Republic of Uzbekistan
Assessment of the Primary Health Care Reform: Transparency, Accountability and Efficiency

May 20, 2009

Poverty Reduction and Economic Management Unit
Europe and Central Asia Region

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CURRENCY AND EQUIVALENT UNITS
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FISCAL YEAR
(JANUARY 1 TO DECEMBER 31)

WEIGHTS AND MEASURES
METRIC SYSTEM

ABBREVIATIONS AND ACRONYMS

ADB  Asian Development Bank
CCH  Central City Hospital
CCDP  Central Consultation and Diagnostic Polyclinic
CEE  Central and Eastern Europe
CFAA  Country Financial Accountability Assessment
CIS  Commonwealth of Independent States
COM  Cabinet of Ministers
CPAR  Country Procurement Assessment Review
CRH  Central Rayon Hospital
CRU  Control and Revision Unit
DPT3  Diphtheria, Pertussis, and Tetanus Immunization
DHS  Demography Health Examination Survey
ECA  Europe and Central Asia Region
FAPS  Feldsherо-Акушерские Пункты - Feldsher (Obstetrician Posts)
FGD  Focus Group Discussion
GFS  Government Financial Statistics
GP  General Practitioner
GMP  Good manufacturing practice
GVP  Urban Health Post
IMR  Infant mortality Rate
ISN  Interim Strategy Note
JPIB  Joint Project Implementation Bureau
JSC  Joint Stock Company
LOS  Length of Stay
MDGs  Millennium Development Goals
MFERIT  Ministry of Foreign Economic Relations, Investment, and Trade
MICS  Multiple Indicators Cluster Survey
MOE  Ministry of Economy
MOF  Ministry of Finance
MOH  Ministry of Health
NCUM  National Center for Emergency Medicine
NTG  National Technical Group
O&M  Operation and Maintenance
OECD  Organization for Economic Cooperation and Development
OHD  Oblast health department
PDK  Postoyanno Deystvuyuushchaya Comissiya (Permanent Committee)
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The assessment of primary health care reform in Uzbekistan is based on the concept note “Development and Governance Constraints to Basic Service Delivery in Uzbekistan: A Sector-Based Assessment,” which was endorsed by the World Bank management on December 4, 2006. The review provided guidance to the team preparing this report on which sector to choose, what governance issues they were likely to encounter, and what approaches to take during their mission to Uzbekistan in April 16-30, 2007.

The team prepared the report in close collaboration with relevant government officials in the Ministries of Health and Finance as well as with local government officials. The government established an inter-ministerial technical working group comprising members from both ministries to provide inputs and comments to the World Bank team during the preparation of the report. Both the government and the Bank agreed to select the health sector and focus especially on primary health care where the Bank had been working with the government in implementing a reform initiative. To assess the impact of this health reform on governance, the government and the Bank agreed to select six rayons in two oblasts (Samarkand City, Jambyo, and Tylak in Samarkand oblast, and Margilan City, Toshlak, and Yazyavan in Ferghana oblast) to be included in the assessment. During the team’s various missions to Uzbekistan, it held workshops with the inter-ministerial working groups to discuss primary health care issues. It also held extensive meetings with government officials and service providers at the local levels on governance issues related to financial management, procurement, and human resource management in the health sector. To finalize the report the team held four consultation workshops to discuss findings and recommendations of the draft report with central and local governments and service providers (managers of SVPs and family polyclinics and financial managers). The final report accounted for comments from the government received in March 2009.

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EXECUTIVE SUMMARY

1. The main purpose of this report is to assess the degree to which progress has been made by the Government of Uzbekistan in increasing the transparency, accountability, and efficiency of its primary health services, and to identify what further steps could be taken to improve the effectiveness of delivery, some of which may be applicable to other sectors as well. The report examines public spending, public financial management, and human resource management and remuneration in the primary health care sector at the local level. It draws lessons from the experience of Ferghana and Samarkand, two oblasts that have implemented reforms in primary health care, and incorporates the findings drawn from other sources, such as public expenditure data, the laws and regulations governing these systems, and the Service Quality Delivery Survey (SQDS) conducted in 2007.

2. The government initiated primary health care reform in Uzbekistan in 1999 with support from the World Bank. At this writing the initiatives are nearly complete and the results achieved are noteworthy. Based on the SQDS, the majority of respondents expressed satisfaction with the improvement of primary health care services. Similarly, service providers have demonstrated that their morale and motivation have improved as a result of improved working conditions, retraining, and the availability of bonus incentives. However, in terms of governance (transparency, accountability, efficiency and thereby government effectiveness), the impact of the reforms has been mixed with a consequent increase in fiduciary risk. In particular, considerable challenges remain with respect to the transparency of public procurement, financial and management accountability, and efficiency in public resource management, all of which adversely impact the effectiveness of health service delivery. These challenges need to be addressed in a timely manner so that the achievements attained to date are not reversed and that the long-term sustainability of the reforms is ensured. This executive summary discusses the key governance issues related to improving service delivery in the primary health care area, and concludes with recommendations tailored to decision makers at the central and local government levels and those in local facilities.

Description of Primary Health Sector

3. Uzbekistan’s health system provides four main types of services: primary care (which distinguishes between rural and urban areas), secondary care, emergency services, and tertiary care. Primary health care services are provided by feldsher-midwifery posts, rural physician points (SVPs), polyclinics, and outpatient clinics in central rayon or city hospitals to citizens registered in their catchment areas. The services that they provide include primary diagnostics, disease prevention, minor surgery, prevention of infectious diseases, health surveillance for people at special risk, reproductive health services, and health promotion and education. According to the 1992 Constitution and the Law on Health Protection (1996), all citizens are entitled to a basic benefits package to be funded by the state. Patients generally make out-of-pocket payments for pharmaceuticals, except for exempted categories of patients whose drugs are provided free of charge. The patient is required to pay service charges (for diagnostic and laboratory tests) if one obtains care directly from an outpatient unit attached to a secondary or tertiary care institution.

Reform and Its Impact on Service Quality

4. The delivery of basic services—including primary health care, which is the responsibility of local governments—has been an important objective of the Government of Uzbekistan for the past 15 years. As a result, the quality of public services in the wake of the country’s independence
suffered relatively less in Uzbekistan than in neighboring countries that share a common heritage. Upon inheriting a Soviet-based health system in 1992, the government proceeded to decentralize authority over some financial resources and management responsibilities within the overall health system to local governments and eventually to health facilities. In 1996, the government initiated a reform to increase efficiency in the rural primary health care sector by trimming its overgrown structure and by diverting its focus from secondary care to primary care. The measures in this reform included: (i) rationalizing the health system by reconstructing or renovating infrastructure and providing medical equipment to facilities; (ii) introducing the concept of general practitioner doctors by providing training for potential general practitioners and for their nurses; (iii) increasing financial incentives to encourage health workers to improve their performance; and (iv) changing how facilities are financed from a line-item expenditure budget system to a per capita system. These reforms have been gradually implemented in pilot projects that began in three oblasts (Ferghana, Navoi, and Syr Darna) in 1999 with the support of the World Bank. The reform is expected to cover the whole nation by the end of 2008. In contrast, the reform of urban primary health care, which only began in 2006, is currently being piloted in four cities (Guristan, Margilan, Samarkand, and Tashkent).

5. At the heart of the health sector reforms is a multi-component, performance-based management model for health facilities. The decentralization of financial responsibility to primary health service facilities (SVPs and family polyclinics) in the areas where the reform has been implemented is the first step in devolving responsibility for all management and operations to the facility level. Basing their financing of each facility on the number of people whom they serve also adds to their autonomy by reducing the role played by the finance and health departments of the rayons in drawing up each facility’s detailed budget and allocating funds. Because they are now independent of central rayon hospitals, the reformed primary health facilities (SVPs and family polyclinics) now have more autonomy to manage their financial resources (including procurement and budget planning) than any other health facilities.

6. Since 1999, health facilities have also been able to establish their own Development Fund (in a separate account opened at a commercial bank) to help them finance items that have insufficient budgets. The resources contained in this fund mostly consist of additional budgetary resources (equivalent to 5 percent of the total annual budget of each facility financed from the facility budget) and any unspent cash balances at the end of each quarter. Health facilities have discretion over how these extra resources are spent provided that they are spent on salary incentives for medical personnel (such as bonuses or pay raises in return for good performance), outstanding accounts payable, and/or operating and maintenance expenses. These funds were designed to give health facilities some freedom from the Ministry of Finance’s tight control over budget execution as they are not subject to the same budget scrutiny as the ordinary budget.

7. The reforms achieved notable results as confirmed by the findings of the SQDS. In the primary care area, the delivery of health care services has improved, particularly in those areas where the reform was implemented early on (Ferghana oblast and rural areas where SVPs are present). More than half of the respondents of the SQDS (66 percent) indicated that the quality of their health care services had improved during the last three years. Patients are now increasingly seeking medical assistance from public health institutions because of their high quality of service, the prompt attention of doctors, and the fact that their services cost less than those provided by private facilities. Most consumers have relatively easy access to free primary health care because they live close to a health facility.

8. While primary health care in Uzbekistan has clearly improved over the last few years, considerable challenges remain as many health outcomes remain unsatisfactory. Uzbekistan’s progress towards meeting some Millennium Development Goal (MDG) indicators, such as infant mortality and under-five mortality, is slow. Child health and child morbidity remain a concern.
The neonatal mortality rate is high relative to the rate in other Central Asian countries, and two-thirds of neonatal deaths occur during the first days of life (mostly due to asphyxia and birth traumas). While the maternal mortality rate has decreased by more than half, pregnancy complications are still the major cause of maternal mortality. Mild and severe stunting among under-five children is prevalent, and HIV cases and TB incidence have increased.

**Key Public Spending Characteristics of the Health Sector**

9. One of the possible reasons why some of Uzbekistan’s health indicators are lower compared to those prevailing in some Eastern and Central European countries is that the financing of the primary health sector is insufficient. Despite an increase in government expenditure on health (from 2.3 in 2004 to 2.5 percent of GDP in 2006), the share of primary health care in the total health budget increased from 20 percent in 2004 to 21 percent of the total health budget in 2006.\(^1\)

10. Even after the considerable increase in real wages as part of the reforms (and the creation of Development Funds for salary incentives as noted above), the salaries of medical personnel remain insufficient to cover the cost of living. Anecdotal evidence from the survey indicates that wages in the health sector cover only between 30 and 60 percent of average living costs. As a result, some health care workers reported that they supplement their income with earnings from other sources, including non-medical entrepreneurial activities (such as managing a shop, drugstore, or café in urban areas or selling agricultural products from their own gardens in rural areas) and second jobs at other health facilities or private institutions. Several respondents in the focus group surveys mentioned that doctors and nurses had been absent during daytime hours.

11. Another source of income for some health care workers can be informal payments from the patients that they treat, but the nature of this remuneration appears to be ambiguous. While consumers are legally entitled to free primary health care, previous analyses have found that informal payments may be more of an issue in secondary and tertiary care than in primary care. Nevertheless, the SQDS conducted in association with this study revealed that as many as 42 percent of the population makes some kind of payment for services. However, there is a range of different circumstances in which patients may make gifts (in-kind or cash) to service providers as a voluntary expression of gratitude or make payments for materials or services without a receipt. Gifts or food as an expression of gratitude are common in close-knit communities, while money is preferred in the less cohesive urban communities. While no information is available on the proportion of such gifts or payments in health care workers’ total earnings, it is likely to depend on where the service provider works.

12. Despite the low wages paid to health care workers in Uzbekistan, personnel costs accounted for a large proportion of total health spending and thus limited fund to spend on other expenditures in the health sector. Available data from selected SVPs and family polyclinics in Samarkand and Ferghana oblasts indicate that personnel costs absorb between 80 and 90 percent of current expenditures at the facility level, as a result, the financing of current operating costs and new capital investment was insufficient compared to the need. In 2006, more than half of the SVPs spent less than 10 percent of their budgets on operation and maintenance costs and an average of 2 percent on medicines and bandages. In 2005-2006, average spending on repairs was around 3 to 4 percent compared with a general amortization rate in the country of 5 to 10 percent. This low spending on operations and maintenance affects the delivery of services, as mentioned by SQDS respondents.

\(^1\) Spending on primary health care increased to 23 percent of total public health expenditure in 2008.
The State of Governance in Primary Health Care

13. This section presents the key findings on the state of governance in primary health care, particularly those related to transparency, accountability, and efficiency. The analyses of the public financial management, public procurement, human resource management and the remuneration systems as well as the results of the SQDS provide consistent evidence of greater transparency in budget and personnel management. However, achievements in improving accountability and efficiency have been mixed and the ongoing reform efforts continued to be constrained by a variety of factors, such as: under-funding, a lack of progress in procurement reform, an emphasis on control rather than flexibility in financial and human resource management, and weak capacity related to internal and external auditing and of health personnel.

Transparency

14. Promising results have been achieved in increasing transparency in the management of public finances and human resources. The introduction of a per capita financing formula has increased transparency by removing the discretion of central rayon hospitals in allocating resources to primary health care facilities. The implementation of a new treasury system—unifying the budget and accounting system and strengthening budget planning, execution, and reporting piloted in several oblasts (such as Samarkand)—has achieved positive results, including more timely cash allocations to health facilities, reduced delays in direct payments to suppliers, and tightened control over expenditures. It has also enhanced local government capacity to prepare management reports, which are now more comprehensive, timely, and accurate. These reports are also available to the public on the website of the Ministry of Finance. These efforts have increased the transparency of budget execution, thereby helping to mitigate governance risks. The personnel management has positive features grounded in medical management practices. Recruitment is competitive and there are formal checks on major personnel decisions via labor code provisions.

15. Transparency in public procurement remains a concern. Public procurement lacks a unified legislative framework and clear guidelines for procurement operations. There is no single unit responsible for developing or enforcing a unified procurement policy in the health sector or for coordinating procurement operations under national or international programs. In fact, multiple government institutions and committees are involved at each stage of the procurement process, depending on the expenditure type, contract value, financing source, and the level of government (central and local) involved. Although this separation of functions and responsibilities was meant to minimize the influence of interest groups on the procurement process, the intention has been compromised by inadequate coordination and a lack of clear procurement rules.

16. Procurement practices in the health sector remain opaque. At the central level, the lack of standard bidding documents and clear evaluation procedures inhibits transparency of the tender process. Contract award decisions are not published nor announced, and the public’s access to information is constrained by the health sector’s lack of computer equipment and limited information technology infrastructure. Nor does the complaint mechanism seem to be effective. No complaints or protests from bidders or suppliers were lodged in the last four years, which, based on international experience, tends to be an indicator of a dysfunctional procurement system. The minimal independent scrutiny of procurement decisions and the lack of any comprehensive anti-corruption measures further increase corruption risks related to health sector public procurement. At the local level, SVPs (or family polyclinics) select suppliers without issuance of written invitations to quote; price lists are not available; and the scope of purchase, terms of delivery, and other critical supply conditions are not specified in the bidding documents.
Accountability

17. The impact of primary health care reform (and later accompanied by treasury reform) on accountability has been mixed. On one hand, the reform introduced strict monitoring of the budget (through detailed sub-item expenditures) and of health personnel performance. On the other, because health facilities have limited autonomy in making financial and human resource decisions to maximize outputs and outcomes within a given resource constraint, strict monitoring in some cases appears to have had an adverse impact on service delivery.

18. In spite of greater autonomy, financial and performance accountability are diluted by the dual subordination that a health facility is subject to: it is responsible to both the rayon and oblast health authorities and the rayon and oblast finance departments. Multiple layers of oversight—also evident in the large and variable number of institutions that support and oversee the SVPs’ human and financial resource management—do not promote accountability for performance because the policy, financing, and budget execution conducted by various institutions are not well coordinated. The transition of SVPs to their new financing mode has not been accompanied by any rationalizing of the control and oversight environment. In fact, there is evidence that the “old system” that preceded the Health I reforms is slowly returning, with rayon finance departments gradually reasserting their authority over the SVPs.

19. Limited control of the budgetary and Development Fund expenditures undermines the financial accountability of SVPs and polyclinics. Currently, the Development Funds are not subject to the same ex-ante control applied to the regular budget. Facility heads do not need approval of the spending requests by the rayon finance departments, although they are required to submit detailed quarterly reports on the use of development funds. This lax control provides scope for misuse. Further, the country’s limited capacity for conducting modern internal and external audits of budget and procurement transactions weakens the accountability of spending entities in the use of public funds and thereby increases overall fiduciary risk in the management of the health sector’s fund.

20. In terms of human resource management and salaries, government has placed substantial importance on enhancing a performance-focus and raising earnings levels of health workers. While the many positive advances deserve recognition, substantial challenges remain. The accountability of health managers and providers for health outcomes are mired by their limited autonomy over key management functions. Although the personnel management system is dominated by centrally set policies and regulations and is narrowly focused and overly rigid, it has several positive features: accountability of providers to the government, a focus on outcomes, the existence of staff performance evaluations, and competitive recruitment. However, basic personnel decisions—namely, the freedom to hire the number and type of workers best suited to local needs—are largely out of the hands of health facility managers and are set according to central government norms. Furthermore, a system that is geared more towards punishment than encouragement can lead to perverse incentives, particularly when evaluations are based on indicators that may be beyond the ability of health facility staff to control. This can lead them to falsify health indicators to give a more positive picture of their performance than is strictly accurate for fear of being punished.

21. Similarly, facilities have little leeway to depart from stringent, centrally set salary rules despite their new responsibilities for managing their own budgets. The remuneration system for health workers is based on a tariff net supplemented by a variety of allowances and payments, all of which are regulated by intricate rules. These allowances do little to supplement regular earnings in primary health care facilities, but extra pay increments due to length of service can add a considerable amount to a health worker’s earnings. Many of these allowances do not seem
to be widely-used in primary health care facilities with the exception of increments for length of service which can add a considerable amount to a health worker’s earnings. Salaries are modest at best, but the recent introduction of financial awards tied to various performance measures has been welcomed by staff and managers since it affords health facilities at least a limited degree of flexibility and local decision-making power.

Finally, the lack of involvement and voice of the population in health institution management is the weakest link in the management system for public health institutions. The lack of any organized consumer input is what makes it possible for health workers to demand informal payments for their services and impedes further improvement in the quality of the services provided by these institutions. Patient satisfaction surveys are not a common practice within the health system; consumers prefer to settle their problems verbally and unofficially without recourse to written documents. In the last two years, few consumers made official suggestions or official complaints, and most of them who did turned to their mahalla (local citizens’ assembly) committees. The household survey and focus group discussions revealed that, despite improvements, there is still plenty of room to improve the interactions between service providers and consumers.

**Efficiency in Resource Management**

Unpredictable delays in financing, most notably in the oblasts where treasury reforms have not yet been introduced, pose serious governance concerns and hinder efficiency. In addition to its tight control on sub-item expenditures, the government practices rationing in its monthly cash releases, delaying payments to SVP staff and suppliers. Consequently, the SVPs cannot execute their budget in the most efficient way because they have no way of knowing whether the promised funds will be available. This may force them to deal with suppliers willing to wait longer for payment rather than other less expensive suppliers. It also can skew their expenditures toward budget line items for which funds may be available but that are not required at the time. As mentioned above, it raises the general cost of doing business.

The ex-ante budget controls that the local government finance departments exercise over sub-item spending of the regular budget is not conducive to effective management of resources. The strict control contravenes the principle of increased flexibility implicit in the per capita financing approach for the SVPs and polyclinics. These controls effectively prevent health facilities from using their resources to achieve the best health outcome. As a result, health facilities remain locked into their approved spending estimates, with little opportunity to change the allocations to respond to changing circumstances. This rigidity also leads suppliers to increase their prices to compensate for expected payment delays.

Similarly, the ongoing treasury reform that consolidates the Development Funds into a single treasury account further reduces the financial flexibility of the SVPs and, therefore, efficiency in resource management. The consolidation of the Development Fund resources is aimed at improving cash flow management and reducing fiduciary risk. However, it implies that funds will be subject to strict control by the treasury, thus reducing health facilities’ flexibility in managing these funds to finance operational and maintenance costs, which was a key principle behind the introduction of the Development Fund.

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2 Budget organized by line item gives no information on the efficiency and effectiveness of programs. It ignores long-term strategic goals by focusing on short-term allocation of resources. Planning is neglected if focus is on historical activities and costs. The focus on detailed inputs leads to excessively tight ex-ante control of the details. Finally, line-item budgeting lacks a performance orientation in budget executors.
26. Generally speaking, ex-post controls, including internal and external audits, are geared towards finding and punishing compliance irregularities. Currently, no modern internal audit function exists in Uzbekistan. The Control and Revision Unit (CRU) and the Chamber of Accounts (COA) of the Ministry of Finance perform ex-post compliance audits on health facilities. The government is moving toward developing an internal audit capacity, which—if applied well—could make the control function a means of increasing efficiency in the use of resources.

27. The lack of transparency in public procurement has undermined resource efficiency and raised concerns about fiduciary risks. Cost effectiveness in procurement is undermined by a lack of clear definitions of the roles and responsibilities of the key players involved. As public procurement represents a substantial portion of health expenditure (40 percent of total health expenditures by the central government and up to 20 percent of health expenditure by local governments), achieving cost-effective procurement has the potential to generate significant savings in public resources. In fact, based on the experiences of other countries, governments can realize savings of as much as 20 to 25 percent through competitive public procurement.

28. The functionality of the procurement market is weakened by a lack of fair competition, which results in the over-pricing of drugs and equipment. Only 30 percent (on average) of reformed and 3 percent of unreformed SVPs use competitive bidding for procuring drugs and medical supplies. Competition is hampered by the lack of a comprehensive and clear regulatory framework, by non-transparent processes (as described above) and by multi-layered controls on the prices, quality, and certification of goods. In addition, the frequent occurrence of late payments and difficulties for importers/suppliers in obtaining foreign exchange tend to discourage competition as do the high costs of bidding documents—often as high as US$600. Finally, conflicts of interests in procurement are symptomatic of the absence of a level playing field.

29. At the local level, efficiency in resource management is undermined by the limited autonomy accorded to the SVPs as they are required to adhere to the approved list of mandatory drugs and spending plan (Smetas). They have no flexibility to form their own list of essential drugs within the existing standards while taking into account actual needs based on local conditions and seasonal factors. As a result, they end up procuring drugs that are not particularly relevant to the needs of the local community. Further, spending plans that do not account for seasonal factors result in medical supplies that are out of stock during critical periods and sometimes higher prices for goods and services procured.

The Way Forward

30. The audiences for this report are the decision makers at the central and local government levels. Most recommendations are modest in comparison with the identified weaknesses. However, they are designed to achieve measurable and realistic results in areas where the government and the World Bank have engaged in dialogue and are prepared to broaden and deepen the health sector reforms. Building on these findings and taking into account the limited capacity and resources available to the health sector, the report confines its recommendations to those discussed with the representatives of the central and local governments, and primary health care providers at the consultation workshops held during June 2-6, 2008.

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3 The CRU also verifies expenditure estimates when registered to ensure that they are correct.
For the Central Government

31. The central government has the overall responsibility for the formulation and approval of the laws and various policies in the health sector, especially in the areas of budget and procurement, health financing, personnel management and the remuneration system. Addressing the governance issues to improve transparency, accountability, and efficiency in the primary health care sector will require significant commitment and involvement of the central government from various agencies, especially the Ministries of Finance, Health, and Foreign Economic and Trade. The following recommendations were discussed with the government during the consultation workshops.

- To address the efficiency problems associated with the insufficient funding of primary health care, the government should (i) allocate more resources to primary health care through either an increase in the health sector's overall budget or through improvement in the efficiency of the hospital sector, both of which requires government financial support; and (ii) increase proportionally the budgets of health facilities to keep pace with wage increases so that facilities continue to have sufficient material resources to provide the best possible services to their patients.

- As efficiency is also being eroded by the existing functional organization and management, the report recommends that the government (i) eliminate dual subordination in the health sector; and (ii) eliminate excessive reporting requirements, inspections, and other administrative tasks that take time away from medical staff on providing health services.

- Attempts to reduce fiduciary risks by exercising strict control on health facilities has tended to limit autonomy and undermine efficiency. The government is therefore encouraged to maintain a balance between control and flexibility by (i) shifting the locus of the treasury's control of the SVPs' budgets (both regular and Development Fund budgets) from the sub-item level to the item level to increase efficiency in resource management; (ii) increasing facility managers' autonomy in making decisions related to recruitment (number and types of skills) best suited to local needs; (iii) maintaining the flexibility of health facilities in using the Development Fund once it is consolidated into a single treasury account by clearly separating the fund from the regular budget, allowing its end-year balance be carried over into the next fiscal year, and increasing flexibility to amend the planned allocation of the Development Fund throughout the year.

- Accountability and fiduciary risks go hand in hand: the latter increases if accountability is limited. To address these issues, the Ministry of Finance should (i) require that the Development Fund be subject to the same ex-ante control as the regular budget; and (ii) strengthen capacity related to the internal and external audits.

- Public procurement is the area of weakest transparency and that poses serious fiduciary risks. The report recommends that the Ministry of Health (i) improve transparency in public procurement by accelerating the completion of the procurement manual to offer guidelines and standard procurement documents to all health budget entities involved in public procurement within the existing framework; (ii) establish a central purchasing agency for the health sector and a procurement policy unit to ensure good procurement practices in the health sector; (iii) improve access to information on the approved health budget, procurement opportunities, and contact awards; and (iv) eliminate conflicts of interest in the cases of Dori Darmon and Uztibekhnikha.

- To improve the overall procurement policy framework, the Ministry of Foreign, Economic and Trade should (i) implement the last CPAR's recommendations (which
have not been put into practice because of lack of progress in reforming the legislative and institutional framework for public procurement but that remain valid); and (ii) eliminate product pre-registration and price verification practices, and reduce the sale price of bidding documents.

- To strengthen personnel management, the Ministry of Health needs to (i) remove factors that are outside an individual's control from the performance evaluation criteria; (ii) develop the criteria for the stimulation fund performance award system around principles such as provision of quality care, client orientation, adherence to good practice, and fulfilling job responsibilities; (iii) review guidelines for recruitment and promotion to ensure adequate guidance on the spirit as well as the process of competitive recruitment to enhance transparency and career development opportunities; and (iv) revise the pay structure by converting seniority pay to something that is more based on skills and performance.

**For Local Governments**

32. The proposed recommendations reflect the responsibilities of the local government, which are to implement the policies set down by the central authorities and to deliver primary health care service to the population.

- Develop technical specifications for the most frequently procured goods with prices below US$100,000.
- Increase the use of competitive procurement methods and consolidate procurement of some medical supplies at the rayon level to improve cost effectiveness.
- Consolidate procurement of some medical supplies for health facilities on a voluntary basis to lower per unit cost achieved from lump-sum procurement.
- Train financial managers of primary health facilities as well as rayon treasury personnel on modern public procurement practices to minimize fiduciary risks associated with limited capacity.
- Improve access to information on the approved health budgets, procurement opportunities, and contact awards.
- Establish a participation mechanism at the level of SVPs and polyclinics to increase consumers' participation in monitoring the delivery of primary health care services.

**For Reformed Facilities**

- Educate consumers about the reforms and patient responsibilities by posting signs at health facilities or distributing brochures to consumers.
1. INTRODUCTION

1.1 In 2006, the Government of Uzbekistan requested the World Bank’s assistance to help it to improve the delivery of basic services to its citizens. In line with its assistance strategy to the country, the Bank agreed to provide an in-depth review of the governance factors affecting service delivery in at least one sector. The World Bank selected the health sector in consultation with the government because of the government’s demonstrated commitment to and ongoing implementation of incremental reforms in primary health care (PHC) since 1995 with support from the Bank and other external partners.

1.2 The objective of this Health Sector Governance Assessment is spelled out in the Interim Strategy Note (World Bank, 2006), which noted the urgent need to improve governance by increasing the effectiveness of service delivery, the participation of civil society in improving service delivery, and government accountability for performance. This assessment will clarify the nature of governance challenges in Uzbekistan, assess how they affect the delivery of key basic services, and identify measures to strengthen governance.

A. THE SCOPE OF THIS ASSESSMENT

1.3 Delivering high-quality health services effectively in any given country depends on an efficient combination of financial and human resources and adequate amounts and timely distribution of supplies, and all of this is conditional on the existence of good governance. In the Uzbek context, good governance can be defined as accountability and transparency in the management of resources, leading to the provision of effective and cost-efficient services. Although there are many indicators to measure governance, they are not all relevant for the health sector. For this reason, this assessment focuses on specific issues that have significant impact on the quality of health governance (Lewis, 2006), including: (i) public health spending including the level of funding for wage and operations and maintenance; (ii) public financial management and procurement practices; (iii) management of health personnel and the remuneration system; and (iv) mechanisms for making providers accountable to consumers.

1.4 This assessment specifically focuses on local governments and their responsibility for public service delivery. This is appropriate for Uzbekistan for several reasons. First, the hierarchical governance structure means that the responsibility for the main elements of governance—such as political stability and the rule of law—rests with the central government. Second, local governments prepare and execute budgets and delivers public services. Thus, they are largely responsible for their own financial management accountability—ensuring that funds reach service providers and are accounted for. Third, the capacity to perform these tasks at the local level is limited, and specific responsibilities are not clearly defined or understood at the local and provincial levels. As a result, there is much potential for overlapping responsibilities.

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4 The literature has developed general principles related to good governance in the health sector, but it is limited mainly to a consideration of corruption. This narrow focus comes from the fact that the health sector is more prone to abuse, due to factors, including: uncertainty, asymmetric information, and the large numbers of dispersed actors that can split up information among different actors (regulators, payers, providers, patients, and suppliers), making the sector more vulnerable to poor governance and deterring transparency and accountability. These factors systematically increase the likelihood of corruption that is difficult to detect, deter, and punish and which hinders a free market from operating, thereby encouraging illegal behavior. See Savedoff and Hussmann (2006).

5 Only about 20 percent of the central government budget is transferred to local governments.

6 For example, the rule according to which budget users can transfer their quarterly savings to off-budget funds to be used at their own discretion.
and duplication. Finally, there are existing mechanisms that can be strengthened to enable local communities to voice their demands for public services and to monitor the actual performance of service providers, thus making service providers more accountable to consumers.

1.5 This assessment focuses on primary health care as provided by rural health points (SVPs) and polyclinics which are run by rural and urban local governments respectively and provide primary diagnostic and consultation, disease prevention and treatment, emergency care, health education and promotion and health surveillance to local communities and by their immediate higher-care counterparts in cities and rayons. We focus on the local level because these are the health outlets that are closest to clients (patients) and, therefore, may be the best conduit for involving citizens in the design and monitoring of actual service delivery. In the course of this assessment, we identify lessons learned from the ongoing reforms in primary health care that might be useful to move the more general health care reform agenda forward.

1.6 Because of time and resource constraints, it was decided to limit the assessment to a comparison of only two oblasts (one an “advanced reformer,” the other a “late reformer”) and a comparison of rural versus urban areas. This partial approach nevertheless allowed us to evaluate the impact of the reforms on various aspects of governance and health service quality. In consultation with the government, the Bank chose the Ferghana oblast as the advanced reformer because it had a long track record of rural PHC reform. Samarkand oblast was chosen as the late reformer. In terms of the rural versus urban comparison, it was found that the rural PHC reform was more advanced than urban PHC reform. Urban PHC reforms were initiated on a pilot basis only in 2006 in Ferghana (Margilan City) and in 2007 in Samarkand (Samarkand City). Each oblast included three rayons, one urban and two rural. In Ferghana, the selected rayons included Margilan (urban), Yazyavan (rural), and Tashlak (rural). In Samarkand, the selected rayons included Samarkand City (urban), Jamboy (rural), and Tylak (rural). Choosing these rayons made it possible to compare governance and service quality in the advanced and the late reformers.

B. METHODOLOGY

1.7 Because governance is a multidimensional concept and because providing health services is a complex operation, it was necessary to use several different methodologies in our analysis, including analyses of laws, reviews of the organizational functions and institutional arrangements of core health management systems, and public expenditures on health, anecdotal interviews, and surveys of service delivery.

1.8 Our findings are based on two main sources of information: (i) our own analysis of the key processes that underpin the health sector (resource allocation, public financial management, procurement, and human resource management and remuneration) and (ii) in-depth interviews of service providers and households and focus group discussions. As part of the first exercise, we reviewed qualitative data and analytical work relating to the legislative, regulatory, and institutional frameworks that prevail in the health sector in Uzbekistan and how local governments apply these frameworks to delivering health service.

1.9 We gathered our second source of information by carrying out Service Quality Delivery Survey (SQDS) that includes various structured survey modules (exit surveys, household surveys, in-depth interviews of service providers, focused group discussions, and facilities survey) built on work undertaken in the Bank’s Health I and II Projects. The surveys were carried out in six rayons of the two oblasts to find out whether consumers and service providers believe that the primary health care services being provided by local governments deliver effective outputs and outcomes to citizens and whether they are accountable. (Further details of the survey
C. The Organization of This Report

1.10 This report is organized in seven chapters. This introduction defines the scope and methodology of the assessment and outlines the content of the other chapters. Chapter 2 provides a description of the health sector in Uzbekistan and defines the governance issues.

1.11 The following three chapters contain our analysis of the three key issues central to governance in the Uzbekistan health sector—resource allocation, public financial management and procurement, and human resource management and remuneration. Chapter 3 examines the allocation of resources within the health sector and highlight the problems associated with the low level of funding available for health care services and specifically for primary health care provided by SVPs. Chapter 4 reviews the public financial management and procurement practices in the health sector and how these affect the care provided at the local government level. Chapter 5 discusses human resource management and the remuneration system in the health sector, reviewing current practices in light of whether they support or hamper local authorities in their attempts to deliver services effectively and efficiently. The chapter also identifies measures to improve human resource management at the local level, given the country's current capacities.

1.12 After this discussion of our quantitative findings, Chapter 6 discusses the results of our qualitative research—the findings of the surveys conducted to assess the opinion of consumers and service providers regarding the quality, access, coverage, pricing, and accountability of local health services. In the final chapter, Chapter 7, we summarize our findings regarding governance constraints and their impact on health service quality and provide a summary of recommendations for improving governance in the health sector in Uzbekistan and thus improving the delivery of primary health care.
2. THE STRUCTURE AND GOVERNANCE OF HEALTH CARE SERVICES

2.1 This chapter gives an overview of the evolution of the health sector in Uzbekistan since Soviet times, setting the context for a discussion of the key governance challenges that currently exist in the health sector.

A. RECENT HISTORY OF UZBEKISTAN'S HEALTH SYSTEM

2.2 The effective delivery of basic services—primary health care, basic education, and all municipal services under the responsibility of local governments—has been an important objective of the government of Uzbekistan for the past 15 years. As a result, Uzbekistan’s public services suffered less of a reduction in quality in the wake of the country’s independence than its neighbors with which it shares a common heritage. The country has made some progress in making structural reforms in recent years, but poor performance in the social sector continues to be one of its biggest challenges as it is in most low-income economies.

2.3 Uzbekistan inherited a Soviet-era health system. Its management structure was tightly centralized, was rigid in its norms and practices, and had limited flexibility to respond to local health care needs. Health services were provided mostly by the public sector through an extensive infrastructure that offered universal access to health care. The traditional health system was widely considered to be inefficient. It emphasized curative care at the expense of primary care, required patient to go through four layers of referrals to access hospital care, and was characterized by poor quality and under-financed facilities staffed by primary care providers with little or no expertise (or motivation) to meet people’s health needs effectively. At the time of independence, Uzbekistan had about 1,350 hospitals with 12 hospital beds per 1,000 people—twice as many as the average number of hospital beds in the Czech Republic, Germany, Hungary, or Austria.  

2.4 In the post-independence era, Uzbekistan moved away from central planning and decentralized responsibility for some financial resources and management functions within the overall health system. According to rules and regulations set up by the central ministry in Tashkent, regional administrations, through their health departments, were given some autonomy in these areas. The extent of this autonomy varied, and some regional administrations remained dependent on the central government for budget and management support.

2.5 In 1993, the government cautiously began the process of privatization by licensing 2,200 private pharmacies, optometry practices, and sanitary stations. In 1995, the Ministry of Health (MOH) issued a total of 2,500 official licenses for private medical practices. This privatization initiative greatly increased the number of private medical practices and the country’s total health expenditures.

B. THE HEALTH REFORM PROGRAM

2.6 Following the approval of the government’s priorities and a new legal framework for the health sector in 1996, the government approved the Public Health Care Reform Program, which

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7 OECD (2003) reported that there were notable variations in the number of acute-care beds, varying from a high of more than 6 beds per 1,000 populations in some European countries (Luxembourg, the Czech Republic, Germany, Hungary and Austria) in 2000.
aimed to rationalize the network of preventive and curative facilities, guarantee the provision of certain medical services free of charge at the state’s expense, and increase efficiency in budget spending in the health sector.

The Reform of Rural Primary Health Care

2.7 In 1996, the government initiated a reform of the primary health care sector in the rural area to shift the focus of the system from secondary care to primary care and to increase efficiency by trimming the sector’s overgrown structure and implemented the primary health care that includes financing and management reform measures. To understand the effects of the reforms, it is first necessary to know that there are five different kinds of rural health facilities in Uzbekistan:

- **FAPs (Feldershso-Akusherskie Punktys)**. Obstetrician posts are primary rural health facilities that provide basic pre-doctor services such as first aid, preventive care, and anti-epidemic work, promote good sanitary and hygiene practices, and act as early detectors of and take initial measures against infectious outbreaks. FAPs employ only mid-level health personnel (up to three people per post), such as obstetricians, doctor’s attendants, and nurses.

- **SVAs (Selskie Vrachebniye Ambulatorii)**. Rural outpatient clinics are primary care facilities staffed by specialist doctors (typically a pediatrician, internist, obstetrician, and dentist) to provide their catchment population with preventive and curative care.

- **SUBs (Selskiye Uchastkovye Bolnitsy)**. Rural precinct hospitals provide first aid and basic secondary care to the rural population in the areas far from other health facilities. SUBs serve a catchment area of about 10,000 people and have 30 beds on average.

- **CRHs (Central Rayon Hospitals)**. Central rayon hospitals are secondary health care facilities that provide both inpatient and outpatient services. In addition to purely clinical responsibilities, CRHs also function as local health authorities. They are financed by their respective rayon budgets and distribute budgetary funds to other rayon-level institutions. CRHs have about 300 beds on average and employ a range of health specialists.

- **SVPs (Selskie Vrachebniye Punktys)**. Rural health points are the main providers of primary health services in rural areas. An SVP employs at least one general practitioner (GP) and may include medical specialists providing a full package of medical and sanitary services, including the promotion of healthy lifestyles, primary diagnostics, disease prevention, minor surgery, and other primary services. There are four types of SVPs based on their catchment population (about 5,000 on average).

2.8 A key priority of the reform was to reduce the number of layers in the referral chain. Before the reform, rural patients had to go through four layers of bureaucracy before they could receive services from a central rayon hospital (CRH), but this was changed to enable patients to be referred to a CRH from a rural health point (SVP). The reform also rationalized the system by requiring almost all FAPs, SVAs, and SUBs to be transformed into SVPs or be eliminated.

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8 This was carried out through the Cabinet of Minister Resolution 182/1996 “On the Improvement of Rural Infrastructure.”

9 From a fedsher obstetrician point to a rural physical ambulatory center to a rural hospital and finally to central rayon hospital.
However, some SUBs and FAPs were left in the most remote and sparsely populated parts of the country. At the end of 2006, there were 1,658 FAPs, 14 SVAs, 135 SUBs, and 163 CRHs.

2.9 The reform also introduced the concept of general practitioners (GPs) and required some specialists to retrain to become GPs. It also adjusted the method of financing SVPs to a per capita system in which the allocation for each SVP depends on the size of the population that they serve (Annex A-1). The reform also increased facilities’ autonomy over the management of their own budget and staff and increased their ability to provide their staff with financial incentives to become more efficient and effective.

2.10 The World Bank supported these primary health care reforms. Its Health I Project (1998-2004) supported the gradual implementation of the reform, beginning with rural primary health care pilots in three oblasts (Ferghana, Navoi, and Syr darya), and was extended in 2004 to cover selected rayons in two more oblasts (Karakalpakstan and Khorezm). The Bank’s Health II Project (2005-10) has extended rural reform to eight more regions (including Samarkand), and the extension of rural PHC reform to all regions is expected to be completed in 2008.

Rural Primary Health Reform in the Ferghana and Samarkand Oblasts

2.11 The government implemented the rural primary health reforms earlier in some geographical locations than in others to test the reform idea and learn lessons to apply to the expansion phase of the reforms, and the Ferghana oblast was one of the pioneers. The Health I pilots were introduced in only three rayons in 1999. With several rayons being added every year, all 16 rayons in Ferghana oblast had become pilots by 2004. The government took a similarly gradual approach to introducing the sub-components of the reform that dealt with the legal independence of SVPs, per capita financing, the separation of SVPs’ balance sheets from those of the CRHs, the opening of bank accounts for the SVPs, the financing of SVPs from the oblast health budget, the introduction of general practitioners, greater autonomy for SVP managers in staffing, and the employment of financial managers.

2.12 By contrast, the Samarkand oblast has been a recent addition to the health reform. Having initiated the reform only in 2007, it is expected by the Health II Project to have extended the reforms to all of its rayons within only two years, even though it took more than five years to cover the whole Ferghana region. Six rayons in the Samarkand oblast have begun implementing the reforms, and the eight other rayons are to begin in 2008. Being on a tight timetable, Samarkand has had to introduce all of the sub-components as a single package (instead of testing them one by one as in Ferghana).

Urban Primary Health Care

2.13 In 2006, the government began implementing reforms in the urban primary health care sector. Services in urban areas are provided by polyclinics and urban health posts (GVPs). Polyclinics provide services to catchment areas that contain between 15,000 and 35,000 city residents and are usually staffed by between 10 and 20 specialist physicians who can refer patients to other specialists in central city polyclinics, city diagnostic centers, or hospitals. In

10 Along with three other oblasts according to Resolution 217, September 28, 2005.
11 The model was developed and introduced under COM Resolution 217 of September 28, 2005 and MOH Decree 12 of January 13, 2006. It covers the transformation of adult and children polyclinics into family polyclinics as independent entities with services to be provided mainly by GPs. Historically, health services for adults and children were provided by separate polyclinics.
12 GVPs have been introduced as experiments in urban areas that are far from city polyclinics. They have not become very popular, and their numbers remain very limited.
contrast, GVPs provide services to smaller communities (of 5,000 to 7,000 people) and have only two or three staff physicians. The new model for urban primary health care has been introduced in 25 pilot clinics in four cities (Margilan, Gulistan, Samarkand, and Tashkent). The reforms have established Central Consultation and Diagnostic Polyclinics (CCDP) in each city under Central City Hospitals as secondary care service providers staffed with specialist doctors to treat patients referred by general practitioners (Figure 2.1).

**Figure 2.1: The New Model of Urban Primary Health Care Services**

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   Central City Hospitals
       ↓
   Central Consultation and Diagnostic Polyclinics (CCDP)
       ↓
   Family Polyclinics
   Family Polyclinics
   Family Polyclinics
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**Secondary Care**

2.14 Secondary health care reform has been limited to a rationalization of the hospital system and a revision of its financing arrangements. Hospital rationalization has mainly entailed reducing the number of hospitals and hospital beds (a decrease of 31 and 47 percent respectively in 2007). The new financing arrangements involve the introduction of alternative sources of financing for hospitals, while preserving the guaranteed package of services that are provided free of charge and gradually replacing other expenses with out-of-pocket payments. As a result of the reforms, the structure of health expenditures on secondary care has changed considerably. Spending on inpatient services fell from 72 percent of total health spending in 1998 to 44 percent in 2005, while spending on outpatient services increased from 20.3 percent to 45 percent (UNDP, 2006).

**Emergency Services**

2.15 Among the most important components of the National Reform Program was the creation in 2001 of a comprehensive emergency care system. The National Center for Emergency Medicine (NCEM) was established to combine all facilities related to emergency aid, including the ambulance service, sanitary aviation. This consolidated pre-hospital and hospital care and increase the responsiveness and efficiency of the emergency services. Emergency units were also established at the rayon and city hospital level under the auspices of the NCEM.


14 Sanitary aviation (air medical service) is an emergency service whose primary purpose is to evacuate people in need of medical aid from remote and hard-to-access areas. Its tasks include transporting health workers and medical cargo using the fleet of helicopters, airplanes and motor vehicles.
Tertiary Care

2.16 To improve the delivery of medical services requiring special treatment and sophisticated technologies, in January 2003 the government established four specialized centers for cardiology, surgery, urology, and eye microsurgery. These centers are financed by service fees and are responsible for determining, for example, their own structural arrangements, the number of beds that they provide, and their remuneration system and wage package—all within an envelope of available funds. However, the government has reserved the right to provide free medical services in these centers to nine patient groups and to reimburse the centers from state funds.

C. CURRENT ORGANIZATION AND OUTCOMES OF THE HEALTH SECTOR

2.17 Since the introduction of these various reforms, the health system in Uzbekistan has been managed by a complex network of players (Figure 2.2), each with a distinctive role and responsibility. Three levels of government are active in the health sector: the MOH at the national level, the 14 regional (oblast) health departments, and the 159 district (rayon/urban) facilities. Each has various health care providers under its management and control. The MOH has overall responsibility for the organization, management, and operation of the health sector and, in turn, the oblasts. Oblasts exercise management oversight over the rayons and over city health-related activities. Rayons and cities manage the activities of the hospitals and clinics within their jurisdictions.

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16 These include children with disabilities, orphans, people with disabilities of categories I and II, veterans of and people who have incurred disabilities in the World War II, pensioners, participants in the “labor front” in 1941-45, people with disabilities acquired while dealing with the aftermath of the explosion at the Chernobyl nuclear power plant, participants in international wars (such as the Afghanistan war during the Soviet period), and families receiving social support.
The Presidential Resolution No. 700 dated October 2, 2007 established the central city/rayon medical union that became effective in 2008. The central city/rayon medical union replaces the rayon/city health departments shown in the above organization chart.

2.18 The outcomes of the Uzbekistan health system are mixed. Some health indicators in Uzbekistan have surpassed those of other Central Asian countries. Table 2.1 compares life expectancies at birth, maternal mortality rates, infant mortality rates, under-five mortality rates, and immunization rates among Central Asian countries. Life expectancy at birth in 2004 was higher in Uzbekistan than in Turkmenistan, Tajikistan, and Kazakhstan. Under-five mortality per 1,000 births in Uzbekistan was the second lowest after the Kyrgyz Republic in 2004, and the immunization rate for measles and DPT3 in Uzbekistan (in 2005) was the highest.
Table 2.1: General Health Statistics

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<th>Country</th>
<th>Life Expectancy at Birth</th>
<th>Infant Mortality per 1,000</th>
<th>Under 5 Mortality per 1,000</th>
<th>Maternal Mortality per 100,000</th>
<th>Immunization Rates 2000</th>
<th>Measles</th>
<th>DTP3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azerbaijan</td>
<td>71</td>
<td>72</td>
<td>84</td>
<td>75</td>
<td>105</td>
<td>90</td>
<td>25</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>68</td>
<td>65</td>
<td>53</td>
<td>63</td>
<td>63</td>
<td>73</td>
<td>50</td>
</tr>
<tr>
<td>Kyrgyz Rep.</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>58</td>
<td>60</td>
<td>68</td>
<td>110</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>63</td>
<td>64</td>
<td>92</td>
<td>75</td>
<td>119</td>
<td>93</td>
<td>45</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>63</td>
<td>63</td>
<td>80</td>
<td>80</td>
<td>97</td>
<td>103</td>
<td>14</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>69</td>
<td>67</td>
<td>65</td>
<td>57</td>
<td>79</td>
<td>69</td>
<td>34</td>
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<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

2.19 However, Uzbekistan's progress towards meeting some Millennium Development Goal (MDG) indicators, such as infant mortality and U-5 mortality, is slow. Although infant mortality declined from 35.3 in the early 1990s to 15.2 in 2004 and child mortality rates from 48.0 to about 20.6 per 1,000 live births, child health and child morbidity remain a concern. The most common cause of child death appears to be respiratory disease (40 percent of all cases). The neonatal mortality rate is high relative to the rate in other Central Asian countries, and two-thirds of neonatal deaths occur during the first days of life. Most neonatal deaths are due to asphyxia and birth traumas. While the maternal mortality rate has decreased by more than half from 65.3 per 100,000 newborns in 1991 down to 30.2 in 2004, pregnancy complications are still the major cause of maternal mortality.

2.20 The poor and the uneducated were less healthy, according to the Bank's recent Living Standards Assessment Update for Uzbekistan (World Bank, 2007). These groups had very little knowledge of diseases such as TB and HIV. The links between poverty, a lack of information and education, and poor health outcomes were evident in conditions such as anemia and stunting. However, the study did not find differences in health outcomes by gender or birth order among children within households.

D. RELEVANT GOVERNANCE OF HEALTH CARE SERVICES

2.21 Good governance is vital for delivering high-quality health services and producing positive health outcomes. In the Uzbek context, good governance can be defined as transparency and accountability in the management of resources, leading to the provision of effective and cost-efficient services. In this sub-section, we identify the key challenges facing developing countries and the Uzbek government in particular in terms of the governance of the health sector. In the rest of the report, we will explore the extent to which good governance prevails in the Uzbekistan health sector through our analysis of the allocation of resources, the public financial management and procurement, and the delivery of services in the sector.

Inadequate Funding of Primary Health Care

2.22 There is much evidence to show that primary health care in developing countries is inadequate. Developing countries, especially transition economies, tend to allocate most of their budgetary resources to hospital care rather than primary health care because budgets are set based on the size of facilities (defined by the number of beds and doctors). This low level of funding leads to: (i) low wages and salaries for health personnel and (ii) inadequate funding for operations and maintenance, which hampers the effectiveness and efficiency of health care service delivery.

2.23 As a result of insufficient funding, informal (under the table) payments for services have become a widespread practice in many developing countries. These payments can be defined as
“direct payments by patients for services they are entitled to for free, usually in the public sector, ranging from ex-ante cash payments to ex-post gifts in-kind” (Allin et al, 2006). The patient makes these payments directly to the doctor or other individual who provides the care that the patient requires. In the countries of the ex-Soviet Union and in Eastern Europe, these informal payments became widespread in the post Soviet-era, when state health systems could not deliver on their promises. After independence, the amount of resources available to fund for health services shrank even further, and as a result the pressure to resort to informal payments grew (Allin et al, 2006).

2.24 Various studies have found that some factors that could exacerbate this trend include: (i) the excess supply of health workers, (ii) their low paid salaries, (iii) the lack of accountability and government oversight of health personnel, and (iv) a lack of transparency in the system in general. Informal payments create an illegal and often under-reported parallel market for services within the public health system. The practice puts a heavy burden on the poor, often forcing them to sell assets or accumulate debt to meet these payment requirements.

2.25 Meager or unpaid salaries cause low productivity as underpaid workers are forced to find other ways to generate revenue, thereby reducing the amount of time they spend doing their health care job or developing their skills. Combined with a lack of resources to equip work stations adequately so that personnel can do their jobs, it is easy to see how job dissatisfaction and low motivation can take hold. Limited financial resources mean that managers do not have the option of offering bonuses and pay increases as incentives to raise productivity or to punish underachievers. This also has a negative impact on productivity and creates an environment that encourages inefficiency.

2.26 The absence of accountability mechanisms in the Uzbek health sector means that absenteeism is rife and workers are rarely punished or sanctioned for it. Absenteeism of health workers limits patients’ access to health care and lowers the quality of the care being provided (Lewis, 2006). This absenteeism can have both legitimate and illegitimate causes. One legitimate reason for workers’ absenteeism can be if they have to travel long distances to pick up salaries, drugs, or vaccines or to receive training, which is usually the case for those who work in remote, rural facilities far from their homes. Illegitimate reasons for absenteeism include workers’ own decisions to arrive late, take long breaks, or hold two jobs because of the low or unpaid salaries that they receive as health care workers.\(^\text{17}\) The end result of absenteeism is under-performance and poor delivery of health services for patients.

Public Financial Management and Procurement Practices

2.27 Poor financial management and poor procurement practices in the health service (including poor budget execution and record keeping, weak audits, limited capacity, and unclear roles and responsibilities) can create bottlenecks that prevent the timely flow of funds through the system. In turn, this can lead to delays in paying staff and in acquiring much-needed inputs such as for example, drugs or repairs and maintenance. These delays are serious because they can result in ineffective treatments and malfunctioning of equipment, thus triggering disruptions in health service access and delivery. At the very least, they result in health facilities having to pay higher unit prices to suppliers to meet the health system’s requirements.

2.28 Transparency and accountability in public financial management and procurement are crucial elements for delivering services effectively. In financial terms, transparency and accountability can be defined as the monitoring, auditing and accounting mechanisms that ensure that allocated public funds are used for the purposes for which they are intended. In many

\(^{17}\) In the literature, holding two jobs is considered a “coping mechanism” rather than corruption. See Vian, 2006.
developing countries, including Uzbekistan, governments do not have the financial and technical capacity to exercise such oversight and control functions effectively or to track and report on the allocation, disbursement and use of financial resources. This lack of financial transparency and accountability provides opportunities for corruption to flourish.

2.29 The procurement of essential drugs and medical supplies is a particular case where good governance is absolutely essential because the availability of sufficient reliable drugs, medical supplies and equipment encourages the continued and expanded use of health services (Cohen, 2006). Conversely, without proper oversight of this aspect of procurement, consumers cannot rely on the availability or the quality of drugs and medical supplies, drugs price to consumers can be set arbitrarily high, and drugs and medical supplies can be stolen and resold.

2.30 Studies have shown that, when drugs are not widely available and/or there is uncertainty about their quality, this discourages consumers from using health services. The smooth functioning of modern and effective pharmaceutical systems require key steps including drug registration, selection, procurement, distribution, and delivery (Cohen et al, 2002). Unless firm institutional checks and balances are in place, poor decision-making at any of these key stages could have disastrous consequences, including the contamination of the drug supply. Also, the process for selecting drugs to be included in the national drug list is full of opportunities for corruption and political interference. Because of the lack of a strong regulatory agency, a strong incentive exists for officials to demand and manufacturers to pay bribes to have their drugs included on this list of essential medicines.

2.31 Drug procurement is particularly vulnerable to corruption for numerous reasons. First, the method by which the Ministry of Health determines the national drug list is subjective due to a lack of clear criteria and the fact that the list is not updated regularly. Different suppliers use various and often inflated prices for the same drugs, and companies often create demand for their drugs through distorted and unregulated marketing and advertising (Cohen, 2006). It is very difficult for governments, including the Government of Uzbekistan, to set and monitor quality standards because of a lack of resources and institutional capacity. This lack of government oversight, enabled by lax inventory management, makes it possible for drugs to be diverted for sale at higher prices on the private market.

2.32 There are also many opportunities for corruption and mismanagement within health facilities at every level. Weak rule enforcement, vague procedures, and lax accountability encourage irregularities and petty theft, thus raising costs to patients.

Management of Health Personnel

2.33 Staff are often considered to be the most important determinant in the delivery of health care services. Yet, while staff can make a highly significant contribution to the effectiveness of a country’s health care regime, difficulties arising from staff issues can have a considerable negative impact on service quality. Poor personnel management can undermine the effectiveness of all of the resources—financial, material, or human—that the health sector has at its disposal. Therefore, this report analyzes specific subset of human resource issues—the key human resource management practices that shape the day-to-day working environment and the salaries and other financial incentives of primary health care staff. These include recruitment, performance assessment mechanisms, and oversight and accountability measures within the hierarchy of the health system.

18 In part, suppliers increase their prices to recover the cost of their capital that is tied up due to lengthy delays in payment by purchasing entities.
Consumers’ Opinions of the Quality of Service Delivery

2.34 Evidence worldwide shows that consumers’ participation in health care service can influence the quality of governance. This can be done through official complaints, patient satisfaction survey, and direct participation in an organization at the facility level to improve health care service. They strengthen accountability of service providers to consumers for the care they provide, and thereby contributing to better quality of care.
3. ANALYSIS OF RESOURCE ALLOCATION IN THE HEALTH SECTOR

3.1 In this chapter, we analyze the current state of public expenditures on health in Uzbekistan and find that funding for national health care in general and primary health care in particular is inadequate. This lack of funding results in low wages and salaries for health personnel and insufficient funds for the operation and maintenance of health care facilities, which in turn has negative effects on the governance of the health care sector. The analysis here is based on data from the Ministry of Finance on the budgets of the SVPs and the SQDS conducted by the World Bank in 2007 in connection with this report.

A. PUBLIC SPENDING ON HEALTH

3.2 Public spending on health care in Uzbekistan slightly increased between 2004 and 2006 both in absolute terms (in local and foreign currencies) and in relative terms (as a percentage of total government expenditure, as a percentage of GDP, and per capita) (Table 3.1). Within the social sectors, the share of health expenditure in total public expenditure increased from 10 percent in 2004 to 12 percent in 2006.

<table>
<thead>
<tr>
<th>Table 3.1: Health Expenditure, 2004–2006 (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Total Government Expenditure (excluding Target Funds)</td>
</tr>
<tr>
<td>Social Sphere, of which</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Health Care</td>
</tr>
<tr>
<td>Culture, Sport, and Mass Media</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Social Welfare</td>
</tr>
<tr>
<td>Relief to Families with Children and Vulnerables</td>
</tr>
<tr>
<td>Economic Expenditure</td>
</tr>
<tr>
<td>Centralized Investment</td>
</tr>
<tr>
<td>General Administration and Judiciary</td>
</tr>
<tr>
<td>Expenditure for Citizen’s Self-Governed Bodies</td>
</tr>
<tr>
<td>Miscellaneous</td>
</tr>
<tr>
<td>Memorandum Items:</td>
</tr>
<tr>
<td>Public Health Expenditure (Million Sums)</td>
</tr>
<tr>
<td>Public Health Expenditure (Million US$)</td>
</tr>
<tr>
<td>Public Health Expenditure per capita (US$)</td>
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<tr>
<td>Public Health Expenditure (% of GDP)</td>
</tr>
<tr>
<td>Public Health Expenditure (% of Total Government Expenditure)</td>
</tr>
<tr>
<td>Public Health Expenditure (% of Total Health Expenditure)</td>
</tr>
</tbody>
</table>

Totals may not add due to rounding.

Source: Ministry of Finance, Republic of Uzbekistan
3.3 This increase in health expenditure was mostly due to an increase in the wage bill (salaries and employers' contributions to the unemployment compensation fund, the pension fund, and trade unions). Wage expenditures increased from 60 percent in 2004 to 69 percent of total health sector expenditure in 2006, reflecting an increase in the wages and salaries of health personnel, especially doctors and medical personnel in rural areas. This was funded not only by an increase in the overall health budget but also by a reallocation of resources within the health sector from Chapter IV expenditures (which consist of operating expenditures on such items food, medicines, utilities, and renovations) to wages and salaries. As can be seen in Table 3.2, the share of non-wage expenditures (except miscellaneous expenditures) in total health expenditure fell between 2004 and 2006.

3.4 Despite the recent increase in the overall resource envelope for health care, it was still only 2.5 percent of GDP in 2006, which was lower than the level of resources allocated for education (6.4 percent). It was also less than the OECD average of 9.0 percent (in 2005) and the EU average of 8.9 percent (in 2001).19 However, it was higher than the 2.9 percent average in the Commonwealth of Independent States (in 2001).

Sources of Funding for the Health Sector

3.5 The resources for public health sector in Uzbekistan come from central government tax and non-tax revenues. They include taxes on income, profits, domestic goods and services, property, resource payments, municipality improvement, and social infrastructure, and customs duties. These taxes are collected by both the central and local governments and are all consolidated in the central government's budget.

3.6 The financing responsibility of the health sector in Uzbekistan is complex. The state budget for health care is allocated to the Ministry of Health, regional governments and Tashkent city, and to other ministries (such as Internal Affairs and Defense). The Ministry of Health is responsible for financing the network of State Sanitary Epidemiology Control Studies, the National Center for Emergency Care and its networks, the Tertiary Care center, and health facilities at the national level. Regional governments (oblasts) are responsible for financing: (i) the health facilities run by the oblasts and the rayons and (ii) family polyclinics in urban areas and SVPs in rural areas (that have been reformed and become legal entities). Local governments (rayons) are responsible for financing special health facilities (such as cardiology, neuropathology, etc) at the urban or district level and nonreformed urban family clinics and rural primary care units.

3.7 There are two methods for allocating resources to health facilities. The tradition method, inherited from the Soviet Republic, is based on input norms set by the Ministry of Health with the agreement of the Ministries of Finance and Labor such as numbers of hospital beds, doctors, and nurses in each facility. This is the method used to allocate budgetary resources to health facilities and institutions that are in parts of the sector that have not been affected by the ongoing primary health care reform. The second method is per capita financing which is applied to reformed

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primary health care facilities (SVPs and urban family polyclinics). The budget for each facility depends on a budget amount that is based on the total number of people enrolled in or registered with each health facility. The funds are pooled at the oblast health department and distributed directly to the reformed health facilities.\(^\text{20}\)

3.8 Another source of funding for health is a Development Fund, which was established by the central government of Uzbekistan in 1999 and modified in December 2005 as an extra source of support for health facilities to help them to finance the items that have inadequate budgets. They may only spend their Development Fund resources on salary incentives (such as bonuses or pay raises in return for good performance) for medical personnel, outstanding accounts payables, and operating and maintenance expenses. The resources contained in this fund come from several sources, including (i) budgetary resources from the health facility budget equivalent to 5 percent of the total annual budget of each facility are allocated to the fund each year; (ii) revenue from donors; (iii) fees paid for medical services (only from those health facilities that are permitted to charge fees); and (iv) any unspent cash balances in the budget of the health care facility at the end of each quarter will be transferred to the Development Fund. Each facility can establish its own development fund that accumulates resource from these sources. The development fund is held in a separate account opened at a commercial bank.

### Bias against Primary Care

3.9 When we analyzed health care spending by levels of care, we found that the allocation of resources within the health sector is biased against primary care. The share of expenditure on primary health care increased slightly in 2006, mostly due to an increase in spending by SVPs (Table 3.3). How much is spent on primary health care is partly dependent on the overall resource envelope for health care and partly on how those resources are allocated within the health sector. In other words, primary health care has to compete for funding with other sub-sectors in the Uzbek health sector, especially hospital services. Spending on primary care, which is considered to be more cost-effective in preventing disease and providing health protection, accounted for only 22 percent of total health spending in 2006; while 65 percent of resources went to hospital care.

3.10 The decline in hospital expenditure can be attributed to a reduction in operating costs. There have been changes in the distribution of the operating costs of inpatient and outpatient services over time. Table 3.4 shows that the operating costs of inpatient services declined from 72

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\(^{20}\) In January 2008, a new government resolution was approved requiring both regional and district authorities to return certain functions to district level, keeping per capita funding based on the number and gender composition of population assigned to the SVP. The law guarantees that budget funding reaches the SVPs intact from the district level. According to the Ministry of Health, the change was due to: (i) heavy workload on the staff of regional health care departments and regional finance departments linked with reviewing and registering the cost estimates produced by the SVPs, collecting and analyzing regular reports; (ii) difficulties for SVP financial managers in remote areas to travel to regional departments and needed relevant supporting documents to justify the business trip (receipts and tickets), high travel costs of the SVPs; and (iii) lack of mechanisms to determine the amount of budget allocations really needed for the SVP to perform its functions, and of mechanisms enabling regional health and finance authorities to oversee the activities of the SVPs and to control proper use of budget allocations.
percent of total health spending in 1998 to 43.6 percent in 2005. Similarly, the operating costs of outpatient services more than doubled from 20.3 percent in 1998 to 45.3 percent in 2004. This reflects in part a shift in priorities within the health sector due to the ongoing health reform away from providing expensive inpatient treatments to providing less costly outpatient care.

Table 3.4: Operating Costs in the Health Sector
(Percentage of total health expenditure)

<table>
<thead>
<tr>
<th>Composition of Operating Costs</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care</td>
<td>72.0</td>
<td>68.4</td>
<td>46.4</td>
<td>45.7</td>
<td>46.8</td>
<td>46.0</td>
<td>45.3</td>
<td>43.6</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>20.3</td>
<td>23.7</td>
<td>42.8</td>
<td>44.8</td>
<td>43.7</td>
<td>43.2</td>
<td>44.2</td>
<td>45.3</td>
</tr>
<tr>
<td>Preventive Activities</td>
<td>4.2</td>
<td>4.8</td>
<td>4.9</td>
<td>4.9</td>
<td>5.0</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Anti-epidemiological activities</td>
<td>0.6</td>
<td>0.7</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Other Expenditures</td>
<td>2.9</td>
<td>2.4</td>
<td>5.5</td>
<td>4.2</td>
<td>4.1</td>
<td>5.5</td>
<td>5.2</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Source: UNDP, “Health for All – A Key Goal for Uzbekistan in the New Millennium,” 2006

3.11 To better understand governance issues related to the under-funding of primary care, we analyzed the composition of SVPs’ expenditure financed by the budget and development funds (Table 3.5). Wages, salaries, and employers’ contributions accounted for about 80 percent of total expenditure by SVPs in both 2005 and 2006. This percentage stayed constant even though the wage bill of SVPs increased significantly by 70 percent in 2006. Meanwhile, SVPs spent only 15 percent of Chapter IV budget headings during the same two years.

Table 3.5: SVPs’ Expenditures Financed by the Budget and the Development Fund
(Percent)

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ordinary Budget</td>
<td>Development Funds</td>
</tr>
<tr>
<td>Wage and Salaries</td>
<td>64</td>
<td>14</td>
</tr>
<tr>
<td>Employer’s Contribution</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Chapter IV Expenditures, of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Repairs and Maintenance</td>
<td>2</td>
<td>38</td>
</tr>
<tr>
<td>Other Maintenance and Operating Costs</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Medicine and Bandages</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Repair and Overhaul</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purchases of Fixed Assets</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Finance, Republic of Uzbekistan

3.12 The introduction of the Development Fund has helped SVPs to increase Chapter IV expenditures. SVPs spent a large share of the Development Fund resources on Chapter IV items including current repairs and maintenance as well as purchases of computers, office equipment, and related supplies (Table 3.5). The Chapter IV expenditure financed by the Development Fund accounted for about 82 percent of total SVPs’ Development Fund spending in 2005 and 72 percent in 2006. Among the expenditures under the Chapter IV heading, SVPs spent nearly 40 percent of their Development Fund resources on repairs and maintenance. Fixed asset purchases by SVPs fell significantly from 18 percent of their Development Fund allocation in 2005 to only 2 percent in 2006.
3.13 The low level of funding for the health sector, especially for primary health care, has created several important governance problems in the health sector in Uzbekistan. They include informal payments and extra activities to cope with low wages and salaries, inadequate funding for operating and maintenance costs, and fiduciary risks. These issues are elaborated in the following sections.

Low Wages and Salaries

3.14 As a result of the low level of resources allocated to primary health sector, the wages and salaries of medical personnel have remained low. Even though the government increased wages several times in 2006, these increases were still insufficient to cover the cost of living. According to the SQDS, the official salaries of health care workers covered only between 30 to 40 percent of their annual living expenses. Their income, even including bonuses of up to 15 percent of a monthly salary, is not sufficient to support a family.

3.15 In recognition of these low wages, the government introduced the Development Fund in 1999. Each health facility was entitled to set up a Development Fund from which it could finance some of its operating and maintenance costs. In 2006, a government mandate required the facilities to spend up to one-quarter of their Development Fund resources on financial incentives aimed at increasing the motivation and improving the morale of its staff. These incentives may consist of paying a monthly premium on a worker's salary or a one-off lump-sum bonus equivalent to one month's salary as a reward for good performance.

3.16 Staff members working in the larger facilities have benefited most from these incentives funded by Development Funds because large facilities have more revenues from other sources to be accumulated in their Funds. In small health facilities such as SVPs, the bonuses and cash rewards are small in value but have a symbolic as well as a financial effect because they enhance staff's morale by recognizing their good performance. The interviews with the SVP chiefs conducted as part of the SQDS made it clear that these rewards bestow prestige on the medical staff, especially if the bonus is discussed and announced in public.

3.17 The low salaries paid to health care workers have a negative effect on governance when these workers adopt strategies to cope with their low pay. These strategies range from trying to solicit unofficial earnings on the job (mostly by requiring patients to make informal payments for services) to engaging in other income-generating activities such as when doctors work night shifts at ambulance stations or maternity houses, work at private clinics, or cultivate their vegetable gardens with the aim of selling their produce.

3.18 The low level of wages increases the likelihood that health personnel will demand informal payments from patients for services that ought to be provided free of charge. These unofficial payments can be in the form of either cash or gifts (which are difficult to document). Nevertheless, the surveys conducted in association with this study have revealed a wide range of circumstances in which patients have given gifts (in kind or cash) to service providers as a voluntary expression of gratitude or have paid for materials or services without receiving a receipt. No information is available on the relative weight of any such gifts or payments in providers' total earnings.

3.19 The extra activities that health care workers engage in to increase their incomes often tire them out, thus making them less productive in their health care jobs. They also have less additional time available to benefit from training and professional development. As a result, the quality of the health care services suffers because medical personnel are tired and do not develop
their skills. Also, if many personnel are absent from their health facilities during the daytime hours to earn additional income, the facilities may have to reduce their opening hours, thus limiting access to primary care services. Participants in the focus group discussions carried out for this report confirmed that this is indeed happening.

**Inadequate Funding for Operating and Maintenance Costs**

3.20 SVPs, central rayon hospitals, and polyclinics have habitually inadequate current operating (Chapter IV) costs and new capital investments. When these entities receive lower cash allocations from the rayon finance department than their approved budgeted amounts, they have to make spending on salaries and benefits a higher priority than operating and capital expenditures. In fact, Chapter IV is effectively a residual amount in these budgets that is determined only after all mandatory expenditures have been covered. SVPs allocate only about 9 to 10 percent of their annual budgets (excluding the development fund) to Chapter IV expenditures.

3.21 Table 3.6 shows spending by all SVPs in the Ferghana oblast during the 2006 fiscal year. One-quarter of all SVPs spent less than 5 percent of their regular budget on Chapter IV items, and two-thirds spent less than 10 percent. Conversely, 32 percent of SVPs spent more than 15 percent of their Development Fund resources on Chapter IV expenditures, and the remaining SVPs spent less than 15 percent of their Development Fund resources.

<table>
<thead>
<tr>
<th>Chapter IV Spending</th>
<th>Regular Budget</th>
<th>Development Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Total</td>
<td>SVPs</td>
<td>%</td>
</tr>
<tr>
<td>Less than 5%</td>
<td>70</td>
<td>26</td>
</tr>
<tr>
<td>5%-10%</td>
<td>111</td>
<td>41</td>
</tr>
<tr>
<td>10%-15%</td>
<td>52</td>
<td>19</td>
</tr>
<tr>
<td>15%-20%</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>20%-25%</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>25%-30%</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Greater than 30%</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>274</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance, Republic of Uzbekistan

3.22 It is not feasible to carry out a complete analysis of the level of maintenance expenditure required by the SVPs. Therefore, we estimated the level of maintenance expenditure from the data presented in the consolidated SVP financial report by the Finance Department of the Ferghana oblast for 2004 (Table 3.7). Under the assumptions given in the table below, SVPs’ annual repair expenses are equal to 3.6 percent of their total building and equipment asset values. This is low relative to standard amortization rates for all types of buildings of 5 percent to 10 percent, rates that would reflect a 20 to 10 year lifespan respectively for the buildings in question. However, should there be more actual assets that require repair and maintenance than is presented in the estimate; this percentage would be correspondingly reduced.

**Wage Expenditure and Fiduciary Risks**

3.23 The World Bank’s 2005 Public Expenditure Review for Uzbekistan expressed concern that personnel costs may be “crowding out” other expenditures in the health sector. The available
data from selected SVPs and polyclinics in Samarkand and Ferghana oblasts indicate that personnel costs constitute between 80 and 90 percent of the current expenditures of most health facilities. This is substantially more than the oblast-level figures (the average of all health facilities in each oblast) of between 67 percent and 72 percent. This finding confirms that SVPs are under more financial pressure than larger facilities because of their smaller budgets and their larger share of fixed costs.

3.24 It is clear that individual facilities are unable to control personnel costs. This is because these costs are determined by decisions made at the central government or oblast level about sectoral budget allocations, per capita financing rates, pay scales, and staffing norms. The Development Fund can only go so far in reallocating funds from personnel costs to capital or operating expenditures. In theory, facility managers could choose to leave positions vacant or lay off staff to free up funds to spend on other operating costs. However, there is limited scope for natural attrition of staff and even less for cutting jobs under prevailing social and economic conditions. Furthermore, the labor code requires trade union agreement for dismissals and other personnel actions and also requires staff who are being laid off to receive (modest) severance payments. Nevertheless, in the future, if facilities are given greater autonomy over their finances and staffing, innovative managers might be encouraged to rethink how their facilities operate.

3.25 High wage expenditures also present potential fiduciary risks. The system at present simply ensures that facilities receive the correct level of budgeted funds to cover their wage bills rather than ensuring that the payrolls themselves are accurate (for example, that there are no “ghost workers” on the payroll). The fact that payroll records are largely paper-based and salaries are paid out in cash also leaves room for improprieties. On a positive note, the Ministry of Finance carries out ex-post audits every two years to check that payments are indeed being given to genuine staff members, but these are not as reliable as more systematic, ex-ante measures would be. It was not possible in the context of this study to assess the extent to which such fiduciary problems actually arise in practice.

C. CONCLUSIONS AND RECOMMENDATIONS

3.26 Our analysis in this chapter has shown that the budget allocation to the health sector in Uzbekistan is low by international standards and in comparison with the allocation received by other sectors within Uzbekistan, such as education. It is also clear that, within the health sector budget itself, allocations are biased against primary and preventive care and in favor of hospital care. Also, both the national level and the SVP level, expenditures are overwhelmingly dominated by personnel costs (about 69 percent of total national health expenditure and about 80 percent of SVP health expenditure). This has left little money available to be spent on operation and maintenance, thus negatively affecting the ability of health facilities to provide good quality care.

3.27 There is a need to maintain the delicate balance in facilities’ budgets between personnel costs and other current expenditures. The low salary levels of health care staff are a real concern that the government has taken steps to address. However, it is no secret that wage bill expenditures dominate the budgets of health facilities, particularly SVPs which cannot bill for their services and have virtually no revenue sources other than their budget. Over the next three years, the government has pledged to make substantial real increases in the minimum wage, which is the cornerstone of the health sector wage grid. It is essential that the budgets of health facilities should be increased proportionally to keep pace with these wage increases so that

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21 Wage funds are allocated and transferred to facilities based on staffing norms rather than on actual numbers of employees. So if a facility reduced its staff numbers, it would not receive a smaller budget allocation.

22 There are some plans to introduce electronic payments to debit cards that would be linked to each individual’s bank account, but these plans appear to be at an early stage.
facilities continue to have sufficient material resources to provide the best possible services to their patients.

3.28 The low level of funding for the health sector, especially for primary health care, has created several important governance problems in the sector. In particular, it affects workers' remunerations, and facilities' repair and maintenance budgets. This has impacted on productivity and attendance of health workers and thereby limited access to services, and reduced the quality of the vital medical inputs that enhance the care provided by doctors.

3.29 There are two options for increasing the resources available for primary health care. First, if the government could increase the overall resource envelope for the health sector by collecting more taxes or reallocating funds from other sectors and ensuring that the budget for primary health care is increased by more than the rest of the sector budget. Alternatively, if funding is limited, the government could reallocate resources within the health sector by rationalizing the hospital sector, thus increases resource flows to the primary health care services.
4. FINANCIAL MANAGEMENT AND PROCUREMENT PRACTICES

4.1 Public financial management (PFM) is an important consideration in any study of governance. In the health sector, one important consideration is the extent to which the budgeting process—from preparation to final decisions on financing levels to actual monthly, quarterly, and annual expenditures—is truly transparent. A transparent financial management system ensures that the managers who make the decisions about the allocation and use of resources are identifiable and can be held to account for the results of their decisions. A second key aspect of good governance in the health sector is clarity and openness in the procurement of goods and services to minimize corruption and promote the rule of law.

4.2 Several donors in partnership with the Uzbek government have carried out several diagnostic studies of the PFM system in Uzbekistan in the past decade. The aim of these studies was to strengthen the Uzbek fiscal environment, improve the functions of the PFM system, increase the transparency of PFM operations, and make the PFM process more efficient and effective.\textsuperscript{23} For several years, the government was unable to respond significantly to the plethora of recommendations made by these numerous donors and consultants.

4.3 However, in 2006, the government adopted a Public Financial Management Reform Strategy (GoU, 2006) aimed at reallocating resources in accordance with the government’s priorities and policies, using public resources more efficiently to deliver services, and strengthening aggregate fiscal discipline. The government has since made significant progress in several areas of the reform strategy including modernizing the treasury system, introducing a unified budget and accounting system, and devising a medium-term expenditure framework\textsuperscript{24} and performance-based budgeting. The government’s budget is now published.\textsuperscript{25} Perhaps the most significant reform so far has been the implementation of a new transparent treasury system that aims to strengthen the treasury function, budget execution (cash management, payments, and financial control), and budget monitoring and accounting, thus increasing the transparency and accountability of public financial management in Uzbekistan. It was piloted in Samarkand in 2005, five more oblasts were added to the pilot in 2006, and from 2007 the system was introduced in all oblasts.

4.4 In contrast, the reform of the primary health care sector, especially the health financing reform, has been moving ahead since it was initiated in 1999. It mandated that budget allocations to reformed health facilities and institutions should be based on a population-based, per-capita financing formula rather than on the traditional line-item, input-focused formula. The budget allocations of these facilities were financed directly by the oblast health department. However, since January 1, 2008 the rayon finance department has been assigned the responsibility to allocate the budget to these reformed health facilities based on the per capita allocation calculated by the oblast health department. Prior to the implementation of the new treasury system, the facilities were responsible for the execution of their budgets to the rayon finance departments. However, they are now responsible to the treasury offices that have been established at the rayon finance departments since the new treasury system began operating in the pilot rayons.

\textsuperscript{23} These studies included a Country Financial Accountability Assessment (World Bank, 2004) and a Country Procurement Assessment Report (World Bank, 2003) conducted by the World Bank; a Public Financial Management Reform initiative in 2005-07, involving the government, the World Bank and the Asian Development Bank (ADB); a Public Expenditure Review (2005), and various budget studies by the International Monetary Fund (IMF).

\textsuperscript{24} See Ibid, page 3.

\textsuperscript{25} Aggregated budget parameters for 2003-2006 are published on its website.
A. MANAGEMENT WITHIN THE HEALTH SYSTEM

4.5 In this section, we discuss the organization and management of the health system including such issues as "dual subordination," the role of various organizations in planning the health sector's budget, the financial management capacity and oversight of SVPs, and performance-based management. These issues all affect transparency, accountability, and efficiency in the health sector to varying extents.

Dual Subordination

4.6 Although management responsibilities in the health sector appear to be straightforward (see Figure 2.2 in Chapter 2), the financing of these facilities is intricate and often results in "dual subordination," in which one entity is accountable for its performance to two separate organizations. For example, rayons and cities both have health departments that are accountable not only to the finance departments of the rayon/city governments (for budgeting purposes) but also to the oblast health department (for health care delivery). Thus, accountability for health service delivery differs from accountability for budget preparation and execution, and financing.

4.7 This presents a disconnection between financing and performance. Health facilities have two separate and distinct chains of accountability, on the one hand for their financial affairs and for their performance in delivering services on the other. For example, SVPs are closely monitored by the rayon health department and its medical specialists. On the financial side, SVPs are financed from the oblast budget and the oblast finance department oversees the preparation of their budgets, but the rayon SVP coordinator helps them to prepare their budgets. Both the oblast finance department and the rayon treasury department are involved in overseeing the execution of the budgets. Thus, the financial accountability of an SVP is complicated and indirect and in no way linked to the performance accountability chain.

4.8 These multiple chains of oversight and direction are not conducive to promoting accountability. While SVPs have been adopting their new financing formula, this has not been accompanied by any reform or rationalization of the traditional, complex oversight function. The government must ensure that the oversight mechanisms for performance and financing are mutually reinforcing and are designed to ensure that health facilities can be held accountable for all dimensions of the health care services that they deliver.

The Role of Health Budget Organizations in Budget Planning

4.9 Consistent with Uzbekistan's antecedents as a centrally planned economy, the central government formulates the strategic vision and framework for the health sector, sets priorities for the sector's future development, and determines funding priorities in the context of its overall expenditure plans. The Ministries of Health and Finance are fully involved in the development of health policies prior to the adoption of any final policy decisions. The Ministry of Health, in conjunction with the Cabinet, is responsible for implementing government policies on health care and for managing the sector's ongoing operations.

4.10 Despite being responsible for ensuring the financing of the health care system, the Ministry of Health is largely absent from the budget preparation cycle for the whole health sector. In the traditional budget preparation cycle, the Ministry of Finance prepares a budget for each sector after receiving separate budget proposals from the sector ministries and the oblast and

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26 This is a common approach in the Soviet governance model and applies to the central planning of every economic sector.
rayon health authorities, after which the Parliament approves the final aggregated budget.\textsuperscript{27} The Ministry of Health is only involved in negotiating the ministry's own budget,\textsuperscript{28} while the oblast and rayon levels prepare, negotiate, and execute the health sector budget by themselves without any involvement from the Ministry of Health. However, this budget preparation process does not apply to the SVPs because their budgets are based on a per capita formula, the annual amounts of which are set jointly by the Ministers of Finance and Health prior to the budget period.

4.11 Effective governance requires that entities be held accountable for their performance. Given that the responsibility for the operational effectiveness and efficiency of the health sector rests with the Ministry of Health, the ministry should have a bigger role in the entire budget preparation and execution process. In this situation, the managers of these facilities will be responsible for both the expenditures and the performance of their facilities as measured by health-based outcomes.

Financial Management Capacity and Reporting Oversight

4.12 Those health facilities (SVPs and family polyclinics) that have been subject to the primary health care reform are required to appoint a financial manager for each facility. A financial manager of an SVP or polyclinic in Uzbekistan is supposed to be “a specialist with a higher or secondary special accounting, economic, or financial education who has successfully completed advanced training in the course Accounting, Financial, and Personnel Management Fundamentals for PHC, or who has at least three years’ work experience.”\textsuperscript{29} These managers have a range of financial, economic, organizational, and administrative responsibilities (details in Annex A-2) and in practice are often in charge of procurement as well.

4.13 The lack of training received by these SVP financial managers leaves much to be desired in terms of accountability and good governance for financial operations and poses a significant fiduciary risk. It has become clear that SVP heads often hire financial managers with insufficient training and experience, which can lead in turn to problems with financial mismanagement. Many of the financial managers of the reformed SVPs lack the academic qualifications and experience specified in the job description. The Service Quality Delivery Survey (SQDS) showed that the financial managers of SVPs require a great deal of help from other sources to discharge their responsibilities for budgeting and reporting (Table 4.1).

<table>
<thead>
<tr>
<th>Organization</th>
<th>Samarkand</th>
<th>Ferghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rayon Health Department</td>
<td>64</td>
<td>77</td>
</tr>
<tr>
<td>Oblast Hospital</td>
<td>20</td>
<td>70</td>
</tr>
<tr>
<td>Rayon SVP Coordinator</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Financial Department</td>
<td>82</td>
<td>33</td>
</tr>
</tbody>
</table>

Source: Facilities Survey, The World Bank

\textsuperscript{27} Described in World Bank, 2003.

\textsuperscript{28} It also finances the State Sanitary Epidemiology networks, National Center for Emergency care networks, tertiary care centers, and health facilities at the national level.

\textsuperscript{29} See Ministry of Health Order 535 (December 2004), Annex 5, paragraph 1.
4.14 The accountability framework for SVP financial managers is obscure and fragmented. It is clear from our study of the SVPs in Ferghana and Samarkand that there is no common pattern of financial reporting consistent with what is expected of them by the oblast finance departments. Table 4.2 shows significant differences between Samarkand and Ferghana in terms of the percentages of SVPs reporting to different rayon and oblast organizations. Clearly, therefore, there is an urgent need to clarify the lines of authority in the financial management function within oblast, rayon, city, and SVP health facilities.

### Performance-based Management

4.15 At the heart of the health sector reforms is a multi-component, performance-based management model for health facilities and institutions. The model presents a systematic approach to performance improvement through an ongoing process of establishing strategic performance objectives, measuring performance, collecting, analyzing, reviewing and reporting performance data, and using that data to drive performance improvement (Oak Ridge Associated Universities, 2005). Such approach provides a focus on strategic performance objectives, a mechanism to link performance to budget, and a framework for accountability.

4.16 As a first step towards implementing this model, the reforms have decentralized responsibility for financial matters to primary service providers (SVPs and polyclinics) and now to the central rayon hospitals. They have clear goals, objectives, and activities in the primary health care. The managers of each facility are now accountable for preparing its annual budget and for developing and implementing a spending plan. The new treasury system can generate summary and detailed financial reports on how these facilities are implementing their budgets and can make them available to policymakers, budget managers, and the public.

4.17 For performance-based management to function, the organizational accountabilities, management responsibilities, delegated authorities, and allocated resources must be aligned. It also requires staff to have adequate skills and capacity, backed up by accurate job descriptions that identify the specific responsibilities of all staff positions. These factors must be combined with managers who are supportive of establishing transparent management accountability for performance. This will significantly enhance the effective governance of the health care sector.

4.18 The next major step will be to develop an IT-based system to capture key performance-based measures of each service provided by a medical facility. This would be complemented by a cost-accounting system to record data on the costs of providing each service, from which can be calculated the average (standard) and the ongoing actual costs of delivering them, thus making it possible to compare standard and actual costs. This system would provide facility managers with comprehensive financial and performance-based information on the performance of their health care facility.

4.19 However, it is unlikely to be possible to adopt any performance-based budgeting system given the financing practices that are now in place in the health sector. The Ministry of finance continues to exercise restrictive input-based controls over spending that prevent both reformed and non-reformed health facilities from using their resources to achieve the best health outcomes. The facilities are locked into the predetermined resource allocations set out in their budget

<table>
<thead>
<tr>
<th>Table 4.2: Reporting Relationships</th>
<th>Ferghana</th>
<th>Samarkand</th>
<th>Difference (Ferghana-Samarkand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To whom SVPs send Regular Financial Reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oblast Health Department</td>
<td>77</td>
<td>22</td>
<td>55</td>
</tr>
<tr>
<td>Financial Directorates</td>
<td>40</td>
<td>62</td>
<td>-22</td>
</tr>
<tr>
<td>CRH</td>
<td>56</td>
<td>46</td>
<td>10</td>
</tr>
<tr>
<td>SVP Financial Coordinator</td>
<td>37</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>Oblast Finance Department</td>
<td>22</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Rayon Health Department</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other (Tax, Social Security)</td>
<td>2</td>
<td>12</td>
<td>-10</td>
</tr>
</tbody>
</table>

*Source: The World Bank Facilities Survey, 2007*
allocation (SMETA) and have little opportunity to respond to changing circumstances. This control contravenes the principle of increased flexibility for SVPs and family polyclinics that was implicit in the adoption of a formula-financing approach.

B. BUDGET MANAGEMENT

4.20 This section discusses current practices in budget and financial management in Uzbekistan. It describes the current structure of the national budget and how it is executed and controlled and highlights the contradictions between the treasury reform and the primary health financing reforms in two areas: (i) how the ex-ante control of SVPs’ expenditure will limit SVPs’ autonomy and (ii) how the consolidation of all extra-budgetary funds including the Development Funds into a unified treasury account may restrict SVPs’ flexibility in spending their Development Fund resources. The treasury reform streamlines the treasury functions, improves cash planning and management by unifying all treasury accounts including all extra-budgetary funds, and strengthens cash payments, financial control, and budget monitoring and accounting. These measures are expected to increase the transparency and accountability of public financial management and increase efficiency in how resources are used.

Ordinary Budgets and Development Funds

4.21 The budget of the health sector in Uzbekistan has two components—the ordinary budget and extra-budgetary accounts. The ordinary budget consists of a common chart of accounts for both the preparation and execution of the budget. Expenditures are recorded by function (such as health care or education), by organization (such as Ministry of Health, a given oblast, or a given SVP), or by economic classification (such as salaries or utility expenditures).

4.22 After the Parliament approves the aggregated budget for the entire government, each budget entity submits an expenditure estimate (a SMETA in Russian) to the financial authorities for approval. The SMETA is a detailed distribution of funds classified according to the government’s chart of accounts. The financial authorities’ controllers use the approved expenditure estimate (SMETA) to ensure that every spending request from any budget entity is legitimate and that there are sufficient funds to cover the proposed spending as itemized in the SMETA.

4.23 The second component of the health sector budget is the extra-budgetary accounts or Development Funds that each health facility may set up to increase the resources available to fund certain specified parts of their operations. Parliament first approved the establishment of these funds in 1999 with the aim of giving facilities some relief from the financial authorities’ strict spending controls and to give them some flexibility in how they spent their resources (World Bank, 2004). Thus, they have maximum flexibility in allocating their Development Fund account balances, as long as they follow the Ministry’s prescribed priorities.

4.24 As discussed in Chapter 3, these Development Funds are financed mainly by resources equivalent to 5 percent of the total annual budget of the facility in question provided to each facility from the facility budget plus any unspent cash balances from the facility’s main budget at the end of each quarter.

4.25 In December 2005, the Cabinet passed a resolution extending the use of these Development Funds to cover salary incentives for medical and pharmaceutical workers. The aim was to increase the remuneration of medical and pharmaceutical workers, to recognize their good performance, and to provide incentives for them to improve their training and certification. All this would improve quality and increase continuity in the delivery of medical services.
4.26 The expenditures from these “incentive” funds had to follow certain priorities. First, a fixed percentage had to be spent only on salary incentives for medical staff, after which facilities could use the resources in these funds to pay any outstanding accounts payable and finance their Chapter IV operating and maintenance expenditures.

4.27 These funds played an important role in motivating health care staff at every level of the health care system as is clear from the responses that we got from the in-depth interviews of service providers and focus group discussions carried out for this report (see Chapter 6).

**Budget Execution and Control**

4.28 The internal control framework established by the 2000 Budget Systems Law (BSL) specifies the responsibilities of all parties and the processes to be followed in the preparation, approval, execution, reporting, and control of the nation’s budgets (World Bank, 2002a).

4.29 The budget execution controls are a combination of ex-ante and ex-post controls. In the health sector, the ex ante controls lie with the financial controller located at the finance departments of the rayon, oblast and central offices. They approve all expenditures after verifying that there is enough money in the sub-item of the budget estimate (SMETA) to fund the expenditure and that the proposed spending is within the budget amount approved by Parliament. After the controller’s approval, the facility may make the purchase or enter into the contract. When the goods or services are delivered, the controller ensures that what was delivered matches what was ordered and, if all is satisfactory, authorizes payment.

4.30 These budget execution controls do allow facilities some flexibility. A facility can change allocations between main expenditure items (salaries, payroll taxes, utilities, purchase of capital & equipment, repairs, O&M, etc.) up to 15 percent of the resources within the total approved budget amount for that particular facility. However, the interviews that we conducted with heads of SVPs and polyclinics indicated that most of them do not seem to understand that they are allowed to do this.

4.31 At the time that this study was conducted, controls are less stringent for Development Fund accounts than for regular budget accounts. However, the government is moving to consolidate all extra-budgetary development accounts into the main budget to improve efficiency in cash allocation and lower fiduciary risk, which may arise due to the lack of ex-ante controls on these expenditures. This will extend the Ministry of Finance’s ex-ante controls over the use of the Development Funds. If not carefully managed, this will severely limit the financial flexibility that was granted to the SVPs under the health reforms.

4.32 There are two forms of ex-post control—internal audits and external audits. In Uzbekistan, both controls are in place but need to be further developed and strengthened. The internal audit activities in Uzbekistan are performed by the Control and Revision Unit (CRU) of the Ministry of Finance; however, they are limited to mainly compliance-based inspections. The inspections of the financial transactions (both revenue and expenditure) that have taken place within an entity or facility to ensure that all rules governing the correct use of resources have been respected. The internal audit activities that identify problems for management to resolve (thus acts as an early warning system) have yet to be developed.

4.33 The Ministry of Finance has completed a feasibility study of establishing a modern internal audit function that could gradually absorb the responsibilities of the inspectorate (and some of its staff), but it is likely to be some time before this can be put in place. It will require significant time to recruit and train staff in modern internal audit techniques and to build internal audit units in all ministries and agencies.
4.34 The external audit function is exercised by the Chamber of Account, which operates outside of the government and its internal control framework and conducts periodic audits of all public entities that receive public funds on a cyclical basis and reports any violations to the entity itself and to Parliament.

Mismatch between the Treasury Reform and the Primary Health Care Reforms

4.35 Some elements envisaged by the treasury reforms have contravened the aim of the primary health financing reforms, which was to provide a degree of financial flexibility and autonomy to local primary health facilities. It is essential to resolve this problem so that the primary health care reforms are not negatively affected. For example, if the Development Funds are integrated into a single treasury account, they will also be subject to the same ex-ante control as the general health budget. Such control of the development funds will be in direct contravention of the intention of the primary health care reform to increase the autonomy of primary health care facilities through the per capita financing formula. It will reduce the already limited flexibility that health facilities have to set their own resource priorities and to use Development Fund resources to offer staff incentives and to cover their operating and maintenance costs.

4.36 Finally, a new treasury office is being set up in each rayon to record and process SVP contracts. It also conducts price verification function to ensure appropriate use of funds. At this stage of its development, the treasury office has significant capacity problems to perform this function due to a high staff turnover. In practice, this appears to curb the limited degree of authority over their own financial affairs that the health reform had given to SVPs.

C. PUBLIC PROCUREMENT PRACTICES

4.37 Transparent, accountable, and ethical public procurement that minimizes opportunities for corruption is an integral part of good governance. In the health sector, effective procurement practices are critical because delivering services entails the acquisition of goods and services and the purchase and maintenance of equipment and the buildings in which the services are delivered. Therefore, improving procurement practices have a direct effect on service quality and patient satisfaction.

4.38 In 2002, the World Bank and the Asian Development Bank carried out a joint assessment of the Country Portfolio Performance Review (CPPR) in Uzbekistan (World Bank and ADB, 2003), which found that the public procurement system in Uzbekistan was substantially underdeveloped and that procurement practices were not cost-effective and were susceptible to fraud. The report listed the weaknesses of the public procurement system as: (i) the absence of a unified legislative framework; (ii) inefficient and non-transparent procurement practices; (iii) the absence of a single institution with oversight or regulatory authority over public procurement; (iv) an underdeveloped system and weak capacity for reviewing bidders’ complaints; (v) the absence of any independent scrutiny of procurement contracts; (vi) the lack of any comprehensive anti-corruption measures; and (vii) the low level of skills and capacity of the staff handling public procurement transactions at every administrative level. The report also found that private sector suppliers and contractors were very unsatisfied with the rules governing public procurement and had little confidence in the fairness of the system and the ability of the procuring entities to conduct the procurement transparently and efficiently.

4.39 The report made a number of recommendations, most of which remain valid due to the limited progress that has been made in this area since 2003. The first recommendation suggested that the government should enact a Public Procurement Law and by-law acts, including a set of
implementing regulations, standard bidding documents, evaluation reports, and should make it mandatory for all procuring entities to use contract forms for procuring works, goods, and services. Second, the report recommended the establishment of a regulatory agency on public procurement that would review bidders' appeals. The third recommendation was to develop and implement a procurement capacity-building plan to build in-country capacity and mobilize resources to train public officials in procurement. The final recommendation was to set up audit units within all ministries and spending units to audit the control system as well as conduct regular internal ex-post audits of random procurement operations.

4.40 In this section, we discuss the legislative and institutional arrangement for public procurement in the health sector and current procurement management and practices by central and local governments including procurement responsibilities and processes (bidding, contract administration, and inspection) in the health sector.

**Procurement Responsibilities in the Health Sector**

4.41 The legislative and regulatory framework for public procurement in Uzbekistan is complex and confusing and contains many loopholes, creating opportunities for bidders to manipulate the procurement process. In the absence of a unified public procurement law, different procurement regulations apply to specific expenditure categories, and this contributes to the lack of transparency in the procurement process. Different procurement methods apply to goods, drugs and medical supplies, civil works, and consulting services. A further complication in the health sector is that small-value contracts under US$100,000 at the decentralized (oblast) level remain unregulated. This means that the responsibilities for the various aspects of procurement are complicated and unclear and often overlap.

*Assessing the Needs of the Health Sector and Preparing Procurement*

4.42 Responsibilities in the procurement process are held by many different agencies at both the central and local levels. At present, several entities share the responsibility for the procurement of medical equipment, supplies, and drugs at the national level. The Ministry of Health formulates and enforces rules and regulations governing procurements and organizes the supply of drugs, medical equipment, and supplies. Within the Ministry, the Center on Drug Policy\(^30\) implements the national pharmaceutical policy and is involved in developing the National Essential Drug List and the methodology used to assess the demand for drugs and other medical supplies as well as to identify health facilities’ drug requirements. The Coordinating Council on Medical Equipment is a government body responsible for identifying the sector’s needs for medical equipment and for supplying this equipment to health facilities and ensuring that it is properly maintained. In cooperation with relevant Ministry of Health departments, the Tender Committee is in charge of central-level procurement by the Ministry of Health based on health facilities’ requests. The Ministry’s Departments for Preventive and Curative Care, for the Development of Technical and Material Capacity, and for Maternal and Child Health and specialized agencies (such as the Center for Drug Policy) participate in identifying required inputs for maternal and child care, preparing technical specifications, and providing expert review while the bids are being evaluated by the Tender Committee. Finally, the Joint Stock Company

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\(^{30}\) The center was established in December 2001. Some of the center's functions relate directly to improving existing procurement practices, as it can make suggestions regarding the organization of the public procurement process and can recommend revisions in legislative and normative acts related to the procurement of drugs and medical supplies and the use of humanitarian aid. The center also performs market research and, if requested, may provide support in preparation of tender documents and carry out procurement of drugs and medical supplies. It is also involved in monitoring procurements by health facilities and the effective use of drugs and medical supplies.
Uztibtekhnika, a state-owned enterprise, is responsible for assessing the medical equipment needs of health facilities and developing feasibility studies and investment projects also for health facilities.

4.43 Table 4.3 summarizes the roles of the key agencies in health sector procurement at the central level including purchasers, tender evaluation, technical evaluation, contract signatory, and consolidators and distributors. A complete description can be found in Annex A-4.

Table 4.3: Roles of Key Agencies in the Health Sector Procurement at the National Level

<table>
<thead>
<tr>
<th>Types of Goods Procured</th>
<th>Procuring Agency</th>
<th>Tender Committee</th>
<th>Working Group</th>
<th>Contract Signatory</th>
<th>Consolidator and Distributor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical supplies financed by the state budget</td>
<td>MOH</td>
<td>Inter-ministerial Tender Committee</td>
<td>Uzmedexport</td>
<td>Uzmedexport</td>
<td>Uztibtekhnika</td>
</tr>
<tr>
<td>Socially significant and emergency care drugs</td>
<td>MOH or Uzmedexport</td>
<td>Inter-ministerial Tender Committee</td>
<td>Uztenderconsulting within the MEFRT</td>
<td>Uztenderconsulting within the MEFRT</td>
<td>Uztenderconsulting within the MEFRT</td>
</tr>
<tr>
<td>Goods and Services for projects financed by the World Bank and the Asian Development Bank</td>
<td>JPIB</td>
<td>Inter-ministerial Tender Committee for goods greater than $100,000 equivalent</td>
<td>Uzmedexport</td>
<td>Uzmedexport</td>
<td>Uztibtekhnika</td>
</tr>
<tr>
<td>Goods and services for projects financed by the Islamic Development Bank</td>
<td>Project Implementation Group</td>
<td>Inter-ministerial Tender Committee</td>
<td>Project Implementation Group</td>
<td>Project Implementation Group</td>
<td>Project Implementation Group</td>
</tr>
</tbody>
</table>

**Decentralized Procurement**

4.44 At the decentralized (oblast) level, health facilities (primarily hospitals and SVPs) are the main procuring entities. They are responsible for procuring the supplies and equipment that they need paid for out of their allocated budgets. Main expenditure categories are goods, which includes drugs, medical supplies, and consumables and minor rehabilitation works. Each facility has a tender committee established annually by the orders of a chief doctor, which is chaired by the deputy chief doctor and includes facility staff. Contracts at this level tend to be well below US$100,000 and the chief doctor signs the contracts. Table 4.4 outlines the distribution of procurement responsibilities between procuring entities by expenditure categories.
Table 4.4: Procuring Entities, by Expenditure Category

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>MOH (central level)</th>
<th>Health Facilities (Decentralized level)</th>
<th>Local governments</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Goods, including:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Centralized Public</td>
<td>Rare occasions for basic equipment</td>
<td>No</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>Procurement (more than US$100,000 and donors' projects)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>IT equipment</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Communication Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Reagents and Consumables</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Maintenance Services</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>II. Civil Works, including:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Construction and Renovation</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Minor Rehabilitation</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>III. Services, including:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultancy Services</td>
<td>Donors' projects</td>
<td>No</td>
<td>Development of detailed technical designs by inhouse engineering unit at</td>
</tr>
</tbody>
</table>

4.45 Recognizing the need for procuring entities to be properly regulated and for procedures to be consistent, the Ministry of Health is developing a procurement manual for medical facility staff. This is especially important at the oblast level where SVPs handle their own procurements of goods and services. It is envisioned that the manual will: (i) define the duties and responsibilities of all participants in the procurement process; (ii) include a detailed description of administrative regulations and applicable procurement procedures; (iii) include model bidding documents and contract forms and give sample specifications for standard or frequently purchased items; and (iv) set out procedures for handling complaints.

The Procurement Process in the Health Sector

4.46 The procurement process is complicated and time-consuming and involves several parties and stakeholders. These processes are managed by both central and local governments. This subsection describes how these steps are implemented.

Procurement Planning and Budgeting at the Health Facility Level

4.47 Health facilities must adhere to approved standards when procuring specific inputs. Each health facility is required to prepare its own roster of drugs, based on the national standards drugs, and have it approved by the tender committee at the rayon or oblast level.

4.48 The Facilities Survey that was carried out for this report showed that health facilities rarely spend their budgets on medical, laboratory, or other equipment (Table 4.5). This is because these items are usually procured by the central government (financed either from the central budget or from donor loans, credits, or aid) and then distributed to the facilities. The extent to which health facilities conduct their own procurement depends on their available budget estimates.
Table 4.5: Expenditure Categories, by Health Facility Type, 2007

<table>
<thead>
<tr>
<th></th>
<th>Samarkand</th>
<th>Ferghana</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td>SVP</td>
<td>CRH</td>
</tr>
<tr>
<td>Drugs</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>100</td>
<td>65</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Maintenance Service an-</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>Renovation of Building</td>
<td>27</td>
<td>62</td>
</tr>
</tbody>
</table>


4.49 Health facilities tend not to do any procurement planning, which means that most of their procurement is ad hoc. What little procurement planning is done by health facilities is, in fact, budget execution planning. It is limited to the preparation of monthly projections, calculated by dividing their annual budget allocation into 12 equal portions. This monthly slice of the budget, therefore, becomes a ceiling for contract payments due in any given month. No adjustments are made for any fluctuation of demand for medical supplies (mainly pharmaceuticals and consumables) during the budget year. As a result, health facilities are often confronted with drug and supply invoices that exceed the monthly allocation, which means that they have to delay paying the suppliers (in most cases for 30 to 45 days). Because this situation occurs quite routinely, suppliers factor these delays into their prices in the next round of procurement.

4.50 Most of the contracts signed directly by health facilities cover the whole budget year and are equivalent to the annual allocation amount. This practice is especially common in the procurement of drugs, reagents, and maintenance services. However, one-time orders are often not properly documented because they are procured from one supplier without having made any price comparisons. Furthermore, health facilities tend to place a one-time order with another supplier during the year without amending the main contract with that supplier whose total contract value is equivalent to the facility’s annual budget. As a result, total commitments under a one-time order (or placed orders) may exceed the amount that had been committed for the whole budget year.

Bidding Process by Health Facilities

4.51 There are no standard bidding documents in the health sector—or in Uzbekistan. Each procuring entity develops its own documents based on its requirements and those of whatever regulations it must follow.

4.52 Central rayon hospitals, SVPs, and polyclinics do not issue written invitations to suppliers to submit bids for supplying goods and services, which is the normal procedure in well-regulated and consistent procurement environments. The facilities do not inform suppliers about opportunities to bid, the scope of their intended purchase, or the terms of delivery. At best, the health facilities collect price lists from potential suppliers and choose from among them. As a result, facilities select a supplier based on the subjective and undocumented opinion of their managers.
4.53 In the case of international import contracts, the Ministry of Foreign Economic Relations, Investment, and Trade (MFERIT) is responsible for verifying contract prices and ensuring contract compliance with "common international trade norms and requirements of the national legislation." To become effective, the contract must be registered with three institutions—the MFERIT, an authorized bank, and the State Customs Committee. This is usually a lengthy process. For example, it took an average of 76 days (a minimum of 23 and a maximum of 186 days) to obtain the approval of the MFERIT for contracts financed under the Bank's Health II Project. After the contract has been successfully registered with MFERIT, importers need to proceed to register the import contract with the other two institutions. If the bank refuses to register the contract, importers have to start the registration process from the beginning, in other words, they have to apply to the MFERIT all over again, thus lengthening the process of contract registration by two more weeks.

4.54 If the MFERIT refuses to issue a registration certificate, the importers cannot go any further. The MFERIT might refuse to register a contract because of overpricing in comparison with average world prices or with world market prices for goods and services of similar parameters and quality. When this happens, the procuring entity must then renegotiate the price with the supplier, and the contract cannot come into force and shipments cannot start until the MFERIT has approved the renegotiated contract. If a procuring entity and supplier fail to reach agreement on a price reduction, the contract is terminated, even if it was conducted by open tender with an adequate number of participating bidders.

4.55 Also, to compensate for exchange risks caused by unpredictable delays in currency conversion (especially for fixed-price contracts), some suppliers include additional charges in their contract prices.

4.56 Quality control and certification procedures for goods are cumbersome. To get customs clearance, all imports of medical equipment, supplies, and pharmaceuticals must have a Contract Certificate. The procedure for acquiring this certificate is cumbersome and time consuming because several national registration and certification bodies can be involved depending on the type of medical equipment and supplies involved. This certification process can take between 5 and 25 days, and it can cause delays in goods clearing customs, thus adding to the costs of the supplier who has to pay storage fees. Suppliers often choose to roll the cost of all mandatory registrations, certifications, and clearances into the prices of the goods they offer, meaning that the country ends up paying higher prices than necessary for medical equipment.

4.57 At the decentralized level, contract administration is hindered by weak capacity, leading to implicit monopolies and least cost-effectiveness. Because facilities have no capacity to verify and inspect the quality of the goods that they purchase, they often choose to use only one supplier whom they know they can trust, thus setting up a natural monopoly. It is difficult for facilities to distinguish between genuine and suspect supplies, especially in the case of pharmaceuticals. Their only option is to reject any deliveries without relevant certificates and/or valid proof of quality. To avoid quality control problems, most health facilities prefer to place orders directly with the drug company Dori Darmon, which has the reputation of being a reliable supplier but which therefore has come to have a virtual monopoly in supplying drugs to Uzbekistan's health facilities.

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31 See Presidential Decree UP-3321 (September 26, 2003), MFERIT Resolution HH-01/01-3771, MOF Resolution 62 and State Customs Committee Resolution 03—02/19-10 dated September 30, 2006.
The new treasury system has also introduced mandatory registration for all budget-funded contracts of budget organizations with suppliers of goods (works, services) and their major construction contracts to prevent any unspecified or unjustified expenditures by strictly controlled expenditure smeta ceilings and a defined purpose for the contracts. At the decentralized level, the rayon treasury offices are responsible for registering and processing contracts entered into by the health care facilities within the rayon. This function also includes price monitoring (price verifications)\(^{32}\) of all procurement contracts, beginning with the prices for bulk commodity purchases such as foodstuffs that are subject to regional price variations and a variety of oligopolistic market conditions. Such function\(^{33}\) would be yet another control over the management of health facilities and a further restriction their flexibility and accountability for management and results.

Health facilities also have to deal with delayed delivery of goods. About 17 percent of facilities surveyed in the Facilities Survey carried out for this report mentioned late delivery by suppliers as the main reason for stock out items, especially drugs. Due to the lack of a competitive procurement framework, procuring entities have no way to ensure the timely delivery of orders and must find informal solutions to contractual difficulties, such as negotiating a compromise or promising not to switch to another supplier, which may breed opportunities for corruption.

**Procurement Inspections (Audits)**

The Ministry of Health’s Control Inspection Unit is responsible for the control of procurement transactions and distribution, for enforcing anti-corruption measures, and for reviewing complaints by bidders and suppliers against the actions of health facility staff. The unit carries out ex-post procurement audits of all facilities. These ex-post reviews of procurement are limited to verifying that: (i) all procured drugs are from the National Essential Drugs List; (ii) the drugs were procured on a competitive basis; (iii) the base price mark-up on procured drugs does not exceed 20 percent; and (iv) procured items are used effectively (this being a judgment call). It would be difficult to implement a compliance audit because the underdeveloped legislative framework leaves plenty of room for individual interpretation. Other problems include the inadequate expertise of Control Inspection Unit staff and a lack of training in public procurement and inaccurate and incomplete procurement records kept by the health facilities.

External inspections are carried out by the Department of Control and Revision of the Ministry of Finance, by the Chamber of Accounts, and other government institutions. These inspections focus mainly on budget transactions.

**D. Governance Issues in Budget Management and Procurement**

There are several governance issues that arise in the context of the management of the budget and of the procurement process. In the area of budget management, delayed financing, limitations on the flexibility of SPVs to manage their own finances, and weak ex-ante control of the development funds are all constraints on the transparency, accountability, and efficiency of

\(^{32}\) Price verification is a process whereby a third party reviews a proposed contract after it has been negotiated with the suppliers to ensure that the agreed prices are consistent with market prices. The verifying entity has the power to set aside the negotiated contract and require that new terms be negotiated before it approves the contract.

\(^{33}\) The price verification function is assigned to the oblast and rayon treasury offices. According to the Ministry of Finance, the objective of price verification is to ensure appropriate use of funds. However, the Ministry of Finance acknowledged that a high staff turnover at treasury offices created capacity problems.
primary health care services. Similarly, limited competition and a lack of integrity and transparency in public procurement undermine accountability and efficiency in the use of resources and pose fiduciary risks. This section discusses these governance issues.

**Budget Management**

4.63 Prudent budget management ensures transparency and accountability, thus lowering fiduciary risks and leading to the efficient use of public resource. However, our assessment of the primary health care reform that accompanied by treasury reform in Uzbekistan shows that governance in budget management is generally weakened by a lack of predictability in the availability of funding and by an excessive control of spending that undermines efficiency. Further, lax internal control of the development funds executed by health facilities, weak in internal and external audits, and limited capacity of financial managers hinder the accountability of health facilities in budget management.

**Delays in Financing**

4.64 Predictability is one of the cornerstones of effective governance, but the health sector in Uzbekistan is characterized not only by a low level of financing in general but also by unpredictability in operational financing. There appear to be two main reasons for this unpredictability. First, the government rations its monthly cash releases sometimes because of revenue shortfalls but more often because it lacks a good cash planning system, which can delay their payment of budget resources and salaries to local health organizations. Delays can also occur at the level of the rayon finance department, which authorizes payments and then releases cash to SVPs so that they can pay to their workers and suppliers. If a rayon finance department does not have enough cash to make the payment, then it can hold up the payment authorization. Thus, facilities cannot execute their budgets in the most efficient way because they have no way of knowing whether the promised funds will be available. Also, it raises the costs of doing business with private sector suppliers who raise their prices to cover the costs of capital associated with late payments. Further, the excessively tight controls exercised by the rayon finance department prevent SVPs from reallocating resources between different items in their budgets to enable them to make essential purchases. This may force them to deal with a more expensive supplier who is willing to wait longer to be paid than other less expensive suppliers. It also can skew expenditures toward those budget items for which funds are available, even if the facilities do not actually require them at the time.

4.65 The Facilities Survey conducted as part of this report confirmed that in 2007 there were many delays in the financing of salaries and renovations, medicines, and municipal services. The survey found that 37 percent of the sample of SVPs in Samarkand oblast experienced an average delay of 10 days in the payment of salaries because SVPs had not received the necessary funding from the central or rayon levels in the first eight months of 2007. Meanwhile, only 13 percent of the sample SVPs in Ferghana oblast experienced an average delay of 20 days. In the sample of urban facilities, 20 percent of polyclinics in Samarkand City and 77 percent in Margilan City experienced delays of 4 to 11 days in the payment of salaries to their staff as a result of delays in payments by the city governments to the polyclinics.

4.66 Delays in financing renovations, medicines, and municipal services were experienced by between 3 percent and 7 percent of the rural SVPs in Ferghana and Samarkand and between 5 percent and 8 percent of the urban facilities in the two oblasts. The main reason for the delays in acquiring medical supplies was a shortage of funds in the facilities' budgets, but it was not clear from our Facilities Survey whether this was due to overspending by the facilities or delays in
receiving their budget allocations. Either way, these delays impaired the efficiency of SVP operations as well as the quality of their health services.

**Flexibility of Health Facilities in Managing Their Budgets**

4.67 The implementation of the new treasury system that requires rayons to exercise strict financial control over the sub-item budget estimates (SMETA) of SVPs to reduce fiduciary risk undermines the flexibility that these facilities now have to manage their own financial affairs. In fact, it will no longer be necessary for the Ministry of Finance to exercise such stringent oversight over health facilities once the new Treasury system is implemented across all oblasts. This is because the Ministry of Finance will then have instant access to the detailed expenditures of all budget entities (including those in the health sector) through the Treasury General Ledger accounts.

4.68 The plan to consolidate all Development Funds into a single treasury account in the main budget will reduce SVPs' flexibility to spend their Development Fund resources for the Chapter IV expenditures. The Ministry of Finance believes that the consolidation will greatly improve cash management (and in this it is supported by the World Bank and IMF) and wants internal disbursements from the Development Funds to be controlled in the same way as any of their other budgetary expenditures. These increased controls will impair SVPs flexibility as they will have to seek the ministry's approval to reallocate funds to different sub-item expenditures within the budget estimate for their Development Fund. Also, incorporating the Development Funds into the main budget means that any excess funds at the year's end will no longer be available for the SVP to spend in the subsequent fiscal year. This contravenes to the SVP's financial autonomy envisaged by the reform of primary health care because the SVPs will no longer have maximum flexibility to allocate their limited Development Fund resources to the areas of greatest need.

4.69 Pooling the resources of all health facilities at the rayon level might make it possible to allocate the health budget according to the needs of the entire rayon. However, this move goes against the principle of the government's own health reform designed to increase the accountability of individual health facilities for delivering quality health services to their patients. Taking away the budget responsibility from the managers of health facilities will erode their accountability for the performance of their facilities. If a manager does not have authority to manage his own spending, he can hardly be held accountable for the outcomes. It is illogical and counter-productive to implement a budgeting process that removes this sense of responsibility and accountability for performance.

**Financial Accountability of Health Facilities**

4.70 Lax ex-ante control of the development funds executed by health facilities lessens accountability of health facilities in budget management and provides scope for increased fiduciary risks. Currently, spending of development funds are not subject to rigid controls exercised by regular budget as health facilities only submit quarterly financial report to the rayon finance department. This lax control is exacerbated by weak capacity for internal and external audit and weak capacity of SVPs' financial managers

**Public Procurement**

4.71 Private sector companies interviewed for this report identified many weaknesses in the public procurement system, especially in the regulatory framework. There is frustration on a number of fronts—frequent changes in legislation, a lack of transparency, difficulties converting local currency into foreign exchange (required for import contracts), delays in payments, the
complicated product registration and certification system, and the frequent re-negotiation of contract terms and prices after a contract has been signed.

4.72 However, the most important areas where significant savings could be realized and governance improved are competition, transparency, and integrity. There are substantial weaknesses in these areas, which lead to the uneconomical and inefficient use of funds and high fiduciary risks.

**Competition**

4.73 There are three main reasons why competition is undermined in health sector procurement: weakness in the national public procurement system, the lack of a comprehensive regulatory framework, and insufficient transparency in selecting suppliers. These shortcomings discourage private companies from participating in public tenders and limit the number of suppliers who competing for public contracts at both the national and decentralized levels. Weaknesses in the national public procurement system include a lack of quality control and the need to register products (drugs or equipment) and direct contracting.

4.74 Private companies are reluctant to bid on public sector contracts because of the multiple layers of mandatory registrations, certifications, price verification, and sample testing involved. In an effort to control the quality of drugs and equipment, bidders participating in an open tender are required to register all of the drugs and equipment that they sell for medical use in accordance with detailed Ministry of Health procedures. Despite these draconian registration requirements, the bidding documents for Ministry of Health tenders set no quality requirements for products or qualifications for bidders. Furthermore, bidders are not required to submit any proof of their qualifications to provide the goods or services for which they are bidding. In annual open tenders for drug procurement conducted by the Ministry of Health, the same 15 to 20 companies tend to make up the pool of bidders. For most items included in such tenders, contracts are awarded to the same suppliers year after year. According to the Center for Drug Policy, no manufacturer (or supplier) has a monopoly for any of the drugs on the National Essential Drug List. Nevertheless, it is not uncommon for the Ministry of Health to make direct contract awards for items that the Ministry originally included in an open tender and then removed. The explanation given by the Ministry is that all but one of the participating bidders were offering unregistered drugs. In a 2005 tender, only one bid was received and accepted for each of the 10 drug items (out of the 107 drug items included in the tender), a situation which the Ministry of Health regards as direct contracting. In 2006, 11 drug items (out of the 84 items included in the tender) had to be cancelled because no registered drugs were offered, even when the bid was re-tendered.

4.75 Market competition is limited because most health sector suppliers and storage facilities are based either in Tashkent or in large regional (oblast) centers. Few of them have invested in the expansion of their business to the extent of owning their own distribution networks. The majority prefer to enter into partnership with Dori Darmon and Uztibekhnika for distributing their goods across the country.

4.76 Late payments and small orders further reduce competition. Payments to suppliers from facilities are usually delayed for between 30 and 45 days (the norm). Usually, facilities only order small amounts of drugs and medical supplies, especially those in remote areas. Most private sector suppliers (even local ones) are not interested in competing under these circumstances. Any

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34 However, tenders for medical equipment and pharmaceuticals financed by the World Bank and the ADB are exempted from registration requirements at the time of bid submission. The post-qualification of bidders, required by the procurement rules of both donors, serves as a means of quality control without restricting competition. Only successful bidders are required to register the goods they intend to supply.
suppliers who agree to supply health facilities normally mark up the base price of their drugs by the 20 percent allowed by the government.

4.77 Direct contracting is predominantly used at the oblast level. The Facilities Survey demonstrated that 100 percent of SVPs in Samarkand oblast and about 70 percent in Ferghana, as well as some central rayon hospitals, do not use competitive procedures for purchasing drugs and medical supplies. For example, the respondent for the Central Rayon Hospital in Samarkand oblast said that it used direct contracting for drugs and medical supplies even though there are at least four suppliers in the area. Table 4.6 shows the extent to which health facilities use competitive procedures for procuring the most frequently purchased items—drugs and medical supplies.

| Table 4.6: The Use of Competitive Procurement Procedures in Samarkand and Ferghana by Financially Autonomous Facilities (Percent) |
|---|---|---|
| | SVPs | Family Polyclinics | CRH |
| Drugs | | | |
| Samarkand | 3 | 38 | 0 |
| Ferghana | 33 | 42 | 67 |
| Medical Supplies | | | |
| Samarkand | 3 | 31 | 0 |
| Ferghana | 27 | 25 | 67 |


4.78 Conflicts of interest give certain companies an unfair advantage and discourage competition. Uzbekistan’s public procurement system neither defines nor regulates conflicts of interest. Box 4.1 gives two examples of conflicts of interest.

**Box 4.1: Conflicts of Interest**

**Example 1:** The Joint Stock Association Dori Darmon, is involved in preparing estimates for health facilities’ annual drug needs (quantities and budget) in Uzbekistan. At the same time, it also supplies drugs and medical supplies to the health facilities at the same prices that it used to prepare the facilities’ budget estimates. Moreover, Dori Darmon acts as a purchaser (on behalf of the Ministry of Health) by signing drug supply contracts awarded under the annual, centrally conducted open tenders. At the same time, Dorī Ta’mīnot, a fully owned subsidiary of Dori Darmon, participates as a bidder in such tenders and then signs contracts for the supply of drugs with its mother company.

**Example 2:** JSC Uztibtekhnika (a state owned enterprise) is a member of the government’s Coordination Council for Medical Equipment. It also represents the Ministry of Health in preparing estimates of the health facilities’ medical equipment needs. At the same time, JSC Uztibtekhnika owns a private company that bids for and has won medical equipment contracts to supply those health facilities.

Source: COM # 490, MOH Order #138 (April 14, 2006), and MOH Order # 506.

4.79 Monopolistic situations also undermine competition. For example, as mentioned earlier in this chapter, the Joint Stock Company Uztibtekhnika is responsible for assessing the medical equipment needs of health facilities and developing feasibility studies and investment projects on behalf of the Ministry of Health. In addition, the company has a monopoly for supplying and managing the installation and maintenance of procured medical equipment because the company has a nationwide maintenance service network, inherited from the Soviet era, with branches in every oblast. Its monopoly was strengthened by Ministry of Health Order 158 in April 2006 that required oblast health departments, medical training institutes, and colleges to contract with Uztibtekhnika’s local service branches for after-warranty service of medical equipment supplied under the investment projects financed by the World Bank and the ADB.

4.80 This lack of competition is clearly correlated with the overpricing of drugs, although there is no data to support this assertion. According to some auditors’ anecdotal comments made to task team members, the lack of competition increases the prices paid by heath facilities for the drugs that they buy. This is a similar conclusion to the results of pharmaceutical procurement surveys carried out in other countries in the region. For example, a World Bank study of the health sector in Serbia
found that competitive contracting in procurement can bring down prices and save the budget as much as 25 percent (World Bank, 2002b).

Transparency and Integrity

4.81 The transparency of a public procurement system can be measured by the extent to which it: (i) gives bidders access to information and (ii) has a system for handling complaints about the procurement process, including administrative sanctions and criminal prosecution. We found that Uzbekistan’s public procurement system is characterized by limited access to information and a lack of an effective complaints and appeal system.

4.82 Access to information is an important part of an open and transparent governance system and is the key element in procurement operations. The Ministry of Health makes every reasonable effort with the available resources to ensure that health facilities and the public have access to all information relating to the health sector, including procurement. The ministry’s external website includes a section containing relevant regulations, ministerial orders and instructions, and some tender notices. Although contract award decisions are not published, tenders with a budget of more than US$100,000 must be advertised and invitations to bid must be published in local newspapers. Occasionally, the Ministry of Health posts tender notices on its website. Bidding participants consider the cost of bidding documents—often as high as US$600—to be unreasonably high.

4.83 A lack of computer equipment and limited information technology (IT) infrastructure in the health sector constrains the extent of this access to information. The health sector is included in Uzbekistan’s national IT development program, and a work plan is being developed to promote the use of modern information systems in the sector. Several donor projects are helping to provide the health sector with computer equipment. The World Bank Health I Project supplied computers to oblast and rayon statistical offices and supported IT training, software development, and the Health II project has assisted the Ministry of Health in the establishment of a Health Information Management System. The potential of IT infrastructure to increase efficiency in pharmaceutical procurements can be seen in the case of Chile, where an open and competitive electronic bidding system was established in the health sector in 1999. This resulted in significant savings of public funds allocated for procurement, with hospitals saving an estimated 5 to 7 percent (US$4 million) on medicines and medical supplies (Cohen and Montoya, 2001).

4.84 In Uzbekistan, the lack of clearly defined evaluation criteria and the absence of requirements for product quality in bidding documents can lead tender committees to make arbitrary award decisions. The evaluation committee can question or reject even a duly registered drug. For example, in 2005 during a consolidated tender for drugs, one bidder submitted a fully compliant bid for generic insulin that was registered prior to the bid being submitted. The tender (evaluation) committee awarded that company, which was the lowest bidder, a contract for only one-third of the quantity. This was done after the committee had opened and analyzed the tenders and despite the fact that the bidding documents had not mentioned the purchaser’s right to increase or decrease the quantities at the time of the contract award. The order for the other two-thirds of the insulin went to a long-time supplier of insulin to Uzbekistan. The tender committee based its decision on the need to lower the risk of purchasing a product that had not previously been used in the country, arguing that it would be dangerous to order an “unknown” product to cover an entire year’s insulin needs. Although the committee’s desire to “protect” consumers had merit, the way in which this was done discouraged bidders from participating in public tenders and undermined bidders’ confidence in the fairness, transparency, and consistency of the procurement process.

4.85 However, the lack of clear procedures for price verification leaves plenty of room for subjective interpretations. Following the awarding of a contract, each procuring entity must submit a concluded contract to the MFERT for approval. There have been occasions when the MFERT required the procuring entity to renegotiate the prices contained in contracts that have been competitively awarded through open tender, and yet on other occasions the MFERT has allowed sole-source contracts to go through the registration process with no question. The impact of price
verification at a local level could not be assessed as it was not yet implemented at the time of this assessment.

4.86 Although there is an official mechanism for appealing against procurement decisions, it may not be very effective. The Ministry of health’s Control Inspection Unit is in charge of reviewing all appeals and complaints, including those from bidders and suppliers. According to the Control Inspection manager, no complaints or protests from bidders or suppliers have been lodged in the last four years. However, the absence of complaints is not necessarily an indication that the system is functioning well. International experience and practice suggests that a lack of complaints can be an indicator of: (i) skepticism on the part of bidders about the probable effectiveness of a complaint resolution system; (ii) a lack of information among bidders on how a complaint should be submitted and how it will be reviewed, and (iii) a lack of adequate legislation and/or its enforcement.

**Assessment of Fiduciary Risks**

4.87 There are several fiduciary risks associated with an inadequate PFM system with limited transparency and weak accountability. It is likely that this kind of system fails to ensure that facilities’ funds are spent for their intended purposes and encourages inefficiencies in the use of funds. The lack of financial management skills among the staff of the SVPs and reformed polyclinics means that there are insufficient controls over these budget transactions. Lax ex-ante controls over Development Fund spending and reporting have probably led to these resources being spent on items and for purposes for which they were not budgeted. Similarly, weak or nonexistent internal audit controls create substantial fiduciary risks at all levels of the government and in health facilities and institutions themselves. Meanwhile, current procurement processes in the health sector present are a source of major fiduciary risk because there is ample scope for fraud and corruption at both the central and local levels.

**E. CONCLUSIONS AND RECOMMENDATIONS**

4.88 As a result of our analysis of the public financial management of the health sector in Uzbekistan, this section proposes some recommendations to address the governance issues emerging from weak budget management and procurement practices that have been discussed in the previous sections.

**Budget Management**

4.89 Delayed financing has a direct, negative affect on the efficient use of resources and the quality of care. It unnecessarily increases the costs of doing business and the prices of medical inputs. Delayed financing also adversely affect the quality of primary health care as it reduces the availability of medical supplies and lowers the morale of health care workers who are not paid on time. Most of these delays are caused by shortages of funds at the central or local levels of finance departments due to lower than expected revenue collections or poor cash management. The problem of low tax revenue will require the government to strengthen tax administration, while the problem of poor cash management can only be solved by strengthening the treasury system and cash management capacity.

4.90 The health financing reform for the primary health care facilities was a deliberate policy to extricate SVPs/family polyclinics from the web of financial budgetary controls in which they were trapped. It was intended to be a major change in the culture of the health system, but cultures are difficult to change. SVPs/family polyclinics are so far the only fully reformed component within the health sector, but well-meaning pressure of those in favor of the status quo is starting to push these reformed facilities back into their former position in the hierarchy of health sector management and control. These pressures come from the implementation of the new treasury system that introduces strict controls exercised over financial management conducted by the reformed health facilities.
Such controls clearly breach the principles of the primary health care reform that deem financial and management autonomy as a central part to good governance, i.e. transparency, accountability, and efficiency in the delivery of primary health care services.

4.91 The government needs to strike a balance between control and flexibility to attain efficiency in the use of resources. In introducing per capita funding, the health financing reform emphasized giving SVPs financial autonomy to encourage efficiency gains, but the treasury reform will take back this autonomy to reduce fiduciary risks. These approaches need to be balanced to maximize efficiency gain and minimize risks. Too much autonomy and too little spending control create opportunities for corruption. Similarly, limited autonomy and excess control results in rigidity and discourages innovation that can lead to greater efficiency.

4.92 In Uzbekistan, the re-imposition of treasury control over SVP spending at the sub-item level reduces the flexibility of those facilities to allocate their resources according to their needs. To meet the needs of both the Ministry of Finance for control and the SVPs for flexibility, the Ministry could choose to exercise its controls only at the item level (for example, utilities) rather than the sub-item level (gas or electricity). It would still have full information on expenditures at the sub-item level because a unified budget and accounting system, once in place, can capture and code every transaction and generate a report at any level of aggregation at any time.

4.93 Similarly, when the Development Fund of each facility is consolidated into its main budget, the Ministry of Finance could also choose to exercise controls only at the item level. Moreover, the government could mandate that any outstanding account balances of the development funds should be automatically added to the SVPs’ annual budget for the following fiscal year.

4.94 In sum, the Ministry of Finance should: (i) tailor all new and existing controls to allow facilities to keep some autonomy over their own spending; (ii) ensure that the new unified budget and accounting system enables effective budgetary control within a framework of devolved authority and accountability at the facility level; (iii) allow any end of fiscal year balances in the SVPs’ Development Funds to be automatically added to their annual budget appropriation for the following fiscal year; and (iv) allow SVPs and other reformed health facilities to file and amend their budget estimates (SMETA) for their Development Funds throughout the fiscal year without the review or approval of the Ministry of Finance controllers.

4.95 Fiduciary risks can emerge when there are few or only weak ex-ante controls over expenditures financed by the Development Fund and little ex-post control of all sources of funding (regular budget as well as the Development Fund). To mitigate fiduciary risks arising from Development Fund spending, the government should exercise the same degree of ex-ante control over spending from the SVPs’ Development Funds as it applies to their regular budgets. Similarly, strengthening ex-post control of spending (internal audits) could mitigate fiduciary risks to all types of public funds.

Public Procurement

4.96 The health sector procurement system does not operate in isolation. It is directly affected by the country’s overall public procurement environment. If the system is characterized by an underdeveloped legislative framework, weak institutional and human capacity, a lack of transparency, little competition, an acceptance of conflicts of interest as the norm, and a lack of an appeals system, then the system leaves ample scope for the inefficient use of resource, the potential misuse of public funds and corruption. Given the lack of a cohesive national regulatory framework for procurement, we make only recommendations that are within the mandate of the health sector.

4.97 We encourage the Ministry of Health to accelerate the development of a detailed Procurement Manual for all procuring entities in the health sector. The drafters can draw on: (i) Samarkand’s experiment with model bidding documents and the advisory services that it provides to procuring entities; (ii) procurement manuals and model documents prepared for projects financed by
donors; and (iii) the findings and recommendations of the pharmaceutical study planned under the Bank's Health II Project.

4.98 The manual should consist of three volumes, covering: (i) general procedures (applicable at both the national and the oblast level); (ii) procedures for consolidated procurement at the central level, and (iii) procedures for procurement by individual health facilities at the decentralized (oblast) level. The contents of the manual should include the elements shown in Box 4.2.

### Box 4.2: Recommendations for the Content of the Procurement Manual

The procurement manual contains information on the following important aspects of procurement:

- The duties and responsibilities of all actors with clear distinctions drawn between the roles for multiple health sector agencies and committees involved in health sector procurement
- Detailed terms of reference for tenders (evaluation committees) at both the national and oblast levels, including a sample format for disclosing conflicts of interest to be signed by the members of the evaluation committees
- A conflict of interest provision
- One consistent set of regulations and Ministry of Health orders to eliminate gaps and contradictions in procedures applicable to health sector procurement
- A sample framework agreement between the Ministry of Health and the oblasts to be used in consolidated procurements as well as criteria for choosing between centralized or decentralized procurement processes
- Model bidding documents for different types of procurement (above and below US$100,000) based on the pilot in Samarkand
- A detailed description of administrative regulations and applicable procurement procedures (including procurement planning, publishing of bidding opportunities, bid preparation, submission and evaluation, and contract administration)
- Guidelines for asset management and inventory control
- Discussion of the need to develop a procurement filing system and to archive all procurement-related documents
- A detailed description of the process for the submission and review of bidder appeals and complaints, at least at the sectoral level.

4.99 To strengthen the institutional framework for the health sector procurement, we advise the Ministry of Health to: (i) establish a procurement policy unit (or assign this function to one of the existing units within the ministry) to promote good procurement practices in the health sector and to develop a sectoral regulatory framework, coordinate procurement activities, and prepare the Procurement Manual and keep it up to date; (ii) establish a central purchasing body for the health sector (or assign this function to an existing agency outside the ministry) to be responsible for consolidated procurement under the procedures set up in the Procurement Manual.

4.100 To increase transparency at the sectoral level, we advise the Ministry of Health to: (i) inform the private sector and citizens about forthcoming tender opportunities and about the results of contract awards by publishing procurement notices on the Ministry of Health's website and the results of all tenders above US$100,000. At the oblast level, introduce similar publications (either on the web or on bulletin boards) for contracts below this threshold at the oblast, rayon, and facility levels; (ii) lower the sales price of bidding documents to cover only the cost of printing and mailing, not to make a profit; and (iii) eliminate conflicts of interest in the cases of Dori Darmon and Uztibtekhnika.

4.101 To improve the procurement oversight and control system, we advise the Ministry of Health to separate the external (KRU) and internal (Control Inspection) audit functions. Internal inspections
should be transformed into a management tool to identify deficiencies in the internal system, advise management on remedies, and make sure they are implemented properly.

4.102 To increase competition for public contracts in the health sector, we advise the Ministry of Health to: (i) Take into account lessons learned from projects financed by UNICEF and other donors in revising quality control mechanisms, in particular, by eliminating the product registration requirement for the submission of bids as well as the practice of price verification; and (ii) Establish a “one-stop” procedure for obtaining mandatory product certification by discussing this with other government agencies outside the health sector.

4.103 To strengthen quality control, we advise the Ministry of Health to learn from other countries’ experiences in protecting their markets from counterfeit products (especially pharmaceuticals) by building effective and affordable quality control systems.

4.104 To increase transparency in public procurement, we advise the Ministry of Health to develop and keep up to date on a website basic technical specifications and requirements for the items that individual health facilities buy most frequently in procurements of less than US$100,000.

4.105 To strengthen human capacity building in the area of public procurement, we advise the Ministry of Health to: (i) develop a training program for staff from the Ministry of Health and from health facilities (procuring entities) in cooperation with the country’s training institutions and donors and request to the donors for funding of the training program; and (ii) organize training for the inspectors in the Ministry of Health’s Control Inspection Unit in how to conduct ex-post procurement reviews. The Procurement Manual should be used as the basic training material.
5. HUMAN RESOURCE MANAGEMENT AND REMUNERATION ISSUES

5.1 In every country, the health sector faces several human resources challenges including the need to ensure an appropriate supply of professionals (both type and number), to maintain and improve the quality of workers’ skills via educational and in-service training systems, and to manage the day-to-day working environment of clinical and non-medical (administrative) personnel. In this chapter, we focus on the management practices that shape the day-to-day working environment of primary health care staff and their salaries and other financial incentives, including recruitment, performance assessment, and oversight and accountability within the organizational hierarchy. We outline the overall institutional framework governing these practices, which in Uzbekistan consists largely of centrally defined policies, but focus largely on the ways in which local practices are shaped by existing policies and the resulting implications for staff effectiveness and accountability. Of particular interest is the extent to which health care workers can influence their immediate work environment, which, in Uzbekistan’s tightly centralized environment, is limited.

5.2 The consequences of poor personnel management can undermine the effectiveness of all of the resources—financial, material, or human—that the health sector has at its disposal. Although it is difficult to find explicit evidence of the link between personnel management and health care quality, expert assessments and abundant anecdotal evidence testify to its importance, even in developed countries.

5.3 A recent study (Lewis, 2006) identified some of the manifestations of inadequate human resource management from international experience, most of which are exacerbated by poor infrastructure and economic hardship. These include, among others, absenteeism (not turning up at all or working short hours), low on-the-job productivity, a lack of concern for clients, unsupervised junior staff delivering services beyond their skills and experience, unfair hiring practices, and misuse of supplies. The extent and severity of these problems vary substantially across countries and settings, and there are few, if any, definitively successful mechanisms for tackling them. There is good reason to steer clear of simplistic solutions, to pay careful attention to implementation, and to make sure that any actions are compatible with the careful, comprehensive reform of the type Uzbekistan is engaged in.

A. HUMAN RESOURCE MANAGEMENT

5.4 In this section, we discuss the basic functions associated with human resource management, starting with a description of the institutional and legislative framework that governs human resource management in the health sector in Uzbekistan. Subsequently, it examines the implementation of these laws and legislations by local governments and health facilities as well as their impacts on staff effectiveness and accountability in the delivery of health services.

Institutional Framework

5.5 The labor code is the overall framework governing health sector workers. It is supplemented by a plethora of sector-specific decrees, resolutions, and regulations issued by the President, Council of Ministers, Ministry of Health, and others, including Ministry of Health Order 535 (December, 2004). This order defines the fundamental workings of rural primary health care clinics (SVPs) and stipulates the type and number of positions that facilities may fill, including the SVP manager (a physician who bears the title “chief doctor”), financial manager, general practitioners, and various
nursing posts. For each position and facility, the order sets a maximum number of full-time staff based on the size of the population in the SVP service area. Also, the Ministry of Health sets staffing norms with the agreement of the Ministries of Finance and Labor. These norms define for each type of facility according to the size of the population in its catchment area the specific type of positions that it is entitled to and the maximum number of staff (expressed in terms of stavkas or full-time workloads). For example, for each 2,000 residents in its service area, an SVP may hire up to 1.5 stavkas of GPs, 0.5 stavkas of physiotherapy nurses, and so on.

5.6 In all SVPs, the chief doctor is appointed and dismissed by the head of the rayon health department (who is, at the same time, head of the central rayon hospital) to which SVPs are accountable for clinical matters. In legally independent SVPs, while hiring decisions need to be agreed with the local citizen's assembly (mahalla), the chief doctor is responsible for all aspects of personnel management such as hiring staff on a competitive basis, dismissals, disciplinary measures and rewards, all in line with the legislation. The chief doctor is also responsible for an annual “audit” of all staff, which is the closest the terms of reference come to a formal requirement to carry out performance appraisals. However, there appear to be no standard guidelines for conducting this audit, so managers take their own approach. In SVPs that are not legally independent, the chief doctor is “involved” in personnel management and decisions (although the exact nature of this involvement is left open), but decision-making power rests with the head of the central rayon hospital. All independent SVPs have to have a financial manager, who also has some personnel duties, although these are predominantly administrative in nature.

Personnel Management in Practice

5.7 Beyond the formal provisions that govern human resource management, two important factors shape actual practices. The first is the hierarchy of the health management and clinical reporting system that, in rural areas, closely connects SVPs to the rayon health department and central rayon hospital and, in urban areas, binds polyclinics to the city health department and central city hospital. Primary health facilities are stringently monitored by rayon and city health authorities and must send regular reports on health indicators to their supervising body. The second factor is the fact that most rural villages and small towns have stable populations, where people have longstanding connections to each other and to their community where relevant information equally flows. Both of these features play a role in most, if not all, of the practices described below.

Management Culture and Reform

5.8 The primary health care reform supported by the World Bank has decentralized some control to health facilities in those areas where the reform has been implemented. Understandably, where reforms are in their early days, attitudes are still evolving toward the changing authority and roles of the various players. Sometimes real or imagined concerns on the part of rayon and oblast authorities about the ability of facilities to take on their new role lead them to take their time in handing over personnel files. In places where the reforms are new, the authorities are skeptical about the likely effectiveness of the new SVP financial managers and the accompanying transfer of finance responsibilities.

5.9 However, the reforms have had a positive impact on the morale and performance of health facility staff themselves. SVP financial managers and general practitioners have received at least some training in personnel management, staffs have benefited from medical training both domestically and abroad, and, in interviews conducted for this report, managers as well as staff cite the new status of SVPs and better equipment endowment as making their work more fulfilling.

35 The head of the rayon health department—who also serves as head of the central rayon hospital—is responsible for health matters throughout the rayon territory. Similarly, the head of the city health department serves as head of the central city hospital and bears responsibility for city health matters.
Likewise, the efforts to increase earnings and the introduction of the Development Funds are widely appreciated by staff. Although problems remain, there is a strong sense that things are moving in the right direction for those who are working in areas that have experienced the reform.

Recruitment and Related Issues

5.10 As specified in the SVP manual and elsewhere, staff should be recruited on a competitive basis, and managers have been instructed in the general steps involved. In practice, managers claim that recruitment is a relatively infrequent event, especially in small rural facilities where populations are stable and staff turnover low. Anecdotally, staffing changes mainly seemed to be from young nurses moving to other communities upon marriage or (commonly) women going on maternity leave. As staff members take maternity leave or vacancies arise, a worker returning from maternity leave may often be available to fill the opening. Alternatively, the workload may be shared among remaining staff, thereby avoiding the necessity to hire a new worker while also supplementing the incomes of the remaining staff.

5.11 There is an apparent oversupply of nursing skills on the labor market—(because the training system turns out too many nurses for the number of jobs available, plus there is perception that nursing training is a useful preparation for marriage), but there are shortages of general practitioners and some medical specialists. Competitive recruitment is virtually impossible for these jobs, as facilities consider themselves fortunate to find even one candidate willing to take the job, especially in rural areas, which are generally seen as less appealing than urban posts. The situation is particularly severe in remote facilities located in “hardship areas,” which may not even be able to recruit even nursing staff. In 2006, the Ministry of Health estimated that some 300 SVPs faced severe shortages of physicians and nurses, and 10 percent of SVPs had no physician on staff. The government is tackling this problem by offering pay enhancements to personnel willing to work in rural areas, giving preferential admission to medical students from rural areas provided that they promise to return home to practice, and requiring that students on government scholarships serve three years in assigned posts in rural facilities after graduation. Some local authorities have also tried to attract health workers by, for example, offering land plots, helping them build homes, or subsidizing a student’s tuition in exchange for a professional commitment.

5.12 Various countries have tried various methods to alleviate the difficulty of getting medical staff to accept jobs in remote rural areas (Box 5.1). Some of these solutions may be workable in the context of Uzbekistan.
Recruiting medical personnel for rural areas is not just a problem in Uzbekistan—it is a struggle in most, if not all, countries around the world, even in developed countries.

Internationally, responses to this perennial staffing challenge range from incentives that increase the job's appeal in hope of attracting applicants voluntarily to more interventionist measures. These approaches have included:

- **Enhanced compensation and support** including higher salaries, hardship allowances, cost-of-living allowances, in-kind benefits, or remote access to information resources and professional networks to alleviate isolation. For example, in 2007, Australia was piloting an “attraction package” that provided recruits with financial assistance with relocation and housing costs, a year-end cash bonus, travel expenses in case of family emergencies, a computer and internet access, and free training.

- **Service requirements or restrictions** including mandatory geographic rotation (as in India’s Andhra Pradesh state) and limits on publicly funded posts in urban areas. Norway has at various times passed legislation on both approaches but has not always implemented them.

- **Modified delivery methods** including short-term visiting staff or temporary internships (Norway and Lesotho), special training to enable junior staff or local residents to provide services (Iran, the US, and the Indian Health Service), or mobile hospitals (China).

Each approach comes with benefits and drawbacks—and all require careful design and implementation. The extra pay required to make remote posts attractive may be prohibitively expensive or make other staff feel discontented and make competing demands. Professionals may be put off by rotation requirements, although rotations can be appealing to staff if the rotations are subject to proper oversight, if staff are given respect and resources, and if accepting a rotation enhances the worker’s subsequent career opportunities. Alternative methods of providing services in these areas (for example, a combination of trained local residents, supplemented with periodic visits by professionals) have been successful in a number of cases, despite some skepticism from the medical establishment in those countries.


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5.13 Despite these practical constraints, managers of SVPs, polyclinics, and central hospitals in rayons and cities in Ferghana and Samarkand oblasts all expressed their concern for and commitment to hiring competent, qualified staff and recognized that poor performance by their staff can lower their population’s health status and be reflected in the indicators that the facilities must report to their supervising bodies. Because these indicators are accepted as a reflection of the facility’s and manager’s performance, chief doctors have an added incentive, beyond their professional commitment, to constantly monitor their staff’s performance. Previous analyses of Uzbekistan’s health system, as well as insiders’ views expressed in interviews conducted for this suggest that some managers may respond by under-reporting or falsifying statistics.

5.14 Opinions differ on who has ultimate decision-making power in recruitment. Our findings from the Facilities Survey suggest that, although respondents perceive facility heads as the primary decision-maker for hiring mid-level and junior medical staff (and also doctors in urban facilities), in the case of SVPs, rayon health authorities have substantial input to hiring doctors and financial managers. One possible explanation for this may be that, given the difficulties in filling these two types of post, SVPs may need help from the rayon health authorities to find candidates. Nevertheless, in interviews conducted in Samarkand and Ferghana oblasts, most chief doctors seemed confident that the choice was theirs and that they could stand their ground against any inappropriate outside influence. In contrast, some rayon and oblast authorities, as the guardians of

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36 Asked to name the primary decision-maker for the hiring of doctors in their facility, 50 percent of respondents in SVPs in Samarkand oblast cited the head of the facility, and the other 50 percent said the rayon health authority/central rayon hospital. In Ferghana oblast, 67 percent cited the rayon health department/central rayon hospital, and only 30 percent said the head of the facility. In the case of the hiring of financial managers, 57 percent of respondents in Samarkand cited the facility head and 33 percent said the rayon authorities, while in Ferghana, 47 percent cited the rayon authorities and only 37 percent the head of the facility.
health in their territories, felt that they had a key role in approving or vetoing candidates. Whether these powers are real or a pro-forma courtesy in the interests of cordial relations is not entirely clear.

5.15 The staffing norms mentioned earlier that determine the type and number of positions that a given facility may have limit the autonomy of facility managers who, to be truly accountable for their facility’s performance, should have considerable authority over budgets and staffing decisions (including recruitment and dismissal). In our facility visits, we found that many managers seemed reasonably satisfied with their staffing allocations, whether because they are truly adequate or because there was no point in complaining about the rigid regulations. However, there is the danger that shortages of certain skills due to restrictions on staffing may hamper the type and quality of care that can be offered to patients.

5.16 One of the most commonly cited concerns—the lack of general practitioners—results not from these staffing norms but from labor supply, since the government’s GP retraining program is still ongoing. Managers cope with this shortage by sharing the workload among their existing staff or by trying to increase the appeal of the vacant position. Given the tightly regulated salary system, they have few discretionary powers to offer any extra inducements to potential candidates. This is also a problem with respect to trying to hire well-qualified financial managers as the base salaries for these posts are low and facility heads have no power to increase them, except to offer bonuses funded from the facility’s Development Fund budget but these tend to be too small to make any real difference.

5.17 Labor code provisions governing recruitment, discipline, and dismissal offer protection to staff from arbitrary actions by including a role for labor unions in making personnel decisions (except for recruitment). Managers of primary health care clinics reported few, if any, instances of having to fire staff for cause. In any case, it would be difficult for them to take such action even if it was warranted as it would require labor union agreement. Managers may recommend that some individuals resign voluntarily to avoid damage to their reputation, which would also spare the manager from having to take any formal action.

Performance Monitoring

5.18 There is no standard system for annual staff performance appraisals along the lines found in private companies and civil services in developed economies and, in interviews with managers at every level of the health sector, even the concept of a formal annual appraisal process seemed alien. These managers expressed confidence in their ability to gauge the performance of their facilities and staff in the course of normal clinical management practices.

5.19 The heads of rayon and city health departments have at least three methods of gathering information on staff performance. First, specialist teams from central rayon hospitals and central city hospitals conduct clinical inspections of each facility at least once a year. The manager (chief doctor of the central rayon or city hospital) then issues a directive to the facility identifying any shortcomings and setting a deadline for them to be rectified. Second, facilities must submit monthly reports to the head of the central rayon or city hospital on some 30 to 40 health indicators. While changes in these indicators can reflect many different factors, including some that are outside the facility’s control, some (such as early detection of illnesses and information campaigns about immunization) are related directly to the performance of the managers and the staff. Finally, the heads of central hospitals hold meetings with the chief doctors (and financial managers) of the health facilities in their jurisdiction several times a month during which they interact face to face.

5.20 Similarly, managers of primary health facilities can draw on several sources of information to evaluate the performance of their staff, including health indicators from each nurse’s territory, the number of people who turn out for immunizations and scheduled check-ups (arranged by nurses),

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37 These are anecdotal findings based on our field interviews. The Facilities Survey conducted in connection with this study found few instances of firing.
and discussions at weekly staff meetings. Because at each outreach visit to a patient’s home, nurses must make entries in the health logbook kept by each patient or family, the head doctor can check the existence and nature of these entries during patients’ office visits and use the notes to assess the nurse’s performance.

5.21 Nevertheless, there appears to be no formal annual staff audit in these facilities. Managers’ awareness of the importance of monitoring and supporting staff performance is commendable, but how well this is done depends entirely on the managers themselves. Thus, Uzbekistan policymakers need to transform current practices into a robust system of annual performance assessments to help managers and staff members to provide a better service to their patients. Although designing and implementing an effective performance assessment system is a challenge, Uzbekistan can draw on ample international insights and expertise (for example, from West European countries) to devise the best system for its own conditions.

5.22 While monitoring staff performance and health outcomes is clearly necessary, it also has several drawbacks. First, drawing inferences about staff performance directly from health indicators may sometimes result in organizations or individuals being punished for events outside of their control. Second, facility managers may feel pressures to misreport information, which would distort the overall picture of the country’s health status. For example, in our in-depth interviews with service providers carried out in August 2007, one SVP chief doctor recalled submitting data to his superiors that, while not negative, departed from expectations. When higher authorities questioned the figures, the easiest response was simply to change the numbers to match expectations. Although the extent of these problems in Uzbekistan cannot be quantified, anecdotal information suggests that they do arise fairly frequently.

5.23 A third drawback of the current system is the considerable burden that frequent inspections and reporting requirements by multiple bodies impose on facilities. In in-depth interviews, health facility managers recognized the importance and benefit of monitoring and reporting practices but described the amount of time and paperwork required as excessive to the point of being a substantial distraction from their medical duties.

5.24 There appear to be few opportunities for on-the-job promotion within health facilities on the basis of good performance. Staff members are assigned a grade based on their professional specialization and their level of certification. Since individuals can take the certification examinations only at specified intervals several years apart and there are only three levels, there is only limited scope for moving up the formal hierarchy (and pay scale). Formally at least, career progression appears to be based almost exclusively on technical measures of skill, without incorporating any objective measures of on-the-job performance. In our in-depth interviews, some individuals suggested that it was necessary to spend both time and money on lobbying health authorities at the oblast and rayon levels, but others disagreed, either because they thought it was useless or because they didn’t think it was necessary.

**Oversight and Accountability**

5.25 Rayon and city health departments are responsible for the oversight of and are accountable for the quality of care provided by primary health facilities and for their health outcomes. The head of one municipal health department, explaining her role vis-à-vis the heads of subordinate institutions, spoke of “having their souls in her grip,” an apt metaphor for the considerable respect she commanded. Each central hospital at the rayon or city level has a deputy chief doctor, charged with overseeing SVPs, and a coordinating financial manager who supports the work of SVP financial managers.

5.26 Moving financing powers to the oblast level under the reforms may have seemed to have undermined the authority of rayon health departments in the clinical hierarchy. However, this does not appear to be happening in practice. The deputy chief doctor of one central city hospital noted that any questioning of its authority was put to an end when the oblast health department stepped in
to explain that the hospital’s responsibilities for health outcomes remained unchanged, whatever the financing arrangements may be.

Findings on Human Resource Management

5.27 The personnel management system in the health sector has many positive features. Important principles such as accountability, performance evaluation, competitive recruitment, and managerial autonomy are all evident in some form, although existing approaches need to be refined and developed to bring them into line with good practice.

5.28 Attitudes and practices are slowly adjusting to changes in roles and authority that the reforms entail. While primary health care facilities in reform areas have gained independent legal standing, their relationships with higher-level authorities remain important for both clinical and operational (administrative) reasons. This is particularly true for SVPs, which can benefit from support from central rayon hospitals to deal with issues that are new to them or that require more resources than their own fairly constrained budgets. However, the line between supportive and dominating can be exceedingly fine.

5.29 The personnel management system is dominated by centrally set policies and regulations, many of them rigid and narrowly focused. On the positive side, the lingering command-and-control mentality seems to result in staff and managers who are reasonably well-acquainted with personnel policies and practices. However, when there is too much emphasis on rote compliance with narrowly defined rigid rules and when the shortcomings of facilities are met with heavy-handed punishments (instead of support to do their jobs better), the ability of facilities to respond effectively to patients’ actual needs suffer. A notable example of this is holding staff or managers directly responsible for poor health indicators that in fact reflect influences beyond their control.

5.30 On a related note, such basic personnel decisions as hiring the number and type of staff best suited to meet local needs are largely out of the hands of facility managers because central government norms stipulate their staffing allocations. This, again, inhibits their ability to adjust their services to local needs.

B. Pay and Incentives for Primary Health Care Staff

5.31 The health sector has its own salary system, distinct from those for other government staff. Although the specific provisions of the system are new, the fundamental approach—a base salary derived from a tariff net (wage grid), supplemented with allowances and bonuses—remains consistent with those used in the rest of Uzbekistan’s public sector. The broader implications of the new pay system as it affects the overall health sector have been discussed in previous World Bank analyses. In keeping with this report’s focus, this section examines pay policies and practices that affect primary health care (Langenbrunner et al, 2006). Technical details and data are presented in Annex B.

An Overview of the Pay System

5.32 Primary health care staff earn a monthly base salary plus allowances and, depending upon circumstances, awards from the SVP’s Development Funds meant to reward and promote good performance by staff. As with many other facets of the health sector, a set of strict, intricate, rules set by the central government leaves local managers little discretion to address specific circumstances related to the pay of their staff.

5.33 The tariff net from which the base salary is calculated consists of a coefficient for each grade in the job hierarchy, which is then multiplied by the official minimum wage. Health workers are assigned a grade based on their professional specialization and their certification level (known as the “category” and awarded by examination). Managers’ grades are linked to the type of facility
where they work and the population served. For certain types of care (for example, in emergency care units), a second coefficient—called an “adjustment coefficient”—increases the original coefficient somewhat, but this is not applicable to the salaries of primary health care providers. Although the tariff net assumes a full-time workload (stavka), staff may be hired for more (or less) than one stavka in increments of one-quarter of a workload. In such cases, base pay is pro-rated accordingly, but seniority pay is not generally awarded.

5.34 The award of regular monthly allowances is largely done on the basis of the characteristics of the job or job-holder. In the primary health care sector, they include allowances for managerial functions and for duties deemed to be hazardous or especially burdensome. Sample earnings data for SVPs and polyclinics indicate that these allowances are rarely awarded and contribute little to staff’s total earnings. In contrast, the most prominent allowance for primary health care workers, in both value and incidence, is for seniority. The seniority allowance—called “continuous length of service”—is calculated according to specific rules under which the number of credited years can be lower than an individual’s number of actual years of work experience within the profession.

5.35 The Development Fund awards (analyzed in more detail in the financial management section in Chapter 4), launched in 2006 as part of the new health sector salary system, were intended to reward and encourage good performance, as well as alleviate economic hardship due to illness or emergencies. A special committee at each facility meets at least quarterly to decide on recipients and award amounts. As with base pay and salary, the central government tightly controls the use of the funds, in this case by regulations defining decision-making procedures (mandating the involvement of multiple parties and careful record keeping and reporting), criteria, award amounts, and details of the scoring system down to the weighting for each criterion. The two types of performance-related awards are a “monthly premium” (either ongoing or one-off), specified as a percentage of base salary, and a one-off “lump-sum bonus” of up to one month’s salary.

5.36 Performance criteria for monthly premiums are intended to focus on four main areas: the quality of care provided, the actual intensity of work (in other words, the number of patients served or procedures carried out as distinct from official stavkas), the complexity of cases treated and the care provided, and the use of advanced, cost-effective methods.

Earnings in Practice

5.37 Having described the formal structure of the pay system in the primary health care sector, we now explore actual practices. Table 5.1 presents examples of actual earnings for a variety of positions, based on payroll data for six SVPs in Samarkand oblast.
Table 5.1: Indicative Earnings in Rural Primary Health Care Clinics (SVPs),
(as of January 1, 2007)

<table>
<thead>
<tr>
<th>Position</th>
<th>Stavkas</th>
<th>Grade</th>
<th>Credited service (years)</th>
<th>Sums</th>
<th>USD</th>
<th>Euro</th>
<th>Base</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Doctor &amp; GP</td>
<td>1.25</td>
<td>6</td>
<td>28</td>
<td>111,994</td>
<td>$88</td>
<td>€ 64</td>
<td>67%</td>
<td>27%</td>
</tr>
<tr>
<td>Chief Doctor &amp; GP</td>
<td>1.5</td>
<td>8</td>
<td>13</td>
<td>150,729</td>
<td>$119</td>
<td>€ 86</td>
<td>73%</td>
<td>24%</td>
</tr>
<tr>
<td>Chief Doctor &amp; GP</td>
<td>1.5</td>
<td>8</td>
<td>n/a</td>
<td>153,834</td>
<td>$121</td>
<td>€ 88</td>
<td>72%</td>
<td>24%</td>
</tr>
<tr>
<td>Chief Doctor &amp; Therapi</td>
<td>1.5</td>
<td>6</td>
<td>none</td>
<td>96,882</td>
<td>$76</td>
<td>€ 55</td>
<td>94%</td>
<td>0%</td>
</tr>
<tr>
<td>Chief Doctor &amp; GP</td>
<td>1.5</td>
<td>8</td>
<td>1</td>
<td>150,729</td>
<td>$119</td>
<td>€ 86</td>
<td>73%</td>
<td>24%</td>
</tr>
<tr>
<td>Chief Doctor &amp; GP</td>
<td>1.5</td>
<td>6</td>
<td>6</td>
<td>105,867</td>
<td>$84</td>
<td>€ 61</td>
<td>86%</td>
<td>11%</td>
</tr>
<tr>
<td>Financial manager</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>55,319</td>
<td>$44</td>
<td>€ 32</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>6</td>
<td>22</td>
<td>90,672</td>
<td>$72</td>
<td>€ 52</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>GP</td>
<td>1.5</td>
<td>6</td>
<td>17</td>
<td>120,896</td>
<td>$95</td>
<td>€ 69</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>6</td>
<td>19</td>
<td>90,672</td>
<td>$72</td>
<td>€ 52</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>GP &amp; Gynecologist</td>
<td>1.25</td>
<td>6</td>
<td>none</td>
<td>75,560</td>
<td>$60</td>
<td>€ 43</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>1.5</td>
<td>8</td>
<td>13</td>
<td>147,624</td>
<td>$117</td>
<td>€ 84</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
<td>8</td>
<td>12</td>
<td>110,718</td>
<td>$87</td>
<td>€ 63</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
<td>6</td>
<td>none</td>
<td>90,672</td>
<td>$72</td>
<td>€ 52</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
<td>6</td>
<td>20</td>
<td>60,448</td>
<td>$48</td>
<td>€ 35</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Sanitary feldsher</td>
<td>1.75</td>
<td>4</td>
<td>1</td>
<td>92,436</td>
<td>$73</td>
<td>€ 53</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.5</td>
<td>4</td>
<td>20</td>
<td>29,979</td>
<td>$24</td>
<td>€ 17</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Field nurse</td>
<td>1</td>
<td>2</td>
<td>n/a</td>
<td>43,361</td>
<td>$34</td>
<td>€ 25</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>Midwife &amp; Field nurse</td>
<td>1.25</td>
<td>5</td>
<td>n/a</td>
<td>79,672</td>
<td>$63</td>
<td>€ 46</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>Field nurse &amp; Immunizati</td>
<td>1.25</td>
<td>5</td>
<td>none</td>
<td>59,880</td>
<td>$47</td>
<td>€ 34</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>Procedure nurse &amp; Field n</td>
<td>1.25</td>
<td>2</td>
<td>none</td>
<td>56,266</td>
<td>$44</td>
<td>€ 32</td>
<td>92%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Polyclinic**

| GP                        | 1       | 9     | 1                        | 114,709 | $91  | € 66  | 71%  | 29%     |
| GP                        | 1       | 8     | 16                       | 84,884  | $67  | € 49  | 87%  | 13%     |

*Source:* Samarkand Oblast Health Department and individual facilities, and World Bank calculations.

*Note:* The SVPs are: Sochak, Urta Kishlok, Dexqonobod, Gazira, Gulba and Kora Ariq. Blank cells reflect omissions in the original data.

(a) Calculated at National Bank of Uzbekistan exchange rates effective on 31 July 2007: $1US = 1,267.01 sums and 1 Euro = 1,748.35 sums.

(b) Since length of service is paid only for the first full stavka, its relative share in total monthly earning decreases as an individual takes on more than a full-time workload, all else being held constant.

(c) While according to regulations GPs are assigned to grades 7 to 10, actual earnings data from facilities include instances where physicians are identified as GPs but ranked in grade 6. A possible explanation is that these individuals have not yet completed the GP specialisation process.

5.38 Analysis of data from these SVPs as well as three polyclinics in the oblast indicates that formal workloads in excess of full-time appear to be common for medical doctors, while mid-level staff (nurses) and lower-ranked workers are more likely to work part-time.

5.39 The Development Funds were introduced to alleviate salary pressures (among other issues), and the government has stated its interest in increasing salaries in real terms (inflation adjusted). To outpace inflation, both the official minimum wage and tariff net coefficients have been increased.
several times since the new system was introduced. In June 2007, base salaries were 44 percent higher in nominal terms than when the new system took effect 18 months earlier. However, with annual inflation at an estimated 15.2 percent in 2006 and 13 percent in mid-2007, the real increase was only around 14 percent.38

5.40 The government projects that, after an increase in the minimum wage on August 1, 2007, average monthly earnings will be SUM 87,000 for in the entire health sector and SUM 128,000 for doctors. In comparison, education sector earnings will average SUM 100,000 for the entire education sector and SUM 117,000 for teachers.39 Even in the best of circumstances, economy-wide earnings comparisons should be treated with extreme caution. But in Uzbekistan, data complexities, discrepancies among sources, and the absence of standardized data (such as average earnings by sector) make broad comparisons even more perilous than usual.

5.41 On a related note, comparing the earnings of public sector staff with the earnings of those who work in privately run health clinics is hindered by variations in job composition and financial standing between the two kinds of facilities, the lack of systematic data, and reluctance by staff to discuss delicate financial matters. In our interviews, private clinic staff asserted that their earnings were comparable to (or lower) than those earned in public facilities. This may reflect the widely held view that some staff of private clinics under-report their earnings to the tax authorities. Alternatively, the small size of the private sector in health care may make it adopt the salary levels that prevail in the much larger public sphere. Although it is generally assumed that salaries in private sector must be higher than in the public sector, no solid evidence is available. It is also worth bearing in mind that Uzbekistan’s private health sector is very small—and thus not an alternative source of employment for most medical professionals. Its appeal may also be limited by perceptions of job insecurity compared with public sector work.

5.42 According to the interviews conducted for this report, health care workers recognize the fact that official salaries are, and traditionally have been, modest but also appreciate the recent trend toward increasing salaries and offering performance awards from the Development Funds. Nevertheless, it seems likely that official salaries still only cover between 30 and 60 percent of living costs but certainly less than 100 percent. Economic pressures on families are alleviated when both spouses work, a situation that is likely to be common, especially considering the prevalence of women in the medical profession. However, health care workers often have to resort to other strategies to supplement their low salaries, such as taking second jobs, engaging in other income-generating activities, or soliciting informal payments from patients. Opportunities for part-time work with private medical practices tend to be limited, although other paid activities outside of the profession may be more widely available. For example, according to the head of a polyclinic in Ferghana oblast, some nurses take on activities such as baking or sewing to supplement their earnings. One particularly enterprising senior doctor had a grove of lemon trees on his property and sold the rights to harvest their yield to small agrobusinesses. Others have been known to grow their own produce or raise livestock for their own consumption or for sale.

Findings—Pay and Incentives

5.43 These remuneration data suggest that medical doctors (especially general practitioners who are in short supply at this stage in the reform process) are often officially “over-employed” at their main job whereas nurses often work part-time because of the apparent surplus of nursing skills on the labor market. Although chief doctors are almost always assigned heavier than full-time workloads because of their duties as facility head in addition to their medical practice, even doctors without management responsibilities commonly work more than one stavka. This should be kept in

38 Inflation estimates are from the IMF. The government’s estimates for the same periods are 6.8 percent and 5.0 percent respectively.

39 Commentary on the latest increase in the minimum wage is posted on the government website at www.gov.uz/ru/content.scm?contentId=28384.
mind when assessing the adequacy of official salary scales, because doctors’ full-time salaries may 
not reflect the full extent of their actual workload.

5.44 Given the highly detailed nature of salary-setting rules—which are determined by the central 
government—increasing doctors’ workloads may be the only way for local managers to exercise any 
discretionary authority over base salaries and to deal with staff shortages. This should not be seen as 
a failing at the local level but rather a natural reaction to the strict regulation of staff allocations and 
salaries.

5.45 Allowances add only a limited amount to regular earnings, which is a positive feature of the 
pay structure because the transparency of pay is enhanced when base salary—rather than countless, 
hard-to-track supplements—makes up most of total earnings. However, the awarding pay on the 
basis of seniority (for “continuous length of service”) is less desirable. As in many other transitional 
economies in Eastern Europe and Central Asia, Uzbekistan continues to use length of service as a 
proxy measure of professional skill. Although the assumption that skills increase over time is 
reasonable in many situations, it fails to recognize the value of up-to-date educational credentials 
and attitudes (especially in times of rapid change) that young professionals can bring to their jobs. 
Strict rules that encourage and reward length of service may discourage professional mobility by not 
crediting the worker with time worked in the private sector or in other parts of the public sector. For 
example, we interviewed a hospital economist who recounted the case of a medical doctor who did 
not receive credit for several years of working within the publicly funded health sector because she 
had changed facilities and career paths within the sector.

5.46 This shortcoming may be particularly relevant to those hired to the recently created post of 
financial manager in SVPs. Their responsibilities in financial, procurement, and human resource 
matters are designed to enable SVPs to assume the full legal and financial autonomy foreseen under 
the reforms. Therefore, it is vital for SVPs to recruit competent individuals for these jobs and to 
retain those who have mastered the knowledge and skills to do the job well. However, as Table 5.1 
revealed, without seniority pay, the total monthly earnings of newly hired financial managers—who 
may have much financial experience but not necessarily in the health sector—fall far short of what 
seems appropriate for this post and grade. Facility managers and expert observers expressed concern 
about the difficulty of recruiting and retaining financial managers, who often are required to handle a 
very heavy workload, when their pay is so low.

5.47 A previous analysis of health sector salaries in Uzbekistan identified some issues that have 
particular implications for primary care (Langenbrunner et al, 2006). Just as the overall budget 
allocation continues to favor in-patient care over more cost-effective outpatient and primary care 
(and, implicitly, affluent and urban populations over rural ones), the salary system gives preference 
to certain types of doctors’ positions over others. While the new pay scale puts general practitioners 
on the same scale as surgeons and ranks SVPs higher than in-patient facilities, it gives higher 
salaries to those working in emergency care. Shortly after the launch of the new pay regulations, it 
seemed that in-patient and emergency care physicians were seeing larger proportional increases in 
their earnings than GPS. If this continues, it will of course negatively affect the appeal of GP posts 
and even of GP training.

5.48 Though heavily regulated, the Development Funds are a valued source of flexibility for 
managers of facilities. Although the Ministry of Health regulates much of how the funds can be 
used, they are unanimously appreciated by facility managers, who welcome the chance to award 
bonuses or hardship payments to their staff (ZdravPlus, 2004). However, facilities serving smaller 
populations are not likely to benefit as much, because per capita financing leaves them with more 
limited funding than larger facilities. Likewise, those facilities that are allowed to charge fees for 
their services can channel more money into their Development Funds than the SVPs can. However, 
if these Funds are managed fairly and transparently, they will continue to provide a valuable way for 
facility managers to exercise some flexibility over the remuneration of their staff and the reallocation 
of their budget in an otherwise rigid system.
5.49 Whether the salary incentives from the Development Funds truly recognize and inspire better performance from health care staff is unclear. No systematic evidence is likely to be available. Indeed, despite obvious diligence on the part of managers in complying with procedures and their sincere interest in supporting good performance, the Development Fund awards may in reality be a rotating salary supplement that is given to staff "in turn," in the words of one manager. The fact that regulations cite infractions for which staff can be "deprived" of an award and managers frequently mentioned "withholding" of stimulation fund awards as a disciplinary measure, also speaks to the potential for awards to be seen as a quasi-entitlement. Because this phenomenon arises in developed countries as well, it is a testimony more to the inherent challenges of bonus systems than to any deficiency on the part of local health facility managers in Uzbekistan.

C. CONCLUSIONS AND RECOMMENDATIONS FOR OPTIONS

5.50 The dedication and concerted efforts of government and health sector staff involved in primary health care reforms deserve recognition. As far as human resource management and remuneration are concerned, Uzbekistan's primary health care system exhibits many notable positive elements that can serve as the foundation for future progress, such as: (i) an overall focus on health outcomes that involves a variety of formal and informal mechanisms for monitoring individual and facility performance, largely via clinical management practices; (ii) recent modifications in the health sector pay system to raise salaries and enhance GPs' standing within the medical profession; and (iii) the introduction of the Development Funds, a transparent, locally managed process to reward good staff performance.

5.51 As Uzbekistan's leaders and health professionals know well, there is still much room to refine and expand these positive features. Simply put, in almost every area examined in this section, local health care administrators and providers are charged with implementing and reporting on centrally set policies and practices but have little autonomy to adapt them to ensure that they work in the local context. Furthermore, they operate within a system that provides inspections and punishment rather than support in its approach to safeguarding and enhancing the public's health.

5.52 Therefore, there is a need for a fundamental change in the approach taken to salaries and human resource management in the health sector in Uzbekistan. This change will need to tackle such powerful forces as the country's long-standing centrist culture and economy-wide factors such as low labor force mobility. This chapter (and this report as a whole) has concentrated on primary health care because of the encouraging progress made in the primary health care reforms in giving facility managers a modicum of control over which services to provide to best meet local needs. The discussion has raised many important issues that will need to be addressed in the next round of reforms and, in this section; we make a series of recommendations based on those issues. Two crucial points must be borne in mind. First, as with any important change, periodic monitoring and evaluation will be essential to keep things on the right track and to readjust the course of reform when necessary. Second, the first consideration in implementing these and other measures should be to safeguard the successes achieved so far and to support the many professionals at the heart of this effort who are carrying heavy loads and grappling with considerable challenges.

5.53 We recommend that health policymakers consider the following measures. In keeping with the focus of this study, they target issues that emerged from our locally focused analysis. They are not intended as a comprehensive system-wide plan.

(a) Increase local managers' input into fundamental staffing decisions, including staffing in their facilities. The mix of positions and skills in any facility is defined by centrally set norms, based on the size of the population that they serve. In practice, patients' needs in different areas are influenced by many other factors. At the same time, under the reforms, primary health care facilities are responsible for managing their own budgets (within certain constraints). They are also accountable for the facility's performance and subject to substantial oversight by higher authorities who monitor
medical standards and health outcomes. Given this combination of budgetary autonomy and accountability, however imperfect, it would be logical to allow managers—who know their service area best—greater latitude to determine what specific staffing complement they need to deliver these services. Such changes could be phased in, with some guidelines and monitoring arrangement continued to ensure a smooth transition. In other areas, such as hiring, facility managers do have formal authority but in higher-level decision-makers often seem to have the last word. It would be worth finding out if higher-level authorities are helping facilities by stepping in (for example, helping them to overcome a lack of applicants for GP posts) or are infringing on their autonomy. This is a medium-term undertaking that could be launched immediately.

(b) **Transform existing ad hoc practices into a robust and transparent system for assessing the performance of managers and staff members.** At present, assessing the performance of health sector staff consists of multiple, informal ad hoc judgments plus a formal requirement for an annual staff “audit” that facility managers appear to understand and apply differently. Nor is it evident that performance-related information is widely recorded, managed, or used systematically. Therefore, it would be advisable to formalize the staff appraisal process by producing guidelines laying out the principles and procedures for a fair and transparent assessment process with the requirement to record all findings to encourage objectivity and to share this information with staff. This should be implemented in way that does not greatly exacerbate the heavy reporting demands that health facilities already have to bear. Further, making promotion dependent on good performance assessments would also reduce the extent to which length of service is regarded as a proxy measure of skill, thereby making the pay structure more closely reflect the actual human capital requirements of the jobs in question (see recommendation below). This is a medium-term undertaking that would require some prior analysis and designing, followed by some technical assistance from donors to implement these actions.

(c) **Ensure that, in carrying out their monitoring and evaluation function, higher-level authorities clearly distinguish between factors directly within the facility’s control—for which they can be held accountable—and those resulting from external forces.** When evaluations are based on inappropriate indicators and the stakes are high, this can give rise to perverse incentives, particularly when any shortcomings tend to be met with punishment rather than help. In addition, holding people directly accountable for factors outside their control is unfair and demoralizing. Uzbekistan’s practices for monitoring health outcomes and the recently introduced Development Fund bonuses for staff have many positive features, yet the system puts local health care providers in a double bind—charged with implementing centrally set policies and practices but with little autonomy to adapt them to ensure that they work in the local context. Policymakers need to recognize and deal with this dilemma and recognize the importance of adopting supportive approaches. This could be done in the near term but would also involve changing attitudes and practices over time.

(d) **Assess the performance of the Development Fund salary award system to identify its achievements and ways to make it better.** Now that facilities are used to using their Development Funds to provide salary incentives to their staff, it is an appropriate time to evaluate its benefits or shortcomings. Facilities have considerably different resources at their disposal to make these salary awards, so the implications of the differing ability to offer this incentive to staff should be assessed to determine whether the program is achieving its aims. The second and third recommendations on managerial input and the performance evaluation design will benefit from clear assessment criteria built around principles such as provision of quality care, client orientation, adherence to good practice, fulfilling responsibilities of job rather than minutia. These criteria for the Development Fund awards should be built on the principles of transparency,
accountability, and good governance. This recommendation entails short-term actions that could be initiated immediately.

(e) **Ensure that recruitment and promotion policies and practices result in the system being staffed with the right people and that it provides staff with opportunities for professional advancement.** Uzbekistan has the formal foundations for competitive recruitment and merit-based promotion, but both of these key functions could benefit from further development. In the case of recruitment, reviewing the guidelines on the underlying principles and steps in the recruitment process to ensure adequate guidance on the spirit as well as the process of competitive recruitment, in order to enhance transparency and objectivity of the recruitment and promotion of staff. This is a near-term undertaking. Enhancing opportunities for promotion presents a much greater challenge. There are currently few opportunities open to health staff to be promoted and these are based almost exclusively on technical skill, with little consideration given to performance in the workplace, which might be recognized through annual performance assessments. Considering the professional dedication evident among health sector staff in Uzbekistan, increasing the opportunities for promotion would be an important additional incentive for staff to work hard and serve their patients well. This is a medium-term undertaking that would require significant planning and revision of existing structures and practices.

(f) **Revise the earnings structure to increase the weight given to human capital and reduce the weight given to length of service.** The pay system currently puts substantial emphasis on seniority as a proxy for increasing skill. Although this is not wholly unreasonable, it disadvantages several groups of workers—young professionals with the most up-to-date skills, experienced professionals who may have spent some time working outside the sector, and staff in newly created positions such as financial managers. Policymakers should examine the merits of changing the earnings system to put more emphasis on the skills needed in a given job and less on seniority. If Uzbekistan develops a robust staff performance assessment system as recommended above, then it might also be appropriate to add a modest element to the salary structure based on performance. This is a medium-term undertaking requiring substantial analysis, deliberation, and careful design. A more immediate, partial measure might be to de-emphasize the relative weight of seniority pay when warranted by a staff member’s skills and objective needs (for example, to hire or retain key staff members).

(g) **Evaluate the extent to which measures for alleviating recruitment difficulties in remote facilities are effective and how they might be improved.** The challenges facing Uzbekistan in this domain are common to many countries, which have tackled the problem in different ways. It is worth considering whether any of these experiences (Box 5.1) could be adapted to meet Uzbekistan’s needs. This measure could begin immediately.

(h) **Press forward with day-to-day measures—so crucial yet easily neglected—to enable facility managers to fulfill their new roles.** In those oblasts where reforms are at an early stage, the learning curve is steep, the list of tasks long, and bigger issues may draw most attention. However, it is important to ensure that seemingly small yet important administrative measures are not neglected, as this could undermine the intent of the reforms. For example, if SVPs are to assume their new responsibilities in full, financial managers should be working at the facility itself, not at the central rayon hospital or other workplace as seems frequently to be the case at the moment. Also, important documents (such as personnel records) should be transferred promptly to the relevant SVPs. This recommendation will entail ongoing attention and reinforcement.
6. QUALITY OF PRIMARY HEALTH CARE SERVICE FROM THE PERSPECTIVES OF CONSUMERS AND PROVIDERS

6.1 The accountability of service providers and the voices of consumers are critical factors affecting governance in the primary health care sector. They affect the capacity of consumers to influence the quality of care they receive and the extent to which service providers are accountable for the quality of care they provide. This chapter presents the findings of a Service Quality Delivery Survey (SQDS), which was designed to obtain the views of service consumers and providers on a range of governance and service quality issues. The SQDS involved both quantitative (household and exit surveys) and qualitative methodologies (focus group discussions, in-depth interviews). The chapter is presented in four sections: Section A examines consumers' perspectives on their primary health care facilities relating to service access and quality, informal payments, and the impact of recent sector reforms; Section B looks at a similar set of issues from the perspective of service providers, that is, chiefs of hospitals and polyclinics, general practitioners, obstetricians, and other specialists, and nurses; Section C presents our findings about how service providers interact with local institutions, such as mahalla committees, to improve the quality of health care services; and Section D presents the main conclusions of the SQDS and recommendations for giving citizens more opportunities to participate in the reform process, and making service providers more accountable for the quality of care they supply to their communities.

A. CONSUMERS’ PERSPECTIVES ON PRIMARY HEALTH CARE

6.2 The household and exit surveys as well as the series of focus group discussions in the two Oblasts focused on how the urban and rural consumers viewed the quality of primary health care they receive based on their own perceptions, experience, and expectations. As summarized below, their responses on a series of questions relating to such factors as accessibility, quality of service, nature and extent of informal payments and gifts, and the impact of the recent sector reforms.

Access to Primary Health Care

6.3 The majority of consumers who were interviewed in Samarkand and Fergana oblasts said that they have access to free primary health care—58 to 67 percent of city residents and 76 to 78 percent of rural citizens. According to the household survey, considerably more urban household members (40 to 48 percent) sought primary health care than rural household members (25 to 31 percent) (see Annex C-1). As shown in Table 6.1, the main reason for seeking the services of a primary health care facility for about half of the respondents in both oblasts was to obtain a preliminary diagnosis or treatment rather than emergency assistance, maternity care, vaccinations, tests, or other services.

6.4 The survey also showed that the presence of children (under 16 years of age) in a household does not affect the percentage of households that visit a primary health care facility in a year. The percentage of households with and without children seeking primary health care in the past year is approximately the same in both regions (Figure 4, Annex 1). However, the presence of children in the household has a significant effect on the frequency of visits to a primary health care facility by

<table>
<thead>
<tr>
<th>Purpose of Visits</th>
<th>Samarkand City</th>
<th>Margilan City</th>
<th>Samarkand Oblast</th>
<th>Fergana Oblast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic/Treatment</td>
<td>48</td>
<td>47</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Emergency Assistance</td>
<td>19</td>
<td>17</td>
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<td>12</td>
</tr>
<tr>
<td>Vaccination Only</td>
<td>9</td>
<td>6</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Maternity Only</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Examinations/Tests</td>
<td>21</td>
<td>24</td>
<td>28</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: SQDS, The World Bank
urban households per year. In Samarkand City, for example, households with children visit a primary health care facility 4.2 times per year compared with 0.6 times per year for households without children (Annex C-1).

6.5 The large majority of households (85 to 93 percent) overall indicated that they had easy access to primary health care. The following are some typical comments made during the focus group discussions, which confirmed that all social groups, including the poor, have access:

The mahalla [local citizens' assembly] gives poor people help with medicines, and SVPs give children free medicines -- FGD-women-24-49, Ferghana

My neighbor is needy, and her son is frequently sick. One night her child had 42 degree temperature. She went to a pediatrician in our mahalla who did not ask for any money. The doctor herself bought all the required medicines for that child.--FGD, women 24–49, Samarkand

6.6 Among the small percentage of consumers who cited having experienced some obstacles to obtaining free health, only 15 percent of urban households complained about being asked to pay for treatment or having to wait a long time to see a doctor. Between 7 and 12 percent of rural residents cited the problem of SVP employees who do not have a car or bicycle and must travel long distances to the health facility. Some focus group participants were concerned about reduced hours of service at a primary health care facility due to the daytime absences of doctors or nurses and about the lack of basic amenities (for example, heating) at the SVP:

They hold “five-minute meetings” at the polyclinic, but they usually last from two to three hours. That's why many patients try not to go to the polyclinic on Mondays.—FGD, urban women 24-49, Margilan

It's very cold in the polyclinic in the winter. That's why they work only an hour and a half instead of three to four hours. The number of patients going to polyclinics is decreasing sharply, while the number of doctors' visits to households is increasing.—FGD urban men-24-49-Margilan

6.7 Consumers do not feel that primary health care facilities give patients preferential treatment on the basis of income. When visiting a primary health care facility, moreover, residents of Samarkand City observe the order of priority more strictly than do Margilan residents, which can be explained by the cultural differences between the two cities. For example, Margilan is a typical Uzbek town, with ancient religious and handicraft traditions. People waiting in line there commonly yield their turn to elderly persons, children, or pregnant women. Samarkand, the former Uzbek capital, is more industrially developed and has a much less religious and more “Russianized” population. At the Samarkand family polyclinic, patients are given a numbered ticket indicating their place in line.

6.8 While most household survey respondents reported that they have easy access to a primary health care facility, a substantial percentage revealed that inadequate ambulance service severely curtails patients’ access to emergency care in both oblasts. They reported that the average waiting time for an ambulance is about 30 minutes, much longer than average response times in many other countries. According to the SQDS survey, ambulance service is worse in Samarkand oblast, where the average response time is 34 minutes in Samarkand City and 33 minutes in the villages. Moreover, 30 percent of the households reported that the ambulance never arrived, while another 12 percent said they did not even have a telephone number to call for an ambulance. The waiting time is only slightly better in Ferghana—25 minutes in Margilan City and 27 minutes in the villages. While ambulance service is generally available in both Samarkand City and Margilan City, the service is better in the villages in Ferghana oblast than in the villages of Samarkand oblast. In Ferghana oblast, 76 percent of the rural households indicated that they have access to ambulance services, but in Samarkand oblast, only 25 percent have access. In addition, 30 percent of the households in the Samarkand oblast and 4 percent in Ferghana oblast reported that the ambulance did not respond to a call.
Choice of Primary Health Care Institutions Visited by Household Members

6.9 Despite a growing number of private doctors in the two oblasts, almost all (90 to 98 percent) of the patients who sought medical assistance in the year preceding the survey went to state health institutions rather than private doctors or tabibs (traditional healer). The percentage of patients seeking primary health care at private facilities was marginally higher in Ferghana oblast than in Samarkand oblast but not high overall (9 percent in Margilan City and 10 percent in the villages). In both cities, most consumers sought help primarily from their own families and from polyclinics. Rural consumers turned more frequently to FAPs/SVPs/SVAs. However, some urban households (7 to 12 percent) sought care in the central and other city hospitals. In rural areas, the situation is different; the large majority of patients in Samarkand (76 percent) and Ferghana (61 percent) sought primary health care at FAPs, SVPs, or SVAs. A small percentage of patients (15 to 19 percent) sought care at the central rayon hospital (CRH), polyclinics, and maternity homes located in the cities and rayon centers.

6.10 When asked why patients go to a particular institution, the majority of patients in both cities (79 percent in the Samarkand City and 70 percent in Margilan City) indicated that the main reason was because they are “registered” there, and to a lesser extent, because the institution is close to home. In rural areas, the situation was about the same; three-quarters of the patients in Samarkand oblast and slightly more than half in Ferghana oblast chose an institution because they lived in its catchment area. A considerably smaller percentage of households in Samarkand oblast (16 percent) and Ferghana oblast (29 percent) mentioned proximity to their home as an important factor in their choice. The third most important factor in choosing a primary health care facility was that the institution was the only one that provided the particular type of assistance needed (12 to 19 percent). Relatively few (6 to 12 percent) chose a facility for its medical specialty or its specialized technical equipment.

6.11 While respondents in the oblasts indicated that the quality of the health service was the least important factor (8 to 14 percent) in choosing a facility, this was a more important motivator in the choice of a primary health care facility among urban households, which reflects their larger number of options as well as higher income and education. In Samarkand City, 27 percent of patients chose a facility because of its high-quality services. This was a significantly higher share than in Margilan City (6 percent), where there are lower levels of education and industrial development than in Samarkand City. About half of the urban households (45 to 48 percent) prefer their district polyclinics, and 24 to 26 percent do not care where the facility is located. Only 11 to 12 percent of the households expressed a preference for private doctors, which reflects the population’s general satisfaction with the quality of care at their primary health care facility.

6.12 Most of the rural households prefer to get their primary care from SVPs than any other facilities (73 percent in Samarkand villages and 79 percent in Ferghana villages). Of the remaining households, few (10 percent) prefer central rayon hospitals and 6 to 11 percent indicated that they do not care where they receive primary health care as long as the quality is good. Despite these findings, there is almost no alternative to SVPs for primary health care in rural regions.

6.13 While most respondents said they seek primary health care from public institutions, a significant percentage uses both private doctors and tabibs (healers). In the cities, slightly more than 30 percent of the households sought assistance from private doctors in 2007 (only 8 to 21 percent of consumers from the rural villages visited by private doctors). Households from Samarkand oblast use private doctors the least (8 percent). Overall, only 3 to 9 percent of the households visited tabibs in 2007.

6.14 Among the households that visited private doctors, most did so because they believed these doctors provide higher-quality care than those in the public institutions. Other reasons cited were availability of qualified specialists or equipment not found at state institutions. Very few went to private doctors because they were recommended by acquaintances and relatives. Among the households that visited tabibs, most said they did so because they trusted the tabibs and their
traditional treatment methods. Other reasons given were that the respondents felt comfortable with them, had previously been cured by them, had been referred by acquaintances and relatives, or had not been cured by official medical science.

6.15 Confirming earlier findings on patient satisfaction with their primary health care services, the two main reasons given by consumers in both cities and the villages for not going to private doctors were that: (i) they can go to good doctors at their district SVP/polyclinic (51 to 53 percent of the households) and (ii) the cost of private doctors is excessive (23 to 28 percent). A small proportion of the households (4 to 10 percent) do not go to private doctors only because none is available in their area. The reasons for not going to tabibs are that: (i) they can go to good doctors in their district SVP/polyclinic (41 to 47 percent) and (ii) they do not trust tabibs, and the tabibs have no modern medical equipment (31 to 47 percent).

Payments for Primary Health Care

6.16 A very small percentage of patients pay a doctor in return for receiving primary health care. According to the exit survey findings, on average, only up to 3 percent paid for some type of service at the facility in Samarkand City and oblast, as well as in rural areas in Ferghana oblast. The exception was Margilan City where 10 percent of the visitors made an official or unofficial payment. Visitors to the rural facilities in Ferghana oblast and Samarkand City indicated that they did not make any payments to a doctor. The average official payment to a doctor in Samarkand oblast was about SUM 500 and, in Ferghana oblast, SUM 3,000. The average unofficial payment made by only 1 percent of the patients to a doctor in Samarkand oblast was SUM 2,500. In Ferghana oblast, no payments were made on the day of the exit survey.

6.17 Consumers are entitled to free services at primary health care facilities but are required to pay for certain procedures. Thus, it is no surprise that the household survey revealed that 42 percent of the population had paid for some kind of primary health service in the previous year. In Samarkand City and oblast, however, patients paid for health services less frequently than in Ferghana oblast and Margilan City where reform is more advanced—21 to 29 percent versus 42 to 40 percent respectively. Most payments were made after treatment rather than before treatment, especially in the cities. In rural areas, the patients paid both before and after treatment much more frequently than in the cities (23 to 32 percent versus 5 to 12 percent).

6.18 Relatively few respondents reported giving gifts to doctors in exchange for primary health care. Among these respondents, some indicated that they gave doctors and nurses gifts or meals instead of money for their services. The value of the gift was equal to SUM 7,000 to SUM 8,000 per patient. Most of the respondents regarded these gifts as signs of genuine gratitude for good treatment (60 percent), but some believed that health workers expected gifts (23 percent), and others (16 percent) were afraid that without such gifts they might not receive good service in the future.

6.19 Gifts are perceived by the patients as a token of gratitude or a form of payment, depending on the situation and the place of service. At SVPs, for example, in-kind gifts are usually made to show a patient’s gratitude. At urban institutions, most gifts are in the form of cash, as remuneration.

My mother-in-law had surgery. Our SVP doctor came to us every day for three months to do an intravenous infusion—at 7 a.m., at noon, and at night. He took no money from us. However, when we had a wedding, we invited this doctor, and made a good sarpo [a gift—a set of clothes] for him.—FGD, women 24–49, Ferghana

When my husband was sick, he was treated by a doctor—our neighbor. My husband offered him money, but he wouldn’t take it. My husband is a musician, so he decided that he would thank the doctor when his son was married. He played at the son’s wedding for free.—FGD, women 24–49, Samarkand

6.20 People usually do not bring gifts for common procedures at SVPs, such as a visit to a doctor for a vaccination, blood, urine, and feces analyses, diagnosis, or the first few injections and
procedures. Gifts tend to be given when a patient is cured or no longer in pain after a course of treatment or non-medical procedures (massage, physiotherapy), and only by people who can afford such gifts (and if the health worker sees that the person can afford them). For example, it is normal to bring a gift after a course of obstetric and gynecological services, but not after a one-time examination or consultation with an ob-gyn during working hours at an SVP.

6.21 Based on the comments of focus group participants, gifts are traditional and vary according to the type of services provided as well as the place and time of delivery. At an SVP, gifts are presented on rare occasions; in most cases, it is some type of food for lunch or dinner. The person who brings the meal may also participate in the meal. If given at mid-day, the gift can be a common second course for lunch, with non-alcoholic beverages, costing up to about SUM 10,000 or SUM 20,000. If given in the evening, a bottle of an alcoholic beverage can be added. If delivered to a doctor’s or nurse’s home, the gift would normally be milk products, fresh bread, vegetables, fruit, or a homemade meal. On special occasions, a patient may present a piece of fabric or item of clothing (a shirt or a suit). Lower-income rural people do not fear consequences if they do not provide a gift. Rather, they are embarrassed because they cannot afford one. In urban and maternity facilities, however, people are afraid of not giving presents. Most households are opposed to unofficial payments for health services that should be free. Margilan City had the highest percentage (80 percent) of respondents opposed to these payments. The respondents from Samarkand City had a less negative attitude toward such payments (55 percent). In the villages, however, most households (60 percent in Samarkand oblast and 74 percent in the Ferghana oblast) believe that this practice is wrong.

6.22 Overall, patients going to an SVP, or referred to a CRH by an SVP, generally feel certain that they will receive free primary health services except for services that are not normally provided by these facilities or services requested during a health worker’s time off.

Every two weeks we have blood tests. I've got a low Hb level, and I'm pregnant. My doctor told me he'd refer me to a hospital for treatment. I said I didn't have any money for that. The doctor said the treatment would be free. It's true—their treatment is free. You only have to bring disposable syringes.—FGD, women 24–49, Samarkand

When I was administered intravenous infusion, I went to an SVP. A nurse told me the doctor should personally attend the procedure, and the doctor did all the infusions. It cost me SUM 15,000. Treatment in the CRB cost me less. There are no free clinics in the city—whether it is a state or a private clinic.—FGD, men 24–49, Ferghana

6.23 Some participants acknowledged that they themselves take the initiative in remunerating health workers and later blame themselves for this practice. As illustrated in the comments below, some fear that without these payments they would not receive quality services or any service at all, while others believe that the payments are justified because it is a tradition.

If we don't give them money and leave a woman in labor, they won't take proper care of her. This thought is always on our mind.—FGD, women 24–49, Ferghana

You give as much as you can and whatever you want, starting with SUM 100, and up to SUM 2,000.—FGD, women 24–49, Samarkand

What we ourselves give them is a sadaka, kumus, khairiya [donation]. If you do not give them anything, you won't feel at ease because someone else can get sick in the future, and you will worry, because you didn't thank the doctor. You're going to need a doctor's assistance as long you live.—FGD, mixed 50+, Samarkand

6.24 Confirming the results of the exit survey, participants in the rural focus groups noted that, on the whole, health workers do not extort money or take money from patients in their districts.

I go for injections for my high blood pressure. I cannot afford to pay, but they always treat me nicely.—FGD, women 24–49, Ferghana
I often visit doctors. I've got small kids. If some of them get sick, I can always ask the doctor, who is my neighbor, for assistance. He would never take money from me, because we all are neighbors in the mahalla.—FGD, men 24–49, Ferghana

I pay for the services with something from my vegetable garden—it's the expression of my heartfelt thanks. They [doctors and nurses] themselves might ask me for assistance one day, and I will never refuse them. They sometimes need my car.—FGD, men 24–49, Ferghana

6.25 The focus group participants were absolutely against the introduction of payments for all services, even if official and affordable. They believe that the poor would be unable to receive services, and official payments would increase patients' expenses even more.

In such a case we will pay both at the cash register and into the hands of health workers. It will not change the situation, only double our expenses.—FGD, men 24–49, Ferghana

Doctors and nurses will wait for you to give them something anyway. If you pay at the cash register, you will always find something for the doctor.—FGD, men 24–49, Ferghana

Doctors will still tell us that they are having inspections “from above” and need money to treat [the inspectors] to meals and will raise the cost of their services.—FGD, men 24–49, Samarkand

6.26 Poor participants believe that even now the cost of some services (for example, blood, urine, and feces analyses needed for diagnoses), for which they pay small amounts unofficially, could be smaller. Others would be willing to pay for ultrasound or physiotherapy, even if the price is higher than in the city or simply affordable.

SUM 300 for a simple test is too much. You can buy a package of tea for this money, and drink tea for three to four days.—FGD, women 24–49, Ferghana

Let them do ultrasound here for money, rather than having us go to the city. If prices are the same as in the city, people would still save money and time.—FGD, mixed 50+, Samarkand

Perceptions of Quality

6.27 One main finding of both the household and exit surveys is that people are generally satisfied with the quality of their primary health care services. Based on the household survey, the vast majority (93 to 97 percent) was satisfied with the primary health care services that they or their family had received during the previous year (see Figure 6.1) with satisfaction levels slightly higher in the villages. Based on the exit survey, the satisfaction rate of almost 100 percent can be attributed to: (i) the short waiting time (10 to 15 minutes) to see a doctor or nurse; (ii) the absence of preferential treatment for high-income or other privileged groups (except for pregnant women, children, and the elderly); (iii) the fact that doctors and nurses allow sufficient time for consultations and procedures, listen carefully to the patient’s complaints, and give adequate answers; (iv) the privacy afforded patients in the consultation room; and (v) patients' ability to continue their usual activities after the visit. Among the small percentage of satisfied household survey respondents, most indicated that the main reasons for their dissatisfaction related to the incompetence of a health worker or to a doctor paying them insufficient attention. Other reasons that were cited less often were the need to pay for medicines, insufficient equipment for examinations, and the long waiting time to see a health worker or to obtain an appointment.
Figure 6.1: General Satisfaction with Primary Health Care Received (Percent of the total number of patients - household members in each region)


6.28 Figure 6.2 illustrates the responses relating to patients’ willingness to return to the same health facility for future care. The majority said that they were satisfied with the services that they had received and would return to the same facility. However, the positive response was somewhat stronger among rural than urban residents (69 to 75 percent versus 58 to 66 percent). Although Ferghana oblast is known to have made more progress in the primary health care reform, the survey revealed that the least satisfied consumers were the patients from Margilan City (58 percent); the most satisfied came from the Samarkand oblast (75 percent).

Figure 6.2: Willingness to Return to the Same Health Facility (Percent of the total number of patients - household members in each region)


6.29 Few survey respondents reported experiencing any problems receiving primary health care in 2007 but of those who did, the share was slightly higher among urban households (15 percent) than among rural households (7 to 12 percent). The main problems reported by urban households were: (i) being asked to pay for services; (ii) having long waits to see a health worker or make an appointment; (iii) not having enough money for treatment; and (iv) the lack of ambulance service. The main problems reported by rural households, were: (i) the SVP is too far away, (ii) long waits to see a health worker or make an appointment; (iii) the incompetence or lack of experience of doctors; (iv) being asked to pay for services; (v) not having enough money for treatment; and (vi) the facility’s lack of, or obsolete, equipment.
While the survey respondents indicated general satisfaction with their primary health care services, the majority suggested several measures for enhancing the quality of and increasing access to service. As shown in Table 6.2, the most important of these measures are: (i) increasing the availability and improving the quality of medicines (53 percent); (ii) improving the training of doctors (49 percent); and (iii) introducing 24-hour services (38 percent).

Table 6.2: Measures for Improving Quality and Accessibility of Primary Health Care
(Percentage of households in each region and on the whole)

<table>
<thead>
<tr>
<th>Statements</th>
<th>City of Samarkan</th>
<th>City of Margilan</th>
<th>Samarkand oblast</th>
<th>Ferghana oblast</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve availability and quality of medicines</td>
<td>59</td>
<td>68</td>
<td>44</td>
<td>56</td>
<td>53</td>
</tr>
<tr>
<td>Improve training of doctors</td>
<td>64</td>
<td>53</td>
<td>34</td>
<td>58</td>
<td>49</td>
</tr>
<tr>
<td>Introduce round-the-clock (24-hour basis) services</td>
<td>17</td>
<td>42</td>
<td>37</td>
<td>43</td>
<td>38</td>
</tr>
<tr>
<td>Reduce the waiting time for an ambulance</td>
<td>24</td>
<td>42</td>
<td>25</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Improve training of nurses</td>
<td>27</td>
<td>20</td>
<td>17</td>
<td>34</td>
<td>25</td>
</tr>
<tr>
<td>Inform the population on free and chargeable health services</td>
<td>10</td>
<td>12</td>
<td>9</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Facilitate the procedure of referral to specialists and to other institutions</td>
<td>16</td>
<td>15</td>
<td>9</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>


The Impact of the Primary Health Sector Reform

The household survey findings suggest that the health care reform can be viewed as having a positive impact on the population. More than half the respondents (66 percent) in the household survey indicated that the quality of their primary health care services had improved during the last three years, with the highest percentage living in the rural villages. Some of the improvements mentioned by participants in the focus group discussions relate to facility location, equipment, convenience, and service availability:

> The SVP has new instruments and devices. Now we do not need to go to the city. —*FGD, mixed 50+, Samarkand*

> We used to go to Jomboy to visit a gynecologist before. Now the gynecologist comes to our SVP. —*FGD, women 24–4, Samarkand*

> We visit the SVP more now because we are in poor health. We did not visit SVP before because they did not have anything to offer, but now they even have physical therapy, massage, ECG, and other services... —*FGD, women 24–4, Samarkand*

With regard to obtaining regular examinations and vaccinations, the responses from those in Ferghana oblast on the whole look better than those from Samarkand oblast. More residents in both the cities and villages in Ferghana oblast actively seek examinations and vaccinations at a primary health care facility on a regular basis than do those in Samarkand (see annex 2). In the villages of Samarkand oblast, by contrast, health workers are more active than those in Ferghana oblast (see annex C-12). Another indication that the reform is more advanced in Ferghana oblast is that the highest percentage of patients given some medication was from villages in Ferghana oblast, while the lowest percentage came from villages in Samarkand. Overall, medicines were prescribed more often for both rural and urban patients in Ferghana oblast than for patients from elsewhere (annex C-1).

Although responses concerning the impact of reform on the quality of primary health care were generally positive, particularly in Ferghana oblast, many of those surveyed expressed concerns
about payments and the shortage of qualified doctors. For example, 74 percent of the respondents agreed that they do not know which health services can officially be charged for and which are supposed to be free. Nonetheless, most respondents (74 percent) agreed that all residents in their settlement have access to free medical assistance. However, a little more than half agreed that there is a shortage of doctors or specialists in their respective institutions.

6.34 Thus, the respondents' answers are an indication of some contradictions that have accompanied the changes in the public health system. On one hand, the quality of health care has improved, and access to these services has increased. On the other hand, the rules governing payment for these services remain unclear, and there is a shortage of doctors and other specialists. Moreover, rural residents are more satisfied than city dwellers with the primary health care system.

B. PROVIDER'S PERSPECTIVES ON QUALITY OF PRIMARY HEALTH CARE

6.35 In-depth interviews with representatives of PHC providers were used to obtain their insights and opinions covering a range of health care governance issues. The interviewees included: heads of SVPs; heads of rayon polyclinics; physicians, obstetricians, nurses, other medical staff from SVP; patients of varying ages, gender, and family circumstances; teachers from medical colleges; chairmen of mahalla committees; traditional healers; representatives of hokimiyat; heads of any relevant health care-related NGOs.

Provider Perspectives on the Impact of Reform

6.36 In Margilan City, where reform is more advanced than in Samarkand City, primary health care providers mentioned various positive changes that have resulted from the primary health care reform. At first, both the population and providers felt suspicious about the changes, but soon they all came to accept the innovations and appreciated their positive effects.

In the beginning, some doctors were not willing to work as GPs. Some left but came back because working conditions were better. They had their own offices as well as necessary equipment and supplies. A doctor in other polyclinics may have only one nurse, but our GPs have two to three.

Chief, family polyclinic, Margilan

Our patients like having one doctor for the whole family. They used to have to go to the children's polyclinics, adults' polyclinics, and women's consultation.

Chief, CCH, Margilan

6.37 Service providers in both Samarkand City and Margilan City noted the positive effects of the Health II Project, which supported the reforms, financed new equipment for SVPs and polyclinics, introduced some direct financing of SVPs and polyclinics, allowed them some independent management of funds and purchases, and improved personnel training.

Last year the World Bank provided us with three ECG apparatuses and instruments for an otolaryngologist, surgical instruments, ophthalmoscopic instruments, stadiometers, and scales.

Chief, family polyclinic, Samarkand

The SVP has been better equipped than our hospital.

Trade union leader, CCH, Margilan

We have a training office, with video films and TV sets, which teach us how to prevent and treat infectious diseases. A doctor shows people these films. We've been able to reduce the rate of infectious diseases.

Chief, family polyclinic, Margilan

6.38 Service providers in the Samarkand polyclinics feel the benefits of the creation of special Development Funds at each polyclinic (some providers call it "the head physician's fund").

I've bought a computer and all kinds of inexpensive equipment. In 2006 we bought more than in the previous three years.

Chief, family polyclinic, Samarkand
Order 276 allows me to grant a bonus to any employee, to add 15 percent to his or her salary three to four times a year. I no longer have problems getting medicines. If there’s not enough money in the state budget, I withdraw some from our special account and buy drugs.—Chief, family polyclinic, Samarkand

6.39 District doctors and patronage nurses noted many beneficial changes for their patients as a result of the health reforms. They include: (i) patients no longer are required to have a permanent residence in a specific catchment area to receive medical assistance at the facility of their choice; (ii) district doctors and polyclinic patronage nurses visiting households discover sick patients and report them to the polyclinics responsible for caring for them; (iii) personnel are now aware of Order 425, which stipulated measures to ensure safe motherhood.

We now have screening centers, where women can be checked for signs of pathologic pregnancy such as threatened miscarriages, a non-developing fetus, and HIV-infection. There were no such centers three to four years ago.—Obstetrician, CCH polyclinic, Margilan

In 1996–1998, the number of TB patients increased sharply. In the following years, however, the incidence of the disease dropped sharply. In the past, we referred 17 to 18 patients to the TB dispensary each year; now we refer only 3 or 4.—Pulmonologist, CCH, Margilan

6.40 As a result of the health reforms, SVP personnel in Ferghana oblast noted various types of improvements related to the training of doctors and increased access to a wider range of educational materials. For example the Raizdravs (Rayon Department of the Ministry of Health) and the Oblzdravs (Oblast Department of the Ministry of Health Protection) organize training courses and seminars for doctors, obstetricians, and nurses to help them to increase their qualifications. One SVP in Ferghana oblast has started publishing its own manuals and instructions for treating patients.

I recently found echinococcosis in a kid, and made the diagnosis myself, without an ultrasound test.—SVP GP, Ferghana

They publish a lot of brochures in the Uzbek language these days. In the past, they were mostly in Russian. Our library has all kinds of books on the same subjects, and we use them. In the past, there were books by only one author on a subject. Now we can use different methods of treatments. We now have 10 to 12 manuals for treating anemia, hypertension. One manual was written in Tashkent—by authors Sabokhatkhon Mirzayeva and our chief nurse Khalimakhon. We used to be provided with manuals from Tashkent, but now we publish them ourselves. —SV chief, Ferghana

In 2002 we were visited by USAID and a doctor from Kazakhstan. After talking with me, she asked me what my position was. I said I was a nurse. She said, talking with me, she thought I was a doctor, and that she had been satisfied with our conversation. I was very pleased.—SVP nurse, Ferghana

6.41 Also, GPs are now able to make independent decisions when diagnosing patients.

We used to have to hospitalize all sick children under one year, now I myself can decide whom to treat at home and who should be hospitalized. Prenatal treatment used to be obligatory, but now it’s not. Now I’m the one making decisions. Before, I could receive only certain types of patients. Now I work with all of them, regardless of their gender or age. SVP GP, Samarkand

6.42 Working with patients has become easier now that facilities have new medical and laboratory equipment, especially in Ferghana oblast.

I used to use only a phonendoscope, a pen, a thermometer, and a tonometer, but now I’ve got a photocalorimeter, an opthalmoscope, an ECG, and we hope to have an ultrasound apparatus soon. Then we will not have to refer our patients anywhere for screening. We can perform surgical operations already because we have the necessary surgical instruments for that.—SVP GP, Samarkand

We used to prescribe up to 10 different drugs for injections to treat this or that disease, but now we treat these diseases with one type of pill. The number of infectious diseases has decreased. We also have new modern equipment in our SVP, such as an ECG and equipment for physiotherapy. On the whole, our work conditions for treating patients have improved significantly.—SVP chief, Ferghana
We've received Russian autoclaves with distillers. They are very easy and convenient to use.

Obstetricians and gynecologists used to check fetal heartbeat with the help of a fetoscope, but now we've got a Doppler apparatus.—SVP chief, Ferghana

6.43 Notwithstanding the improvements associated with the health reforms, SVP workers have noticed a dramatic increase in the amount of paperwork that they need to handle, the time needed to fill out numerous forms, and the need to consult with higher authorities and organizations. They believe that these pressures affect not only the quality and detail of the information put into the forms but also the quality of the services provided to patients.

We have to knock ourselves out submitting the same data on different papers to different places—the same monitoring information to both a gynecologist and an internist, for instance. We fill books and books with patient records and statistical letters. Major institutions have a special person who does these things from morning till night, but we are a small facility.—SVP chief, Samarkand

We are supposed to prepare 3 to 4 reports for one sector only (cardiology, pulmonology, urology, and gastroenterology) - 30 reports in all. We used to have inspections once a year; now it's 3 to 4 times a year. This is a huge waste of time, effort, and our own health.—SVP chief, Samarkand

The very purpose of a health worker's work is being ignored—we are working for papers rather than for our patients. We need to report how many infants are drooling. We report, “1 out of 60.” They write back, “This cannot be true. At least 10 should be drooling.” We rewrite our report and put in, “10 infants are drooling.” They do not trust us and think we are submitting fake data to them. Yes, we are—but only after they themselves force us to do that. —SVP chief, Ferghana

6.44 All employees are required to work almost twice the normal number of days because of the additional mounds of forms to be filled out. For example, a normal working day is six hours for a doctor on one stavka, but he or she actually works eight to ten hours a day—nurses even more—plus they take papers with them to fill out at home. Such overtime work is usually compounded by patients:

Even if they know they should take a patient to a hospital, they call and wake you up in the middle of the night, because they need to hear from you that this patient needs to be hospitalized.—SVP GP, Samarkand

Nobody pays you for overtime—maybe because our higher authorities think our patients pay us for our work. Even at home we don't have a moment's peace.—SVP chief, Samarkand

Demand for Primary Health Care

6.45 The rural population’s demand for primary health care services has significantly shifted from urban facilities to the SVPs. Most rural residents can now go to a nearby SVP. Proximity is especially helpful for poor and vulnerable people who were unable or could not afford to go to the city.

Patient traffic at SVPs seems to have increased by 70 to 80 percent during recent years. People come in not just for routine medical check-ups but as soon as disease symptoms occur.—SVP chief, Ferghana.

6.46 SVP services (full and provisional diagnosis, treatment assignments, and uncomplicated treatment procedures) are more diverse, of better quality, and available close to home. In particular, SVPs can do the blood, urine, and feces analyses needed for diagnoses and for simple check-ups before going to work or away to study. For more complex tests that cannot be done at the SVP, test samples are taken at the SVP and are then evaluated at the central rayon level, with the results reported to the SVP the next day. Although the situation is not ideal, both demand for SVP services and satisfaction with them are growing for two main reasons: (i) the SVP facilities are designed and constructed to be both staff- and patient-friendly. SVPs are within 4 to 5 km or an hour's walk from most patients’ homes. The nearest city facility, where people used to have to go, is usually about 30
to 50 km away; and (ii) health care personnel have received medical and laboratory equipment, medical and surgical instruments, and bags for medical nurses. This has allowed local health workers to administer primary health services to their communities.

6.47 As consumer satisfaction has grown, the number of patient visits to SVPs has increased to the point where SVPs cannot satisfy demand.

People come to us from other districts now. More than 15,914 people live in our SVP’s district. That’s a lot. It’s hard to work with such a great number of people. — SVP chief, Ferghana.

We used to refer people with a cold to a hospital. Now we do everything ourselves. — SVP chief, Samarkand

6.48 The number of patients from middle-income and poor families has increased as a result of the outflow of the urban population from the cities and the inflow of migrants from rural areas to the cities. This dynamic has not only increased demand for services but has also shifted it toward preventive activities.

We have more patients from poor families these days, and single elderly people, because they are more susceptible to diseases due to malnutrition and lack of proper sanitation. Why do we have more patients? Because our services are free.—Chief, family polyclinic, Margilan

There are now more pensioners, disabled persons, and single people among our patients. That is because we offer many benefits for this group of patients. They can be examined for free and get free treatment. If you have a look at the board at the entrance to our polyclinic you can see that it says “free” for everything.—Chief, adult polyclinic, Samarkand

Thanks to the work of our mahalla committees and health workers, more people come to see doctors nowadays. Nurses visit every household and make notes in each household’s journal about the state of their members’ health. If some get sick, the nurse takes them to the polyclinic. If they cannot come themselves, a doctor visits them and examines them at home. If a sick person needs specialized assistance, the district doctor brings in a specialist for an examination.—Chief, family polyclinic, Samarkand

6.49 Providers, especially those from urban hospitals, noted a decrease in the number of visits by certain population groups to a primary health care facility for the following reasons:

There are fewer men now, because many of the men aged from 16 to 50 have left for Russia in search of work.—Physician, adult polyclinic, Samarkand

Men don’t have time to be sick. And if they get sick, they treat themselves with folk medicine.—Chief, CCH, Margilan

We see fewer patients from the villages now. We see 20 to 40 patients a day from our district, only about 5 of them from the villages. The number of patients from the villages has dropped, because their SVPs are doing a better job. Now they know their district doctors and maternity nurses.—Obstetrician, polyclinic, CCH, Margilan

Providers’ Income

6.50 All of the service providers indicated that their salaries are low, covering only up to 30 to 40 percent of their living expenses. Even with the addition of bonuses, which can equal as much as 15 percent of their salaries, doctors do not earn enough to pay for their families’ food.

Look at my shoes—they cost SUM 65,000. However, they were given to me as a gift by my brothers. They’ve been battered as a result of too much walking. I am a doctor with a lengthy service record, a manager of a polyclinic, but I cannot afford to buy new shoes, not to mention a car. What can I buy with my SUM 110,000? Every month I think what to buy—food or clothes? I am going to retire soon, but what do I have?—Chief of a facility, Margilan

A salary should suffice to buy food and pay for children’s studies, and for a kindergarten. We should be able to afford to buy a refrigerator or a TV. The size of our salary hasn’t been changed since Soviet
As discussed in previous chapters, due to their low official salaries, service providers often supplement their income with earnings from three sources—non-medical entrepreneurial activities, secondary jobs at other facilities (including private institutions), and payments from patients. The proportions of these earnings depend on where the service provider works. At hospitals, the main non-salary earnings of health personnel are payments from patients, while at polyclinics, the main earnings come from managing a shop, drugstore, or café, or tutoring school children, or working as craftsmen. Earnings in the form of gifts or food are common in close-knit communities, while money is preferred in less-cohesive urban environments. Thus, working as a craftsman as a way of making additional income is more common in Margilan City, while cash payments are more common in Samarkand City.

It’s not usual here to ask something from a patient, and it’s simply not possible. What is given as a token of thankfulness is such a trifle, being just the sign of respect and gratitude, nothing more. Our services are free, and it’s a small city.—Chief, family polyclinic, Margilan

We bake buns in our family and sell them at the market. The income is about SUM 50,000 to SUM 100,000 a month. In Soviet times, a doctor used to work only as a doctor, a teacher only as a teacher. But it’s all different now.—Obstetrician, polyclinic, Margilan

An SVP doctor in the countryside can keep livestock, a garden, and a vegetable garden. But in the city, our job is our only source of income. That’s why doctors take night shifts. The income from night shifts makes up 30 percent to 40 percent of a salary.—Chief, family polyclinic, Margilan

The situation in Samarkand is somewhat different from that in Margilan, in the opinion of the service providers.

Some patients bring coffee, chocolate, and grapes. Those who have their own vegetable garden bring their vegetables and fruits. Those who have money thank us with money. If I see that the patient is poor, I won’t take money.—Physician, adult polyclinic, Samarkand

They can bring you lunch. Why not?! If, say five relatives visit a patient today and each brings lunch, why not give extra food to nurses, instead of throwing it away?—Trade union, CCH, Samarkand

Doctors receive nothing else but their salary at work. And after work, many go to private clinics for a second job.—Trade union, CCH, Samarkand

All the providers believe that having to find additional sources of income significantly limits their opportunities to enhance their professional qualifications, and thus improve the quality of the services they provide.

First of all, a person gets tired, and second, he can be late for work the next morning, and third, he does not have time for self-development. Instead of going home where he could read new literature in his field, a doctor works in his vegetable garden, etc.—Chief, CCH, Margilan

Our urologist works at the polyclinic and at a private urological clinic. These days every third employee has an outside source of income. Nurses here work as social workers, bringing food to households.—Chief, adult polyclinic, Samarkand

Our doctors work nights at the ambulance station. Gynecologists take night shifts at the maternity home.—Chief, family polyclinic, Margilan

**Attitude toward Private Providers**

Although public facility providers generally have a positive attitude toward private practice, few are interested in working in a private health care facility.
Private practice and state budget organizations both compete with and supplement each other. This helps raise service quality. A private practice is usually started by an experienced specialist. Others are afraid of starting a private medical practice for fear of bankruptcy.—Chief, CCH, Margilan

When we cannot administer in-depth medical examination using special equipment, we advise patients to go to a private clinic for the examination and come back to us with the results. Chief, family polyclinic, Samarkand

Private facilities can relieve the main symptoms of an acute disease, using strong medicines, and the patient starts to think he has recovered. But in 10 days the disease returns in a more severe form. At this point, patients go to a state facility.—Chief, family polyclinic, Margilan

**Evaluation of the Quality of SVP Services**

6.55 The work quality of SVPs and their personnel is evaluated by several external and internal entities. The external evaluations involve specialists from Raizdrav and Oblzdrav, as well as joint commissions and inspections. Also, if an SVP service provider has a problem in clinical practice, he or she may ask Raizdrav and Oblzdrav specialists for advice. Even if no advice is requested, Raizdrav and Oblzdrav specialists provide training in specific areas on their monthly or quarterly visits to SVPs.

People from the Health Project visit us, comparing, analyzing indicators. They used to criticize us mercilessly, but now they explain everything to us and give us advice on how to prevent mistakes and flaws. —SVP GP, Ferghana

Our work is regularly evaluated. Oblzdrav and Raizdrav specialists review our monthly and quarterly reports.—SVP chief, Ferghana

They come to us from Raizdrav and Oblzdrav—to look at our patients' cards, to attend our meetings, and to estimate the quality of our work. —SVP chief, Samarkand

6.56 The internal evaluation of the work quality of SVPs is based on a point rating system developed for SVPs and approved by the Ministry of Health (Order No.276).

Points are assigned for prompt service, lack of complaints from patients and supervisors, appearance, etc. The work of SVP doctors and chiefs is rated on the results of their clinical and organizational work, the quality of their subordinates' work, and the quality of their reports, protocols, and documents. My salary is calculated in relation to the results of my activity. Your salary tells you whether your work is rated good or not so good.—SVP chief, Ferghana

If a nurse hasn't visited a patient at home, the patient calls to tell us no nurse has visited, or I check on nurses' visits myself. —SVP chief, Samarkand

6.57 These evaluations by SVP doctors and nurses are based on indicators required by the authorities. They involve detection of disease incidence and changes in the birth rate. Increases in either rate are considered an indicator of “bad” work.

I look at the number of medical check-ups performed in the previous same period. If I had 1,891 check-ups last time, but now it's 1,560, I set myself the task of bringing this figure at least to the previous level. —SVP chief, Samarkand

An increase in the number of births or patients in my district means I'm doing a poor job. —SVP nurse, Samarkand

For example, 10 patients from my district, all from different streets, go to see a doctor. The doctor asks each of them on what street they live, who the patronage nurse is, how often she visits them, whether she talks to them, measures their blood pressure, and examines their children. What they say gives the doctor an idea of how I work.—SVP nurse, Samarkand
6.58 SVP chiefs and employees appreciate the inspections and evaluations of their work quality, but they expressed concern about their frequency:

These methods help us improve our work quality. Even I make mistakes sometimes and would correct them after these inspections. However, these commissions come to us almost every week. For example, they bring us some equipment from the Health Project each week, but they do not simply leave after that. They start checking gynecological cards, patients' visits, etc. What for?—SVP chief, Ferghana

6.59 In a reward and reprimand system as prevails in Uzbekistan's health system, for a doctor's first offense, the inspector usually starts by reprimanding him or her in private. In the rare instance that the reprimand is ignored, the reprimand or deprivation of bonus is publicly announced by the chief doctor. As for incentives, bonuses and cash rewards have more symbolic effect than real material value because they tend to be small (US$5 to US$10). Sometimes employees are given higher bonuses (US$30 to US$50), but this happens no more than once or twice a year. According to the service providers that we interviewed, even a symbolic reward means a lot for a worker's prestige if accompanied by a public announcement of the award.

You can see it even in their step, when individuals receive a bonus. It makes them feel appreciated by the team. —SVP chief, Ferghana

Honestly, even when somebody says to me “thank you” for my job, it makes me happy. I don't need them to pay me SUM 1,000 [US$1].—SVP chief, Ferghana

We hold meetings every Thursday where I announce candidates for bonuses and explain what they have done to qualify.—SVP chief, Samarkand

6.60 For mid-level and nursing staff, by contrast, even small bonuses, or being deprived of bonuses, have greater significance because nurses' salaries are so low. Thus, SVPs tend to grant bonuses more to nurses than to doctors because doctors do not feel comfortable receiving them when nurses are in greater need of money. Although the nurses' bonuses are not high, penalties for poor performance, though rare, can be substantial—up to 30 percent of their salary. In practice, it is mainly visiting nurses who are penalized for faulty work.

Cash rewards are very important, but, unfortunately, we haven't received any for a long time.—SVP visiting nurse, Ferghana

I signed an order granting bonuses to N. and several nurses and nurse-maids to the total amount of SUM 30,000 (US$25). We looked into our budget, found the necessary amount. Quite frequently we reward N., a nurse-maid and a registry clerk. Registry is a “mirror” of our SVP.—SVP chief, Ferghana

If you do a poor job, you will be reprimanded first, but next time 30 percent will be deducted from your salary, and eventually you can be dismissed.—SVP chief, Ferghana

6.61 The main reasons the inspectors cite for a “poor work” finding are: (i) a reduction in the number of patients or the birth rate; (ii) lax work discipline, especially for nurses, who, for example, report late for work or skimp on household visits; and (iii) complaints from patients.

C. INTERACTIONS BETWEEN SERVICE PROVIDERS AND LOCAL INSTITUTIONS IN IMPROVING THE QUALITY OF HEALTH CARE SERVICES

6.62 The “weakest link” in the primary health care system is the fact that consumers have little or no influence over the activities and quality of the health sector. This lack of influence has made it possible for an informal payment system to arise in the public health system and has prevented further improvements being made in the quality of services provided by facilities.
Means for Lodging Complaints

6.63 Consumers seem to be unwilling to fight for their individual rights or officially express dissatisfaction with their primary health care services. In the two years preceding this study, for example, only 2 percent of consumers (only 18 of the 1,000 households interviewed) had officially made suggestions to the health sector authorities for improving the quality of primary health care services or had lodged an official complaint. Among those 18 households, 10 had turned to their mahalla committees. Nonetheless, the focus group discussions revealed that it is common for people who are dissatisfied to make verbal complaints to SVP chiefs about a particular doctor or nurse or to a doctor or a chief nurse about another nurse.

6.64 The survey and focus group participants confirmed that they are aware of channels for making complaints against their primary health care services. However, the submission of official or written statements is rare because people feel that written statements should only be made as an "expression of gratitude" because people have a fear of official papers. There is a popular Uzbek saying: "Your name is on a paper—you are in trouble." As a result, patient satisfaction surveys are not common in the Uzbek health system.40

6.65 Another reason that respondents cited for not wanting to make official statements and complaints is that they sympathize with and respect health workers, many of whom who could be their neighbors, and a willingness to protect these workers from being punished by a "strange" official.

That girl didn't injure my arm with an injection on purpose. She was just inexperienced. It's not worth going to her supervisors to complain about my neighbor."—FGD, men 24–49, Ferghana

6.66 People are generally reluctant to express their personal opinion and would rather have their concerns raised by a group or an official institution. Discussions with both urban and rural consumers revealed that they preferred to work through the mahallas in expressing their concerns to the health authorities about their local primary facility, despite the recent opening of city branches of the Consumers Rights Protection Society, “health groups,” and other similar consumer organizations. This is probably because mahallas have already been involved in interacting with health authorities and have demonstrated their effectiveness in that role.

A mahalla representative should be made responsible for the medical treatment of people in his district. If somebody is sent for a surgery or some other treatment, he could come there and ask whether the treatment is successful or not.—FGD, women 24–49, Ferghana

Doctors are turning to mahalla committees these days, asking them to conduct educational activities with the population. They gather mothers-in-law and explain to them the importance of timely visits of their pregnant daughters-in-law to doctors. They tell them women shouldn't carry heavy things during pregnancy, etc.—FGD, urban women 24–49, Margilan

Mahalla committees play an important role nowadays. They organize discussions, meetings with doctors.—FGD, urban women 24–49, Margilan

We organize a “health corner” in all mahallas and distribute booklets with information about our work. Meetings were also organized in each mahalla. We have 26 mahallas and interact closely with all of them. Our visiting nurses have detected many people with HIV with the help of the mahalla. Sometimes Mahalla representatives call facilities saying, “We have an ill woman in our mahalla, she is single and needs an operation or insulin. Please, come and visit her.” There are, certainly, more active and less active mahallas, depending on their leader. —Chief, adult polyclinic, Samarkand

6.67 No focus group participant mentioned having heard of any case of a malpractice suit even if a doctor made an incorrect diagnosis, the wrong treatment was administered, or procedures and injections were improperly used. In such circumstances, the wronged party would complain to the

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40 Findings from one-off patient satisfaction surveys that have been conducted by some agencies outside the Ministry of Health were not yet available at the time of writing (November 2007).
head physician or to a mahalla committee and could raise the issue at public meetings. The focus group participants believed that individuals’ complaints to the head physician produce results, but that complaints and suggestions are better made through mahalla committees or citizen groups.

A mahalla committee shouldn't act on behalf of one person. It should be a complaint submitted by a group of citizens. —FGD, women 24–49, Ferghana

It would be good if there were a drugstore at the SVP and if we could have our tests done here. Now we have to go to the rayon. We'd better save that money to buy drugs with it. That's what I said at a mahalla meeting at our school. Many supported me in this opinion. —FGD, women 24–49, Samarkand

We submitted complaints to our mahalla committee. Nurses do not visit their patients. We have never seen them visit people in the mahalla. Our SVP is probably the worst in the rayon. It doesn't have necessary equipment, you can never find doctors there, and nurses do not want to serve patients, even to give them injections. —FGD, men 24–49, Samarkand

6.68 Ultimately, many people do not file official complaints because they do not believe they will have any effect. Whether this is true or simply a common misconception is not clear. Nonetheless, participants in both the rural and urban focus group discussions expressed the following views:

Say I have to go to a mahalla committee with a complaint against a doctor. This doctor will always find a way to agree with the mahalla committee. Three or four days later they will become friends with the mahalla committee. —FGD, men 24–49, Samarkand

Nobody is going to consider your complaint. It will just be shunted from one place to another. —FGD, urban men 24–49, Samarkand

If you complain, nobody will be nice to you next time. You will have to turn to the same doctor or nurse, and they will associate your name with a row. —FGD, urban women 24–49, Samarkand

6.69 Officially, there are no institutions that involve the public’s participation in the improvement of SVP services. Even when representatives of communities or women’s organizations are members of SVP Councils (which is the case in one SVP in Ferghana oblast), their participation is not recognized.

There is a Kengash (Council) at the SVP, consisting of representatives of the trade union, the Women's Council, and the mahalla committee. We are discussing major issues (not medical) at meetings of this Kengash. —SVP chief, Ferghana

6.70 While SVP managers and employees recognize the need for some level of participation by the population in ensuring the quality of the SVP’s services and even expenditures, they do not want it to mean introducing another layer of control in the existing series of inspections and commissions. To avoid this, SVP employees suggest including representatives of the population in the Councils and health groups currently functioning at some SVPs. They also noted that for the population to be able to participate, they will need to be taught not only the methods of control but the methods of providing assistance to SVPs as well.

Representatives of the population should be included into the commissions controlling the activity of our SVPs. Or, people can be asked to fill out questionnaires —to find out what they like about the work of their SVPs, and what they don't like. —SVP chief, Ferghana

People have their own rights, which should be honored by public health authorities. Sometimes it happens that a doctor is late for work, while there is a line of patients waiting for him. We have a Complaint Book at our facility, but there are mostly expressions of gratitude there. —SVP chief, Ferghana

6.71 The findings of the focus group discussions suggest that mahalla committees generally can meet community members’ needs for health education targeted to specific groups (for example, pregnant women, the elderly) and for communicating a member’s concerns to an SVP when he or she has a specific problem or complaint. However, they are less effective in encouraging broader citizen participation in ensuring overall quality of service provided by the SVPs.
D. Conclusions and Recommendations for Improving the Quality of Primary Health Care Services

6.72 The main conclusions from the SQDS are that consumers are generally satisfied with their primary health care services, do not feel any pressure to make unofficial payments for their care, and do not find that a particular segment of the population receives unfair preferential treatment. They see the impact of the health reform, though still unfolding, has having been generally positive in terms of increasing access to primary health care and making available a wider range of services. However, even in Ferghana oblast where the health reform is more advanced than in Samarkand, consumers highlighted the need for more and better qualified doctors, a more responsive ambulance service, and shorter waiting times to see a qualified doctor. From the perspective of service providers, the health care reforms have brought several benefits, including the introduction of the principle of fair budget allocation based on per capita financing, the expansion of the populations’ access to primary health care facilities, an increase in the supply of medical laboratory equipment to rural SVPs, and the official granting of the right to choose a service provider to rural consumers. Notwithstanding these positive trends, providers complained about their low salaries, which do not cover living costs or compensate for the significant burden that the recently introduced administrative requirements have put on their time.

6.73 We make the following recommendations based on the survey findings and other inputs from service users and providers to enhance accountability in the primary health care sector and to allow consumers’ voices to be heard.

6.74 Educate the public about the reforms. The findings of the SQDS strongly suggest that the public needs clearer information on the implications of the health care reform and how to secure better primary health care services. Among other issues, consumers need information on: (i) the actual changes in their facility services and procedures as a result of the reforms; (ii) which services should be free, which services are not free and how much they cost at each primary health care facility; (iii) how to access emergency services (for example, having a telephone number for calling an ambulance); (iv) the schedule of when doctors and nurses are available to treat patients; and (v) how to lodge a formal complaint about poor service quality. The primary health care facility should take the lead in supplying this information to consumers by posting signs and distributing brochures as well as posting notices at mahalla committee centers. In addition, the Ministry of Health could fund a countrywide publicity campaign to let consumers know about the implications of the reform and measures they can be taken to influence the quality of service at their primary health care provider.

6.75 Establish a special board, council, or committee at public health facilities to strengthen their accountability to the public. The legal foundation for creating these boards already exists as the basis for decentralizing the management of social services in accordance with government policy. Members could include representatives of CRH, citizens’ self-management bodies, Women’s Committees, and the mahalla committee. The role of such a board or committee can include: (i) recruiting staff on a competitive basis, (ii) approving the list of services for which the facility may charge a fee; (iii) developing and approving a transparent payment system for processing the fees charged for medical procedures; (iv) seeking funding for facility development; (v) establishing a system to give consumers the opportunity to complain about poor service and receive a satisfactory response, provide feedback about service quality, or to suggest ways to improve medical care at the facility; and (vi) distributing and collecting citizens’ score cards twice a year to solicit feedback from consumers in the facility’s service area.

6.76 The Ministry of Health would need to draft regulations for the boards or committees and fund the training of board or committee members in public or consumer outreach, consumer relations, and other skills. The board’s composition, functions, role, and reporting arrangements would be discussed agreed among the local community. In developing these arrangements, the
community should consider whether to include a member that would be assigned the role of advocate for a specific disease or group of diseases (for example, HIV, tuberculosis). The community would also need to decide how the board would relate to the mahalla committee, which would report to the board from its constituency and continue working with the SVPs in providing specialized health education (such as teaching nutrition to expectant mothers).

6.77 Civil society institutions can be trained to supplement mahalla committees, local government, and central management in monitoring the public health care system. The mission of these institutions would be to increase the efficiency of management and improve the quality of services and medicines provided by public health institutions, ensure the enforcement of laws related to health care workers who make mistakes, and raise public awareness about the need for vulnerable groups to protect their health, have regular health examinations, or use birth control.

6.78 Reduce bureaucracy. Service providers recognize the need for facilities to be subject to periodic inspections. However, most agree that the excessive reporting requirements, inspections, and other administrative tasks (for example, lengthy meetings and time-consuming paperwork) reduce their efficiency and prevent them from treating patients.
7. SYNTHESIS OF THE FINDINGS AND RECOMMENDATIONS

7.1 It is team's view that the ongoing primary health care reforms, combined with the treasury reform recently initiated on a pilot basis, helped to increase the effectiveness of primary health care providers in Uzbekistan. However, because the reforms are being implemented incrementally, their impact on governance and health service delivery has been uneven across different dimensions of governance, regions, and sub-sectors.

A. QUALITY OF GOVERNANCE

7.2 The reforms have increased government effectiveness in providing primary health care services by increasing the predictability of financing for local health facilities and the availability of resources for drugs, medical supplies, physical infrastructure, repairs and maintenance, and salary incentives. These incentives combined with increased medical training have increased health workers' earnings and morale and have thereby increased productivity. The introduction of staff performance evaluations that are based on clinical reporting of health outcomes has caused health workers to pay more attention to their patients' health status. The majority of consumers interviewed in Samarkand and Ferghana oblasts said that they regularly visit local facilities for free primary care in the areas of diagnostics and treatment, emergency care, and vaccinations. One main finding of both the household and exit surveys is that people are generally satisfied with the quality of their primary health care services. They are willing to return to the same health facility in the future, and they prefer to visit public health facilities rather than private doctors because there are good doctors at their district SVP or polyclinic and because of the high cost of private doctors.

7.3 However, the under-funding of primary health care has undermined its effectiveness. Although the reforms have increased access to primary health care, several obstacles remain. For example, urban consumers cited such problems as service providers requiring informal payments for treatment or having to wait a long time to be seen, while rural consumers cited such problems as the long distance to SVPs, unscheduled absences of doctors or nurses, and a lack of basic amenities (for example, heating). A substantial percentage revealed that an inadequate ambulance service has severely curtailed patients' access to emergency care in both oblasts. These obstacles reflect, to some extent, the under-funding of primary health care, specifically the resulting low wages and salaries of doctors and nurses and inadequate funds for operations and maintenance.

7.4 Inefficient resource use caused by delays in financing and unfair competition in public procurement has continued to impede government effectiveness. Delays in financing seemed to occur most notably in the oblasts where the treasury reforms have not yet been undertaken, which means that hopefully the treasury reforms are alleviating this problem. These delays prevent SVPs from executing their budget in the most efficient way, force them to deal with suppliers who are willing to wait longer for payment but may charge more, and skew expenditures toward those budget line items for which funds may be available but which the SVP might not need at the time. Unfair competition in public procurement leads to the overpricing of drugs and equipment. All of these factors result in the costs of health care services being unnecessarily high.

7.5 Greater transparency has been achieved in public financial management. The treasury reforms have made it possible for the Ministry of Finance to produce reliable, timely, and comprehensive financial reports of any kind and at any level of detail to be used as inputs into management decisions. After these reforms have been implemented in full, they are expected to make the health budget even more efficient. We found that the recruitment and promotion of health personnel are based on clear guidelines and principles, but we were required to base this conclusion
on a small sample because of the low turnover in health staff. Transparency in procurement remains an area of great concern because of the fragmentation of the legislative and institutional framework and a lack of clear guidelines for procurement procedures from the tender stage through to the registering of a contract. Transparency is obscured by the limited dissemination of information about procurement operations (tender opportunities and contract decisions and awards), the frequent recourse by health facilities to direct contracting, and the lack of a system for handling complaints.

7.6 Accountability is undermined by the current arrangements and practices in the health sector and a lack of capacity. Dual subordination creates unclear lines of accountability for the performance and budget preparation, execution, and financing of health facilities. There are different reporting arrangements for management and finance because health facilities are accountable to two different organizations. The limited involvement of the Ministry of Health and of health facilities (except SVPs and reformed polyclinics) in budget planning undermines performance accountability because their budgets are determined outside their control. The weak treasury oversight of the Development Fund expenditure and weak internal audit capacity do not help to make health facilities accountable for how they spend their budgets. In procurement, a lack of capacity in the Ministry of Health limits the extent to which it can exercise audit and inspection controls creates ample scope for fraud and corruption. Finally, facilities' accountability to consumers is compromised by traditional practices such as sympathy and respect toward a health worker and reluctance to express their personal opinions and a lack of trust of consumers in the existing lines of accountability.

7.7 A command-and-control mindset limits the autonomy of service providers and thus leads to inefficiency in the use of resources. For example, SVP budget execution is subject to tight treasury controls down to sub-item expenditure categories, which prevents SVPs from reallocating their spending in response to changing needs. The strict application of the Ministry of Health's mandatory drug list deprives SVPs of the flexibility to form their own lists suitable to local conditions. As a result, they end up spending their scarce resources on drugs that are not needed. Close oversight and strict monitoring of health staff has helped to improve staff performance. However, because their performance evaluations include factors that are outside the staff's control, their fears of punishment for not performing effectively has created perverse incentives for them to underreport or falsify health statistics.

7.8 Limited transparency and accountability create opportunities for the misuse of funds and thereby increase fiduciary risks. Findings from our review of financial and procurement management in Uzbekistan indicate that the use of Development Funds, conflicts of interest, and the limited competition in public procurement all increase fiduciary risks to the use of health resources. Unless these issues can be tackled, efficiency in resource use will be compromised, thereby adversely affecting outcomes in the health sector.

7.9 In comparison, we found a commendable amount of good governance in Ferghana oblast. As a reform pioneer, Ferghana benefited from a greater increase in its health budget for major renovations and medical equipment than Samarkand. It also benefited more than Samarkand from donors' technical assistance and training in the implications of the new per capita financing system, in financial management, and in medical training and practices. As various reform components were implemented incrementally over several years, Ferghana also benefited from the lessons learned from the pilot rayons, while Samarkand oblast has had less time to implement all of the reform components.

7.10 For these reasons, the Ferghana oblast had better outcomes than Samarkand in terms of the delivery of rural primary health care service. Financial managers and health personnel in Ferghana oblast have more capacity and more experience in managing their health budget. Because they now have more financial autonomy, the SVPs are empowered to make decisions on the use of their budget and take new responsibilities in procurement while the SVPs in Samarkand have just gained autonomy in managing their own finance. Competitive procedures were used in a wider range of procurement expenditure categories in Ferghana than in Samarkand. Also, more consumers in Ferghana oblast were quite satisfied with the quality of health care than in Samarkand oblast, and
access to emergency care service in Ferghana was better, based on shorter waiting times for ambulance service.

7.11 However, Ferghana fared less well than Samarkand in some areas of financial management because it was a late reformer in terms of its treasury system. Delays in paying for salaries and medical supplies were longer in Ferghana. Its treasury played a limited role in assisting SVPs with contract administration, while Samarkand assisted its SVPs by providing them with model contract forms.

7.12 There is also clear evidence that primary health care in rural areas as delivered by SVPs has improved more than in urban areas where primary health care services are provided by polyclinics. The proportion of rural consumers who are satisfied with the quality of delivered by SVPs is higher than the proportion of urban consumers who are satisfied with the care provided by polyclinics in urban areas. More rural than urban residents reported they had access to free primary health care.

B. LOOKING AHEAD

7.13 Looking ahead, this report offers the government both medium- and long-term measures to further improve primary health care services. The list of proposed recommendations is exhaustive, but the government will need to prioritize them depending on how much commitment and capacity there is on the ground for each recommendation. Table 7.1 summarizes the governance objectives discussed in this report, some proposals for how to meet these objectives, and the most appropriate implementing agencies at the central and local levels.
Table 7.1: Recommendations for Improving Health Care Service in Uzbekistan

<table>
<thead>
<tr>
<th>Governance Objectives</th>
<th>Areas</th>
<th>Detailed Actions</th>
<th>Implementing Agencies</th>
</tr>
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<tbody>
<tr>
<td><strong>Short-term</strong></td>
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<tr>
<td>Increase government effectiveness by improving the incentives and the morale of health personnel.</td>
<td>Human resource management</td>
<td>1. Exclude factors outside the control of health personnel from performance evaluations.</td>
<td>MOH/OHD</td>
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<tr>
<td></td>
<td></td>
<td>2. Improve the implementation of the Development Fund performance award system by introducing clear assessment criteria built around principles such as provision of quality care, client orientation, adherence to good practice, fulfilling responsibilities of job.</td>
<td>MOF and MOH</td>
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<tr>
<td>Increase effectiveness of SVPs in service delivery</td>
<td>Delivery of primary health care services</td>
<td>3. Reduce bureaucracy by eliminating excessive reporting requirements, inspections, lengthy meetings, and time-consuming paperwork.</td>
<td>MOF/MOH/OHD/CRH</td>
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<tr>
<td>Increase government effectiveness by using resources more efficiently</td>
<td>Financial management</td>
<td>4. Increase SVP autonomy over budget management by changing the MOF controls for health spending from the sub-item to the item level of expenditures.</td>
<td>MOF, Budget Department</td>
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<td></td>
<td></td>
<td>5. Continue to permit the SVPs’ and polyclinics’ to carry over their unspent Development Fund balance at year-end by an automatic re-appropriation of unspent balances with no reduction in annual appropriation.</td>
<td>MOF and MOH</td>
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<td></td>
<td>6. Grant SVPs and other reformed health facilities the flexibility to amend the planned allocations of their Development Funds throughout the fiscal year without a rigorous MOF review process.</td>
<td>MOH and CRH</td>
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<td></td>
<td>Procurement</td>
<td>7. Establish a central purchasing body for the health sector.</td>
<td>MOH</td>
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<td></td>
<td>Personnel management</td>
<td>8. Increase facility managers’ responsibility for recruitment (number and type of jobs best suited to local needs) and in setting salaries to reduce skill shortages.</td>
<td>MOH and MOF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Improve recruitment and promotion policies and practices to provide career advancement opportunities.</td>
<td>MOH</td>
</tr>
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<td></td>
<td></td>
<td>10. Revise pay structure to lessen the importance of length of service and increase importance of skills and qualifications.</td>
<td>MOH</td>
</tr>
<tr>
<td>Governance objectives</td>
<td>Areas</td>
<td>Detailed actions</td>
<td>Implementing agency</td>
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<tr>
<td>Improve transparency and efficiency by increasing competition for public procurement to achieve greater “value for money.”</td>
<td>Procurement at the central level</td>
<td>11. Establish a procurement policy unit to take the lead in promoting good procurement practices in the health sector. 12. Accelerate the development of health sector procurement manual. 13. Increase private sector access to information on procurement opportunities and to contract award results at all levels. Reduce sale prices of bidding documents. Eliminate conflicts of interest in the cases of Dori Darmon and Uzitbehtika. 14. Increase competition by eliminating product pre-registration and price verification practices. 15. Disseminate widely details of the approved health budget.</td>
<td>MOH</td>
</tr>
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<td></td>
<td>Procurement management at local facilities</td>
<td>16. Develop technical specifications for most frequently procured goods with prices below US$100,000 and strengthen procurement staff capacity.</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Financial accountability in budget and procurement</td>
<td>17. Exercise the same ex-ante control of the Development Fund spending as that for regular budgets. 18. Strengthen internal audit capacity at MOH (by inspection control unit) and at MOF (by KRU). 19. Gradually introduce output-based and outcome-based accountability framework for budget.</td>
<td>MOF/MOH</td>
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<td></td>
<td>Performance accountability</td>
<td>20. Formalize the staff appraisal process by producing guidelines laying out the principles and procedures for a fair and transparent assessment process with the requirement to record all findings to encourage objectivity and to share this information with staff. 21. Gradually introduce output-based and outcome-based accountability for personnel management.</td>
<td>MOF and MOH</td>
</tr>
<tr>
<td></td>
<td>Facilities’ accountability to consumers</td>
<td>22. Educate the public about the reforms by supplying information to consumers through posting signs and distributing brochures at health care facilities. 23. Institutionalize Boards of Trustees at the level of SVPs and polyclinics. 24. Train civil society institutions to supplement mahalla committees, local governments, and central government in monitoring the public health care system.</td>
<td>PHC Facilities</td>
</tr>
<tr>
<td></td>
<td>National public procurement system</td>
<td>25. Develop and adopt new procurement law consistent with international standards.</td>
<td>MOH, MFERIT, Ministry of Economics, and the State Committee for Architecture and Construction</td>
</tr>
<tr>
<td><strong>Long-term</strong></td>
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</tbody>
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ANNEX A

1. FINANCING MECHANISMS OF HEALTH FACILITIES

1. Financing of the SVPs and reformed family polyclinics is based on per capita formulas (Box 1). The formulas ensure the base level of financing is not less than the previous year’s budget and that the per capita budget reflects the characteristics of the catchment population.

**Box 1: SVP Capitation Financing Formula**

1. Base per capita rate for SVPs

\[ BCR(t) = \frac{[RHB(t) \times SRPHC(t)]}{PRPHC(t)} \]

*Where:*  
- \( BCR(t) \) = the base capitation rate for SVPs in an oblast (region) in year \( t \)  
- \( RHB(t) \) = the total of the health budget of an oblast in year \( t \) (with the exception of allocations for sanitary epidemiological services, capital investments, and centralized special activities)  
- \( SRPHC(t) \) = the average share (percent) of SVPs in the oblast budget in year \( t \) (this share should not be less than the actual expenditure of the SVP sector in the preceding year)  
- \( PRPHC(t) \) = the total number of population enrolled with the SVPs in year \( t \)

2. Annual capitated allocation to an individual SVP

\[ YCB(k, t) = BCR(t) \times P(k, t) \times SAC(k, t) \times OC(k, t) \]

*Where:*  
- \( YCB(k, t) \) = the yearly budgetary allocation per capita made to SVP \( k \) in year \( t \)  
- \( BCR(t) \) = the base capitation rate for all SVPs in year \( t \) in the oblast where SVP \( k \) is located  
- \( P(k, t) \) = the number of population enrolled with SVP \( k \) in year \( t \)  
- \( SAC(k, t) \) = the composite gender-age adjustment coefficient for the population enrolled with SVP \( k \) in year \( t \)  
- \( OC(k, t) \) = other adjustment coefficient for SVP \( k \) in year \( t \) (such as catchment-population density adjuster)

*Source:* COM Resolution 217 (September 28, 2005) and MOH Order 484 (October 4, 2005).

2. Gender / age adjustment coefficients are the same for the entire country (Box 2). These coefficients were based on a study of PHC utilization by various age and gender groups and were approved by the MOH. However, the order contains a provision for the MOH to revise the coefficients in light of additional experience and information.

**Box 2: Gender / Age Adjustment Factors**

<table>
<thead>
<tr>
<th>Gender-age groups</th>
<th>Adjustment Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male and female children aged up to 12 months</td>
<td>2.6</td>
</tr>
<tr>
<td>Male and female children between 13 months and 14 years</td>
<td>0.8</td>
</tr>
<tr>
<td>Women between 15 and 49 years</td>
<td>1.9</td>
</tr>
<tr>
<td>All other adult population &gt;15</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*Source:* COM Resolution 217 (September 28, 2005) and MOH Order 484 (October 4, 2005).

3. Population density factors (PDFs) are an optional adjustment, made at the oblast level, if needed. They were introduced to supplement the financial allocations to SVPs with a comparatively smaller catchment population, and thereby enable them to offset the relatively higher proportion of fixed costs in their respective budgets. Because the SVP funds are pooled at the oblast level and the oblast health department, as the “purchaser” of SVP
services, acts as the budget-approving authority for the SVPs, it is the oblast that determines the need and appropriateness of incorporating the PDFs. Once the oblast health department decides that PDFs should be introduced, they become applicable for all SVPs within the oblast. The values of the density coefficients are prepared in the oblast and approved by both the oblast health department and the oblast finance department. This exercise is part of the annual budget preparation process. The factors in box 3 are applied in Ferghana oblast.

4. Because 2007 was the first year of implementation of the SVP reforms in Samarkand, however, its oblast health department chose not to use the PDFs for that fiscal year. It also opted to apply per-capita allocations principle only for human resource items discussed in section IV (for both salary and non-salary operating expenditures). Beginning in 2008, Samarkand will fully apply per-capita financing—including use of population density and/or other adjusters as needed—for all of its SVPs.

5. Rayon and city finance departments prepare their budget proposals using the assumption of self-sufficiency in financing. Both levels derive their revenues from local levies and predetermined shares of republican levies. All health activities for which the rayon and city health departments have funding responsibility are financed through the traditional budget process.

6. **Polyclinics.** The health sector reforms were extended to city polyclinics in pilot form in 2006. This is being piloted in a number of cities in several oblasts, including both Samarkand and Ferghana (box 4). The operations of these polyclinics represent the first level of health care service in the city settings. For this reason, the government is using the same structure of capitation calculations as it did for the SVPs. The polyclinic capitation formula is generally structured the same way as for the SVPs, including population mix and density factors as determined by the oblast health department. Apart from the gender-age adjusters, