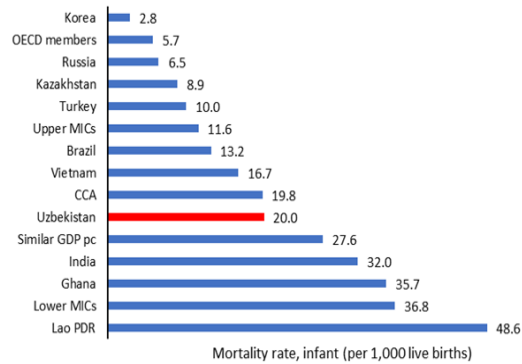


Spotlight 3. Health Expenditures

Uzbekistan’s health outcomes and government health spending are similar to those of its regional and income peers. Stunting is still high. Given the country’s substantial share of prime working age population, keeping adults healthy is also a key requirement for bolstering human capital and boosting productivity.

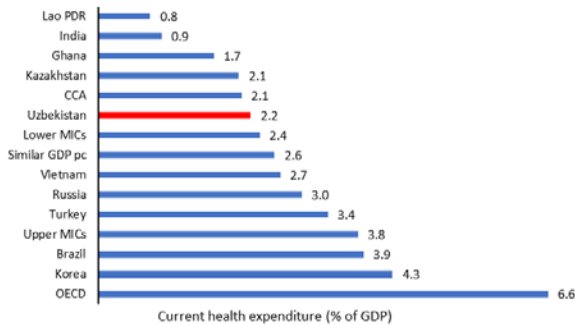
Uzbekistan has achieved significant improvements in key health outcomes. Life expectancy at birth increased from 69.7 years in 1990 to 73.5 years in 2014 and compares with 77.9 years in the EU. Infant mortality declined from 59.4 deaths per 1000 live births in 1990 to 20 deaths in 2017. Uzbekistan’s indicator on infant mortality is in line with the average for countries of the Caucasus and Central Asia and countries with similar income per capital. Uzbekistan does lag Korea, Vietnam and Turkey, however, its aspirational comparators (Figure S3.1). Vaccination coverage is high,¹ but nutritional outcomes are poor, and prevalence of severe and moderate stunting is 20 percent. Growing burden of non-communicable diseases leads to 84 percent of premature deaths in Uzbekistan and presents new health challenges. Mortality from cardio-vascular diseases, cancer, diabetes or chronic respiratory disease between the ages of 30 and 70 was 29 percent in 2015, more than twice the average for EU countries.

Figure S3.1. Infant Mortality Rate Per 1000 Live Births, 2017



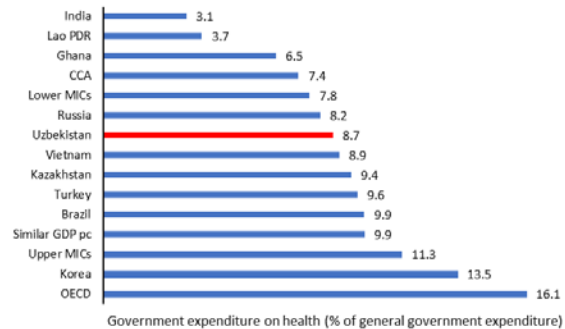
Source: World Development Indicators (2019).

Figure S3.2. Government Health Spending, 2018 (in percent of GDP)



Source: WHO Global Health Expenditure Database (2019)
 Note: For Uzbekistan 2018, for the other countries 2016

Figure S3.3. Government Health Spending, 2018 (in percent of budget spending)



Source: WHO Global Health Expenditure Database (2019)
 Note: For Uzbekistan 2018, for the other countries 2016

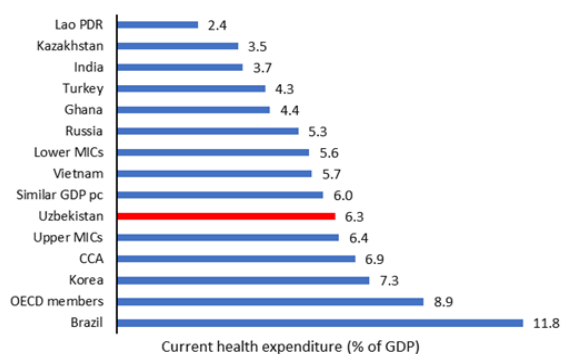
¹ Coverage of BCG, HepB3, DPT, Pol3, and measles was 99 percent in 2017 (WHO vaccine-preventable diseases: monitoring system 2018 global summary).

The Government’s program aimed at strengthening primary and preventive care has been recognized as a priority and its implementation is underway. However, curative care provided at hospitals and specialized outpatient facilities is still the dominant form of service delivery. New approaches to planning and financing are required to improve efficiency of the health care delivery system.

Government spending on health in Uzbekistan is not unlike that in lower middle-income countries and the average for the Caucasus and Central Asia. Both as a share of GDP and as a share of budget expenditures, health outlays are modest (Figure S3.2 and Figure S3.3). However, relative to the overall consolidated government spending, which is almost twice as large as on-budget expenditures, health outlays are well below any of the relevant comparators and closer to what India and Lao spend.

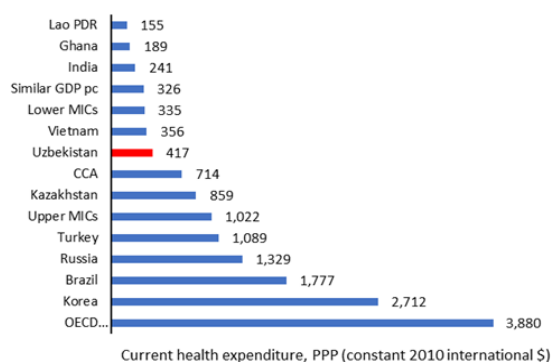
Largely due to higher spending by the government, overall health spending – both public and private – rose from 5.3 percent of GDP in 2007 to 6.3 percent in 2016. Overall health expenditures are little different from that in countries with similar incomes per capita and the upper middle-income countries (Figure S3.4). When measures in PPP terms, expenditure is little changed from the average for the Caucasus and Central Asia and closer to that average of lower middle-income countries in PPP terms (Figure S3.5).

**Figure S3.4. Total Health Spending, 2016
(in percent of GDP)**



Source: WHO Global Health Expenditure Database (2019)

**Figure S3.5. Health expenditure per capita,
2016
(in US dollars, PPP)**

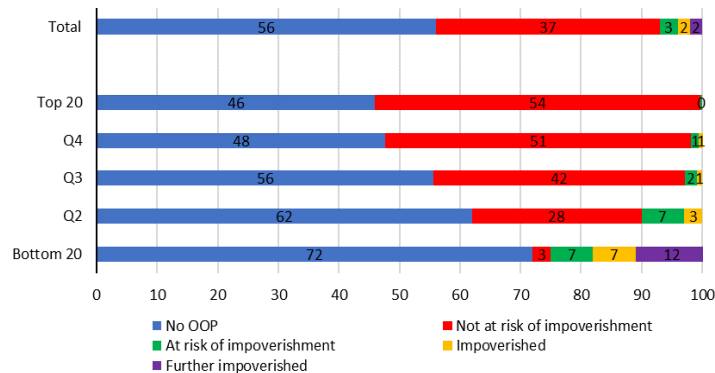


Source: WHO Global Health Expenditure Database (2019)

The share of private, out of pocket health spending is about half of the total health expenditures. Out of pocket payments (OOPs) represent a serious financial risk to the population. Concerns are increasing about the equity of healthcare services and its financing.

For households on social assistance, with disable members in the family or elderly over 65, the health care requires significant extra expenditure, which becomes impoverishing and represents a very significant source of vulnerability. About 7 percent of households from the bottom quintile face catastrophic health expenditures (more than 25 percent of their expenditures on health) and 3 percent of the population from the second quintile (Figure S3.7) are impoverished because of the catastrophic health expenditures (Carraro, Honorati et al., 2018).

