordination and working towards stronger dialogue within the Government and other stakeholders to accelerate reform implementation; • introducing monitoring and evaluation frameworks to drive implementation of key health financing strategies and plans. This would also allow the Government and population to understand if key priorities are being acted upon, if money on health is spent in an efficient manner and if desired goals in terms of improving population health and financial protection are achieved; and • strengthening the analytical capacity of the Ministry of Health to evaluate health financing reforms.	Progressing ●●○○

Revenue raising	Out-of-pocket (OOP) expenditures constitute most of the total health expenditure in the country, resulting in major problems with access to health care. Patients' expenditures when accessing health services is the major source of total health expenditure in the country, accounting for 65% in 2020 *(4)*. Furthermore, most OOP payments for services are made informally, resulting in a lack of protection mechanisms for those in need. A legal framework to introduce a social health insurance system (and link benefits to the contribution of the earmarked health taxes) was approved in 2008, but the implementation has been continuously postponed. Public spending on health is covered from the general budget, and this reliance on general taxes (as opposed to reliance on employment contributions) is a strength of the system and provides a foundation for further development.
	
	It is recommended that Tajikistan develops policy to make shifts in the following directions:
	
	• implementing changes to the 2008 regulation to expand reliance on general taxation, ensuring that health benefits are guaranteed to everyone and that access to health care services is not dependent on employment status or payment of specific health taxes;
	• building capacity within the Ministry of Health to better engage in budget negotiations for greater prioritization of revenue for the health sector. This could start with basic analysis of government spending on health and setting realistic targets for gradual increases in government health spending; and
	• decreasing reliance on OOP payments by:
	  • conducting an analysis of OOP payments including drivers, i.e. which services or goods are procured by patients, and in which care settings patients need to pay for care (e.g. outpatient/inpatient);
	  • increasing public spending on health to provide essential health services to the entire population; and
	  • assessing and addressing reasons for providers charging informal under-the-table payments.
		Progressing
		●●○○

Summary of findings and key recommended actions

Assessment area	Summary findings	Status
Pooling revenues	The pooling of health care resources is organized at district/municipality level and is highly fragmented. It limits purposeful allocation of health resources and much needed purchasing reform. The lack of effective pooling is a result of the decentralized system of public financing and consequently the separate funding streams for health services result in overlaps across the three administrative levels (national, oblast and district/municipality). This system does not allow redistribution of resources, and leads to duplication in funding streams and inefficiency in funding use. On a positive note, low-income areas with fewer resources are subsidized by regional and national resources. The per capita normative a capitation amount used both to define the central government allocations to poorer regions, and also as the basis for primary health care (PHC) budgets in better-off regions. This mechanism de jure supports the basic redistribution of resources, but in practice is not followed universally. It is recommended that Tajikistan develops policy to make shifts in the following directions: • starting gradual implementation of the pooling of resources at a higher level – first by introducing oblast-level pooling, and later moving to a single national pool.	Progressing 
Purchasing health services	Tajikistan's approach to purchasing health services is passive – health providers are paid based on inputs and historic allocation and budget allocations are not informed by providers' performance or the health needs of the population. This approach does not reward patient–centredness, better health outcomes or increased efficiency. There are no mechanisms to incentivize more rational use of resources or to improve the quality of services. On the contrary, it stimulates an increase in input resources – more beds and more working staff becomes the only way to increase facility financing, regardless of which services are provided. It is recommended that Tajikistan develops policy to make shifts in the following directions: • establishing a single strategic purchasing agency and developing necessary capacity; and • taking a stepwise approach in implementing strategic purchasing, starting with some planned pilot schemes. Focus in new purchasing arrangements should be given to primary health care services, which are a government priority and easier to implement. Changes of payment arrangements for inpatient care should be planned for the later stages of health financing reforms.	Progressing 

Summary of findings and key recommended actions

Assessment area	Summary findings	Status
Benefits and entitlements	Tajikistan has invested in efforts in making entitlements more explicit and clearer to the population. Before 2023 the country had two different benefits schemes, covering approximately half of the country's districts each and differing in terms of co-payment rates. Formally, both packages had a strong focus on universal entitlement to essential PHC services and maternal and childcare, as well as extended entitlements for vulnerable population groups. However, primary care lacks certain benefits to ensure effective coverage (e.g. simple diagnostic tests are not available at the level of PHC and should be paid OOP; basic pharmaceuticals for outpatient treatment are not free of charge). Patients who are not included in exempted groups must pay high co-payments for specialized services, making these services accessible only to the relatively wealthy population. As a result, public facility budget resources subsidize the relatively well-off patients, and facilities are incentivized to focus their effort on those who can pay, and not necessarily patients who are in higher need of care. The prevalence of informal payments is reported to be due to providers directly requesting these payments from patients, possibly prompted by low salaries in public facilities. Additionally, some services such as laboratory diagnostics and medicines are not covered by the Government and must be paid OOP. The two benefit schemes were used differ in the co-payment rate (50% or 80% of service cost) for specialized care services, and the regulation on how co-payment revenues could be used at the facility level. In 2023 the Government abolished the scheme with 50% co-payment, and extended the 80% co-payment scheme for the whole country. It is recommended that Tajikistan develops policy to make shifts in the following directions: • revising benefit packages to focus on comprehensive and extended PHC services, including outpatient medicines and laboratory diagnostics and maternal and child services; • developing specific policies to address informal payments. This can be done by first assessing the reasons why providers charge informal payments, and how well the benefits align with available resources, followed by the introduction of provider accountability mechanisms to ensure that people are not requested to pay; • revising the co-payment policy. Priority specialized services should be included in the benefit package with no or low fixed co-payment for everyone, while other specialized care services should be paid out-of-pocket by patients with no subsidies from the Government. A single co-payment rate should be implemented throughout the country; and • expanding the list of social groups who are granted co-payment exemptions, to include children over 1 year and pensioners under 80 years old.	Progressing 

Summary of findings and key recommended actions

Assessment area	Summary findings	Status
Public financial management	The public financial management system is rigid and restricts the flexible use of public resources. Health facilities have limited financial autonomy and face cumbersome requirements for spending approval from local financial authorities., Any unspent funds must be returned to the local budgets at the end of fiscal year, which creates financial disincentives to more efficient use of scarce public resources. In regard to co-payments received from patients, facility managers do have a larger degree of financial autonomy over these funds, although this feature of the system creates a focus on service provision for the relatively wealthy. With this said, a strength of the system is the high level of predictability of available resources. This gives facility managers an extended planning horizon, although their ability to allocate resources based on locally assessed needs is limited. It is recommended that Tajikistan develops policy to make shifts in the following directions: • setting clear health sector priorities and strengthening data collection and information systems to support a shift from historic budgeting to one health and resource needs assessment; and • identifying and addressing constraints to increasing provider autonomy, such as rigid budgets, untimely disbursement of funds to facilities or lack of guidelines. As greater financial flexibility and autonomy are given to providers, corresponding accountability mechanisms must be put in place. In particular, as facilities are allowed to retain co-payments, rules (e.g. reporting requirements) could support their more effective use.	Progressing 
Public health functions & programme	Prevention and treatment of many diseases (e.g. tuberculosis, HIV, child illness management, healthy lifestyle counselling and family planning) is often organized in parallel structures. The process for integrating these services into PHC is ongoing at the local level (for example, in child illness management and family planning), but no national strategy or guidance are available to define how and which services should be integrated.	Progressing 

Summary of findings and key recommended actions by desirable attributes of health financing

Policy process and governance

Desirable attribute GV1[2]	**Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual- and population-based services**
Key areas of strength and weakness in Tajikistan	**Strengths** • Tajikistan has adopted the Strategy on Health Care of Population of the Republic of Tajikistan up to 2030, which outlines goals and objectives for the health care system in line with UHC vision. **Weaknesses** • The Strategy's implementation remains problematic, unachieved goals from the previous version of the strategy have been moved to the current document.
Recommended priority actions	• Ensure strong coordination and dialogue among government and non-government stakeholders to support strategy implementation. • Build a strong and consistent monitoring system to track the implementation of the Strategy.
Desirable attribute GV2	**There is transparent, financial and non-financial accountability in relation to public spending on health**
Key areas of strength and weakness in Tajikistan	**Strengths** • Tajikistan has a computerized financial reporting system (SGB-net) which is used by government institutions. State health providers are connected to this system and report in a timely manner. The computerized financial reporting system captures both provider and local budget expenditures. • The aggregated financial information on government funding for health care is officially published on the Ministry of Finance website. **Weaknesses** • Not all financial data are published and published information is not presented in a user-friendly format. • Non-financial performance monitoring is limited, and where collected, the data in terms of health needs and health outcomes are not used for improving access and quality of care.
Recommended priority actions	• Strengthening of data collection efforts/health information systems would support governance of the health financing system and policy development. • Further transparency of financial data should be adopted, e.g. publishing data in a more user-friendly format. • Accountability in terms of non-financial data should be strengthened to allow better understanding concerning whether money allocated to health care is spent in an efficiently manner, and if desired objectives are achieved.
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**

Key areas of strength and weakness in Tajikistan	**Strengths**
	• Tajikistan collects some of the important indicators using internationally approved methodology:
	  • from 2009, Tajikistan implemented the National Health Accounts (NHA), a key tool for monitoring health expenditures.; and
	  • the Household Budgetary Survey (HBS) is also routinely conducted in the country to allow monitoring of health expenditure by population.
	
	Weaknesses
	• Tajikistan lacks tradition, expertise and practical experience in using evidence and data when developing new policies, forming health budgets and making decisions about the content of the benefit package.
	• Data from the NHA, HBS and other studies are underutilized for the development and monitoring of health policies. Results are mainly used for analytical reports and cross-country comparisons by development partners.

Recommended priority actions	• Government analytical capacity (e.g. in assessment of burden of disease, cost–effectiveness of different types of services, etc.) should be improved to support the use of evidence in the development and implementation of policies.

2 Abbreviations GV1, GV2, and GV3 are used as labels for desirable attributes as described in the country assessment guide *(9)*

Revenue raising

Desirable attribute RR1[3]	Health expenditure is based predominantly on public/compulsory funding sources
Key areas of strength and weakness in Tajikistan	**Strengths** • Currently the public financing of health is based on general budget allocations, which makes health services accessible to all patients despite their employment status or payment of specific health taxes. **Weaknesses** • On 18 June 2008, Parliament approved Law 408 on Health Insurance *(5)* which introduced a new social tax for health, to be jointly paid by employers and the government on behalf of socially vulnerable populations. The Law stipulates that access to guaranteed services is linked to the contribution of earmarked social tax for health. However, the implementation of the Law has been postponed several times, the new social tax has not been implemented and the general government budget remains the source of public funding for health. Changes to the law suggested by WHO to ensure a realistic funding base and avoid separate benefits for population groups with different employment status have not yet been implemented. International evidence suggests that the success of payroll taxes in financing health system is highly dependent on the labour market being close to full employment, and a minimal role of the informal sector in the economy *(6)* – conditions which are not met in Tajikistan. Furthermore, according to WHO estimations *(7)*, introducing a payroll tax will only contribute a very modest increase to the health budget, equivalent to 3.3% of annual public spending. • The Tajik health system is heavily dependent on OOP payments; in 2020, household payments made up more than 65% of the total expenditure on health care *(4)*. • The government priority on health is relatively low: the share of health spending in general government spending accounted only for 7% in 2020 *(4)*.

Recommended priority actions	• Changes to the existing legislation need to be adopted by Parliament to ensure that general taxation remains the key source of funding, and that all citizens have access to the defined benefit packages, regardless of their employment status.
	• The issue of high OOP payments should be addressed by:
	
	  • increasing public spending on health, so that the country can provide the entire population with essential health services;
	  • better prioritization of most cost-effective and needed services; and
	  • conducting an analysis of OOP payments to better understand which services or goods are drivers of patients' expenditures, and the reasons for informal under-the-table payments.

Desirable attribute RR2	**The level of public (and external) funding is predictable over a period of years**
Key areas of strength and weakness in Tajikistan	**Strengths** • The level of financing is stable and predictable. The Medium-Term Public Expenditure Framework (MTEF) in the health sector has been used since 2008 to both perform 3-year planning of health expenditures and to define spending priorities in midterm perspective. • Foreign aid flows are relatively stable, and the country's reliance on external financial support for health has, encouragingly, been on a downward trend; although a steep increase was observed in 2020 due to the COVID-19 pandemic *(8)*.
Recommended priority actions	• Work for a stronger dialogue between health and financing sectors when defining health budgets, to better account for the multiple fiscal objectives and health priorities of the country.
Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in Tajikistan	**Strengths** • Resource allocation to providers is predictable because it is based on historic spending by each facility. • Budget execution is high as it strictly follows the line items with salary spending accounting for more than 80% of total spending *(8)*. **Weaknesses** • The high level of budget execution is the result of the rigid public financial management system and the fact that most resources are allocated to salaries.
Recommended priority actions	• At facility level, financial flexibility and autonomy should increase with appropriate accountability mechanisms in place.

3 Abbreviations RR1, RR2, RR3, and RR4 are used as labels for desirable attributes as described in the Country assessment guide *(11)*

Revenue raising

Desirable attribute RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms

Key areas of strength and weakness in Tajikistan	**Strengths**
	• Tajikistan's excise tax system includes taxes for tobacco, alcohol and sugar-sweetened beverages (along with other bottled beverages):
	  • tobacco tax accounts for €19 per 1000 cigarettes, from €8.5 to €17 for cigars and from 30–70% for other industrially produced tobacco and tobacco extracts *(9)*. The recent increase of excise taxes puts Tajikistan ahead of neighbouring countries in terms of taxes on cigarettes;
	  • alcohol tax is €2.5 per litre of spirit with alcohol concentration above 80% and €3.5 per litre of pure alcohol. Tajik alcohol taxes are higher compared with some of the neighbouring countries; and
	  • Tajikistan has taxed sugar-sweetened beverages for over a decade; currently €0.03 per litre of product.
	
	Weaknesses
	• The same tax rates are applied for both sweetened and other (non-sweetened) bottled beverages; therefore, the excise tax does not encourage healthier behaviour of the population.

Recommended priority actions	• Tajikistan should continue the current practice of systematically reviewing the design of tobacco and alcohol taxes. • The sugar-sweetened beverage tax should be increased to discourage consumption of the product. There is no universal benchmark on how high this tax should be, but international evidence suggest that it should account for at least 20% of retail price in order to have an impact on consumption *(10)*.

Pooling revenues

Desirable attribute PR1[4]	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
Key areas of strength and weakness in Tajikistan	**Strengths** • Measures to address the existing fragmentation of funding are planned in the Strategy on Health Care of Population of the Republic of Tajikistan up to 2030 through a pooling of funds at the regional and national levels. The Law on Health Insurance envisages pooling of resources at the national level (although the implementation of the regulation is continuously postponed). • In 2016 Tajikistan adopted a per capita normative for PHC budget planning. This initiative has potential to address unequal financing of health services and to allow allocation of additional resources to poorer regions. **Weaknesses** • By design the Tajik financing system is highly fragmented and, therefore, is a limited potential for the redistribution of funds – most funds are allocated to health by local government from their revenue without any actual pooling at the higher level (even if de jure these funds are approved as a part of the national budget).
Recommended priority actions	• Actual pooling of financial resources for health should be implemented, so that allocation of resources can be based on need instead of local revenues and physical resources. • A step-wise approach could be used: the accumulation at oblast level could be a first step towards national-level pooling.
Desirable attribute PR2	**Health system and financing functions are integrated or coordinated across schemes and programmes**
Key areas of strength and weakness in Tajikistan	**Strengths** • Single approach in revenue raising, pooling and purchasing of health services is used in the healthcare system of Tajikistan.
Recommended priority actions	–

4 Abbreviations PR1and PR2 are used as labels for desirable attributes as described in the country assessment guide *(11)*

Purchasing health services

Desirable attribute PS1[5]	Resource allocation to providers reflects population health needs, provider performance or a combination

Key areas of strength and weakness in Tajikistan

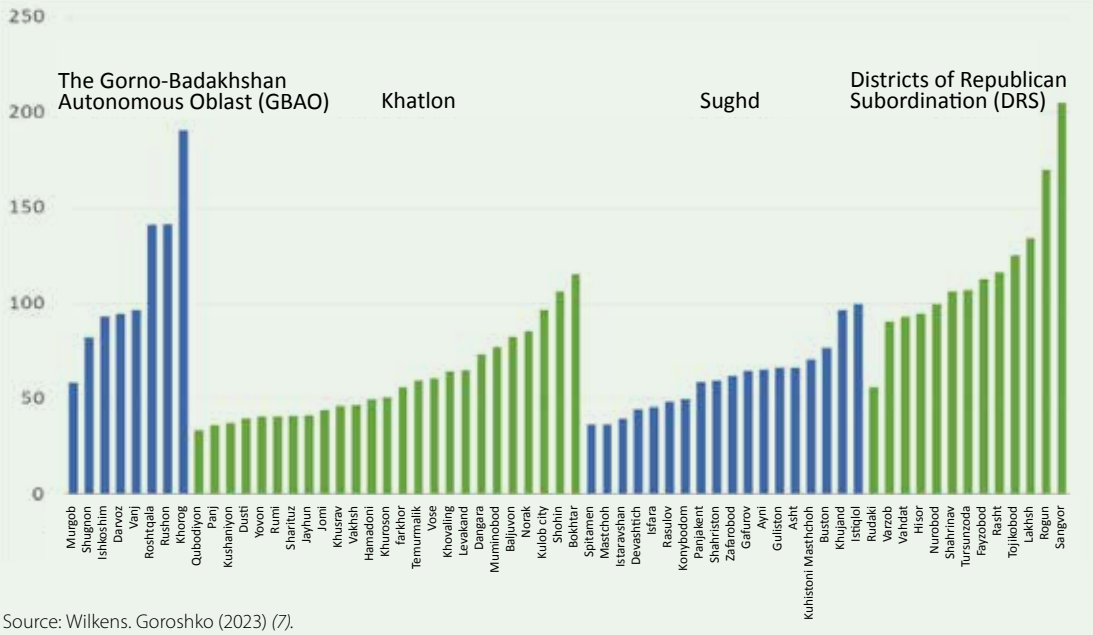
Strengths

- Measures to improve the resource allocation mechanisms are planned in the Strategy on Health Care of Population of the Republic of Tajikistan up to 2030 through introduction of new payment methods.

Weaknesses

- Population health needs are not assessed or analysed.
- The financing that providers receive from the public funds is based on historic spending, infrastructure, the number of beds, and staff. The payment amount is not informed by the health needs of the population. This arrangement is a passive approach of purchasing services.
- The level of allocation to providers depends on the local budgets' fiscal space for health (and the regions' ability to raise revenues), not actual health needs or performance of health care providers;
- The per capita normative for PHC was introduced in 2016 and is often referred to as an introduction of the new payment method during the in-country discussions. In fact, it was not used as a new payment method but rather as the basis for budget allocation when forming PHC budgets at the local level. It is also not followed universally – actual per capita allocation in poorer districts can be below the official minimum level.
- Actual per-person spending on health can differ by up to two times between the poorest and richest districts/cities within one oblast (Fig. 4).

Fig. 4. Per capita spending on PHC in district budgets (somonis), 2020



Source: Wilkens. Goroshko (2023) *(7)*.

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Recommended priority actions

- Tajikistan should move from passive to more strategic purchasing of health care services, which includes:
  - using information concerning people's health needs to better inform which services to purchase;
  - using information on providers' capacity to deliver care and their performance to purchase services;
  - using new payment methods to pay for health services; and
  - transitioning to contractual relationships instead of line-item financing of health facilities.
- Establishment of the single purchasing agency and development of Government capacity in this area is a prerequisite for successful implementation of strategic purchasing reforms.
- The country should take a stepwise approach in implementing strategic purchasing. The first step could be the implementation of the pilot in Sughd oblast with the introduction of new PHC payment methods. Other pilots should be continued and evaluated to allow the Government and providers to get the necessary practical experience.
- This allocation for health should be seen as an investment in the country's future prosperity, not as a burden to the public finances system.

5 Abbreviations RS1, RS2, and RS3 are used as labels for desirable attributes as described in the country assessment guide *(11)*

Purchasing health services

Desirable attribute PS2	Purchasing arrangements are tailored in support of service delivery objectives
Key areas of strength and weakness in Tajikistan	**Strengths** • Service delivery objectives are approved within the National Health Strategy 2030 and are in line with the vision of UHC. **Weaknesses** • The current health financing system in Tajikistan cannot support the service delivery objectives, as no instruments for it are available within the currently applied passive purchasing approach.
Recommended priority actions	• When implemented, strategic purchasing instruments should be assessed for their ability to create desired and undesired changes in service delivery. One of the examples of undesired consequences could be a major increase in the provision of non-priority services if financing methods create incentives for this. • A better use of information covering both clinical and financial data is needed to understand if new purchasing arrangements will support achievement of planned objectives. Therefore, a data collection system should be implemented, and the analytical capacity of the Ministry of Health to support development of the health financing policies should be enhanced.
Desirable attribute PS3	**Purchasing arrangements incorporate mechanisms to ensure budgetary control**
Key areas of strength and weakness in Tajikistan	**Strengths** • The system is protected from unforeseen overspending at the public resource level due to the use of line-item budgeting. **Weaknesses** • Budgetary control mechanisms are too rigid and do not allow for the more efficient use of resources.
Recommended priority actions	• Tajikistan should consider implementation of more liberal budgetary measures along with new accountability mechanisms to ensure that money is spent efficiently and that there is space for the greater provider autonomy.

Benefits and entitlements

Desirable attribute BR1[6]	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in Tajikistan	**Strengths** • Population entitlements and conditions of access are defined. • Entitlements are communicated to the patients in health facilities via posters.
Recommended priority actions	• Continuous effort should be invested in communication of entitlements, particularly when any new rules are put in place.
Desirable attribute BR2	**A set of priority health service benefits within a unified framework is implemented for the entire population**
Key areas of strength and weakness in Tajikistan	**Strengths** • The population is guaranteed universal entitlement to essential PHC and maternal and childcare services. Some extended entitlements are provided for vulnerable population groups. **Weaknesses** • Some of the essential components of PHC are not included in the benefits. For example, simple diagnostic tests are not available at the level of PHC and should be paid out-of-pocket. The outpatient medicines are not part of entitlements. • Numerous specialized care services are included into the benefit schemes, partially financed by the public budget, along with high-percentage co-payments (80%) which should be paid by patients. As a result, public resources are used to partially cover the cost of services for the relatively well-off population, who can afford the high co-payment rate, while poorer patients most likely forego receiving specialized care. This creates a system in which the Government subsidizes care for richer population. • Co-payment rates are perceived as the source of additional revenues for health facilities, local and national budgets: 5% of all co-payments for services go to the general local budget to be spent according to local needs, not necessarily on health, and under the Decree 600 "About the procedure for the provision of medical services to citizens of the Republic of Tajikistan by facilities of the government health care system" scheme, a further 5% of revenues from co-payments goes to the special Ministry of Health account to be spent on health at the national level.
Recommended priority actions	• Tajikistan should review the currently used benefit schemes relying on evidence of population health needs and epidemiological patterns – delivering more (and higher-quality) services at PHC level represents the most efficient way forward.

6 Abbreviations BR1, BR2, BR3, BR4, and BR5 are used as labels for desirable attributes as described in the country assessment guide *(11)*

Benefits and entitlements

Desirable attribute BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
Key areas of strength and weakness in Tajikistan	**Weaknesses** • There is no formal and transparent process in place that would determine benefit design on an iterative basis, including assessment of changes in terms of cost–effectiveness, health technology assessments and budget impact analysis. • Budget impact assessment is challenged by the financing system architecture – the actual per capita spending differs significantly at local level. Therefore, services which are affordable in one district may be non-financially sustainable in another district because of differences in health budget. • The fact that almost the half of the health budget is spent on inpatient care *(8)* is reflective of weaknesses in the prioritization of more cost-effective types of care such as PHC services.
Recommended priority actions	• Tajikistan should establish a formal process, general principles and criteria for choosing services to be included into the benefit package. • The focus in the process of benefit package development should be given to selection of the most needed and cost–effective services available to all, and not on detailed co-payment rules and hospital services affordable only to the relatively richer population.
Desirable attribute BR4	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in Tajikistan	**Weaknesses** • The system does not allow matching benefits with available resources – the cost data are not analysed because the financing system uses the historic spending level and allocates resources according to inputs, not outputs. • The availability of resources for health differs significantly at district/city level, while the unified scope of benefits is guaranteed throughout the country. Therefore, resource and health guarantees alignment in one region do not mean that services will be provided in other parts of the country in a financially sustainable manner.
Recommended priority actions	• During the revision of the scope of benefits, the Government should use the cost–effectiveness and budgetary impact assessments to inform decisions about the future health benefits.
Desirable attribute BR5	**Benefit design includes explicit limits on user charges and protects access for vulnerable groups**
Key areas of strength and weakness in Tajikistan	**Strengths** • The vulnerable groups and frequent users of services (listed in Stage 1 of the assessment) are exempt from co-payments. **Weaknesses** • Co-payments are set as a percentage of service cost, which results in patients with greater health needs paying more or foregoing care. The percentage co-payment usually means that people cannot know in advance how much they will need to pay for receiving care. This creates barriers towards seeking medical care. • De facto, the high level of percentage co-payments effectively means that the current system subsidizes access to services for people who most likely would be able to pay the full price of service, without using scarce public resources. • Co-payments from patients are viewed as legitimate sources of revenue for health providers, creating financial incentives for providers to induce demand for services delivered to a relatively rich population. • The co-payment exemption is granted to children younger than 1 year old, meaning that the financial protection of elder children in case of disease is rather low (unless they can receive exemption as member of another social group). • The co-payment exemption is granted to pensioners aged 80 years and older, other pensioners will need to co-finance their care (unless they can receive exemption as member of another social group). The health needs increase significantly for the older patients, particularly in terms of managing NCDs. The need to co-finance care for older people creates major barriers in accessing care, as well as makes it unlikely for the country to achieve major progress in responding to NCDs. • The health services co-payment list is not revised on an annual basis considering real inflation rate and drug price increases. As a result, the cost of services may not cover the expenditures for providing service, which creates conditions for informal payments from the population. The costing of the services used for setting the co-payment rates is not explained and not clear. • The level of informal payments is high: informal and private payments account for 47% of total facilities' revenues, while official co-payments account only for 6%, meaning that the introduction of formal co-payments has not resulted in formalization of patient payments *(8)*. • Patient surveys indicate a high rate of providers asking for informal payments: in 2016 52% of patients reported being asked for informal payment for services, which were supposed to be free of charge. Rural citizens faced this problem twice as often as citizens living in urban settings *(8)*.

Recommended priority actions	• To address the issue of high OOP payments, the country needs first to analyse the drivers of OOP payments by service type, care settings (inpatient vs. outpatient), public or private sectors and to assess and address reasons for providers making under-the-table charges.
	• Tajikistan should work on development of the new single benefit scheme for the whole population, with the main focus on comprehensive PHC services (including basic medicines and laboratory diagnostics), maternal, and child services. Services, which currently have the high level of co-payments, after careful analysis should be:
	  • either included into the benefit package for the general population (beyond their coverage for exempt groups) with no or low fixed co-payment; or
	  • excluded from the benefit package for the general population and be fully paid out-of-pocket.
	
	• The vision of co-payment should be changed from viewing it as an additional revenue to health care providers. Patients in Tajikistan already contribute 65% of the total health expenditure in the country, and the future policy should focus on how to ensure people are financially protected when using health services, not on how to make people pay even more.
	• The list of social groups who are granted the co-payment exemption should be expanded for frequent health care users, including children and older people younger than 80 years old.

Public financial management

Desirable attribute PF1[7]	Health budget formulation and structure support flexible spending and are aligned with sector priorities
Key areas of strength and weakness in Tajikistan	**Strengths** • Tajikistan has developed an MTEF which is used in the health sector. The framework is used to perform 3-year planning of health expenditures and to define spending priorities in a mid-term perspective. **Weaknesses** • The annual budget formulation is not closely linked to priorities and is organized using line items of input resources.
Recommended priority actions	• Explicitly define annual priorities for the health sector from the MTEF in order to support building links to the annual formulation of health budgets. Gradually support incremental changes from budgeting based on historical inputs to budgeting aligned with sector priorities (e.g. aggregating line-items into broader lines). • Shift from budgets being based on historic resource allocations and local fiscal space to being informed by an assessment of health and resource needs. • Build the capacity of the Ministry of Health to support their engagement with the Ministry of Finance in budget formulation process (e.g. skills in developing budgets, forecasting costs, analysing budget impact). Improve the dialogue between the Ministries of Health and Finance when defining the budget for the health sector within the process of health budget development.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in Tajikistan	**Strengths** • Providers have relatively greater flexibility to manage the funds received from patient via co-payments. **Weaknesses** • The system of public financial management is rigid and does not allow for the more flexible use of public resources. Some of the regulation allowing greater autonomy is in place, but it does not result in practice. For example, regulations allowing lump-sum financing of PHC facilities and the more flexible use of resources were approved in 2015 *(12)* but have not resulted in any actual change in practices. Most facility managers note that they have limited autonomy in the reallocation of public budget funds by obtaining permission from the local financial authorities. Typically, managers are held accountable for spending according to line items. • Greater autonomy in use of co-paid funds is likely to risk shifting provider focus from service delivery to raising revenues from patient payments over which they have higher level of autonomy.
Recommended priority actions	• Constraints and/or concerns to increasing provider autonomy in general (especially in regard to the lump sum for PHC facilities) should be identified and addressed, for example, by streamlining cumbersome spending approval procedures, lack of guidelines. • At the facility level, the financial flexibility and autonomy should increase in tandem with adequate accountability mechanisms in place.

7 Abbreviations PF1 and PF2 are used as labels for desirable attributes as described in the country assessment guide *(11)*

Stage 1 assessment

Stage 1. Health coverage schemes in Tajikistan: health financing arrangement

Before 2023 the country relied on two benefit schemes referred as Decree 600 and the State Guaranteed Benefit Program (SGBP). In 2023 the Government abolished the SGBP scheme and extended the use of Decree 600 for the whole country.

Key design feature	Decree 600	SGBP
A) Focus of the scheme	All citizens of Tajikistan have the right to guaranteed medical services, defined by the Government. Both schemes define the scope of services and some of the rules for accessing care free of charge or with co-payments.	
B) Target population	In 2022 the Decree 600 benefit scheme was implemented in 34 districts throughout Tajikistan.	In 2022 the SGBP was implemented in 31 pilot districts throughout Tajikistan (compared with 19 pilot districts in 2019).
C) Population covered	In 2022 68% of the country's population were covered within the Decree 600 benefit scheme.	In 2022 32% of country's population were covered within the SGBP scheme.
D) Basis for entitlement/ coverage	The legal basis for coverage or entitlement is automatic by citizenship according to the Health Code of the Republic of Tajikistan, with set rules for co-payments based on the by-laws. The co-payment exemption is guarantees are same for both benefit schemes. **List 1.** Groups of the population entitled for free medical services by social status. 1. Participants and people with disabilities who participated in the Great Patriotic War. 2. Heroes of the Republic of Tajikistan, Soviet Union or the People, awarded with three classes of the Order of Glory. Heroes of Socialist Labor. 3. Soldiers: internationalists, veterans of military actions in the territory of other states. 4. Pensioners with honourable and special merit. 5. Citizens who suffered as a consequence of the Chernobyl nuclear power station accident. 6. People with disabilities who were injured during military service. 7. People with disabilities from childhood. 8. Children with disabilities under the age of 18. 9. Orphans and children without parental tutelage. 10. Children under the age of 1. 11. People with class I or II disabilities. 12. Members of poor families and low-income single citizens. 13. Older people aged 80 years and over. 14. People living in retirement homes. 15. Unemployed citizens officially registered by the employment authorities. 16. Victims of human trafficking and victims of domestic violence (at the first stage of the situation). **List 2.** Groups of the population entitled for free medical services as per medical conditions. 1. Patients who have had myocardial infarction (for the first two weeks). 2. Cancer patients in terminal stages. 3. Children with acute respiratory and diarrhoeal diseases aged under 5 (within the framework of the Integrated Management of Childhood Disease Program). 4. Haemophilia patients. 5. Leprosy patients. 6. Rabies patients. 7. Diphtheria patients. 8. Tuberculosis patients (within the scope of the directly observed treatment, short-course programme). 9. AIDS patients. 10. Diabetes (insulin-dependent form) patients.	

E) Benefit entitlements	The scope of services within two schemes are almost identical and include the following types of care:
	• ambulance and emergency medical care, including medicines.
	• PHC services:
	  • prevention service
	  • diagnostics (free lab diagnostics only for patients from exemption groups) and treatment
	  • vaccination for children under the age of 5 years.
	
	• Obstetrics care for women who received four antenatal check-ups.
	• Inpatient-specialized service for groups of the population entitled to free medical services.
	• Emergency dental care and prevention check-ups for pregnant women and children.
	
	The SGBP defines the benefits for antenatal care more explicitly than Decree 600. It provides additional guarantees for exemption groups in terms of free-of-charge medicine provision, with a fixed cap on Government expenditure per patient per year for outpatient treatment. In 2022 the cap of expenditure per patient per year amounted to128 somoni per year, but actual access to medicines was dependent on local budget capacity to finance these expenditures.	

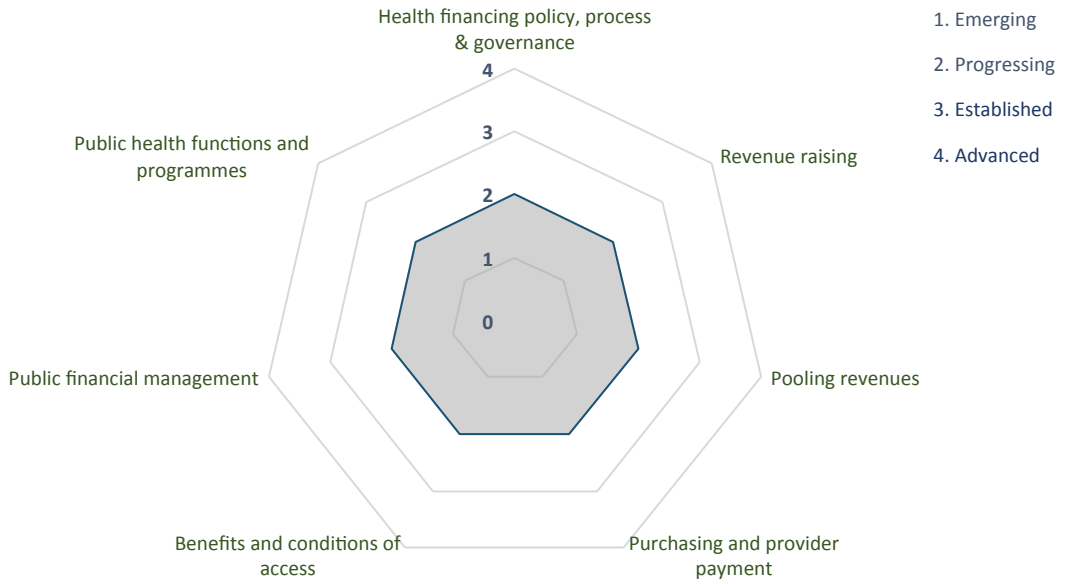
Key design feature	Decree 600	SGBP
F) Co-payments (user fees)	According to legislation, users have to pay co-payment for the covered services, except for the defined categories of population exempt from co-payment. The co-payment set as percentage to the payment rates for the fixed tariff for the 606 diagnostic and 1489 services (price list). The co-payment level for the laboratory, diagnostic and specialized services at the outpatient level is set as a percentage of the unified price list for health services. The inpatient level used the average cost scale for disease-based grouped services and the share of the cost of these groups for the definition of the co-payment level. Under Decree 600 for the provision of health services (specialized care at the outpatient level and inpatient care), a patient makes a co-payment in the amount of 80% of the cost of services with a family doctor's referral, or without a referral will pay the full (100%) cost of service.	Under the SGBP for the provision of health services (specialized care at the outpatient level and inpatient care), a patient makes a co-payment in the amount of 50% of the cost of services with a family doctor's referral and without a referral pays 70% of the cost of services. Under both programmes the Ministry of Health develops and regularly (every 2 or 3 years) revises the single price list, which is approved by the Antimonopoly Agency.
G) Other conditions of access	In addition to the co-payment that users will have to pay, there are the special conditions that must be met in order to access services. The special conditions are referrals, limits on treatments, place of residence and form of health organization. All patients must go through a referral system (referrals from a family doctor, therapist, paediatrician and obstetrician–gynaecologist of the PHC facilities). Citizens from other cities and districts, when receiving specialized health care at an outpatient level in districts where SGBP is being implemented pay the full cost of services based on the single price list, and at the inpatient level, pay the full cost of services based on the scale of the average cost of a treated case. Under Decree 600 expensive inpatient medical services performed using high diagnostic and treatment technologies are paid according to the price list. Haemodialysis performed in a hospital is paid according to the price list. Under both programmes, if the de facto cost of inpatient treatment exceeds twice the cost of treatment according to the price list, the medical and supervisory commission of a facility will consider the patient's additional payment to the facility.	
H) Revenue sources	From public funds, both schemes are funded by local budgets from general taxes. Patients' co-payments are also transferred to local budgets (under both schemes, 5% of all co-payments for services go to the general local budget to be spent according to local needs, not necessarily on health) and under the Decree 600 scheme, a further 5% of revenue from co-payments goes to the special Ministry of Health account to be spent on health at the national level.	
I) Pooling	The Decree 600 scheme is implemented for republican, oblast, city and district level facilities; therefore, the funds to finance care in these facilities are pooled at the respective level.	The SGBP scheme only functions at the city and district facility levels and therefore, pooling is also organized at city and district levels.
J) Governance of health financing	The Ministry of Health is responsible for national health policy but has no control over the overall health budget and only directly manages health facilities at national level. Local authorities are more directly responsible for health and education. The oblast health departments (Gorno-Badakshan Autonomous Oblast (GBAO), Khatlon and Sughd) are responsible for the health care provision of oblast-owned health care facilities and, together with the executive local authorities (khukumats) of cities and rayons, for the activities of city and rayon health facilities within the respective oblasts.	

Key design feature	Decree 600	SGBP
K) Provider payment	Tajikistan uses a passive purchasing approach – health providers are paid based on input resources (wages according to payment schedules and normative, utility cost) and historic allocation and the financing does not depend on provider's performance and actual needs of population in the catchment area. This approach does not reward patient–centredness, better health outcomes or increased efficiency. On the contrary, it stimulates an increase in input resources – having more beds and more staff working becomes the only way to increase facility financing, regardless of which services are provided. In 2016 the Government introduced the PHC per capita normative, which was designed to increase and equalize PHC spending. Two PHC normative are approved by the Government every year – one each for district and municipal level facilities. In 2022 the district normative was 65 somoni per person per year and municipal was 76 somoni. The difference in normatives is motivated by the higher level of equipment and service availability in City Health Centres, which creates concerns for the equity of access to care for people living in different types of settlements. The per capita normative should not be viewed as implementation of the per capita payment method, but rather as a resource allocation and budgetary transfer tool. Adopting new payment methods usually requires a contractual relationship between purchaser and provider of services and direct payment of funds to provider according to the agreed terms, as well as more flexible resource use at the level of provider. None of these conditions are met after the introduction of a per capita normative. Within the framework of donor funding, the World Bank is implementing performance-based financing at PHC level in 10 pilot districts. The per case financing of inpatient services is piloted within the ADB-supported project. WHO is going to support the pilot on introduction of oblast-level pooling of resources and per capita financing for PHC services in Sughd oblast.	
L) Service delivery and contracting	Tajikistan has different types of service delivery units for PHC, specialized outpatient and inpatient care. PHC is provided by city or district health centres (where health workers are family medicine doctors, family medicine nurses, narrow specialists), rural health centres (where health workers are family medicine doctors and family medicine nurses), health houses (family medicine nurses) and an ambulance station (doctors and feldshers). The total number of PHC facilities in 2019 was 2860. Inpatient facilities at the secondary level are city and district central hospitals and rural hospitals. Inpatient institutions of the tertiary level are regional and republican specialized hospitals and centres. The total number of the tertiary facilities is 107. Public health centres include sanitary-epidemiological facilities, immunization centres, AIDS centres, healthy lifestyle centres, tuberculosis facilities and other centres for the implementation of vertical health programmes. The total number of public health centres is 524. In 2019 there were 479 private health facilities in the country, 403 of which were outpatient, mainly diagnostic centres and 12 hospitals. All health facilities are accredited by the State Service for Supervision of Health Care Activities.	

Stage 2 assessment

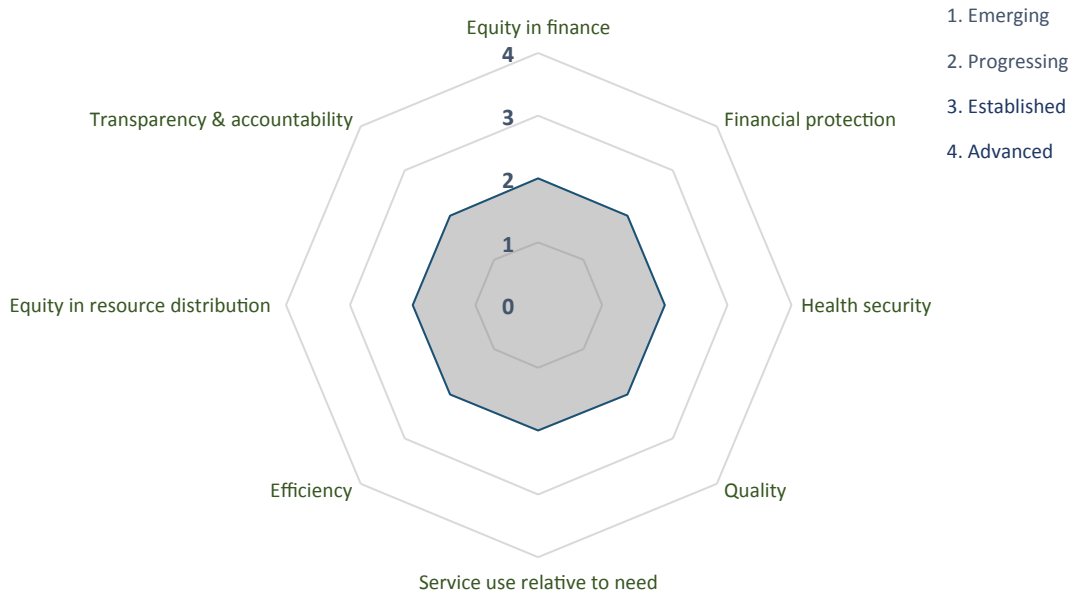
Summary of ratings by assessment area

Fig. 5. Average rating by assessment area (spider diagram)



Source: World Health Organization, 2020 *(11).*

Fig. 6. Average rating by goals and objectives (spider diagram)



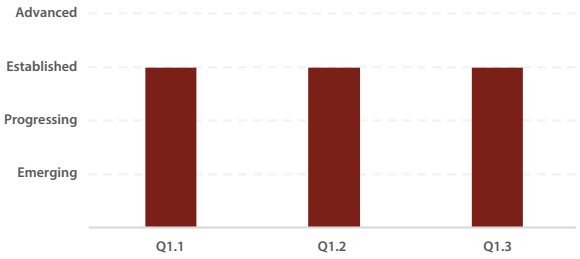
Source: World Health Organization, 2020 *(11).*

Assessment rating by individual question

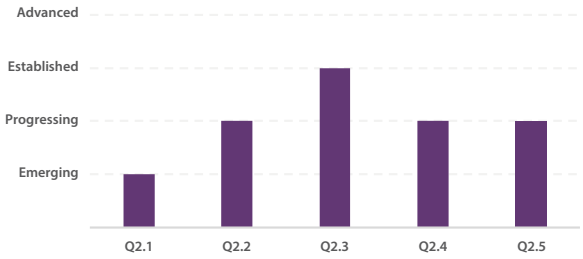
The Figure 7 summarizes the ratings of Tajik health financing system by individual question of the HFPM (see Annex 3 for question details).

Fig. 7. Assessment rating by individual question

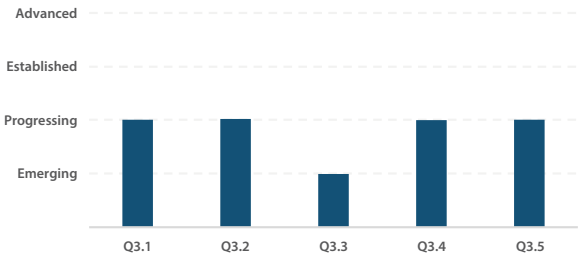
1. Health financing policy, process and governance



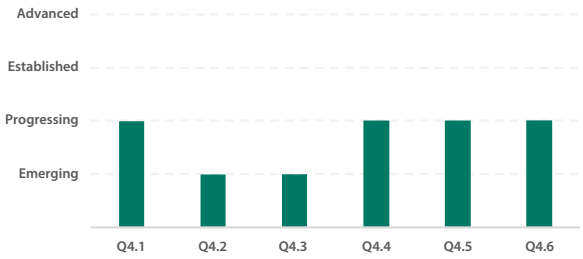
2. Revenue raising



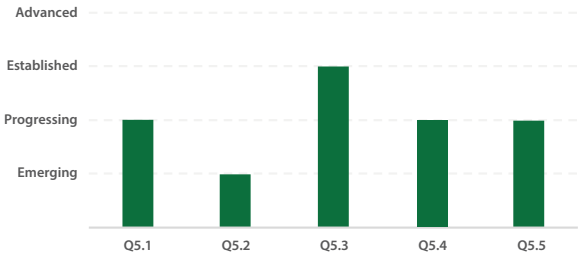
3. Pooling revenues



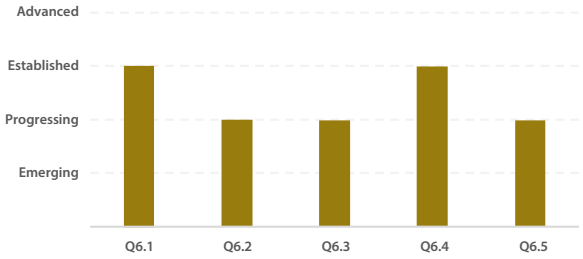
4. Purchasing and provider payment



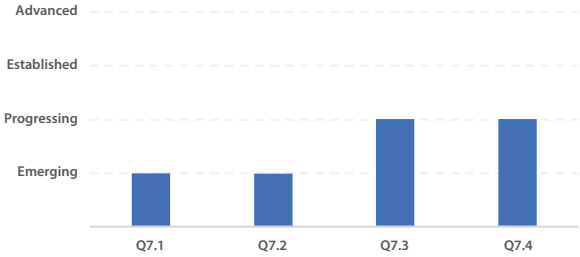
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes



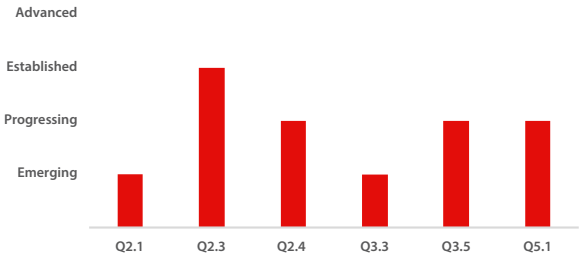
Note: Q stands for question

Assessment rating by UHC goals

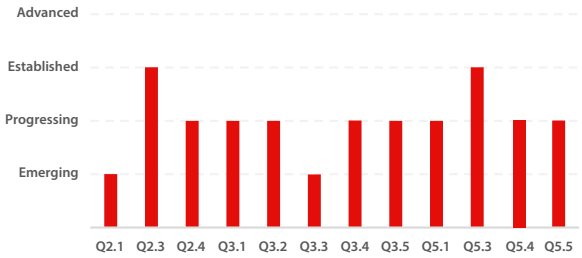
The Figure 8 summarizes the ratings of Tajik health financing system by UHC goals (see Annex 3 for question details).

Fig. 8. Assessment rating by UHC goals

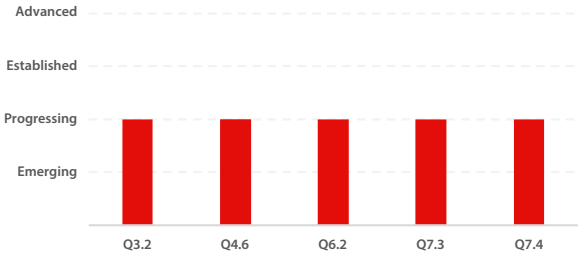
Equity in finance



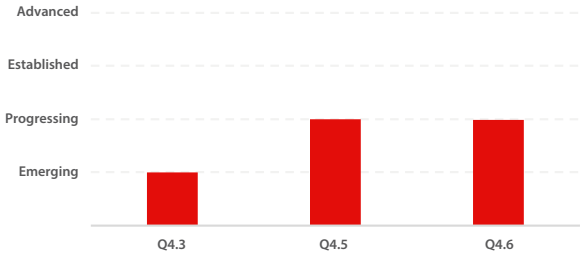
Financial protection



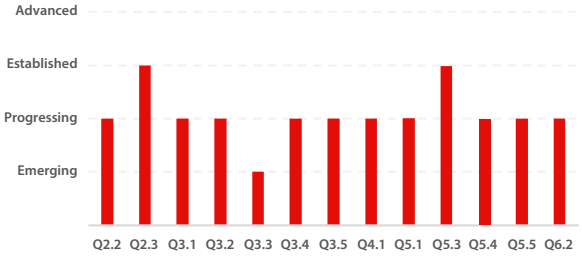
Health security



Quality



Service use relative to need

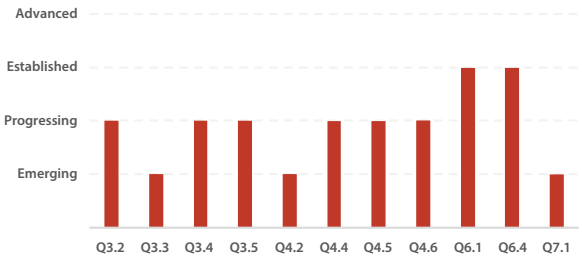


Assessment rating by intermediate objective

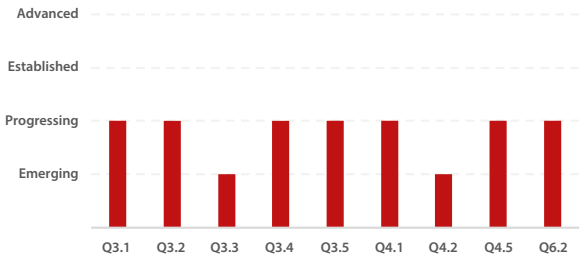
The Figure 9 summarizes the ratings of Tajik health financing system by intermediate objectives of health systems (see Annex 3 for question details).

Fig. 9. Assessment rating by intermediate objective

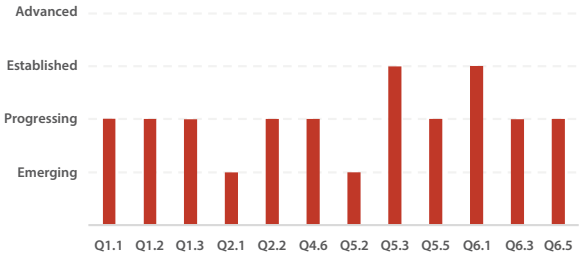
Efficiency



Equity in resource distribution



Transparency & accountability



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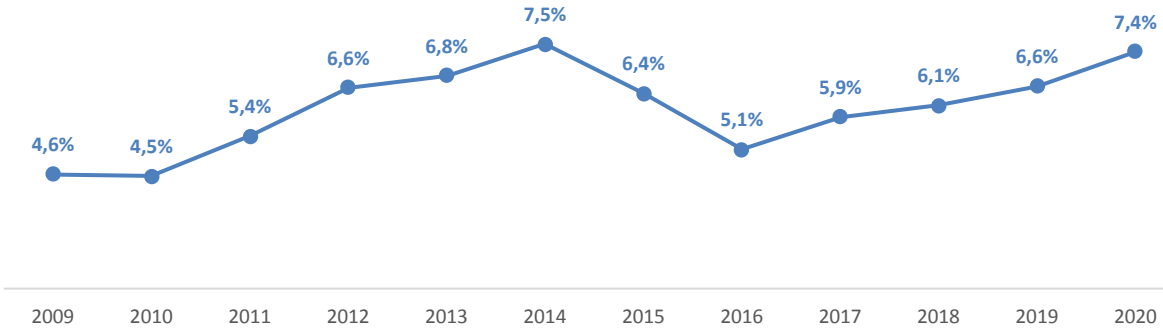
Annexes

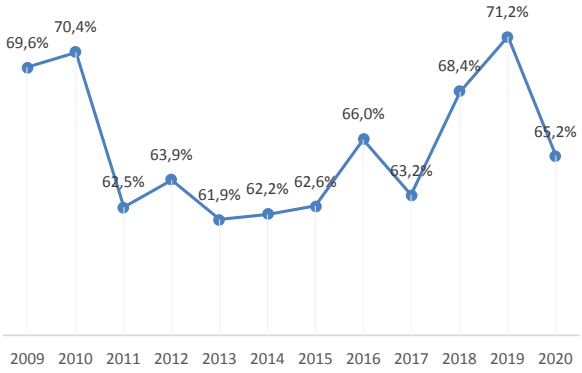
Annex 1: Selected contextual indicators

Fig. A1.1. Health expenditure indicators for Tajikistan

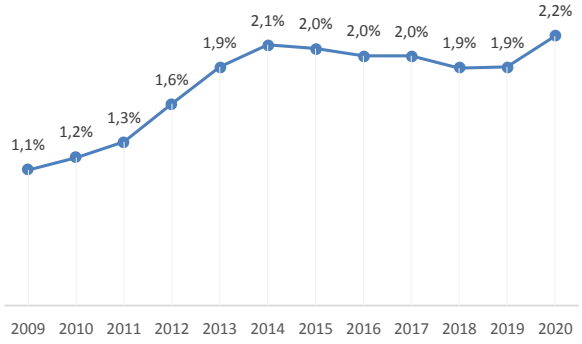
General goverment expenditure (GGHE-D % GGE)



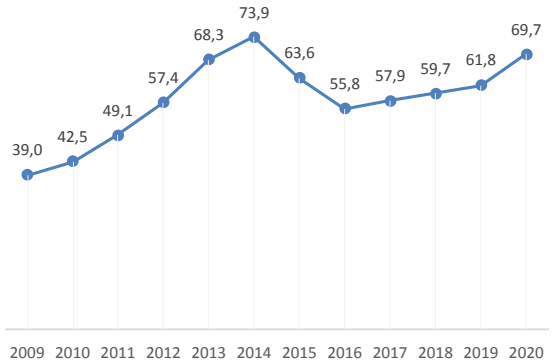
Out of pocket spending (OOPS % CHE)



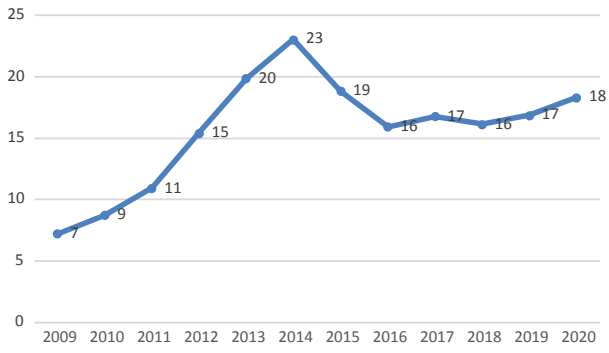
Public spending on health as % GDP (GGHE-D % GDP)



Total health spending (CHE per capita USD)



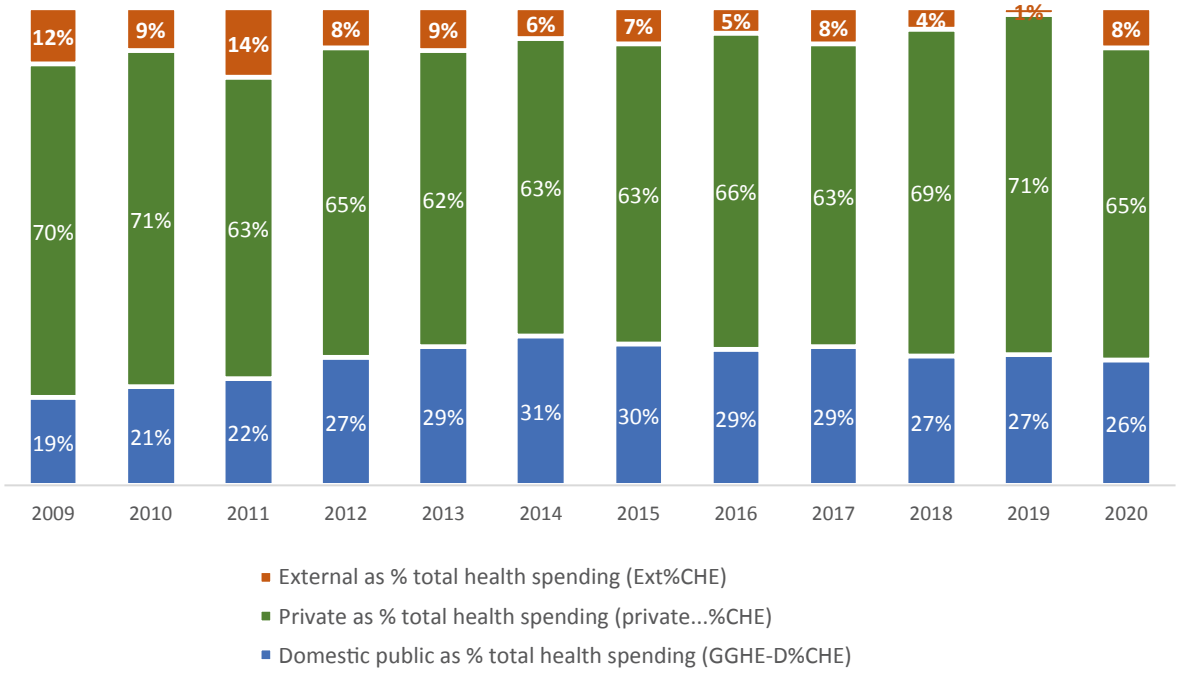
GGHE P.C.



Source: World Health Organization, 2020 *(1)*.

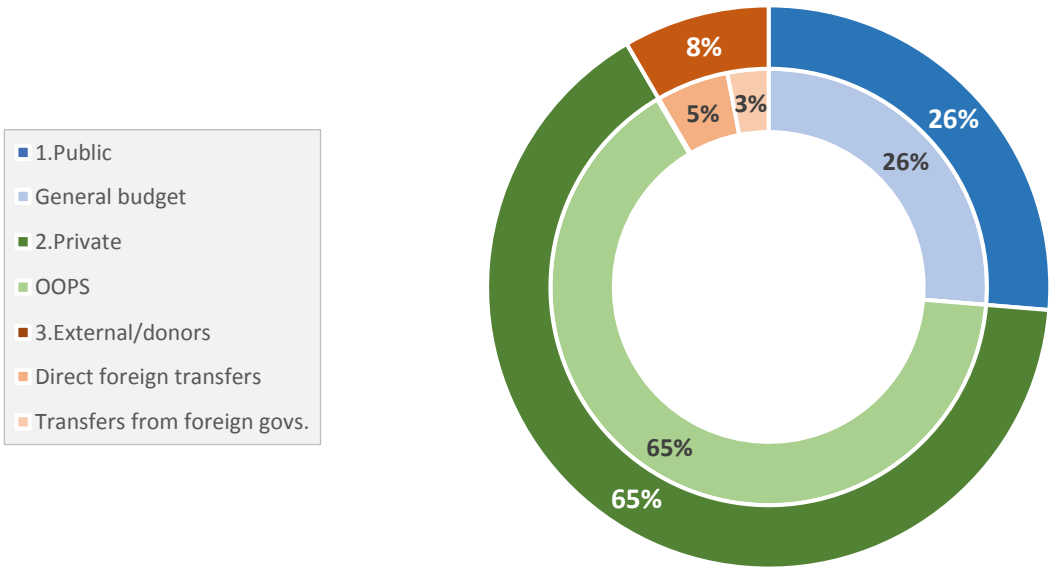
Note: CHE: catastrophic health expenditure; GDP: gross domestic product; GGHE-D % GGE: domestic general government health expenditure as a percentage of general government expenditure; P.C: per capita.

Fig. A1.2. Revenue sources for health in Tajikistan



Source: World Health Organization, 2020 *(1)*.

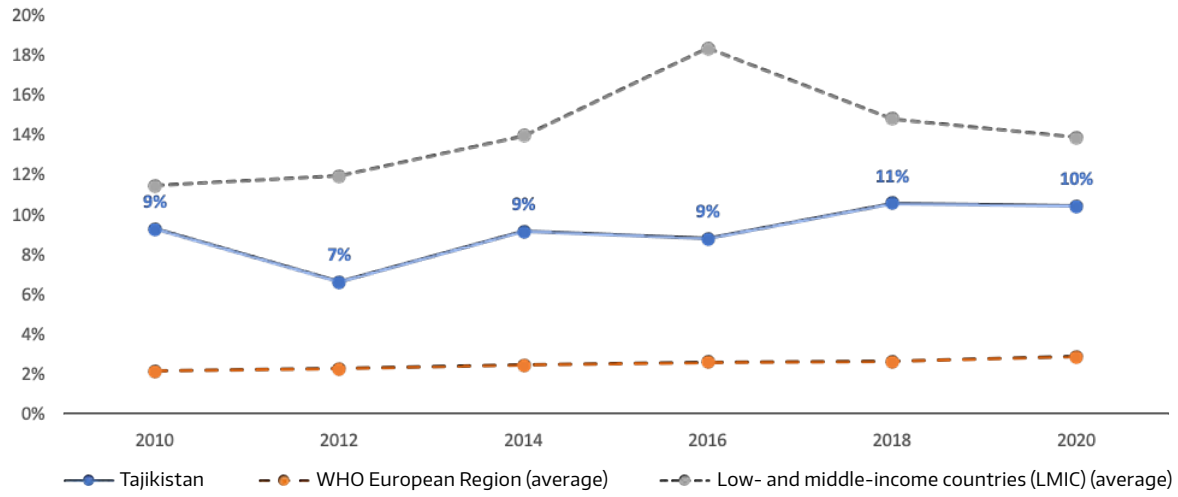
Fig. A1.3. Revenue sources, disaggregated, 2020



Source: World Health Organization, 2020 *(1)*.

Fig. A1.4. Cigarette affordability in Tajikistan

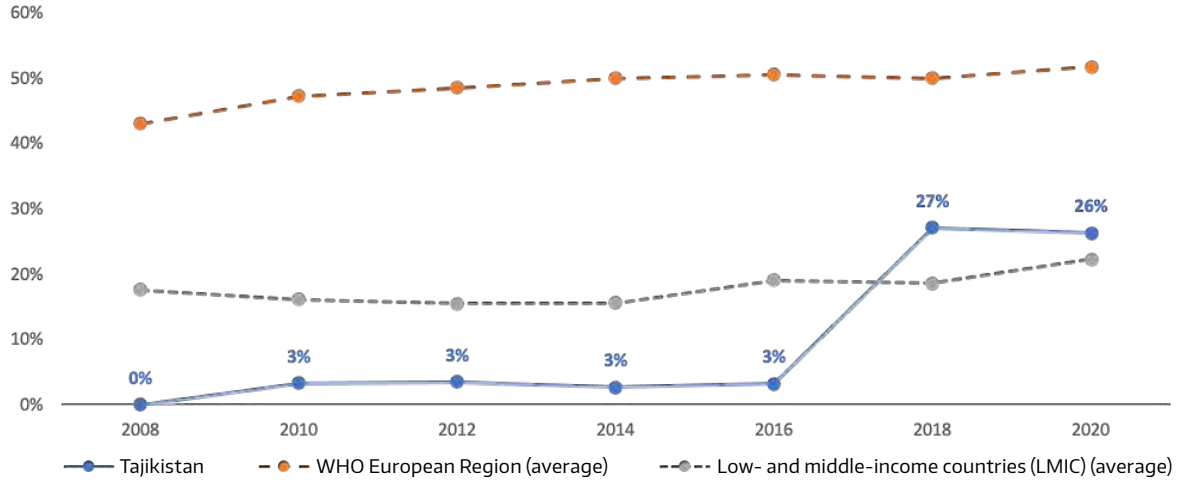
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short term changes in affordability are also presented.



Source: World Health Organization, 2019 *(2)*.

Fig. A1.5. Excise tax share in Tajikistan

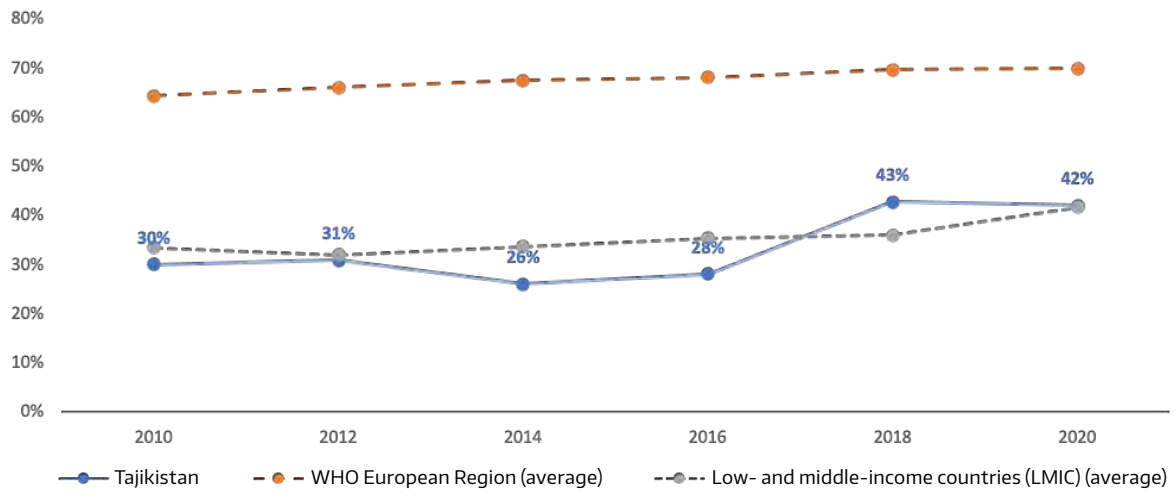
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: World Health Organization, 2019 *(2)*.

Fig. A1.6. Total tax share in Tajikistan

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: World Health Organization, 2019 *(2)*.

References

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Annex 2: Desirable attribute of health financing

Policies which help to drive progress to universal health coverage are summarized in terms of 19 desirable attributes of health financing policy. For further information please see the WHO Guidance paper on assessing country health financing systems *(1)*.

Table 1: Desirable attributes of health financing systems

Health financing policy, process and governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing and provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits and conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them and report on spending and output

Table 1: Desirable attributes of health financing systems

Public health functions and programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Note: Abbreviations used in the second column are used as labels for desirable attributes as described in the country assessment guide *(11)*

References

1. Guidance paper: assessing country health financing systems: the health financing progress matrix. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017405, accessed 26 February 2023).

Annex 3. Health Financing Progress Matrix assessment questions

Assessment	Question number code	Question text
1) Health financing policy, process and governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing and provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

Assessment area	Question number code	Question text
5) Benefits and conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) Public health functions and programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on universal health coverage intermediate objectives and goals, as explicitly defined below.

Objective / goal	Question number code	Question text
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective / goal	Question number code	Question text
Transparency and accountability	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

The WHO Regional Office for Europe

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