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Primary health care financing: a situation assessment and policy options for Tajikistan

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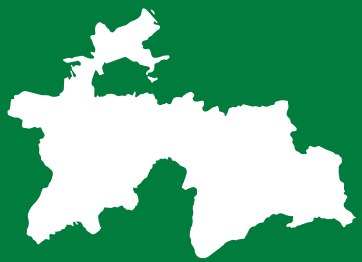

Tajikistan

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Abstract

In Tajikistan, developing the primary health care system is crucial to ongoing health sector transformation. Primary care is rooted in a family medicine model and is regarded by the Government of Tajikistan as a priority sector for future reforms. This policy paper, informed by global best practices in primary care financing, aims to evaluate the current state of primary health care financing in Tajikistan and offer policy considerations to further strengthen it. Despite the increase in primary health care financing over the years, per-capita public spending on primary care is among the lowest in the WHO European Region, and remains based on an historical financing system which draws from local budgets and has not yet been updated to reflect new financing methods. Progress can be seen, in terms of making the primary health care benefits package more explicit, but informal payments prevail and some essential services are not covered through the public budget. Primary health care services (together with outpatient specialist care) are organizationally and financially separate from hospital services. The model of care is yet to be developed, and a shortage of family doctors prevails. To strengthen primary health care financing, Tajikistan should implement strategic purchasing reforms, starting with regional pilot of a per-capita payment system for primary health care services, reviewing the benefits package to allow better access to essential services, and supplementing the financing reforms with service delivery reform and development.

Keywords

PRIMARY HEALTH CARE
HEALTH CARE FINANCING
HEALTH CARE SYSTEMS
TAJIKISTAN

UHC watch

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#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

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Abbreviations

GDP	gross domestic product
GHED	Global Health Expenditure Database
MABAs	main administrators of budget allocations
MoHSPP	Ministry of Health and Social Protection of Population
NCDs	noncommunicable diseases
PHC	primary health care
STEPS	STEPwise approach to NCD risk factor surveillance
TB	tuberculosis
TJS	Tajik somoni

Key messages

1. Strengthening the primary health care (PHC) service delivery system

The Tajik PHC system is rooted in a family medicine model. The service delivery network covers the entire country and includes various service delivery modalities, with services provided by 88 District/City Health Centres. These are organizationally and financially separate from inpatient care facilities and provide both primary care and outpatient specialist services. Managerial autonomy of health-care providers is low, as the central level of government (MoHSPP) has a strong impact on the hiring and dismissing process at the level of District/City Health Centres.

The country currently has what is known as a vertical system of health-care service delivery (which includes healthy lifestyle promotion, integrated management of childhood diseases, reproductive health, tuberculosis, HIV/AIDS, vaccine logistics, and so on). In most cases, these services are provided by organizations which are separate from District/City Health Centres; less often, they are integrated within them. Public laboratory capacity is managed by a private provider; the intent behind changing the laboratory capacity management arrangement in Tajikistan is to improve quality of testing and ensure better access. However, there is no evidence to assess whether this has been achieved.

The Government has approved a high-level strategic vision for PHC development, but the specific reforms needed to reshape the service delivery model and to plan the infrastructure have yet to be formulated. For instance, the country is intending to integrate the separate vertical services into District/City Health Centres, but the specific vision and executive decision-making are yet to be announced.
Tajikistan is experiencing a significant lack of family doctors; their number is decreasing, both in terms of medical university graduates and their density in relation to the population. Rethinking service delivery at community level may help to increase the availability of health-care personnel at outpatient level: examples have shown that relocating doctors and nurses working in small rural inpatient facilities to rural health centres can significantly increase the availability of health professionals. The number of family nurses is also growing; increasing the scope of responsibilities of nurses (along with efforts to increase their capacity) offers great potential to improve service availability and continuity of PHC.

The level of unnecessary hospitalizations is high in Tajikistan, while the data from patient surveys show that hypertension and type II diabetes are massively underdiagnosed. This suggests suboptimal performance in PHC settings, with significant room for improvement.

Specific recommended steps include:

- setting the vision for future PHC development, outlining both the service delivery model and service integration plans; expanding the autonomy of health facilities, starting with allowing more managerial autonomy in hiring health professionals;

- addressing the challenge presented by the shortage of family doctors, with multifaceted policies (including: relocating staff from rural inpatient facilities to District/City Health Centres, introducing additional incentives, developing a comprehensive retention strategy for health-care personnel, and revising medical education and retraining plans for family doctors); and

- strengthening the scope of practice of family medicine doctors it is crucial to increase capacity and competences of family doctor teams and to define care pathways with clear definition of roles between family doctors and narrow specialists.

2. Revising the PHC benefits package to better meet population needs

The current benefits package is approved by Government legislation (Order No. 600; 2 December 2008). Its strengths include free family doctor consultations and several maternal and child health services for everyone. The weakness of the current benefits package is that it falls short in terms of effective management of noncommunicable diseases (NCDs) due to the narrow scope of the health services covered; lack of free-of-charge medicines to treat NCDs; absence of basic laboratory services from the package; need for patients to pay for most of specialized care services; and the lack of a clearly defined and standardized framework for determining which services that should be provided free of charge at the level of facility.

The current benefits package offers payment exemptions for specialized outpatient care services and laboratory diagnostics for the most vulnerable population groups (for instance, poor people, people with disabilities, and people with specific diseases), but no data are available to monitor if representatives of vulnerable groups actually use these services. Despite official exemptions from payments, many poor people pay for health-care services; the current system identifies specifically only a small proportion of the poor population, as social assistance registers are used to identify target groups, but most poor people in Tajikistan do not have official status as belonging to a poor family. The list of vulnerable groups notably excludes certain people who typically have higher health needs, such as children (aged over 1 year), people aged under 80 years, and people with chronic diseases (cardiovascular diseases and/or type II diabetes).

Informal payments are prevalent, and catastrophic health spending remains high and is predominantly caused by out-of-pocket payments on outpatient medicines. The provider revenues from official co-payments accounted for a very small share of provider revenue in 2018; however, these are growing significantly, which may yet worsen the financial protection of the population.

The benefits package is a solid foundation for future development and for prioritizing PHC services. The way the package is defined could be improved for clearer communication with the population about what is covered by the Government, as current contradictions in legislation could cause additional barriers to understanding and access.

Specific recommended steps include:

- establishing a system to regularly review the benefits package (as definition of benefits is an evolutionary process);
- ensuring that the benefits package is aligned with the available budget;
- making comprehensive PHC benefits a priority of the next iteration of the benefits package, with a focus on basic laboratory diagnostics and basic medicines to diagnose and treat most prevalent NCDs (where there are currently gaps);
- addressing the issue of informal payments, starting with better understanding the root causes of informal payments and developing comprehensive policies for improvement, which should go beyond health financing;
- implementing a standardized approach to defining which services are available free of charge to the population at the facility level; and
- reviewing user charges policy and implementing effective exemption mechanisms for formal payments.

3. Implementing new financing arrangements for PHC services

Tajikistan has a highly decentralized system of defining allocations for District/City Health Centres: all decisions on health facility funding are made by the respective district and city councils. In an attempt to implement a more coordinated budget planning process, in 2016 the Government introduced the per-capita normative, which is a capitation amount used to define national/regional[1] allocations to poorer territories and PHC budgets. This should be taken into consideration by local councils (at the district or city level) when planning their funding for the District/City Health Centres; in practice, there is no leverage at the central level to ensure its use, and the decision on budget allocation is dependent on local fiscal space. This means that richer districts and cities tend to spend more on health, and there is significant inequality in actual per-capita spending. This inequality is likely to result in differences in access to and quality of care for patients.

The design of the per-capita normative has inherent inequalities: the Government approves the normative separately for District/City Health Centres, and the rate is usually about 20% higher for urban territories. It is motivated by the hypothetical higher level of equipment availability in City Health Centres, which in theory should require higher maintenance cost. Still, the scope of benefits and equipment requirements are identical for both District/City Health Centres, according to the regulation.

Most of the resources of District/City Health Centres are spent on staff salaries; even so, the actual average salary of health workers is lower than national average salary by as much as 34%. Very little of the budget is allocated to medicines, which are the predominant cause of catastrophic spending through out-of-pocket payments in Tajikistan. Furthermore, the budget execution rate for medicines tends to be lower compared to other spending categories, and data on the actual procurement of medicines suggest that this scarce resource might in reality be spent on non-essential medicines or those underpinned by weak evidence of effectiveness/efficacy. In addition, the financial autonomy of District/City Health Centres is low.

Specific recommended steps include:

- reducing the fragmentation of the PHC budget, as a first step, by pooling health funds at the regional level and, in the longer term, at the national level;
- introducing a simple capitation model and using this payment method within contracts between purchaser and providers;
- establishing the purchasing function within the Government to move towards more strategic allocation of the health-care budget to the provider level;
- implementing regional pilot project encompassing these essential mechanisms, to pave the way for national health financing system transformation.

1. In this report the term "region" is used to mean local government level, covering several districts and cities. The words "region" and "oblast" are used interchangeably.

4. Increasing government spending on PHC

Government financing of District/City Health Centres increased in real terms over the last decade, most likely caused by the general growth in Government health spending. That said, the share of PHC and outpatient specialist care in total health spending has actually slightly decreased.

As already mentioned, the District/City Health Centres provide different types of services, including PHC, outpatient specialist care, and some of the separate vertical services. Currently, no tools are used to analyse and understand actual PHC spending.

Specific recommended steps include:

- prioritizing PHC spending within the health budget in both the current budgetary planning system and future health financing reforms;
- improving the process of health budget planning; and
- establishing a system to effectively monitor actual PHC spending for prioritizing PHC services. The way the package is defined could be improved for clearer communication with the population about what is covered by the Government, as current contradictions in legislation could cause additional barriers to understanding and access.

Background

Tajikistan set the ambitious goal of moving towards universal health coverage, to reduce inequities in health, and increase the efficiency of the health system. These objectives are outlined in the Strategy for the Healthcare of the Population of the Republic of Tajikistan for 2021–2030 (known as the National Health Strategy 2021–2030). The strong PHC system is seen as a foundation of the future health system of Tajikistan and as a prerequisite to achieving the goals set.

This report aims to support the Government of Tajikistan in strengthening the PHC system. It provides a comprehensive overview of different aspects of PHC organization, coverage policy, financing arrangements, and use of resources. It also analyses the implemented and planned pilot projects aiming to improve PHC financing. Based on the analysis conducted (studying the legislation and using official national statistics and more detailed data on PHC provision and financing in Sughd Region), recommended action points are outlined to support PHC reforms with key objectives to improve the quality and efficiency of the PHC system. To better understand the situation at local level, in-depth interviews were conducted with key stakeholders working in regional health and financing departments and heads of PHC facilities. Further consultation with national stakeholders and discussion of key recommendations was carried out during the Winter School on Health System Transition for Universal Health Coverage, organized by WHO in February 2024.

The report is structured as follows. Chapter 1 analyses the service delivery model of PHC provision and current challenges the country faces in terms of management of human resources for health. Chapter 2 looks at the design of the benefits system in terms of services, population and price coverage, as well as its potential effect on access to health care and financial protection of the population. Chapter 3 covers financing issues, including the current planning and funding arrangements, the implemented and planned pilots, as well as budget execution by health facilities. Chapter 4 describes the policy recommendations for strengthening the service delivery system, reviewing the benefits to better addressing population health needs and to amending financing methods to support PHC reforms.

1. The service delivery system in primary health care (PHC)

1.1 PHC model of care

Family medicine is at the heart of Tajikistan's PHC system. Family doctors and family nurses represent the first point of contact between the population and the health system. The reform of the health-care system – historically heavily dependent on hospitals – and the shift toward a PHC model was initiated with the introduction of family medicine-based approaches, including the promising early establishment of the Institute of Family Medicine. This laid the groundwork for policy reforms in the early 2000s as a step toward a robust PHC model of care.

The overall vision for the development of the PHC service delivery system is outlined in the Strategy for the Healthcare of the Population of the Republic of Tajikistan for 2021–2030 (National Health Strategy 2021–2030) *(1)*. This strategic document sets the objectives of improving access to and quality and responsiveness of PHC, enhancing integration and development of essential PHC services, improving access to medicines, and developing the electronic health information system. According to the Government's Prioritized Action Plan *(2)*, developed to support implementation of the National Health Strategy, in 2024–2026 the Government should develop the PHC service delivery model and implement it in two pilot districts, which would serve as demonstration sites for best practices. The Government also plans to approve a Master Plan to rationalize the infrastructure of health care sector, including both inpatient and outpatient facilities. The Master Plan would guide investment in infrastructure, including reconstruction of facilities providing PHC. Thus far, these documents have not been approved.

