World Health Organization
European Region

Transforming primary health care in Tajikistan

Pilot of health financing reform in Sughd region

Funded by the European Union

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Abstract

Launched on 1 January 2025 in the Republic of Tajikistan, the Sughd Pilot for Health Financing Reform aims to achieve universal health coverage by implementing planned health financing reforms, alongside crucial governance and service delivery transformations. To this end, it builds on the national Strategy on Health Care of the Population of the Republic of Tajikistan for the Period up to 2030. This pilot, conducted in five districts/cities of the Sughd region, seeks to address significant challenges such as high out-of-pocket expenditures, limited coverage for chronic conditions and unequal resource allocation. By rehearsing initial reform steps, expanding primary health care (PHC) access and building administrative capacity, the initiative intends to showcase PHC's role in delivering high-quality, needs-based care efficiently. Key activities include regional health budget pooling, establishing a regional purchasing entity, introducing a new payment method, increasing facility autonomy and integrating vertical services into PHC.

KEYWORDS

PRIMARY HEALTH CARE
HEALTHCARE FINANCING
PUBLIC EXPENDITURES
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Contents

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Abbreviations

NCD	noncommunicable disease
PHC	primary health care
TB	tuberculosis

Executive summary

Launched on 1 January 2025 in the Republic of Tajikistan, the Sughd Pilot for Health Financing Reform builds on the concept of universal health coverage – providing access to high-quality health care and medicines for all – and aims to pave the way to achieving such coverage with the instruments of health financing reform, supported by key governance and service delivery transformations. Health financing reform is seen as a catalyst of health system transformation as it builds the basis for more equal and needs-based allocation of resources, improved access to services and enhanced system efficiency.

The pilot is based on specific steps that have already been planned by the Government of Tajikistan in the Strategy on Health Care of the Population of the Republic of Tajikistan for the Period up to 2030, but which have not yet been implemented. The aim of the pilot is to address a number of crucial health system challenges observed in Tajikistan: high out-of-pocket expenditures, the need to expand coverage for chronic conditions, and unequal allocation of health resources to different regions of the country.

The pilot will transform the health system in five districts/cities of Sughd region. Sughd region was selected for pilot implementation because of its extensive experience in implementation of other health pilots, which have helped to build the necessary capacity in local government. The five districts/cities were selected based on criteria of relying heavily on regional-level financing for health care.

The pilot seeks to showcase how primary health care (PHC) can be instrumental in increasing access to high-quality care based on need and make more efficient use of the scarce resources of Tajikistan's health system. More specifically, PHC can be enhanced through health financing reforms, complemented by transformations in service delivery and governance. The specific objectives of the pilot include:

- demonstrating the first steps for reform in health financing (along with service delivery and governance transformations) – previously outlined in strategic plans but not yet put into practice;
- expanding access to PHC for residents in the pilot districts/cities; and
- building expertise and capacity within public administration to support the implementation of nationwide health system reforms.

The pilot activities consist of key transformations in health financing, governance and service delivery, with implementation carefully designed for the Tajik context:

Health financing

- Pooling of the health budget at regional level
- Establishment of a purchasing agency at regional level
- Use of new payment methods
- A refined benefits package

Governance

- Increased managerial and financial autonomy of health facilities

Service delivery

- Integration of vertical services into PHC

The current pilot design can be complemented by addressing additional health system challenges, and scaling up is possible both by expanding to more districts and cities and by introducing more system transformations (for instance, enhancing health workforce capacity and improving access to outpatient medicines and laboratory diagnostics at outpatient level).

The pilot is aligned with other health reform undertakings supported by development partners in Tajikistan. More specifically, the pilot provides valuable lessons for national reforms in health financing planned within the Millati Solim (Healthy Nation) Project, which is funded by the World Bank and the Global Financing Facility. The pilot also complements the effort of the "Promoting the Health of Pregnant Women, Mothers and Newborns" project (implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit), which focused on improving the quality of PHC.

Introduction

Tajikistan has set forth its vision for health system development in the Strategy on Health Care of the Population of the Republic of Tajikistan for the Period up to 2030 (referred to hereafter as "Strategy 2030") *(1)*. This strategic document sets the ambitious goal of progressing towards universal health coverage, reducing health inequities, and enhancing the efficiency of the health-care system. Strategy 2030 covers a wide range of areas where reforms are planned, including reforms of health financing mechanisms. More specifically, it emphasizes improved equity of funding, a new approach to purchasing health services, and increased autonomy of public health-care facilities. It also underscores the need to improve financial protection of the population when using health services.

In 2023–2024 teams from the Ministry of Health and Social Protection of the Population, the Ministry of Finance, the Sughd Regional Administration, the WHO Country Office in Tajikistan and the Interagency Expert Group of the Ministry of Finance worked on developing a new Government Regulation to enable implementation of new health financing mechanisms for primary health care (PHC) services in five pilot districts/cities of Sughd region, the northernmost region of Tajikistan. The regulation was approved by the President of the Republic of Tajikistan, Decree No. 438, as of 31 July 2024 *(2)*. The pilot started on 1 January 2025.

This concept note aims to describe the key performance challenges that the pilot seeks to address, the overall pilot design and some of the implementation details (as outlined in the approved Government Regulation and the two-year Action Plan) ***(3)***. It also describes the challenges the pilot faces during the initial stage of implementation, and ways to address these challenges.

While this document focuses on Sughd region, the issues of health system performance and the structural problems in service delivery and financing are relevant in a national context. Similarly, the changes to the health financing system that have been initiated and the midterm vision of the reforms are designed to be relevant and applicable nationally – for example, introducing a capitation payment and integrating key services into PHC, as well as establishing the national purchasing agency which will be responsible for financing health services, as planned within both Strategy 2030 and the Millati Solim Project.[1] Thus, the lessons learned from the pilot's preparation and early implementation stages are equally valuable for future national reforms.

[1] The Millati Solim (Healthy Nation) Project is a World Bank initiative in Tajikistan which aims to improve PHC by introducing significant health financing reforms, including introduction of strategic purchasing of health services. Specifically, it will provide technical assistance to create the Health Services Purchasing Structure and build institutional capacity to implement strategic purchasing of PHC in two regions (Dushanbe city and Sughd region) *(4)*.

Challenges within the health system and their underlying causes

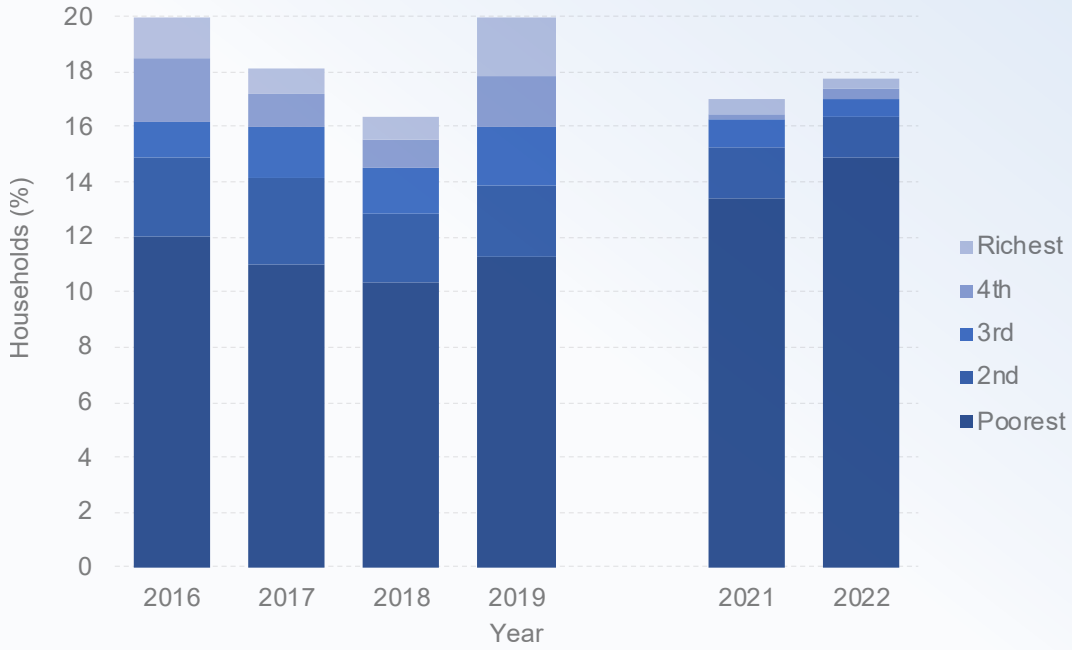
Tajikistan has an opportunity to make progress by more forcefully implementing its health sector strategies. The Sughd pilot serves as a valuable opportunity to drive system level changes through the phased, local implementation of national strategies starting with the health financing component of country's comprehensive reform plans. Tajikistan's health care system faces multiple challenges, and the delay in implementing much needed reforms may exacerbate them even further.

Two of the health system challenges specifically addressed by the pilot are:

1. Affordable access to health care is precarious

In Tajikistan many people pay a large share of their resources to access health services and medicines. A recent WHO analysis *(5)* suggests that the financial protection of patients in Tajikistan is one of the lowest in the WHO European Region: in 2022, 18% of households experienced catastrophic health spending (Fig. 1).[2] Most of these households were also impoverished or further impoverished after out-of-pocket spending on health care, and most of the catastrophic expenditures are concentrated in the poorest households.

Fig. 1. Incidence of catastrophic health spending in Tajikistan, by consumption quintile, 2016–2022[a]



[a] Data are not available for 2020. Break in series in 2021; data before and after 2021 are not comparable due to changes in the questionnaire. Results for 2016 to 2019 were adjusted to address issues with the survey sampling design.

Source: (5).

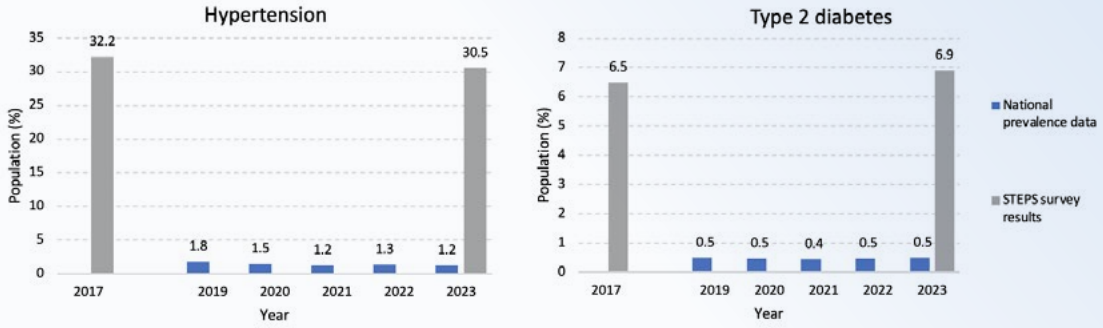
[2] Catastrophic health spending is one of two main indicators to measure financial hardship. Catastrophic health spending is measured as the share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care (which is measured as total household consumption minus a standard amount to cover basic needs such as food, housing and utilities).

Outpatient medicines are the leading driver of catastrophic health spending in Tajikistan, accounting for 73% of catastrophic expenditures in 2022. Although it is not known how many of these medicines are from the WHO Essential Medicines List *(6)* and/or are prescribed by protocol, the high share of outpatient medicine costs highlights a critical gap in Tajikistan's benefits package, which lacks sufficient coverage for essential medicines. Other significant contributors include inpatient care (16.5%) and diagnostic services (3.3%).

2. Chronic conditions such as hypertension and diabetes are highly prevalent, yet often underdiagnosed and underdiagnosed and undertreated

Tajikistan's PHC can become more effective by detecting and managing highly prevalent chronic conditions and thereby prevent severe illness in the population and save health-care resources. According to national statistics, in 2023 the prevalence of hypertension in the adult population was 1.2%, while the prevalence of type 2 diabetes was 0.5% (Fig. 2). At the same time, the population-based STEPS survey *(7)* indicates that, in 2017, 32.2% of the population aged 18–69 had high blood pressure and 6.5% had type 2 diabetes. The next round of STEPS, conducted in 2023, shows similar prevalence, which is again much higher compared to official prevalence data: 30.5% had hypertension and 6.9% had type 2 diabetes (Fig. 2).[3] These data suggest that diagnosis and official registration of cases is low and that the performance of the health-care system is inadequate in terms of diagnostics and registration of these key noncommunicable diseases (NCDs). This situation creates major health and social challenges, as a high level of undiagnosed and untreated chronic conditions leads to unnecessary hospitalizations, avoidable disabilities and premature death.

Fig. 2. Official prevalence data of hypertension and type 2 diabetes (2019–2023) and results of STEPS surveys (2017, 2023)



Source: STEPS surveys *(7)*; Statistical Agency under President of the Republic of Tajikistan.

Both of these challenges represent complex health system problems that have multiple underlying causes, including the following:

[3] STEPS survey data from 2023 had not been published at the time of writing.

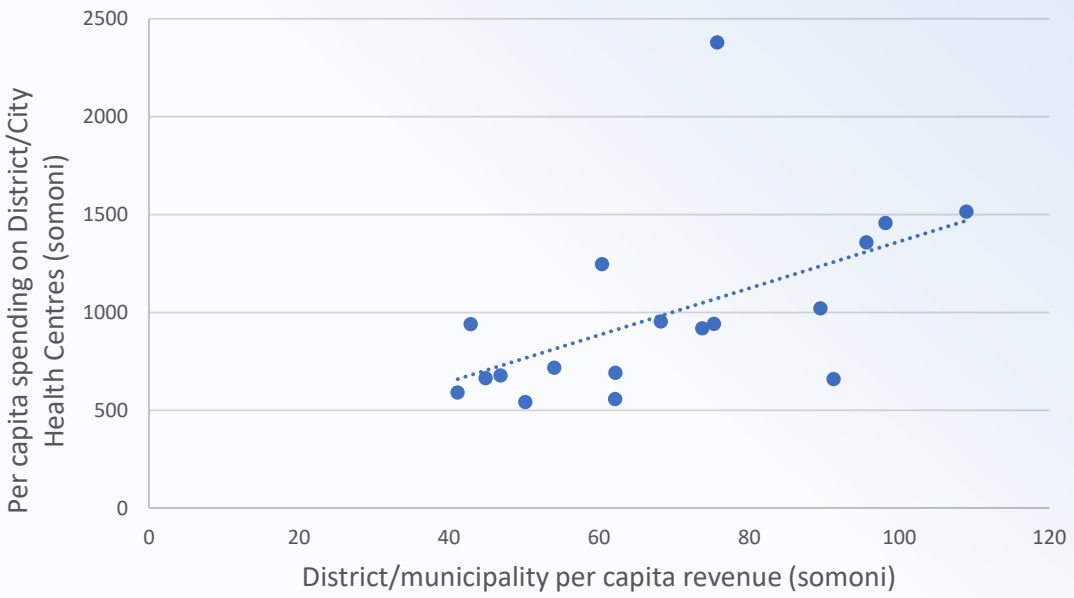
Low level of public spending on health

The incidence of financial hardship is related to the share of health spending covered by the Government. Generally, the lower the share of health spending the Government covers, the higher the incidence of financial hardship. In Tajikistan the share of government spending on health within total health expenditures remains low compared to other countries in the WHO European Region: public expenditures on health accounted for only 2.2% of gross domestic product in 2021, compared to a 3.1% regional average, while the incidence of catastrophic health spending is one of the highest *(8)*.

Highly fragmented financing system in Tajikistan

In addition to low public expenditure on health, almost all health revenues are collected and spent at district/city and regional levels. Local collection of revenues is a key factor determining the size of the health budget at district/city and regional level, which in effect leads to health resources being particularly scarce in poor districts and cities. The Government of Tajikistan has attempted to address this challenge by introducing a per capita normative, which is approved annually and should be followed by local councils when deciding on the allocation for District/City Health Centres. However, evidence shows that the normative is not followed (Fig. 3), and other measures are needed to ensure that the budget available for health is adequate. To some extent, the current allocation of regional and republican funds to poorer districts mitigates this problem, but the difference in actual spending is still high.

Fig. 3. Per capita district/city revenue and spending for District/City Health Centres, Sughd region, 2022

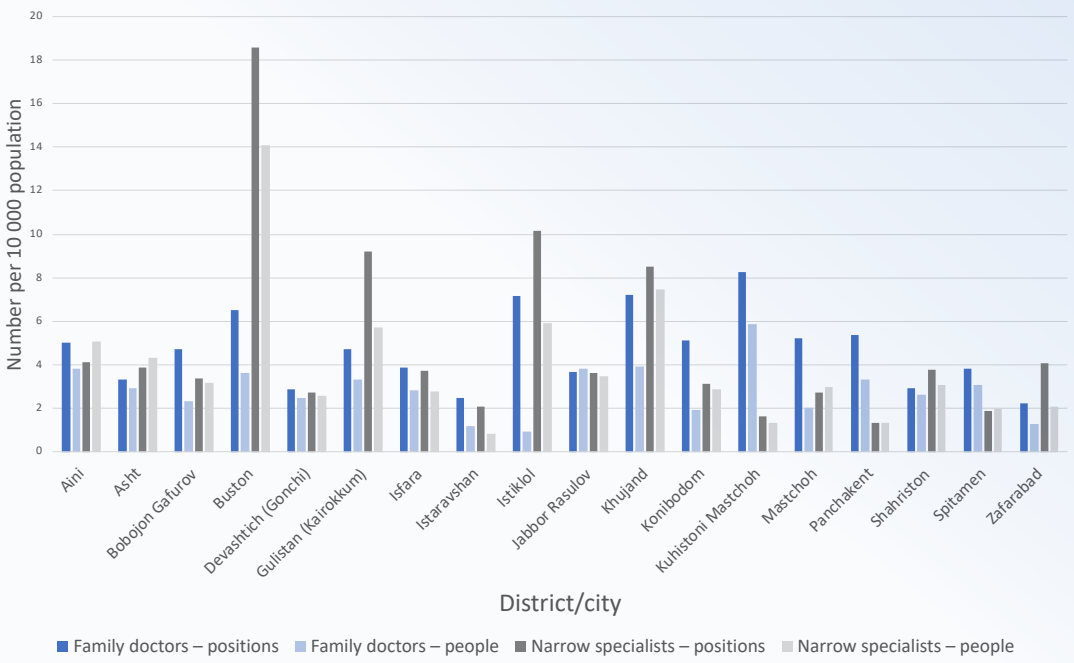


Source: Sughd Regional Finance Department.

Variation in staff availability at the facility level

The variation in the level of funding partly contributes to a variation in staff availability at the facility level. This applies both to the number of positions and to the number of professionals actually working. A national staff normative exists, but it is not applied automatically, and the actual number of positions is dependent on the budget available at the local level (and has to be agreed with the local finance department). This applies both to family doctors and to narrow specialists (Fig. 4). Consequently, there is a significant variation in terms of the actual availability of doctors.

Fig. 4. Number of positions and working professionals (family doctors and narrow specialists) per 10 000 population, Sughd region, 2022



Source: Sughd Regional Finance Department.

Governance and budgeting system not conducive to improving system performance

The situation of scarce and unequally allocated resources is exacerbated by a governance and budgeting system that is not conducive to improving system performance. Tajikistan relies on strict budgetary controls, which limit managerial autonomy but do not result in effective spending of the health budget. The experience of neighbouring and other countries shows that financing reforms should be accompanied by increased autonomy at provider level, supported by public financial management reforms.

Benefits package not fully covering essential health services

The benefits package currently used in Tajikistan does not include some of the essential health services required for effective management of key conditions at PHC level. The most important gaps

in terms of coverage of health services are the absence of basic laboratory tests and key outpatient medicines. In addition, the scope of benefits that are provided as paid services differs at the facility level, as permission to provide paid services is granted by a special commission of the Ministry of Health of Tajikistan, and the list of these paid services may vary depending on which permissions were given to the facility concerned. In practice, this means that there is no single benefits package available for the population free of charge.[4]

Variable service delivery structure of District/City Health Centres

There is a legal framework setting the standard organization structure at PHC level. In practice, however, facilities have different structures and, as a result, provide a different scope of services. For instance, in some districts and cities vertical services (such as reproductive health centres, healthy lifestyle centres and integrated management of child diseases) are provided within District/City Health Centres, while in others they are organized as independent facilities with separate legal status and budgets. In addition, some of the District/City Health Centres provide ambulance services (prehospital urgent care), while in other districts and cities ambulance services may be placed within the hospital sector. This heterogenous service delivery structure creates challenges for the implementation of new payment mechanisms.

In summary, PHC in Tajikistan is underfunded, particularly in districts where it is difficult to collect enough public revenues. District/City Health Centres cannot use the available resources in the most effective way as their managerial and financial autonomy is very limited. The benefits package at PHC level lacks some of the most essential health services, such as basic diagnostics and medicines. This contributes to a situation in which health centres are unable to effectively detect and treat certain key chronic conditions, even though they constitute the bulk of illnesses and are largely manageable within PHC.

[4] More details on this situation are provided in a 2025 WHO report on PHC financing in Tajikistan *(9)*.

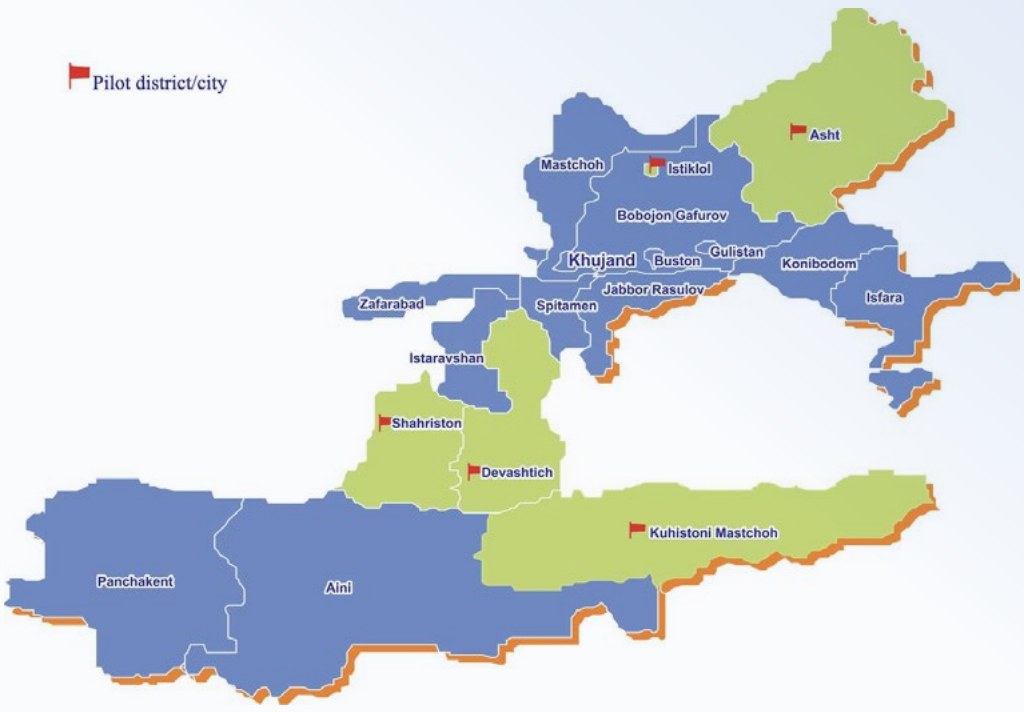
How the pilot aims to address some of the key health system problems

The underlying causes of the performance challenges described in the previous section originate within a range of health system components, such as health system financing, governance and service delivery. Within the pilot, health financing reforms are seen as an entry point for broader transformation. Thus, the pilot focuses primarily on addressing the health financing challenges and also plans some reforms in governance and service delivery organization.

The pilot will be implemented in Sughd region at the level of District/City Health Centres. The District/City Health Centres provide both family medicine and outpatient specialized care. The pilot will be implemented in five pilot districts/cities of Sughd region (with 2023 population figures in brackets) (Fig. 5):

1. Asht district (population 182 062)
2. Devashtich district (population 189 891)
3. Istiklol city (population 19 117)
4. Kuhistoni Mastchoh district (population 25 200)
5. Shahriston district (population 48 743)

Fig. 5. Map of Sughd region and the five pilot districts/cities



The selection of these five districts/cities was motivated by the low level of their own financial resources available to finance the health-care sector. The selected districts/cities have the highest reliance on regional-level subventions for funding health care, and it was considered that this would make implementation of resource pooling relatively easy. It is planned that the other districts and cities of the region will join the pilot at a later stage of implementation.

As mentioned above, the pilot aims to demonstrate how family medicine and outpatient specialized care can be transformed by means of health financing reforms supported by certain service delivery and governance changes. Specific pilot objectives include:

- to demonstrate the first steps for implementation of the reforms in health financing (supported by service delivery and governance changes), which have long been described in strategic documents but have not yet been implemented, as well as to provide valuable lessons for future reform implementation at the national level;
- to improve access to family medicines and specialist outpatient care for the population in pilot districts/cities; and
- to generate experience and capacity in public administration to implement national-level health system reforms.

Key changes planned within the Sughd pilot

As mentioned above, health financing-related reforms are the primary focus of the pilot. This chapter describes these health financing changes, as well as other planned transformations.

Health financing transformations

Strategy 2030 *(1)* outlines key objectives in health financing, including promoting equity in financial resource allocation; improving health-care purchasing mechanisms such as per capita financing for PHC services and establishing a purchasing agency; standardizing the benefits package; and increasing the autonomy of health-care facilities. The pilot's health financing components focus on implementing these plans in practice.

Regional-level pooling of the health budget

Pooling of health resources determines the level at which the health budget is accumulated. Possible options include the district/city, regional or national budget. Global practice shows that pooling at the highest possible system level minimizes resource fragmentation and improves system efficiency and equity in financing health-care services *(10)*.

As part of the pilot, the budgets of five District/City Health Centres are pooled at the regional level, with the Sughd Regional Health Department serving as the budget holder. At the initial stage, district and city revenues are not being transferred to regional-level finance services within the pilot as doing so would introduce excessive complexity and the selected locations are mostly dependent on regional funding. The budget is sourced from regional-level revenues, while districts/cities will continue to fund legally separate facilities, such as HIV and tuberculosis (TB) centres. This approach is a good starting point, but for future reform scale-up, district and city health spending will need to be transferred to the regional- or national-level pool. During the pilot preparation, several implementation options were considered, as outlined in Box 1 (overleaf).

Establishment of the purchaser of health services and contractual arrangements between purchaser and providers

The establishment of a purchaser is an important cornerstone of this health financing reform. Within the new health financing ecosystem, the purchasing agency is responsible for allocating pooled funds to health-care providers based on population health needs and provider performance. Establishment of a purchaser is of high importance for the system change as it allows the system to transition from so-called "passive purchasing" (for instance, financing of health facilities using line-item budgets based on costs for inputs) to a more strategic and purposeful allocation of health resources.

The pilot envisages the establishment of a purchasing function within the current regional government structure. The Sughd Regional Health Department acts as the purchaser of health services. To support this new function, the Unit of Purchasing Health Services has been established within the Department, and its employees are civil servants. The future health financing reforms at the national level envisage establishment of a national-level purchaser. The pilot creates capacity and generates the experience to support the national-level reforms in building new institutions.

Box 1. Options for transferring district/city health budgets to a higher system level

The Tajik public financing system overall is highly fragmented, and this has implications for the health budget: most taxes are collected locally and decisions on the use of these revenues are also made locally (more specifically, at the level of districts and cities). Thus, to allow pooling of resources at a higher level (for instance, at regional level), it will be necessary to change either the taxation system or the specific mechanism used to ensure that locally (at district and city level) collected taxes are transferred to regional level to cover health expenditures of the region from one pool. The following two options for regional pooling implementation were reviewed during the pilot preparation.

Option 1. Transfer of local revenues to the regional-level budget

This option envisions that revenues are collected by districts and cities and transferred to regional level from every local budget. There are two ways in which the amount to be transferred can be defined:

- Based on historic district or city spending on District/City Health Centres. This option is not preferable as the level of historic spending depends on revenues, health priority compared to other sectors, and priorities within health (such as inpatient treatment) compared to other services. Thus, this approach would replicate historic decisions and might not be in line with the capacity of districts or cities to finance District/City Health Centres.
- Based on the district/city's revenue base, in which every district/city transfers a specific share of its revenues to the regional budget. This approach ensures less subjectivity and less reliance on historic spending, but instead builds on a district or city's wealth and ability to collect revenue.

There are challenges with timing and sequencing: transfer of funds from local level to regional budget might take time, and if delays occurred in at least some districts/cities, the regional budget would lack funds to pay to District/City Health Centres.

Option 2. Amendments to the taxation system

Currently the financing of services provided by District/City Health Centres is a mandate of local administrations. The taxation system is based on the assumption that these administrations collect taxes to cover the cost of service provision. If pooling is moved to a higher (regional or national) level, the mandate to collect and keep taxes should be moved to the higher level as well. For instance, now 100% of VAT (value-added tax) collected by districts and cities is kept at their level, and the same applies to corporate income tax, personal income tax, excise taxes, etc.; other rules apply to Sughd region and some of the cities. If regions become responsible for

financing of District/City Health Centres, the mandate to collect selected taxes and keep revenues could be given to regions. This option, though preferable from a public finance management point of view, might be difficult to implement given the political economy and current high level of tax decentralization.

At the moment of pilot scale-up, the regional budget will not be able to cover expenditure on District/City Health Centres for the whole region, as the taxes the region currently collects will not be enough to pay for service delivery.

The introduction of contractual arrangements is another important component of the pilot. It envisages that the purchaser (Sughd Regional Health Department) and providers (District/City Health Centres) sign a contract that defines the responsibilities of each party (in terms of payments, monitoring, etc.), the scope of services to be provided to the catchment population, and the contract budget. This change will bring much higher transparency and accountability to the financing system.

Within the pilot, as well as in the future national reforms, the purchaser's functions extend beyond signing contracts and monitoring contractual performance. According to the Government Regulation controlling the pilot, the responsibilities of the purchaser include development of the benefits package, calculation of the payment rate and approval of the contract template. During the pilot preparation, the purchaser led the discussions on pilot design, analysis of possible risks and communication with stakeholders.

Use of new payment methods

The pilot uses a mixed payment approach: a global budget and per capita payment. As noted above, Tajikistan uses a per capita normative as a planning tool intended to guide local administration when defining the budget of their District/City Health Centre. The pilot extends the per capita normative to a payment method. The global budget is an additional payment method used to ensure financial stability of service provision.

Initially, it was planned that the facility budget be defined solely on a per capita principle and paid as a lump sum to the facility to replace the currently used system of line-item financing. The per capita rate was calculated based on staffing norms and information on current facility spending. The following cost components and assumptions were used to calculate the rate:

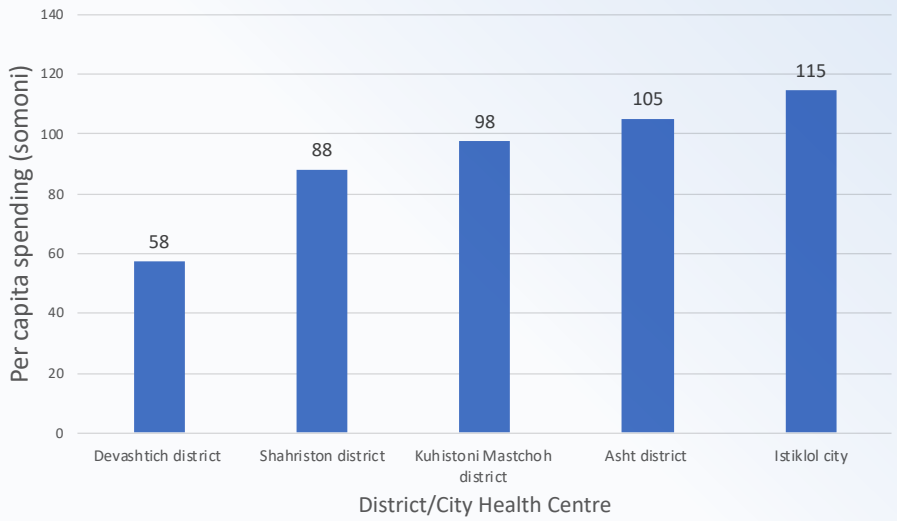
- labour cost of family doctors (based on the actual workload of a family doctor in five pilot districts/cities, considering a 10% increase in availability of family doctors to allow facilities to hire more doctors);
- labour cost of family nurses (while the current normatives require positions for two family nurses for every family doctor, the pilot aimed to give facilities sufficient funding to hire more nurses; thus, the per capita payment includes three nurses for every family doctor);
- labour cost of specialists and nurses working with specialists (the pilot used the new staff normatives for specialist outpatient care, which were developed by the Ministry of

Health and are yet to be approved; the normative sets the number of doctors and nurses separately for adult and paediatric specialists; realistically, paediatric specialists are not available in any of the pilot facilities, so only adult specialists and nurses – who serve both children and adults – were included in the calculation);

- administrative costs (estimated based on the average actual spending in the five pilot districts/cities);
- consumables (including consumables for laboratory testing) (estimated based on highest per capita spending across the five pilot facilities);
- utility cost (estimated based on highest per capita spending across the five pilot facilities); and
- medicines and other expenditures (estimated based on highest per capita spending across the five pilot facilities).

The labour cost for the per capita calculation included a 40% salary increase for health personnel, which was planned for implementation from 1 July 2024. Using this approach, the pilot team suggested a per capita rate at a level of 135 somoni per person per year. The proposed per capita rate represents an increase over the actual per capita spending in 2024 (Fig. 6).

Fig. 6. Actual per capita spending of District/City Health Centres, 2024

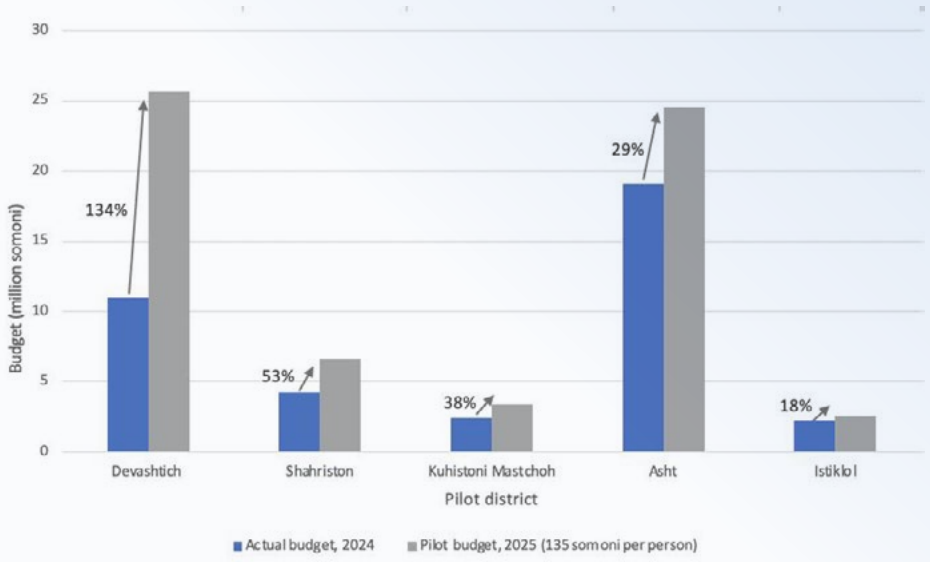


Source: Sughd Regional Health Department.

The total pilot budget was calculated using the per capita rate of 135 somoni per person per year multiplied by the population residing in the pilot districts/cities. The total comes to 62.8 million somoni, which represents a major increase in financing compared to the 39 million somoni of the five pilot facilities in 2024. Initially it was planned that an additional budget would be allocated to cover prehospital urgent care, but this plan was not followed up, so the pilot budget would also need to cover ambulance service costs (about 4 million somoni).

In the pilot preparation and planning, exclusive use of per capita payment was found to be unfeasible. The budget modelling revealed major changes in the budget for several facilities and risks that some facilities might not even be able to cover their salary costs. Compared to the 2024 budget, the increase in funding within the pilot varied from 18% for the Istiklol City Health Centre (which will not allow facilities to implement the 2024 salary increase for health workers) to a 134% increase for the Devashtich District Health Centre (which may not be effective as it is unlikely that the facility will be able to utilize the rapidly increased budget within a year) (Fig. 7). Given these major differences in budget, the pilot team opted for a different payment approach.

Fig. 7. Change between actual budget (2024) and estimated pilot budget (2025) for the five pilot districts/cities



Source: Sughd Regional Health Department and authors' own compilation.

Instead, the pilot would rely on a combination of the global budget (to cover salary costs) and the per capita payment for nonsalary-related expenditures. More specifically, the components of a facility budget within the pilot would consist of the following:[5]

- The global budget, calculated as the facility's actual salary cost in 2024 with an additional 40% salary increase as per the government decision (resulting in 46.4 million somoni). For facilities where ambulatory services are included in their structure, the actual spending for this service will also be paid in a form of global budget (total of 3.7 million somoni).
- The per capita budget component at the pilot level, defined as the difference between the total pilot budget and the global budget to cover the salary cost (resulting in 12.7 million somoni). This budget is then divided by the population of pilot districts/cities, giving a per capita allocation to be used when defining the contract budget of 27.3 somoni per person per year.

[5] This approach was used to calculate the facility budget within the pilot. The Government Regulation setting the legal framework for the pilot stipulates that the contract budget should be calculated using per capita (135 somoni) multiplied by the population, and coefficients to reduce major budget fluctuations are allowed. Thus, to comply with the set legal framework, for each facility the team calculated the coefficient (calculated by dividing the possible budget based on using 135 somoni per person per year, by the budget that would be paid by a combination of the global budget and the per capita payment for nonsalary costs).

The budget components to be paid for each facility are shown in Annex 1.

The approach of combining the global budget for salaries and per capita payment for nonsalary costs is a pragmatic implementation solution for the Tajik public finance and human resources context, which will push the system in the desired direction. The share of nonsalary budget at the facility level would increase, allowing facilities to allocate more funds to medicines and laboratory diagnostics (Table 1). In addition, the magnitude of inequality in de facto per person spending would decrease: in 2024 the highest and lowest spending varied between districts/cities from 62% to 124% of the average per capita allocation, while the new payment approach makes this range narrower – from 74% to 114%.

Table 1. Share of salaries in total facility spending in 2024 (actual spending) and 2025 (to be paid with global budget)

Pilot district/city	2024 (%)	2025 (%)
Asht	94	79
Devashtich	84	69
Istiklol	92	77
Kuhistoni Mastchoh	94	80
Shahriston	90	78

The proposed option of combining global budget and per capita payment is a temporary measure, as it has several significant disadvantages. As mentioned above, the current system of staff composition varies between pilot facilities and results in gaps in health-care service coverage. Fixed payment of the salary budget would prolong this situation and not create incentives to change it. It may also encourage facilities to further extend the number of positions (without necessarily having more doctors working in the facility).

The transition to a capitation payment incorporating entire facility budgets will require joint analysis of staff positions in all pilot facilities to understand the underlying cause of some facilities not being able to cover salary costs. To address this issue, both financing and service delivery measures would need to be taken (for instance, reducing the proportion of administrative personnel in staff composition, or reviewing and correcting the number of available positions without changes in composition of actually employed people). Another option for implementation of full capitation payment is to separate payment methods for family medicine and outpatient specialist care. In this case, full capitation should be paid for family medical services (as the differences in terms of staff availability are not as acute for this level of care), while another payment approach could be used for specialist outpatient care (for instance, the global budget).

At the beginning of the pilot, the per capita payment will not be adjusted to take account of age and gender, as the population structure is similar in the pilot locations. However, as the pilot is scaled up and the per capita component plays a bigger role in the payment structure, these and possibly other adjustments would need to be introduced to better reflect the health needs of the population.

Refined benefits package

Currently the scope of benefits in Tajikistan is defined according to Decree No. 600 of the Government of Tajikistan "On the procedure for the provision of medical services to citizens of the Republic of Tajikistan by facilities of the government health-care system" *(11)*. A recent WHO analysis shows that some of the benefits listed in various documents are contradictory *(9)*. In addition, the benefits package is neither linked to nor aligned with clinical protocols; national legislation does not establish any formal connection between the benefits package and clinical protocols *(9)*.

The pilot works with currently guaranteed services and rules on user charges, but the benefits are presented in a clearer and more understandable manner. The rationale behind not changing the scope of benefits is that Tajikistan is working on a comprehensive revision of its benefits package at the national level (with technical support from WHO); too many changes of benefits might be confusing for the population, and there are gaps in facility readiness to provide the standard guaranteed scope of services. Thus, the national-level review of the benefits is a parallel workstream and is not integrated into the pilot. The Sughd pilot benefits package is summarized in Box 2.

Box 2. Sughd pilot benefits package

The benefits package within the pilot covers the following services:

- Consultations provided by family doctors and narrow specialists.
- Prevention of communicable diseases (including vaccination) and NCDs.
- Confidential consultation on HIV and sexually transmitted diseases.
- Reproductive health consultations.
- Basic laboratory testing (general blood test as indicated; blood test for malaria; general test of donor blood for bloodborne infections; general urine test as indicated; microscopy of a smear from the urethra and vagina of a pregnant woman; sputum analysis; determination of sugar in the blood and urine as indicated).
- Basic laboratory diagnostics, including general blood tests, general urine tests, glucose tests, cholesterol tests, pregnancy tests, troponin tests, HIV tests, viral hepatitis B and C tests, SARS-CoV-2 tests, malaria tests and sputum analysis.
- Diagnostics and prescription of treatment.
- Basic palliative care services, including needs assessment, medication prescription and caregiver education.
- Antenatal care.
- Preventive dental care check-ups for children and pregnant women.
- Provision of medicines required during emergencies occurring within the facility and for the treatment of paediatric diseases, folic acid for pregnant women, and iron supplements for children and pregnant women.

Recent WHO analysis shows that the Tajik benefits package does not ensure access to outpatient treatment of key NCDs (hypertension, type 2 diabetes and asthma) *(9)*. The pilot considered covering this gap with an extension of benefits to include the most essential medicines, but for the first year of pilot implementation this extension was not included for budgetary reasons. Overall, the following options for specific implementation arrangements were considered: (i) regional-level procurement of medicines and distribution through family doctors; (ii) procurement of medicines by District/City Health Centres using the per capita budget; and (iii) reimbursement of medicines through pharmacies. After assessing the pros and cons, the team suggested starting with regional-level procurement of medicines, as physical access to pharmacies is suboptimal and the purchaser needs first to develop basic capacity in managing the contracts with health facilities. Another challenge concerned the correct assessment of demand for medicines because – as mentioned above – official statistics of disease prevalence underestimate the true number of cases; the lack of reliable data on actual health needs complicated the budgetary planning process.

Governance: autonomy of health facilities, financial management and use of data

The transformation in the governance sector includes the issues of how facilities can manage the funds and how data are used within the pilot. Broader transformations in governance are the subject of future reforms and are not addressed within the Sughd pilot.

The current Tajik system of public financial management does not permit more flexible and efficient use of public resources *(12)*. Heads of the District/City Health Centres have limited autonomy in use of public funds – for instance, permission from the local financial authorities is required to reallocate funds between items of expenditure. Typically, managers are held accountable for spending according to line items. Furthermore, the Government regulates the internal allocation of resources to rural service delivery units within facilities, but the regulation is hardly followed *(9)*. According to the regulation, when planning its budget, the management of a facility should prioritize expenditure on units located in rural areas (and specific allocations are set based on the per capita principle), but in practice this strict regulation does not result in equal allocation of resources, and there is inequality in actual expenditure for different rural service delivery points within a single facility because of differences in actual staff availability.

The pilot builds on transitioning from input-based controls to an output-based monitoring system, and there are new rules to establish greater financial autonomy and improved accountability. These rules can be summarized as following:

- managers of District/City Health Centres can increase salaries of family doctors and family nurses based on the number of people they serve;[6]
- performance payments to family doctors and nurses can be used to reward staff for achieving performance targets (the targets are to be set at the facility level);

[6] During the next stages of pilot implementation, the scope of incentives will be extended, as relying solely on the size of the catchment population can create incentives for not filling existing vacancies.

- when procuring medicines provided for within the benefits package, a facility should prioritize expenditure on treatment of urgent cases, prevention, and treatment of communicable diseases and NCDs, and is limited by the stipulations of the national essential medicines list (currently facilities often procure non-evidence-based and nonessential medicines using public funds);
- internal allocation of resources to rural service delivery units should be organized according to the actual number of people working, and distribution of medicines and medical goods should be planned based on the number of patient groups (for instance, children and pregnant women); and
- funds that are not spent by facilities by the end of the year are not returned to the local budget and should be kept by pilot facilities.

These adjustments are essential first steps in fostering trust and confidence in the reforms of facility governance, as currently there is a lack of trust at national and regional government levels that facilities are able to manage funds efficiently when given greater autonomy.

The pilot will also revise the reporting forms used at facility level, as well as introduce a monitoring and evaluation framework to understand if the planned objectives are achieved.

Service delivery organization: integration of vertical services into District/City Health Centres

The transformations in service delivery are limited to integration of vertical services into the general service delivery system. The pilot payment approach requires a more homogenous service delivery structure, as it envisages payment for a standard set of services. For this reason, the pilot includes activities intended to integrate vertical services into the District/City Health Centres. Within the pilot, this issue specifically concerns the health system in the Shahriston District Health Centre, where separate legal entities provided reproductive health and healthy lifestyle services, as well as integrated management of child diseases. These separate facilities had been integrated into the Shahriston District Health Centre before the pilot implementation. A similar approach will need to be used for other centres that join the pilot at later stages of implementation.

Challenges in early-stage pilot implementation and strategies to overcome them

After the pilot started on 1 January 2025, the pilot team encountered some unforeseen challenges concerning implementation.

The first set of challenges concerns the internal rules of the electronic system (SGB.net) used by the Treasury of Tajikistan. In preparation for broader health financing reforms, one-line accounting (involving payment of a lump sum) had already been implemented in the Tajik legal framework in 2023 (code 2.2.31), but in reality the electronic system could not process payments within this code. As a result, temporary measures were found to pay salaries, but payment for other expenditure was delayed. An update and additional IT (information technology) development of the payment module are required in the SGB.net system to allow payments. Another challenge was identified at the level of purchasing entity: the SGB.net system does not allow inclusion of the necessary number of people (including civil servants working on actual pilot implementation) to sign payment documents. Payments for ambulance care is challenging as well, as it was calculated separately from other types of care. The plan was that the line-item system would be used for this type of care, but it turned out that the electronic system could not manage two different approaches simultaneously. A more detailed assessment of the actual technical capacities of the SGB.net system is recommended before any further implementation of the financing reforms.

The pilot regulation envisages monthly payments to facilities. This creates problems for procurement of medicines and medical goods at facility level, as at least a quarterly allocation paid in advance is required for the facility to be able to organize tenders. This situation is likely to require amendments to the Government Regulation on pilot implementation.

The pooling of resources at regional level created challenges in collection of social taxes. According to the Tajik regulation, the social tax is paid into the budget at the level at which the salary source originates. Thus, the social tax of people working in the District/City Health Centres is planned, historically, at the level of districts and cities. Within the pilot, payments are processed at regional level, thus social taxes are paid into the regional budget. This creates a problem of district and city budgets not complying with revenues as originally planned. This should be considered at the next stages of pilot implementation, and local budgetary revenue plans should be amended accordingly.

Pilot scale-up and future national reforms

It is planned that the pilot will be scaled up to include more districts/cities of the Sughd region with a primary focus on districts/cities that are less dependent on regional funding. Expansion of the pilot locations should be accompanied by rehearsing pooling of health budgets, through transfer of local funds to the regional level (as the next step after funding the pilot with regional revenues).

This work is an important practice ground to learn lessons for nationwide reforms; it provides local proof of practice and gives a real-world example of how an alternative to the status quo is possible. When implemented, the pilot will generate the knowledge and capacity needed to implement national-level reforms. This includes the experience of the purchaser established within the pilot, which could be applied at the national level when the decision to establish a purchaser is made by the Government.

The current pilot design does not address all the health system challenges. This leaves space for synergies with transformations planned by development partners in Tajikistan. The scale-up of the pilot is possible not only by expanding the number of pilot districts/cities, but also by extending the system transformations within the current locations. Some of the most needed additional components to complement the current pilot efforts are increasing the capacity of the health workforce (for instance, additional education in the area of NCD management or broader reforms in increasing the responsibilities of nurses), introducing effective coverage of outpatient medicines, and creating a vision for the future development of laboratory diagnostics at PHC level in Tajikistan.

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Annex 1. Pilot facility budgets

District/City Health Centre	Ambulatory services (global budget)	Salary cost (global budget)	Per capita payment for nonsalary part of the budget[a]
Asht District Health Centre	3 104 995.00	21 220 043.25	4 969 687.20
Devashtich District Health Centre		12 949 387.50	5 182 440.00
Istiklol City Health Centre	644 162.50	3 525 004.00	520 971.60
Kuhistoni Mastchoh District Health Centre		3 260 925.50	687 355.20
Shahriston District Health Centre		5 408 140.50	1 328 341.20
Total	**3 749 157.50**	**46 363 500.75**	**12 688 795.20**

[a] This component of the facility budget is calculated using a rate of 27.3 somoni per person per year.

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