Figure S3.6. Share of Households at Risk of Impoverishment Because of Health Expenditure by Quintile

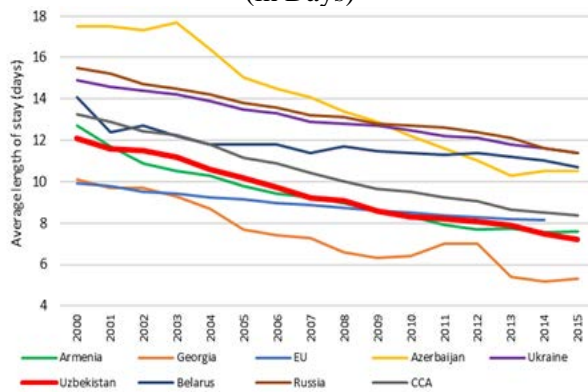


Source: Analysis of Listening to the Citizens of Uzbekistan 2018.

There is substantial room to improve the efficiency of the health system. Consider:

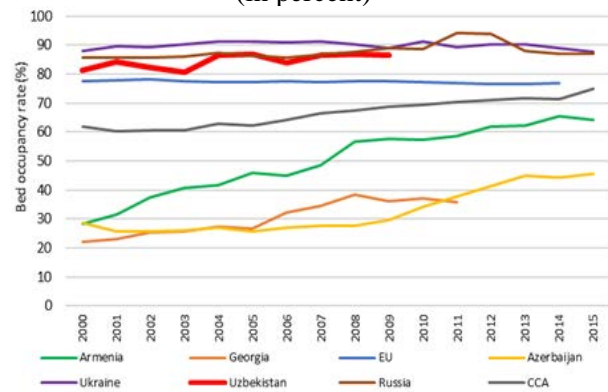
- Improving the quality and efficiency of health spending, and specifically on preventive care, is important to provide better and affordable health care to citizens. The healthcare system is still hospital centered with input-based financing, an extensive network of health facilities with heavy physical structure and staffing. On the positive side, while the average length of stay in hospitals is broadly similar to that in the EU, it is low compared to countries in the region other than Turkey (Figure S3.7). The bed occupancy rate is very high, which may indicate that patients are seeking care at later stages of illness, or that the population is being hospitalized for conditions that could be managed at the primary care level (Figure S3.8).
- In most cases, individuals seek outpatient care at the central regional hospitals. This allocation of resources is inefficient given that outpatient care at central hospitals is more expensive than at the primary care level. Preventive services also appear to be under-utilized.

Figure S3.7. Average Length of Stay, All Hospitals (in Days)



Source: WHO European Health for All (2019).

Figure S3.8. Bed Occupancy Rate, Acute Care Hospitals (in percent)



Source: WHO European Health for All (2019).

- The outpatient contacts per person were 9.7 in 2015, higher than in the EU on average. Further information is needed to understand the location (primary care level or hospital level) of those services. A shift in the health allocation way from hospital care to PHC will be needed, along with the appropriate per capita financing scheme, to improve the motivation for staff to deliver quality PHC services and adequate funds for basic medications and maintenance.
- The health management system has major challenges. Financing and organization of the health system still maintains the Semashko model, based on centralized planning of resources and personnel, primarily public ownership of health care facilities, input-based allocation of funds, and no clear provider-purchaser split. The Ministry of Health is responsible for the provision of services, while the Ministry of Finance and local authorities provide public funding from general revenues. Local authorities, financed by the central government, allocate budgets to health facilities using historical line-item budgeting largely based on inputs (i.e. doctors and beds). Expenses of health facilities are dominated by fixed costs (salaries and utilities), leaving very little space for service provision (including treatments, procurement of medical supplies, and consumables).

Uzbekistan is going through multi-dimensional modernization of all sectors, including the health sector, with the aim to identify areas for potential improvement and more efficient use of resources. A detailed analysis of the health sector through a health PER will review the challenges with the goal of improving health outcomes and providing coverage in an equitable, efficient and sustainable manner.

This short note on health will be followed by a full review of health expenditures in the next phase of the PER. Potential areas for the review, pending confirmation of government interest and data availability, include:

- Assessment of the efficiency of spending (human resources, medicines and inputs, infrastructure)
- Assessment of the efficiency of the service delivery model: spending on inpatient, outpatient specialists, outpatient primary curative, and outpatient primary preventive care.
- Assessment of specific health financing processes: contracting of health personnel, distribution of health personnel, financing modalities, procurement modalities for medicines and inputs.