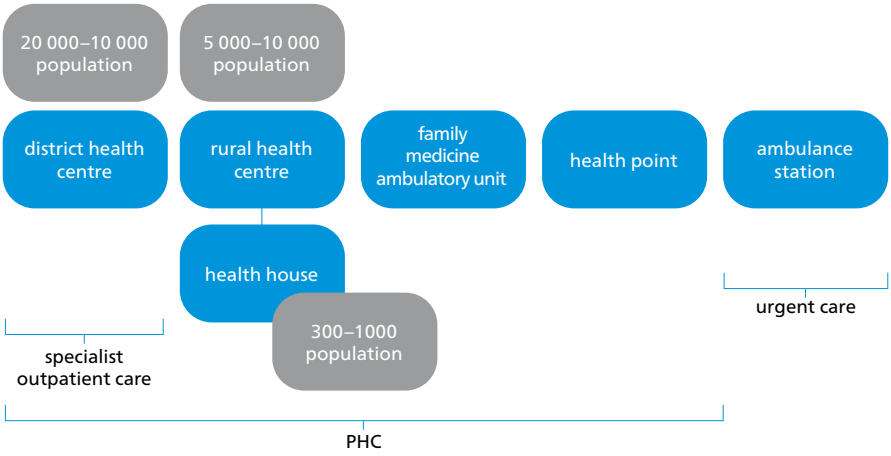
In Tajikistan the PHC service delivery system is organizationally and financially merged with outpatient specialist care. At the level of district/city, primary care is organized and provided by District Health Centres or City Health Centres (see Fig. 1 and Fig. 2 in Box 1). Although these institutions are referred to in the national legislation as PHC providers, they in fact provide broader range of services: family medicine, specialized outpatient services, specific vertical programmes and, in most cases, ambulance services. A District/City Health Centre works as single legal entity, has one administration and network of facilities. Box 1 provides more details, including clarification of the terminology used[2]. The roles and boundaries between family doctors and narrow specialists providing outpatient care (who often share premises) are not well defined, which may result in fragmentation or lack of continuity of care, unnecessary referrals and unclear care pathways.

2. In this report the terms District Health Centre and City Health Centre (capitalized) are used to refer to the legal entities, which include numerous service delivery points and provide a wide range of services. The terms district health centre and city health centre (lower case) refer to specific types of service delivery point, which provide both PHC and outpatient specialist care.

Box 1. Types of legal entity and subordinated facilities providing PHC in Tajikistan

A **District Health Centre** is composed of multiple facilities: a central facility or facilities known as district health centres (which would usually provide both PHC and specialist outpatient services), as well as rural health centres (including subordinated health houses), health points, ambulatory family medicine units and ambulance stations.

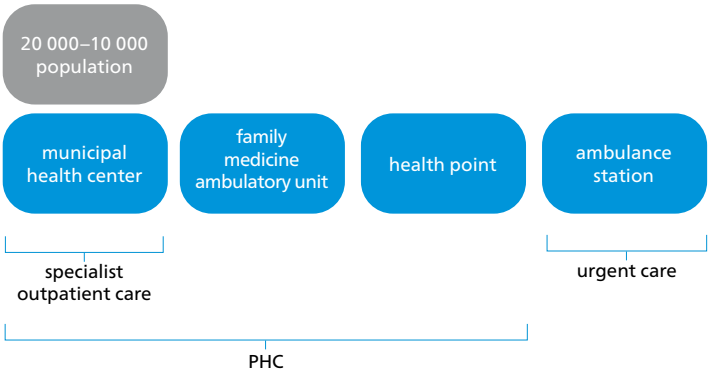
Fig. 1. Structure of a District Health Centre (excluding vertical programmes)



Source: Government of Tajikistan Resolution No. 525 (2002) *(3)*.

A **City Health Centre**, established in cities and towns and can include the following types of service delivery points: the city health centres (central facilities, which also provide both PHC and outpatient specialized services), ambulatory family medicine units, and health points *(3)*. City Health Centres may also include an ambulance station.

Fig. 2. Structure of a City Health Centre (excluding vertical programmes)



Source: Government of Tajikistan Resolution No. 525 (2002) *(3)*.

City and district health centres are expected to serve 10 000–20 000 people, rural health centres 5000–10 000 people, and health houses 300–1000 people *(4)*.

Both District and City Health Centres have equal scope of responsibilities *(5)* and equipment requirements *(4)*. Patients are expected to seek care in a facility located in their district or city of residence (see Section 2 on the PHC benefits package).

Currently PHC is provided by 88 District/City Health Centres. As already mentioned, these facilities provide both PHC and outpatient specialist services. According to the Prioritized Action Plan supporting the National Health Strategy *(2)*, the Government of Tajikistan aims to further expand the network of providers of PHC and outpatient specialist care. More specifically, planning is under way for the construction of eight new city health centres, five new district health centres, 56 new rural health centres, and 168 new health houses. Reconstruction of existing service delivery points and procurement of additional equipment are included in the Government's plans. These capital investments are expected to be funded with the support of international donors.

District/City Health Centres are financially and organizationally separate from hospitals. In 2002 the Government implemented a major service delivery reform: hospital polyclinic departments were reassigned to District/City Health Centres *(3)*, so nowadays hospitals do not provide any outpatient services. In rural locations, districts would often have rural hospitals to provide basic inpatient care services; these are also separate from service delivery points managed by District Health Centres.

Some essential PHC services are organized in separate vertical systems, which causes inefficiencies in service delivery. Tajikistan has a large number of vertical health-care delivery programmes, which were established to address specific health system challenges. Among others, these cover reproductive health, healthy lifestyle promotion, integrated management of childhood diseases, tuberculosis (TB), HIV/AIDS, and vaccination (specifically, vaccine logistics). These vertical service delivery programmes often have separate designated facilities with their own management and budgets, but in some districts/cities, so-called vertical facilities are part of District/City Health Centres (consequently, some District/City Health Centre budgets include funds for providing these vertical services, while others do not). Most vertical facilities are independent – in 2021, out of 180 vertical facilities in the country, 117 were functioning as separate legal entities *(6)*. This parallel work of the District/City Health Centres and vertical service delivery programmes creates duplication in the system and leads to inefficiencies; it also undermines the role of primary care, with many of the aforementioned vertical services belonging to the core PHC functions. The National Health Strategy 2021–2030 outlines that vertical service delivery should be integrated into District/City Health Centres, but the specific approach for achieving this has not yet been developed, and the executive decision-making on integration is still needed at the national level.

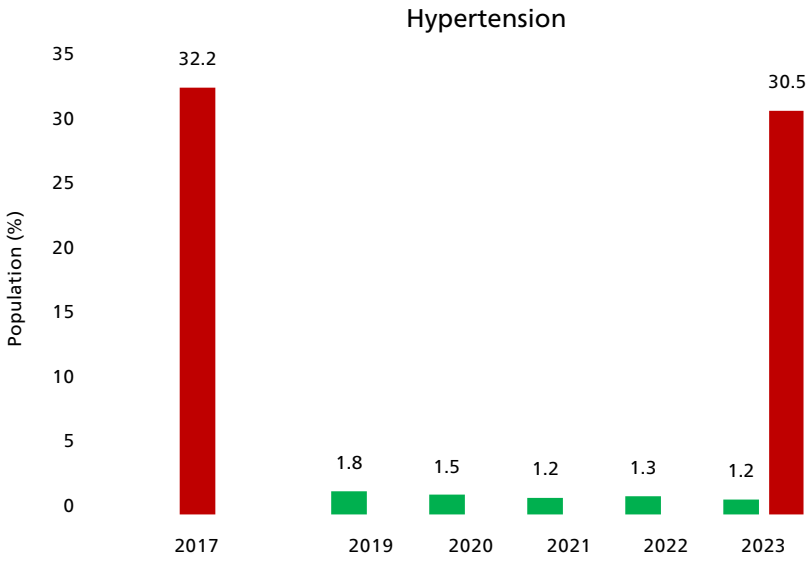
Before 2017, most District/City Health Centres managed their own laboratories. In 2017 the Ministry of Health and Social Protection of Population (MoHSPP) requested to change the organizational model of laboratory diagnostics, with laboratory capacity of District/City Health Centres managed by the private provider through the private laboratory company Behdoshti. The intention and expectation behind this change implemented by the MoHSPP was to improve access to and enhance quality (including accuracy) of laboratory diagnostics, due to better equipment and consumables available through the private providers. However, no data are available to assess if these objectives have been achieved. The general provisions of the contract with Behdoshti (since 2017) envisage that District/City Health Centres provide Behdoshti with their laboratory capacities and partially cover the salaries of the personnel working in the labs. In return, the company invests in laboratory capacities of the facilities and performs the basic lab tests for the vulnerable population groups free of charge (without payment from the District/City Health Centre), and all other patients must pay the full price for the services direct to Behdoshti. The private provider pays a share of its income (10% of all revenues) into a special account of the facility. In some locations, the company has not entered into the contract with District/City Health Centres, either because of a lack of basic capacity required, or due to the area's remoteness and/or small population. No data are currently available on how many patients received services, nor how many paid or received them free of charge, so the effectiveness of introducing this measure remains unknown.

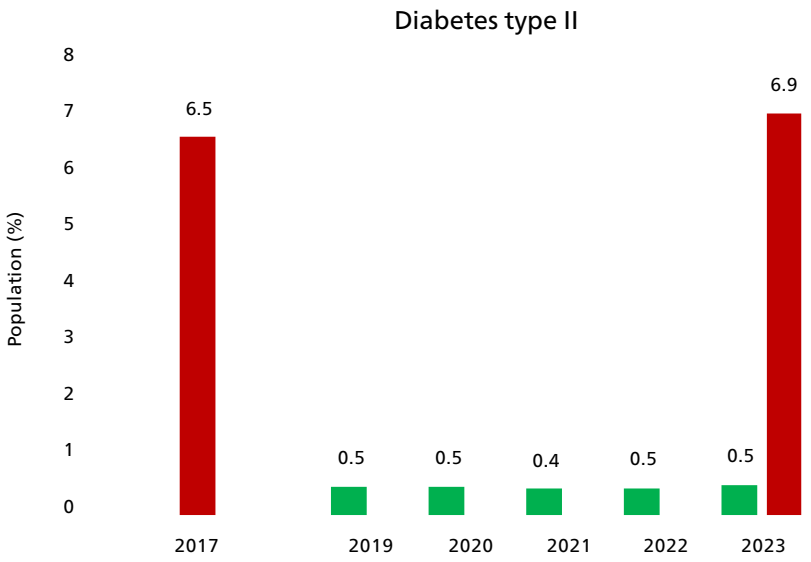
The level of unnecessary hospitalizations is high in Tajikistan, indicating ineffectiveness in PHC performance. The high level of hospitalizations serves as a proxy for analysing PHC effectiveness, as conditions leading to unnecessary hospitalizations can often be managed at the PHC level. Although comprehensive data on unnecessary hospitalizations for the entire health system are not available, a recent study assessed avoidable hospitalizations among children and pregnant women, revealing that 41% of children and 69% of pregnant women were unnecessarily hospitalized *(7)*.

Chronic conditions like hypertension and type II diabetes are heavily underdiagnosed and undertreated, which also suggests that the PHC performance is suboptimal. According to unpublished national statistics data provided by the MoHSPP, in 2023 the prevalence of hypertension among the adult population was 1.2%, and the prevalence of type II diabetes was 0.5%, suggesting that the registration of these diseases is negligibly low. At the same time, two rounds of the population-based survey STEPwise approach to NCD risk factor surveillance (STEPS) show much higher prevalence: in 2017, 32.2% of the population aged 18–69 years had hypertension (measured as having increased blood pressure or taking medication to control it), and 6.5% had type II diabetes (measured as having raised fasting plasma glucose or currently taking medication for diabetes) *(8)*. In 2023, these indicators were similarly much higher compared to official prevalence data: 30.5% had hypertension, and 6.9% had type II diabetes (Fig. 3).[3] This implies that the health system performs poorly in terms of diagnostics and registration of these key noncommunicable diseases (NCDs). Furthermore, in 2023, among people with hypertension, only 11% achieved controlled blood pressure levels, suggesting that the majority of people with elevated blood pressure were at significant risk of developing serious medical conditions.[4]

3. STEPS survey data from 2023 were unpublished at the time of writing.
4. Ibid.

Fig. 3. Prevalence of hypertension and type II diabetes (2019–2023)





National prevalence

STEPS estimations

Sources: STEPS surveys from 2017 *(8)* and 2023 (for which data were unpublished at the time of writing); as well as unpublished national prevalence data provided by the MoHSPP.

1.2 PHC workforce

The number of professionals in the PHC workforce is regulated by legislation, but these normatives are not followed universally. The national regulation sets the number of doctors per facility based on the (number of) catchment population. It also sets the standard workload per family doctor position (or a full-time equivalent) at the level of 1200–1500 people (including children and adults) *(4)*. This normative should be followed when planning the number of positions at facility level, but the facility-level data suggest that the actual number of people per family doctor position is twice that: in 2022, on average, there were about 2900 patients per family doctor position. The actual number of family doctors working in public facilities is even lower, resulting in higher workload: in 2021, on average it was about 4500 people per family doctor *(9)*. There are significant variations in terms of availability of family doctors in different regions of the country: from about 1900 patients per family doctor in Dushanbe to about 8500 patients per family doctor in Gorno-Badakhshan Autonomous Oblast. In the District Health Centres, family doctors work both at central facilities (district health centres/former polyclinics) and in rural divisions. In 2022, only 59% of family doctor positions were filled at the level of district health centres, and 35% of positions were filled in the rural divisions (established through Form 17).[5]

Narrow specialists form part of the workforce of District/City Health Centres. The national regulation defines a comprehensive list of specialists who should be available at District/City Health Centres, including surgeons, oncologists, urologists, nephrologists, rheumatologists, otorhinolaryngologists, ophthalmologists, pulmonologists, neurologists, infectious disease specialists, cardiologists, allergist-immunologists, and endocrinologists. In 2022, family doctors accounted for 30% of all doctors working in District/City Health Centres, while 70% of all doctors were what is known in Tajikistan as narrow specialists.

The number of family doctors is decreasing and the current strategy of education and retraining is not sufficient to guarantee access to PHC. While the population of the country continues to grow, for the past three years the number of family doctors decreased by 15% (established through Form 17). There are several options to achieve the qualification of family doctor: medical university education, with postgraduate training in family medicine;[6] or completing the six-month retraining programme, which is available to narrow specialists. The number of medical graduates has been steadily growing in Tajikistan, but fewer students choose the family medicine profession: there has been a 45% decrease in the number of enrolments into family medicine per 100 000 population between 2014 and 2022 *(9)*; in 2022 this figure amounted to 129 people. According to WHO estimates, the country would need to produce three times the number of family medicine graduates in order to meet the official national normative *(9)*. Although the six-month retraining programme helps to increase the number of family doctors, the number of retrained doctors will not ensure the national workload standard is met; for instance, in 2021 only 103 doctors were retrained into family medicine, while the total number of family doctors decreased by 179 (established through Form 17).

Family doctor tasks, requiring a wide range of skills and knowledge are

5. Unpublished health workforce data received directly from the MoHSPP, gathered through the Government's mechanism for reporting health-care provider human resources data, known as Form 17 or "healthcare personnel report".

6. This takes the form of *internatura* (one-year post-diploma clinical residency) or *ordinatura* (two-year post-diploma for those with honours or those undertaking practical work in their chosen field).

defined by the Government. It is expected that a family doctor is able to provide preventive, diagnostic and treatment services for the most common ailments in adults and children. These include respiratory, circulatory, digestive, rheumatic and liver and biliary tract diseases, as well as conditions of the urinary system, hematopoietic system, endocrine system and metabolic disorders. Family doctors are also expected to have the knowledge and skills to provide obstetrics care (including antenatal care, delivery and postnatal care), basic mental health services, and basic emergency services.

Family nurses are part of the PHC team in Tajikistan. The national regulation mandates two nurse positions for every family doctor position. In health houses (which are service delivery points run by nurses in rural areas), there should be two nurse positions for every 1200–1500 people. In District/City Health Centres, nurses also work with narrow specialists, and the national normative specifies that one nurse position should be available for every narrow specialist position.

The availability of family nurses is increasing, and this capacity can be used to improve service delivery. In 2022, there was one nurse per 1100 population *(9)*, which means that the national normative has not yet been met, but the density of family nurses has increased by 71% since 2014.[7] This capacity could be used to improve service provision and continuity of care by delegating more tasks to nurses and midwives, and increasing their role in PHC. In order to achieve this, the mechanisms of initial training may need to be improved and continuing professional development should be introduced to support this change *(9)*.

Most facilities have infrastructure to implement task-sharing, at least to a certain extent. A recent study shows that a physical examination office is available in 73% of the surveyed District/City Health Centres, to enable pre-examination before seeing a doctor *(6)*. In these offices, nurses can perform anthropometry, measurement of blood pressure and temperature, pulse oximetry, and arm circumference measurement in children. No data are available on whether these premises are used or whether task-sharing is carried out. However, it is understood that some facilities (such as rural health houses) are completely run by nurses.

A major increase in PHC capacity at rural level is possible through the relocation of personnel under District/City Health Centres. District hospitals have a decentralized structure, with some small divisions working in rural areas and providing inpatient care at community level. In 2021, there were 128 rural hospitals and 67 rural facilities known as numeric hospitals throughout the country. There is potential to enhance the efficiency of the health-care system and to improve availability of health professionals at PHC level by relocating health professionals according to need. Analysis of potential relocation options was performed for Devashtich District Health Centre in Sughd region, with the results suggesting that relocating personnel (and salary budget) from inpatient to outpatient levels would require (only) a 3% increase in staffing costs, given that family doctors receive a higher salary than other health-care professionals), while potentially increasing the number of family doctors by 68% and number of nurses by 43%. Box 2 provides details of this analysis.
The MoHSPP exerts significant influence on the hiring and dismissing

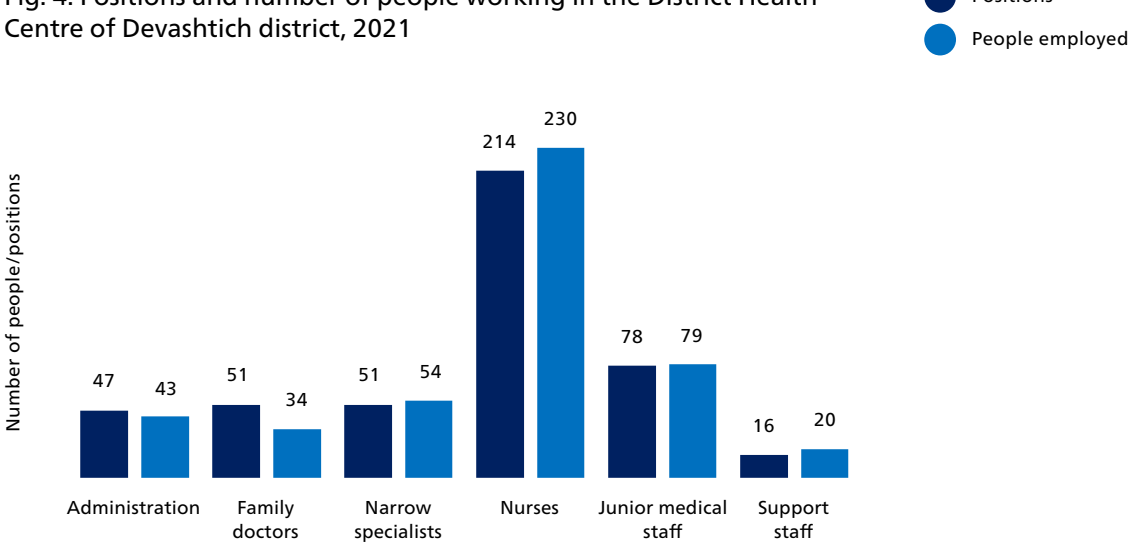
7. Significant regional disparities can be observed: in 2021, the density of family nurses was 13.4 per 10 000 population in Dushanbe, compared to 3.9 in Khatlon region.

Box 2. Modelling of staff relocation from rural hospitals to PHC facilities in Devashtich district

Devashtich is a relatively large district with wide network of health facilities. As of 2021, the population of Devashtich was 178 000 people. Primary and outpatient specialist care is provided by the District Health Centre, which includes two district health centres, 18 rural health centres and 20 health houses. The actual per-capita spending for financing the District Health Centre in 2021 was 44 Tajik somoni (TJS), which was lower than the official national per-capita normative of TJS 54.

The Devashtich District Health Centre has unfilled family doctor positions, while all narrow specialist and nurse positions are filled. In 2021 there were 51 family doctor positions in the facility, and 34 family doctors were employed. The actual average workload per family doctor was about 5200 patients. If all positions were filled, the workload would be about 3500 patients, which is still far above the national workload norm of 1200–1500 people per family doctor position (Fig. 4). In 2021, 54 narrow specialists were working in both district health centres of the facility, for which there were 51 narrow specialist positions. About half of all personnel working in the facility are nurses: 230 nurses worked in the facility, for which there were 214 nurse positions.

Fig. 4. Positions and number of people working in the District Health Centre of Devashtich district, 2021



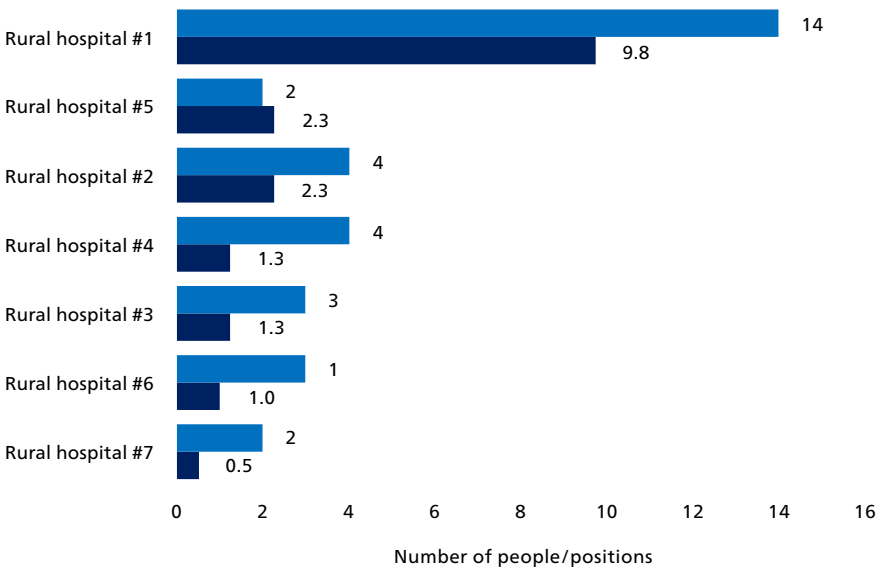
Source: unpublished data provided directly from the District Health Centre in Devashtich District.

Source: authors' own compilation, based on unpublished data provided directly by colleagues at the District Health Centre in Devashtich and the Devashtich District Hospital.

Inpatient care in Devashtich is provided by Devashtich District Hospital, which has seven rural hospitals within its structure. The central district hospital is located in the district capital Ghonchi and has 325 beds. The subordinated rural hospitals are relatively small facilities, with far fewer beds (from 20 to 50, except for one facility which has 135 beds). The distance from rural hospitals to the central facility is relatively short, ranging from 12km to 40km.

Rural hospitals employ more doctors than there are technically available positions, and their salary is about four times lower than the average salary of a family doctor in Devashtich District Health Centre. In rural hospitals, doctors work part time and receive smaller salaries. To a lesser extent the same applies for nurses – in all rural hospitals, the number of actually employed nurses exceeds the number of positions (Fig. 5). The actual salaries for personnel working in the hospital are lower than the salaries of family doctors and family nurses: the average salary of a doctor working in rural division hospitals is TJS 335 per month, and a nurse's salary is TJS 374 per month, compared to the average salary for a family doctor of TJS 1285 per month, and the average salary of family nurses of TJS 578 per month.

Fig. 5. Doctor positions and number of people working in rural hospitals in Devashtich district, 2021



Source: unpublished data provided directly from Devashtich District Hospital.

With a small additional budget added to Devashtich District Health Centre and more efficient use of human resources at local level, availability of PHC staff could increase significantly. For example, transferring all doctors and nurses working in therapeutic and paediatric departments of rural inpatient facilities (23 doctors and 87 nurses) to rural health centres could increase the number of family doctors by 68%, and the number of nurses by 43%, if these professionals were also to receive additional training in family medicine. The additional cost of this shift in staffing represents 3%[8] of the District Health Centre's salary budget. The proposed staff relocation also foresees that people would stay in the same district or even village and would not need to move. In addition to general family medicine training, training in specific areas (for instance, management of NCDs) could be offered to purposefully address health challenges faced by the district's population.

8. Within this model, current salaries were also transferred to the District Health Centre budget, and currently vacant positions at PHC level were accounted for when calculating the need for additional budget.

process of District/City Health Centres. The heads of District/City Health Centres, as well as deputy heads and chief accountants are appointed and dismissed by the Minister of Health upon agreement with local administrations *(10)*. The relevant legislation stipulates that the head of facility is responsible for hiring and dismissing all other staff, but according to interviews with key informants, facility managers still seek MoHSPP approval when hiring family doctors and narrow specialists, making the process of hiring new health professionals unnecessary long and cumbersome.

2. PHC benefits package

Since 2023, Tajikistan has in place a unified benefits package across the country. Before 2023 there were two schemes – the basic benefits package (also known as the programme of government guarantees) and the benefits package according to the Government Decree No. 600 (known simply as Decree 600) *(11)*. The scope of benefits at PHC level was same within the two schemes, with the difference being in the co-payment rates to be paid by patients when accessing specialist care, as well as some of the rules on how facility revenues from user charges should be used. In 2023, the Government decided to apply the scheme as per Decree 600 throughout the country.

The basic PHC services provided by family doctors are guaranteed free of charge to the entire population. The benefits include a range of preventative services (such as vaccinations for children, consultations on healthy lifestyle, and disease prevention activities), as well as consultations with family doctors (Box 3). Most laboratory diagnostics and outpatient medicines are not included in the benefits package.

The benefits package offers additional services free of charge for specific population groups (referred to as vulnerable groups). Representatives of these groups are entitled to free basic laboratory services and free medical interventions; they can also receive free outpatient specialists' consultations. Two lists define the people eligible for the extended benefits: the first list is based on social status or demographic characteristics, such as veterans, children aged under one year, the unemployed, poor people, individuals aged 80 years and older, and people with disabilities. In 2022, official statistics indicated that 6.2% of the population belonged to these groups.[9] The second list is based on specific diseases, including HIV/AIDS, TB, people with cancer in the terminal stages, type I diabetes, and haemophilia; about 2% of the population belonged to these groups in 2022.[10] Notably, these lists also exclude some groups that typically have higher health needs and tend to use health services more often, such as children aged over one year old, people aged under 80 years, and individuals with chronic diseases like cardiovascular diseases and type II diabetes. As per the programme of government guarantees, people who did not belong to vulnerable groups had to pay a 50% co-payment for specialized care services if they had a doctor's referral, and a 70% co-payment if they did not have a referral. The general rule under Decree 600 sets the co-payment rate for the general population at 80% for patients with a doctor's referral; however, in practice, this rule applies only to inpatient care. At the level of District/City Health Centres, individuals who do not belong to vulnerable groups must pay the full cost of service out of pocket for specialist outpatient care, even if they have a doctor's referral. The District/City Health Centres are permitted to charge patients only if they have special permission from the MoHSPP. If a facility lacks this permission, it is obliged to provide services free of charge to all patients. This special permission is granted for specific services, not for specialist outpatient services in general. As a result, District/City Health Centres have variable lists of paid services (and, consequently, the list of services provided free of charge is also variable). In practice, this means that the scope of benefits differs at the facility level, depending on which permissions for paid services were granted. This approach is likely to cause confusion among the population regarding guaranteed services. It also complicates the implementation of future

9. Data gathered from relevant institutions, including various NGOs, unions, ministries and the national statistics agency (TajStat).
10. Unpublished data provided by the Ministry of Finance.

health financing reforms, as it creates challenges for adopting a single payment principle for specialist outpatient care.

Box 3. PHC and outpatient specialist services included in the benefits package, 2023

Services provided free of charge for everyone include prevention, diagnostics, treatment and dental care.

- Prevention involves:
  - consultations and promotion of healthy lifestyle;
  - vaccination of children according to the national immunization calendar;
  - anonymous counselling on HIV/AIDS and sexually transmitted infections;
  - health check-ups for children aged under 5 years;
  - health check-ups of schoolchildren;
  - dispensary observation of diagnosed patients, with the exception of additional laboratory and instrumental diagnostics; and
  - targeted measures to prevent diseases.

- Diagnostics includes:
  - examination of the patient by a family doctor;
  - basic laboratory diagnostics for pregnant women.

- Treatment involves:
  - urgent medical care;
  - immobilization;
  - prescribing medications and other types of treatment;
  - injections of medicines purchased by patients (intravenous, intramuscular, subcutaneous); and
  - medical interventions (according to a predefined list, which was supposed to be approved by the MoHSPP but has not yet been released).

- Dental care includes:
  - preventive examinations for children and pregnant women, twice per year;
  - emergency dental treatment; and
  - specialist dental care provided to vulnerable groups.

Extended services are available free of charge for vulnerable groups, and can be provided as paid service for the general population. These include:

- specialist consultations, with a referral from a family doctor; and
- basic laboratory and diagnostic tests (basic blood screening, blood test for malaria, testing of donor blood for bloodborne infections, general urine analysis, microscopy of urethral and vaginal smear tests of pregnant women, sputum analysis, blood sugar testing (and urine), electrocardiography).

Note. a Dispensary observation is term referring to continuous monitoring of patients with chronic conditions (consultations and limited scope of diagnosis).

Data suggest that the current system to target people eligible for extended benefits is not reaching those most in need. While poor families are included in the list of vulnerable populations, which should ensure access to increased benefits within the health-care system, in reality official social assistance registers are used to select eligible population groups, and this registry is not universal (that is, it does not include all (poor) individuals, who should be included). Official statistics indicate that only 157 000 people are classified as poor (1.6% of the total population), while poverty estimations based on the national poverty line (TJS 323 per month) and household budget surveys indicate that 23% of the population in 2021 were classified as poor *(12)*. This discrepancy suggests that most poor people do not have official status as belonging to a poor family and thus are not guaranteed extended benefits.

Entitlements to PHC services are described in several legal documents, which partially contradict each other, causing confusion among patients. For instance, Decree 600 guarantees access to some laboratory tests for everyone *(11)*, but the joint 2014 Ministry of Finance and Ministry of Health and Social Protection Order No. 938-135 describing the rules for co-payment of health services in public health facilities *(13)* stipulates that these services – along with specialist outpatient consultations – are guaranteed only to vulnerable groups, accessible s a paid service to the general population. Interviews with key informants suggest that some services are not explicitly included in the regulation but are considered part of the guaranteed scope of benefits. For example, services within antenatal care are not explicitly listed but are provided to pregnant women free of charge, while the legislation explicitly lists only diagnostic tests for pregnant women. The documents that were intended to specify the entitlements have not yet been developed and approved: Decree 600 states the specific list of interventions was supposed to be approved by the MoHSPP *(11)* but it has not yet been published.

The scope of benefits relevant to laboratory diagnostics does not allow for the effective diagnosis and treatment of even the most common NCDs. Officially, the provisions of the benefit package include basic blood and urine tests, sugar level tests (blood and urine), TB and malaria tests, as well as microscopy of urethral and vaginal smear tests for pregnant women (guaranteed either for everyone, or only for vulnerable groups). This list is not sufficient to diagnose and manage the most common NCDs. For an effective PHC system, basic laboratory tests should be available to everyone, free of charge. At the same time, some of the guaranteed laboratory tests could be deprioritized: the PHC benefits package includes donor blood testing, but blood transfusion does not fall under PHC responsibility.

While the official benefits for laboratory diagnostics are already very narrow in scope, in reality, access to diagnostics may be even lower. Interviews with key stakeholders suggest that even people who belong to vulnerable groups may not have access to basic laboratory diagnostics free of charge and must pay out of pocket. As already mentioned, currently no data are available to assess how many patients receive laboratory services overall, nor how many representatives of vulnerable groups accessed diagnostics free of charge.

Most outpatient medicines are not included in the benefits package. At PHC level, patients are guaranteed free insulin, basic medicines for some common childhood illnesses (such as diarrhoea, respiratory infections), and some medicines for urgent care (administered in health facilities). Patients must purchase all other medicines. The basic benefits package offers additional guarantees for vulnerable groups, allowing providers to procure needed medicines up to a defined expenditure limit per patient per year. In 2022, this limit was TJS 128, but actual access to medicines depends on local budget capacity and decisions, limiting universality. District/City Health Centres procure medicines for outpatient use, and analysis of some procurement lists shows that many of the medicines procured were not essential for PHC service provision, or had a low level of evidence of effectiveness/efficacy (see Subsection 3.4).

Limited coverage of outpatient medicines forces people to pay for their needed medicines out of pocket, contributing to the high level of catastrophic health spending in Tajikistan. In 2022, 18% of households experienced catastrophic health spending *(14)*. Such spending is heavily concentrated among the poorest households, which often include at least one person aged over 65 years or have an unemployed person as the head of household. About 70% of all cases of catastrophic spending are caused by people's expenditure on outpatient medicines.

The benefits package is not linked to and not aligned with clinical protocols. The national legislation does not regulate any link between benefits and clinical protocols. However, when a patient receives a paid service, a contract between the patient and the facility implies that treatment will be provided in accordance with protocols. The benefits are not aligned with protocol requirements (in particular, in terms of guaranteed laboratory services and outpatient medicines).

The general rule is that patients are expected to seek care in District/City Health Centres (either a central facility or one of its branches) located within their district or city of residence, which may create access barriers for individuals needing to access publicly covered health-care benefits. If someone from a vulnerable group needs a service not available in their facility, they can receive this service free of charge in facilities of other districts/cities, with a referral from a family doctor. Patients not belonging to vulnerable groups can receive laboratory diagnostics and specialist consultations at full cost. This system creates access barriers for patients who do not belong to vulnerable groups. People residing in villages with basic PHC facilities can seek care in other branches or the central facility of their District Health Centres.

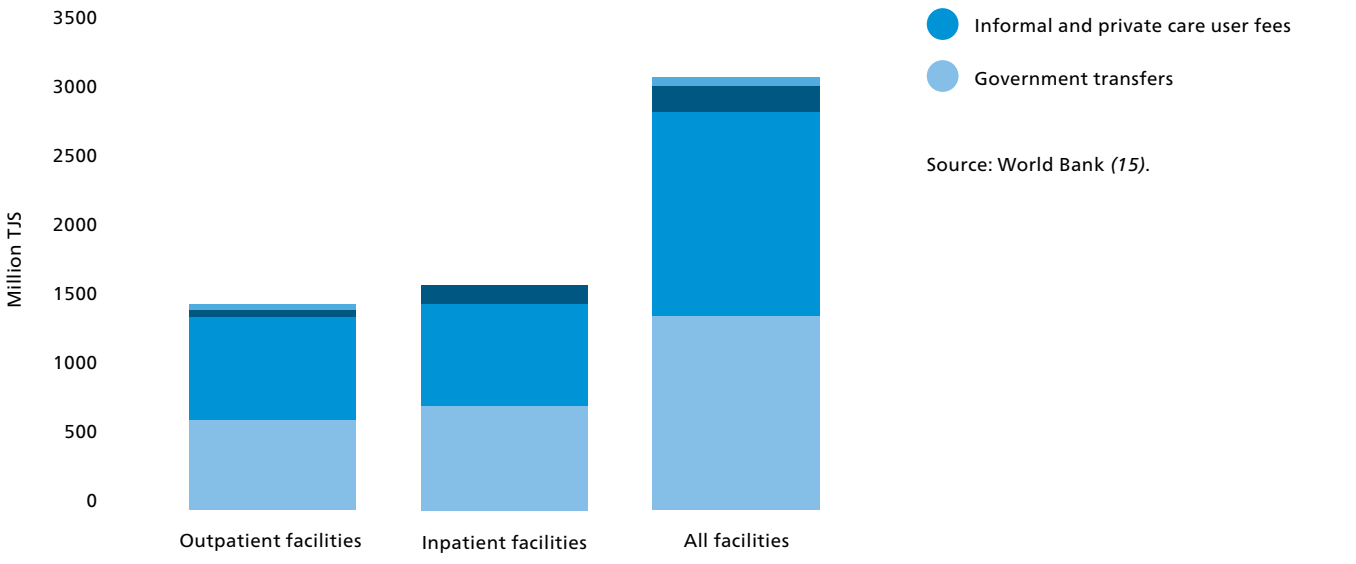
The current system of user charges leads to inefficiency and inequity in accessing PHC and outpatient specialist care. Patients who do not belong to vulnerable groups must pay out of pocket to access laboratory services and specialist outpatient care. If patients are not able to pay, they are likely to forego care. With the current design of formal payments, only the relatively wealthy can afford to use services. The list of service prices is approved by the MoHSPP, in coordination with the National Antimonopoly Committee. The most recent revision of co-payments was carried out in 2018, and the rates have not been amended annually to adjust for inflation. For laboratory diagnostics, the rates for patients are

calculated by the private provider and agreed with the MoHSPP and the National Antimonopoly Committee.

User charges account for a minor share of facilities' revenues, but they have been growing in real terms since their introduction in 2016. Initially, official co-payments were introduced with the key objective of substituting informal spending, but the available data (since 2018) – which indicate a very low share of formal payments in total revenues – suggest that this policy has had only limited impact (Fig. 6). The data on informal expenditures at PHC level specifically are not available, but according to Tajik Health Accounts data, in 2018 informal payments constituted 50% of all resources at the level of District/City Health Centres[11] while formal user fees constituted only 3% of total facility revenues *(15)*. Still, the revenues from formal co-payments have been growing since their introduction, for both outpatient and inpatient care. For District/City Health Centres, the revenues from official user charges in real terms increased by 2.5 times in the period 2016–2022 (Fig. 7). This suggests that further analysis is needed to better understand how official fees may have impacted patients' spending on health.

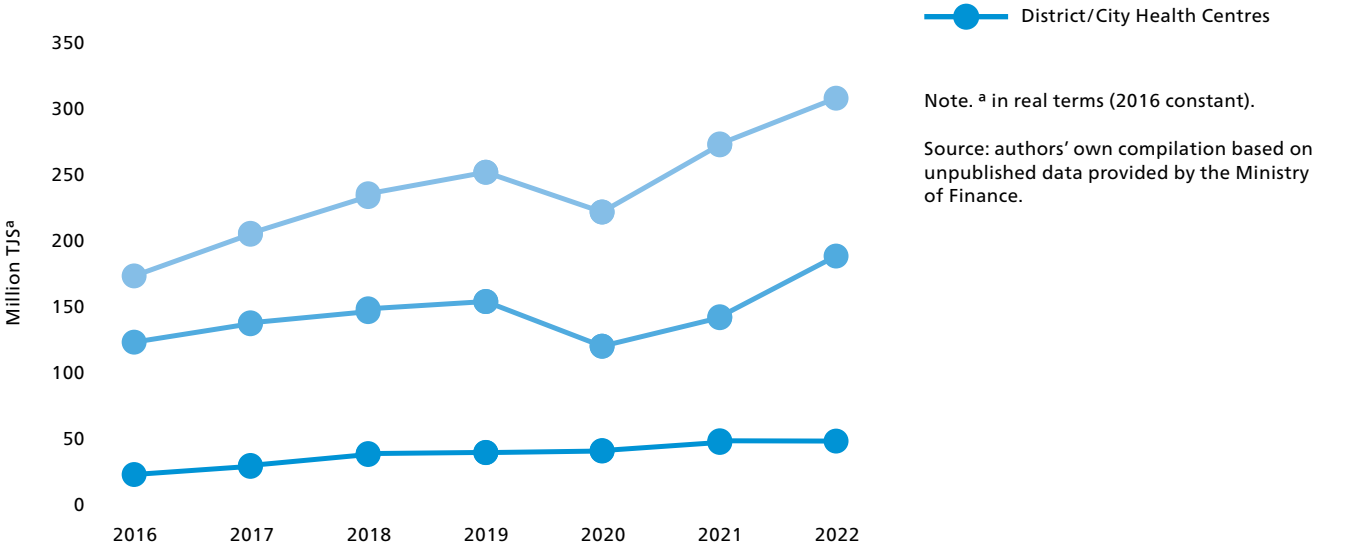
11. These data also include facilities in vertical service delivery programmes.

Fig. 6. Revenue structure of health facilities, 2018



Source: World Bank *(15)*.

Fig. 7. Revenues from formal co-payments and paid services for outpatient and inpatient facilities, 2016–2022



Note. [a] in real terms (2016 constant).

Source: authors' own compilation based on unpublished data provided by the Ministry of Finance.

Patients pay out of pocket for services because they are asked and expected to pay, as well as in the hope of higher quality of care or faster access to it. No specific data are available about how often informal out-of-pocket payments are made to PHC personnel specifically, but the data for the health sector overall suggest a high prevalence of direct out-of-pocket payments to providers. In 2016, 47% of households that used health-care services reported making out-of-pocket payments to health personnel *(15)*. The most common reason for informal out-of-pocket payments (cited by 38% of respondents) was health personnel asking for informal payment, followed by patients stating that they knew they were expected to pay, and paying in the hope of getting better or faster services. Still, some improvement was observed in prevalence of informal payments, dropping from 55% in 2010 to 47% in 2016. More recent data were not available at the time of writing.

3. PHC budget and purchasing cycle

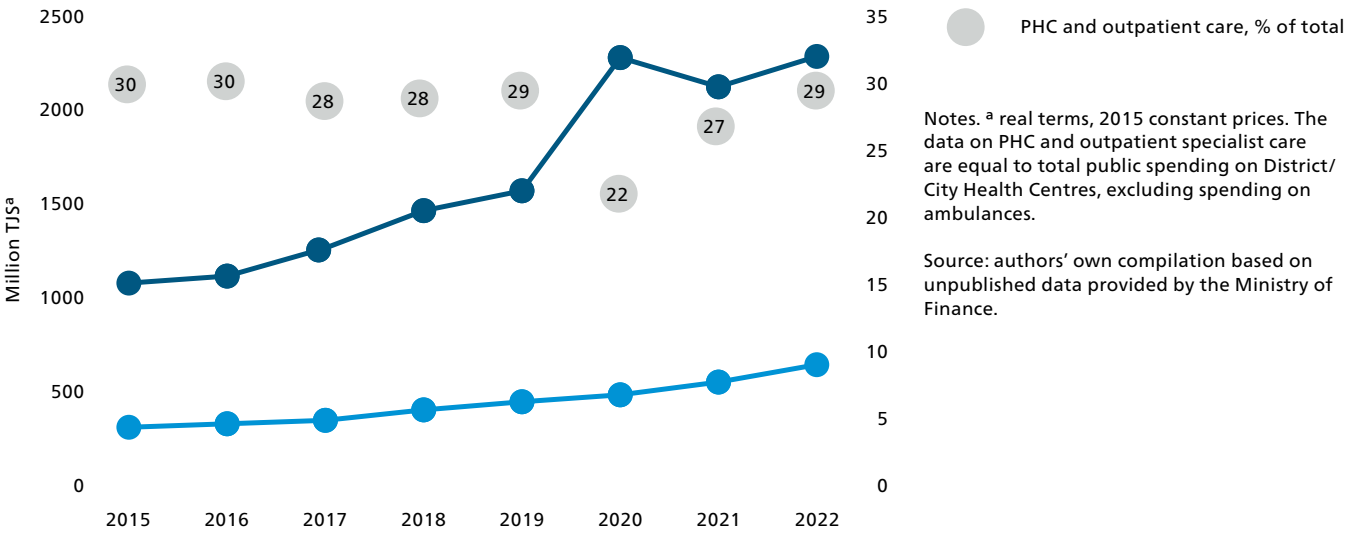
Strategic purchasing of health services has not yet been implemented in Tajikistan and allocations of resources to providers are made as part of the budgeting process, relying on line-item budgeting and based on historic spending. As the country has not yet implemented purchasing reforms, this chapter focuses on the budgetary process, budget planning at the national level, its approval at local level, and analyses of the implemented and planned pilots to support health financing reforms.

3.1. PHC expenditures

Government spending on District/City Health Centres has been increasing in real terms alongside the general increase in public spending on health. Both general health spending, and spending on PHC and outpatient specialist care have been growing over the years. According to unpublished Ministry of Finance data, the District/City Health Centres' budget as a share of total health spending has slightly decreased, accounting for about a third of the total health budget (30% in 2015; 29% in 2022) (Fig. 8).

Tajikistan's public spending on PHC is lower than that of neighbouring countries and other countries of the WHO European region. In 2019, public spending on PHC (including external funding sources) was 0.69% of gross domestic product (GDP) (Fig. 9), which is lower than in other countries of the Region. The per capita spending on PHC from public sources in 2019 was US$ 5.9 *(16)*. In the same year, PHC expenditure from government resources accounted for 22%, while the remaining 78% was covered by households *(16)*. The average expenditure on PHC from patients' resources was US$ 21 (per person per year). These resources include both services and outpatient medicines (the latter of which patients mostly buy themselves).

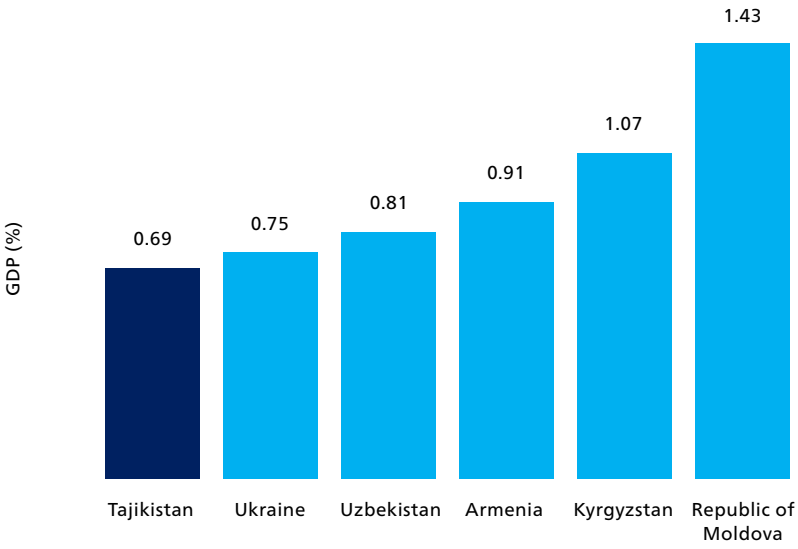
Fig. 8. Government spending on health, PHC and outpatient specialist care, 2015–2022



Notes. [a] real terms, 2015 constant prices. The data on PHC and outpatient specialist care are equal to total public spending on District/City Health Centres, excluding spending on ambulances.

Source: authors' own compilation based on unpublished data provided by the Ministry of Finance.

Fig. 9. Public spending on PHC as a share of GDP, 2019/2020



Note. The GHED methodology on defining PHC expenditures does not include specialist outpatient services in PHC spending, while these services are provided by District/City Health Centres in Tajikistan and are included in the national expenditure estimates. Thus, the GHED and national budgetary data are not directly comparable.

Source: 2019 data from the WHO GHED *(16)* (with the exception of data for Armenia and Ukraine, for which 2020 data are used).

3.2. Defining budget allocations at the local level

In 2016, Tajikistan introduced the per-capita normative for planning budget allocations to District/City Health Centres. The per-capita normative is an estimated capitation amount per person per year to cover the provision of health-care services by District/City Health Centres. The key objectives of introducing the per-capita normative were to: (i) increase funding availability for District/City Health Centres; (ii) improve the equitability of resource allocation across facilities; and (iii) place greater emphasis on PHC and specialist outpatient services within health system spending at district and city levels. The first attempt to implement new budget allocation principles at the level of the District/City Health Centres was undertaken in 2007, in the form of a pilot project in Sughd region. On the basis of Government Order No. 827 *(17)*, in 2016 the country began implementing this new approach to financing District/City Health Centres. The new regulation stipulated that the per-capita normative would be approved by the Government on an annual basis. Local councils would then use this to decide allocations to District/City Health Centres. The Government implemented the per-capita normative gradually: in 2016, 55 districts and cities started using this new allocation principle; in 2017, 11 districts and cities followed; and a further 22 joined in 2018–2019. In 2023 the normative allocated was TJS 81 for urban areas and TJS 68 for districts (Table 1).

Table 1. Per-capita normatives by administrative areas, 2016–2023 (TJS per person per year)

Source: authors' own compilation based on government data provided for each year through the annually updated State budget law (for 2023: Law No. 1916 of 7 December 2022, with amendments (*18*)).

	2016	2017	2018	2019	2020	2021	2022	2023
City Health Centres (urban)	48.82	48.24	51.60	55.96	59.00	67.00	74.00	81.00
District Health Centres	34.16	38.47	39.68	45.54	48.00	54.00	57.00	68.00

The per-capita normative is intended to finance all types of services provided by District/City Health Centres, not specifically PHC services. It is designed to calculate allocations for the Centres, which means that it should include all services, including PHC, specialized outpatient care, ambulances, and some of the services delivered through vertical health-care delivery programmes (in the event they are provided by the facilities concerned). Despite the heterogeneous service delivery structure in Tajikistan, the per-capita normative is not adjusted according to the actual scope of services provided by the District/City Health Centres.

The per-capita normative for urban providers is about 20% higher, despite there being no differences in requirements or services. This creates inequalities in resource allocation and access to care between urban populations and those living in rural districts. For instance, in 2023 the normative for City Health Centres accounted for TJS 81 per person per year, while for District Health Centres it was TJS 68 (Table 1). The disparity between urban (City) and district capitation levels is motivated by a perceived higher level of (more costly) equipment available in City Health Centres, which in theory engenders higher maintenance costs. At the same time, the staffing and equipment norms for both types of providers are identical, and City Health Centres are not considered as having broader responsibilities or scope of services compared to District Health Centres; the scope of benefits is considered to be the same in both types of facility.

The basic annual per-capita normative is defined using a top-down approach, based on historic spending, without taking into account the actual cost of delivering services outlined in the benefits package. The methodology for calculating the per-capita normative was approved by joint Ministry of Health and Social Protection and Ministry of Finance Order No. 675-231 (30 July 2015) *(19)*. The approach means all available financing for District/City Health Centres in a given year is divided by the total population and adjusted by inflation and some other coefficients (such as a geographic coefficient, allowing the normative to be increased for facilities in mountainous or remote areas, and those with low population density). The available budget is defined based on the actual budget of service providers from the previous year and, if relevant, accounts for Government intentions to raise the salaries of health workers when the relevant decision was taken by the President of Tajikistan. Since the calculation approach does not take into account the actual cost of providing services, it is not able to ensure quality and access, since the guaranteed scope of benefits is not considered for the per-capita normative calculation. In addition, the use of coefficients by the

various regions does not account for the share of people represented in vulnerable groups.

The per-capita normative is not adhered to or applied universally; it serves as a planning tool rather than a payment method. The normative is used as guidance for local councils regarding the minimum funding that should be allocated to District/City Health Centres, and as a basis for the subventions from the central/regional to local levels for the poorer districts and cities *(17)*. According to key informant interviews, the central Government and regional administrations do not have any leverage to ensure the normative is adhered to by district and city authorities. For instance, in 2022, out of 18 districts and cities in Sughd region, 10 had managed to allocate resources at or above the per-capita normative, while in 8 districts and cities the actual per-capita spending was lower than the approved normative level. This situation was also observed in previous years. This lack of adherence to the per-capita normative by local authorities was explained (by the key informants) as being a result of their inability to generate sufficient revenues.

Tajikistan has experience in implementing performance-based financing for PHC services in two regions of the country. Piloting of new financial incentives at PHC level demonstrated some positive results in terms of clinical quality of care and availability of infrastructure *(20)*, but the piloted model was not sustained. This experience demonstrates the need to ensure that the current public finance management system is adjusted, capacity of the responsible public institutions is developed and further issues that go beyond health financing arrangements are addressed (for instance, problems relating to access to diagnostics and outpatient medicines). More specific details on the pilot implementation projects are provided in Box 4. It will be important to remember and take into account the lessons learned from the pilot implementation when Tajikistan rolls out the health financing reforms, including the introduction of strategic purchasing of health services.

Box 4. Piloting performance-based financing at PHC level

In 2015, with support from the Word Bank through the Health Services Improvement Project, Tajikistan initiated a pilot of performance-based financing in eight districts of Sughd and Khatlon regions, using quantity and quality indicators. The pilot used nine quantitative indicators and their achievement was financed using fee-for-services payments. The indicators focused on child health (vaccination, growth monitoring and nutrition advice), maternal health (antenatal and postnatal care provision, use of contraceptives), and hypertension management (number of diagnosed cases and treatment). In addition to the nine quantitative indicators, the pilot used 93 qualitative indicators in 10 categories, with different weights assigned to each of them when calculating the final score. Facilities scoring more than 55% received a quality bonus, the amount of which was dependent on the actual score. Facilities with a high score could effectively double their bonus payment (received through achieving quantitative indicators) *(20)*.

The performance-based financing pilot significantly increased District Health Centre budgets in pilot districts and provided capacity-building for health-care personnel. The additional financing to cover performance-based payments accounted for US$ 2.3 per capita per year, while the average per-capita spending on PHC allocated from the Government budget in 2016 accounted for US$ 6.0 *(16)* and the per-capita normative was US$ 6.3 for City Health Centres (urban) and US$ 4.5 for District Health Centres, thus the additional financing represented a significant increase of funds. The additional resources were supposed to be used according to the pilot rules: up to 70% could be distributed as top-ups to staff salaries (which resulted in a 62% salary increase in pilot districts, compared to the control group), and at least 30% had to be reinvested in the facility. As part of the pilot, the clinical health-care professionals received training in family medicine with a focus on maternal and child services and management of NCDs.

Evaluation of the pilot's impact showed some positive results in terms of clinical quality of care and infrastructure, but gaps persisted in terms of coverage. The availability of equipment and medical supplies improved, along with infection control, which may be explained by additional resources becoming available to facilities: on average facilities' budgets increased by 80%. Providers' clinical knowledge also improved, particularly on topics related to child health. Results in terms of service coverage were more modest: positive impact was observed only on timeliness of postnatal care and blood pressure measurement for people aged 40 years and over. The absence of positive change in hypertension treatment may be explained by only few facilities offering laboratory diagnostics and a lack of pharmacies in rural areas, as a result of which people may have opted out of receiving cardiovascular disease care in higher level facilities that did not participate in the pilot.

Despite showing some positive results, pilot sustainability was not achieved; however, it was continued and modified in 2020, with its continuation financed by the Second Additional Financing to the World Bank-funded Tajikistan Health Services Improvement Project. The sustainability concern was raised when planning for the pilot continuation. As a result, the number of quantitative indicators was reduced to seven, and the performance payments were reduced to allow for greater financial sustainability; incentives for quality indicators remained the same as in the initial pilot design *(21)*. With the second stage of implementation, the pilot was extended to new districts. It was estimated that to continue performance-based financing in pilot districts the Government would need to additionally allocate US$ 3 million annually, which corresponded to 1.9% of public spending on health. The pilot stopped in 2023, and the incentive payments were discontinued. The key prerequisites to achieve pilot sustainability were not met, including lack of Government commitment to allocate additional resources and low verification capacity. In addition, the pilot implementation relied on external contractual financing arrangements (incentive payments were made by the consulting pilot project implementation team), while the main administrators of budget allocations (MABAs) – who are responsible for PHC financing – were not directly involved. The pilot also relied on non-budgetary financing schemes, and the transition to public financing would have been significantly obstructed by the strict public financial management arrangements.

3.3 Planning and approval of District/City Health Centre budgets

Total spending on District/City Health Centres is planned as a part of general government budget formulation process, as the first stage of budgetary planning. The budgetary process begins in February each year with the Ministry of Finance issuing instructions on budget preparations to all MABAs. Funding requests are submitted by MABAs (which include Gorno-Badakhshan Autonomous Oblast, two regions, the city of Dushanbe, and 13 districts of national subordination) to the Ministry of Finance around July, followed by budget hearings and negotiations, as well as amendments to budget requests, as necessary. The health budget (including budgets of District/City Health Centres) is incorporated into the general government budget. The MoHSPP does not consolidate the general health budget; this function is assigned to the 17 MABAs, which prepare and submit budget requests on behalf of District/City Health Centres within their territories, and the budget is then consolidated by the Ministry of Finance. At the central level, the Parliament approves the budget every year, in a form of an annually updated Law on State Budget *(18)*. This law does not detail District/City Health Centre financing at the local level, but approves the total health spending in the country, as well as spending on health care provision financed via the national budget.

Specific allocation to District/City Health Centres is decided by district and city local councils. After the national budget is approved, information on the total budget is cascaded to the local level, where regions (as well as cities and districts of national subordination) approve local budgets by decisions of the regional, city or district councils (*madjlisi*). At regional level, the budget of districts and cities is approved as a lump sum, without specification according to sector. After the budget is approved by the regions, decisions on health budgets – including specific allocations to District/City Health Centres – are approved by district and city councils, along with budgets of other health facilities. Thus, both total health spending and specific spending on District/City Health Centres are decided by the districts and cities, not the regions. Regional administrations provide recommendations on spending, using per-capita normatives, but they cannot influence local decisions. The final decision on financing of PHC may differ from the initial budgetary request and from the financing which was defined in the national health budget. After all District/City Health Centre budgets are approved by district and city councils, the respective administrative finance department (region/city/district of national subordination) consolidates this information and provides it to the Ministry of Finance. The expenditures on PHC specifically come under District/City Health Centre budgets but are not accounted separately from specialist outpatient care and ambulance services, which means that there are no actual data on PHC spending and, consequently, no Government monitoring of PHC-specific spending.

Local budgets are the main source of financing for District/City Health Centres and funds allocated from national or regional levels constitute only a small proportion. In total, 81.9% of public expenditure on health comes from local budgets. The rest is covered by the national budget for

poor districts/cities in the form of subventions. For District/City Health Centres, the role of local budgets is even greater: 99% of funds are allocated from local budgets, and 1% from the national/regional level.[12] Subventions from the national government at facility level can only be spent on salaries, and not on other types of expenditure.

Lack of effective pooling of resources at the national or regional levels results in little or no redistribution of resources, which leads to inequalities. Richer districts and cities tend to spend more on health (Fig. 10): the difference between the highest and lowest per-capita allocation in financing District/City Health Centres in 2022 was 2.6 times. This results in inequalities and health spending being dependent on local economic development. Given the limited role of regional/national subventions in District/City Health Centre budgets, the redistribution effect from richer to poorer territories is marginal.

According to the relevant legislation, the overall budget of District/City Health Centres must be approved as a lump sum, and the internal facility spending plans are organized by line items. The spending plan (known as *smeta*) is organized and monitored by an established economic classification of expenditures,[13] approved by facility managers and agreed with the respective local (district/city) financing department.

The Government regulates the internal allocation of resources to rural service delivery units within District Health Centres, but the regulation is scarcely followed. The joint Ministry of Health and Social Protection and Ministry of Finance Order No. 675/231 on the implementation of per-capita financing at PHC level (30 July 2015) *(19)* approved the formula to be used for defining the per-capita allocation for rural health centres and health houses (which are service delivery units within District Health Centres). This regulation was developed with the objectives of ensuring District Health Centres finance appropriately their divisions in rural areas and preventing resource concentration in central facilities. In 2023, the per-capita normative for rural health centres was TJS 58, and TJS 46 for health houses (Table 2). The Government regulates internal allocations only for these types of facilities, and when planning the budget, the management of District Health Centres should prioritize expenditures on these divisions in rural areas, ensuring resources are allocated there before planning the budgets of central/larger facilities within the District Health Centres. In practice, this strict regulation does not result in equitable allocation of resources; for instance, in Shahristan District Health Centre (in Sughd oblast), in 2022 the per-capita spending of health houses varied from TJS 29 to 64 per person per year (Fig. 11), while the officially approved normative for health houses was TJS 38. The difference in actual per-capita spending is caused by higher numbers of staff working in certain service delivery points that therefore spend more on staffing (salaries).

12. Unpublished data from a forthcoming analysis by WHO, assessing public financial management in the Tajik health sector.
13. The classification includes the following categories: salary and social taxes; medicines and consumables; gasoline; maintenance costs; repairs; utilities; communication services; service payments; premises insurance; social support and pensions; and salaries of auxiliary personnel.

Fig. 10. Per-capita district/city budget and per-capita spending of District/City Health Centres, Sughd oblast, 2022

Source: unpublished data provided by the Sughd Regional Health Department.

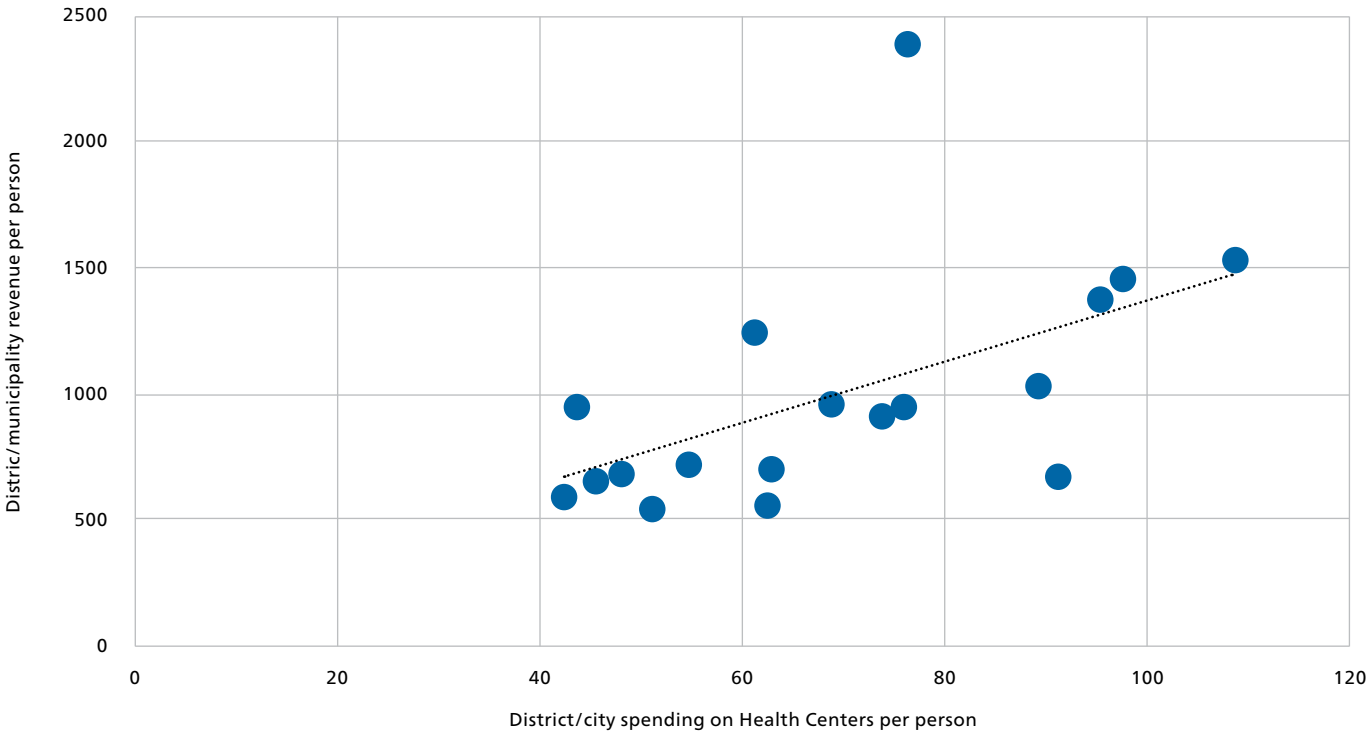
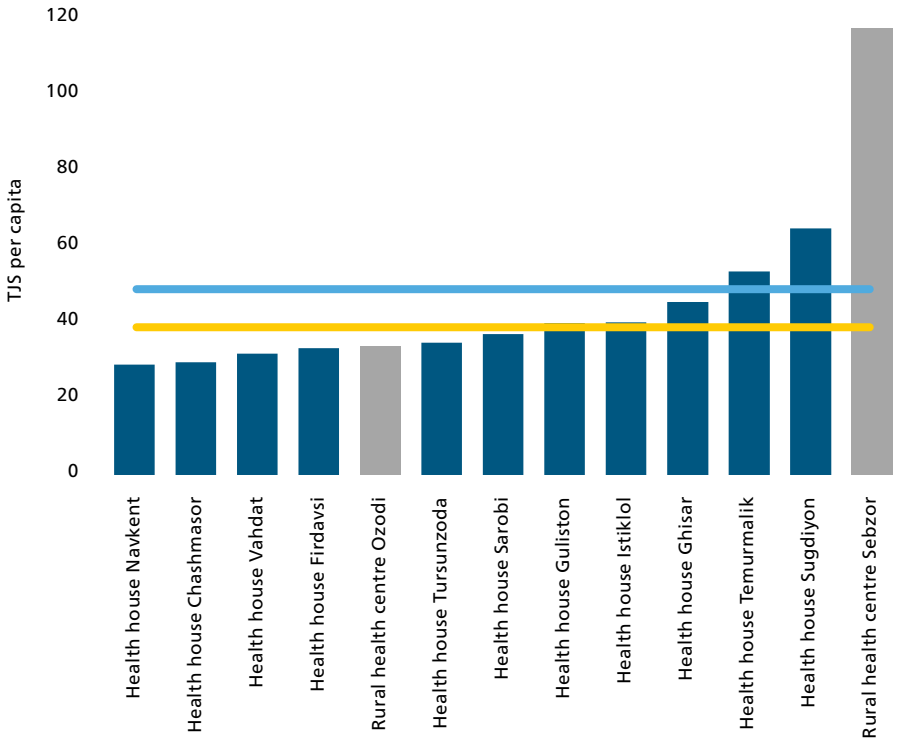


Table 2. Norms for internal allocation of resources (TJS per capita) for rural health centres and health houses, 2016–2023

Source: authors' own compilation based on government data provided for each year through the annually updated law on budget allocation (for 2023: Order No. 52 of 30 January 2023, with amendments *(22)*).

	2016	2017	2018	2019	2020	2021	2022	2023
Rural health centres	32.31	31.78	32.44	38.40	39.00	44.00	48.00	58.00
Health houses	17.57	21.30	21.42	25.84	27.00	35.00	38.00	46.00

Fig. 11. Per-capita allocation of funds (TJS per capita) in rural health centres and health houses, Shahristan District Health Centre, 2022



Source: unpublished data provided by the Sughd Regional Health Department.

The spending plan for funds received from these paid services (planned separately from the spending of budgetary allocations) is prepared annually by facility managers and approved by the finance department of the respective district/municipality *(10)*. According to the relevant legislation, part of these funds (5%) should be transferred to the local-level budget to support implementation of health programmes, and a further 5% of revenues from the paid services are transferred directly to the MoHSPP to finance national health programmes.[14] The remaining funds are kept at facility level and can be spent on salaries (up to 40% of all revenues and after full provision of diagnosis and treatment of the patient *(13)*), procurement of medicines, consumables for laboratory and diagnostic tests, and utilities. Despite facilities having de jure greater autonomy over revenue from user charges and formal payments, key informant interviews revealed that local finance departments interfere in spending by impacting planning priorities and by blocking funding within the treasury mechanisms, which means that facilities in reality cannot spend their funds.

Although paid services provide only a small share of funding to District/City Health Centres, they may create barriers to accessing care. Revenues generated from providing paid services accounted for TJS 46 million in 2022 (Table 3), but this constitutes only 7% of District/City Health Centre

14. This norm is determined and updated annually in the State budget law by the Majilisi Oli (Parliament) of Tajikistan (for 2023: Law No. 1916 of 7 December 2022 *(18)*).

budgets, indicating that paid services do not play a significant role in the overall budgeting of District/City Health Centres.

Table 3. Total public spending on District/City Health Centres and facilities' revenues from paid services and co-payments, 2016–2022

Source: authors' own compilation based on unpublished data provided by the Ministry of Finance.

	2016	2017	2018	2019	2020	2021	2022
Public spending on District/City Health Centres (million TJS)	377	403	463	520	572	644	719
Revenues from co-payments and paid services (million TJS)	18	28	36	40	40	49	46
Revenues from co-payments and paid services as a share of public spending on District/City Health Centres (%)	7%	8%	9%	9%	8%	9%	7%

3.4 Budget execution at the District/City Health Centre level

Salaries represent the primary expenditure category within facility budgets, accounting for 83% of total District/City Health Centre expenditures in 2022. There is some regional variation, from 71% in districts of national subordination to 89% in Khatlon region (Fig. 12). In the capital city Dushanbe, facilities on average spent 73% of their budgets on salaries, while 10% of their budgets were allocated to capital expenditures, 7% to medicines and medical goods, and 6% to repairs and maintenance. In contrast, facilities in Khatlon region (which is the most populated region of the country) spent a substantially smaller share on non-salary expenditure categories – 2% of their 2022 budgets were allocated to capital expenditures, 4% to procurement of medicines and medical goods, and 2% to repairs/maintenance. In 16% of District/City Health Centres, salaries constituted 90% of their total budgets. City Health Centres spent slightly less resources on salaries, compared with District Health Centres (78% versus 83%, respectively), which is the result of the need to locate staff in numerous service delivery locations in rural areas of a district. While salaries account for the majority of District/City Health Centre expenditures, in 2022 health professional salaries were 34% lower than the average monthly salary in the country (US$ 95 compared to US$ 134) *(9)*.

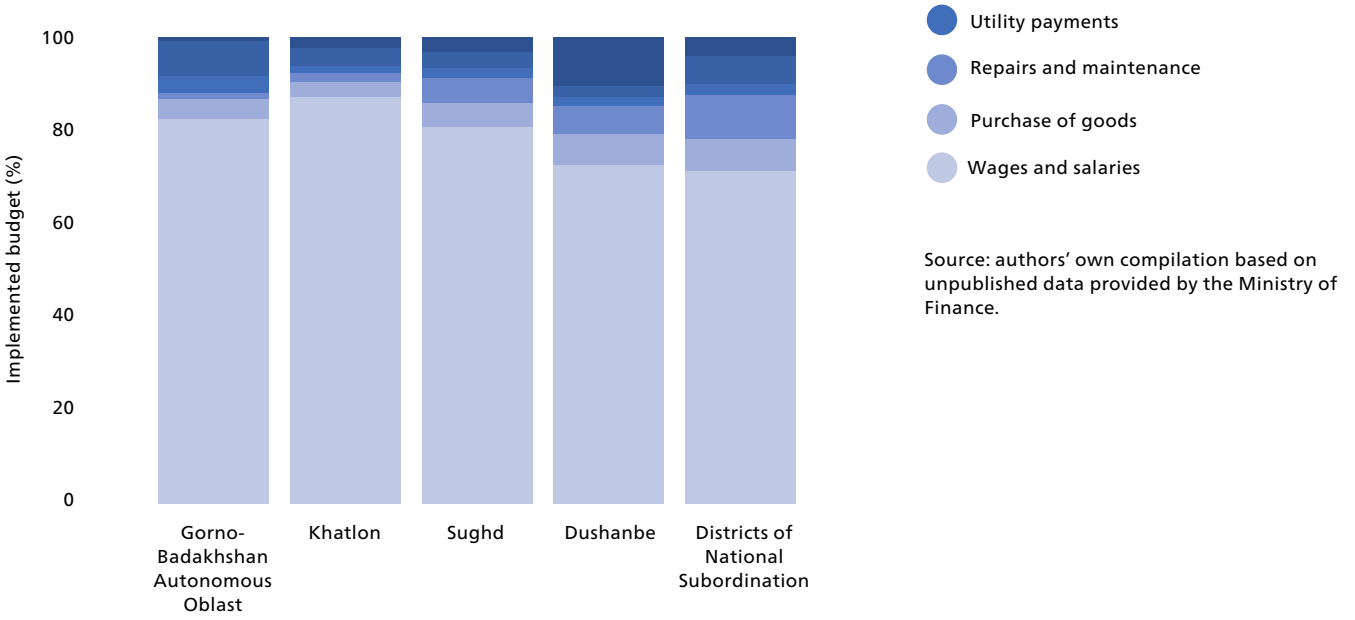
As salaries represent the major spending category, the budget execution rate is high. In 2019–2021, the budget execution rate was about 94%, with some of the money initially planned for procurement of medicines and goods, and recurrent repairs not being fully spent. In 2022, the actual budget exceeded the planned allocation by 10% – mainly because of salary increases taking place in the middle of the year. Still, in 2022 the funding allocated for medicines and goods was 16% underspent.[15]

Expenditures on medicines and medical goods account for a very small share of District/City Health Centre spending (4% of their total resources in 2022).[16] Procurement of medicines by facilities is poorly regulated, and

15. Unpublished data provided by the Ministry of Finance.

16. Unpublished data provided by the Ministry of Finance.

Fig. 12. Implemented budgets of District/City Health Centres by economic categories and regions, 2022



Source: authors' own compilation based on unpublished data provided by the Ministry of Finance.

this results in inefficiencies, partly due to facilities procuring some of the basic medicines and medical goods on their own. Reviewing the actual procurement lists of one District Health Centre revealed that, out of 194 medicines procured by the Centre, only 81 belonged to the WHO Essential Medicines List and 10 more were considered relevant and needed for PHC practice, while the remaining 103 medicines were either non-essential medicines, or those with only weak evidence of effectiveness/efficacy. Further analysis is needed, but these findings suggest that there is scope for significantly more efficient use of resources allocated to medicines within District/City Health Centres.

Interviews with key stakeholders suggested that the actual disbursement of District/City Health Centre budgets can be impacted by local authorities. Resources are allocated and spent using the government treasury system. When a facility budget is approved, the funds should be disbursed to the facility account. The key informant interviews suggest that the financial authorities often withhold funding by not transferring the approved budget to the facility; this is done to keep funding in reserve in case salaries are later increased, resulting in a need to increased funding. This means facilities may not have access to all resources to which they are entitled.

The Tajik legal framework has multiple provisions for the budgets of District/City Health Centres being protected from cuts. Government Order No. 827 on implementing per-capita financing in PHC (31 December 2015) states that the budget of a District/City Health Centre cannot

be lower than the actual expenditure of the facility in a previous year, and the whole budget is considered protected *(17)*. This means that in the event that a facility implements changes that increase efficiency, the level of financing should not decrease. However, according to key informant interviews, budget cuts had indeed been implemented as a direct consequence of changes optimizing service delivery mechanisms in facility management or operation. This practice creates disincentives and may increase resistance to service delivery optimization, putting potential efficiency gains at risk.

4. Policy considerations

1. Strengthen the PHC service delivery system

This can be achieved by setting the vision for future PHC development, including the service delivery model and service integration plans. Development of comprehensive PHC model of care is needed, based on a family medicine approach. The future service delivery model should focus on improving accessibility of and coverage with PHC services, as well as efficiency of service delivery. The integration of the current vertical service delivery programmes into the network of District/City Health Centres should be finalized throughout the country, with a standard set of services provided by all facilities to allow smoother implementation of strategic purchasing reforms. There is also a need to enhance the comprehensive management of health conditions and to increase collaboration between PHC and public health interventions.

Gradual expansion of the (managerial) autonomy of health facilities is a prerequisite for improving efficiency of health services, as well as for successful implementation of new financial incentives. The system of governance of health facilities in Tajikistan should move from strict input norms and regulation to monitoring of actual resource availability and service provision to the population. The first step towards greater autonomy could be in allowing more independence for heads of facilities when hiring health professionals. Expanding provider autonomy would require both the development of a new regulatory framework and increased investment in the education of facility managers and government officials.

Addressing the challenge of the shortage of key health professionals – particularly family doctors – will require the introduction of complex policies. Staff will need to be relocated from rural inpatient facilities to District/City Health Centres, with additional financial and non-financial incentives introduced for family doctors and family nurses (beyond what is already offered by the Government). In addition, a comprehensive retention strategy for health-care personnel should be developed, revising the current medical education and retraining plans, as well as enhancing the appeal and prestige of family medicine. As the number of nurses is increasing in Tajikistan, implementing task-sharing from doctors to nurses and midwives is an opportunity to improve coverage of and access to care. Staffing norms should be reviewed and amended, working towards a more realistic possible workload per family doctor.

Strengthening the scope of practice of family medicine could be achieved through improved training programmes, increased capacity and competences of family doctor teams to diagnose and treat key conditions, as well as clearly defined care pathways with transparent, well-defined roles established between family doctors and narrow specialists.

2. Revise the benefits package to better meet population needs

This can be achieved by establishing a system to regularly review the benefits package. Definition of the benefits package is an evolutionary process, and the scope of benefits should be regularly reviewed, with government funding decisions made as part of a regular budgeting

prioritization exercise. Patients and systems benefit most if this prioritization is carried out transparently and in a participatory manner, with the priorities themselves made explicit. The process of reviewing the benefits package requires a clear set of rules and procedures, as well as effective institutional arrangements (within which stakeholders are engaged, have clear roles and necessary capacity).

The benefits package should be aligned with the available budget. The mismatch between the actual budget and government commitments is known to lead to increased levels of informal (out-of-pocket) payments, unmet need for health services, and low patient trust in the public PHC system.

Comprehensive PHC benefits should be made a priority of the next iteration of the Tajik benefits package. A significant proportion of the disease burden in Tajikistan consists of conditions that can be managed at low cost within PHC, in particular cardiovascular diseases. While family doctor consultation is available for everyone, laboratory testing and medicines require out-of-pocket payment, and this interrupts the chain of effective disease management. Basic laboratory diagnostics, which are necessary for diagnostics and management of most common and prevalent diseases, should be made available to everyone free of charge, and monitoring system assessing actual service utilization by different population groups should be implemented, to enable access gaps to be identified. Basic medicines for NCDs should be incorporated into the benefits package and either provided free of charge or with small fixed co-payments from the population (along with co-payment exemption for the most vulnerable groups).

The issue of informal payments needs to be addressed. The introduction of formal co-payments for health services has not entirely resolved the issue of informal out-of-pocket payments in Tajikistan. To address this challenge the Government needs to better understand the root causes of out-of-pocket payments and tackle them with comprehensive policies that go beyond changing the financing method of PHC, to include additional investments in care provision, raising salaries of health workers, making the benefits package more explicit for the population to understand, establishing accountability mechanisms and the system for reporting and monitoring out-of-pocket payments.

A standard approach should be used to define which services should be provided free of charge at the level of District/City Health Centres and which services are subject to user fees. This will help create greater predictability for patients and lay the foundation for future health financing reforms.

Effective exemption mechanisms for official payments should be implemented. Formal payments should not apply for basic PHC services, as well as for the most important specialist services (provided by both District/City Health Centres and inpatient facilities); these services should be provided free of charge. For services which would require formal payments, the new system of exemptions should protect the most vulnerable from high levels of health expenditure.

3. Implement new arrangements for pooling health resources and purchasing PHC services

Fragmentation of the PHC budget should be reduced by pooling health resources at a higher budgeting level: first, by pooling health funds at the regional level and, in the longer term, at the national level. Regional-level pooling could be a first practical step on the path to implementing national-level pooling of resources. This would require accumulating both central subsidies for health, and all district/city health budgets into one single pool. Currently, local budgets are responsible for both collection of taxes and allocations of raised revenues on health, so implementing a higher level of pooling would require structural changes in public finance management. In practical terms, the options for implementation are either to transfer local tax revenues (to a higher budget level, while the tax collection mandate stays with districts/cities), or to revise the tax-collection arrangements (to designate the task to a different government level (in this example – regional)). Pooling resources at a higher level will allow an increase in equity of health spending, as it will create the basis for resource reallocation between territories.

A simple capitation model should be introduced, with this payment method used within contracts between purchaser and providers. Per-capita payments envisage use of a specific rate, not only for planning, but also for actual payments to facilities within contracts between purchaser and providers. The per-capita rate should be based on cost analysis, to ensure it is sufficient to deliver high-quality services as outlined in the benefits package. Based on international experience, capitation is considered a cornerstone of PHC financing *(23)*. Once such a capitation model is introduced, the Government may consider the use of more complex/blended payment strategies (including reintroduction of performance payments). At the beginning of the reform process, the country could use the basic per-capita model to pay for both PHC and specialist outpatient care, and at the later stage a differentiated approach could be applied, introducing other payment strategies for specialist outpatient care.

To achieve this, it will be necessary to establish a Government institution capable of performing contracting and introduce new payment methods. Transition towards more strategic allocation of the health-care budget to the provider level requires establishing the appropriate purchasing function within the Government. If Tajikistan aims to establish a national-level purchasing agency, introducing new payment methods for PHC (or PHC and outpatient specialist care combined) is a good practical starting point for the new institution to implement the reforms, as a simple capitation mechanism tends to be easier to implement than new payment methods for inpatient services, for example. As the first step towards establishing the purchaser, the country could pilot this function at the regional level (for instance, within the Sughd region pilot – see Box 5). Paving the way for national health financing system transformation could start with the implementation of regional pilot. Practical experience acquired by Tajikistan in implementing the Sughd region pilot will serve as a solid basis for further health financing reforms and establishing a single purchasing agency. The pilot implementation would reveal further challenges that the future health financing reform will encounter

(Box 5). It is therefore crucial for the pilot to be implemented by government institutions, using the public financing system.

4. Increase government spending on PHC

PHC spending should be prioritized within the health budget. By its design, PHC can tackle a substantial part of the burden of disease and provide many cost-effective interventions. Thus, in situations where resources are scarce, the state budget should prioritize PHC and increase its budget allocation (both within the current budgetary system and in the future health financing reforms). The increase of allocations to PHC should also be aligned with planned changes to the scope of benefits, taking into account the need to increase financial incentives for health-care staff and potential changes in the service delivery model.

Box 5. Sughd pilot project: demonstration platform for national-level health financing reforms

The Government of Tajikistan is intending to pilot a new purchasing arrangement for PHC and specialist outpatient services in Sughd region. Government Decree No. 438 on pilot implementation was adopted in 2024 *(24)* and it is planned that the pilot will start in January 2025. As a first step, the pilot will be implemented in four districts (Ash, Devashtich, Shahristan and Kuhistoni Mastchoh) and a city (Istiklol) of Sughd region. The pilot envisages changes across various key areas.

Financing arrangements

A **simple capitation model** will be introduced to pay for PHC and outpatient specialist care, with **contracts between provider and purchaser.** The pilot will implement simple capitation, and the payment amount for every provider will be calculated based on official population data. Modelling of health budgets for the pilot shows that some facilities might experience the significant and rapid growth of their budget (as much as 160% increase); to ensure that budget growth is manageable and used efficiently, the pilot will also implement some budget restrictions.

The Sughd pilot envisages pooling of funds at regional level. The four districts and one town selected for the pilot are currently dependent on regional-level subventions, and it was considered that for these budgets the pooling would be easier to implement as role of local revenues in current financing of service provision is lower compared to other territories. Four policy options were reviewed to decide on pooling of districts and city revenues (currently used to co-finance District/City Health Centres) into the regional-level pool:

(i) changes in distribution of tax collection between budgetary levels, so that some taxes are collected and then spent by the region, not districts and cities;

(ii) transfer of funds from district/city budgets to regional level, using historic estimations of District/City Health Centre spending by those districts/cities;

(iii) transfer of funds from district/city budgets to regional level, using the average estimation of District/City Health Centre expenditures; or

(iv) substitution of currently allocated district and city resources with the regional budget, without the need to transfer districts and city budgets.

The Government decided to cover local contributions from regional budget for the Sughd pilot (option iv above), but this arrangement is unsustainable for pilot expansion to the whole Sughd region, as the regional budget alone will not be sufficient to cover the whole system of District/City Health Centres.

The purchasing function will be established within the Regional Health Department. A new Unit of the Implementation of New Health Financing Mechanisms has been established within the Sughd Regional Health Department. It is assigned with the purchasing function and will contract District/City Health Centres in pilot districts/city.

Service reorganization

In pilot districts/town the **service delivery system is diverse** in terms of level of integration of services provided within vertical health-care programmes. Some facilities provide PHC and outpatient specialist services only, while others have divisions providing what are known as vertical services, such as HIV and TB treatment, childhood diseases, healthy lifestyle communication, and so on. The differences in organization of service delivery presents challenges to fully financing a facility with a single per-capita payment system, as the actual scope of work differs for these facilities. Thus, the pilot project will include integration of selected vertical services into District/City Health Centres.

The process of health budget planning should be improved. This would require enhancing the dialogue between the MoHSPP and the Ministry of Finance, analysing the health-care needs of the population and the need for resources to deliver high-quality PHC services.

An effective system to monitor actual PHC spending is needed. As the current system does not allow separation of spending on PHC and specialist outpatient care, a new system of reporting would be valuable to enable better understanding of how much of government resources are used for PHC specifically. In addition, more detailed information on formal payments (disaggregated by social status of patients) is needed to understand the reality of the accessibility of PHC services.

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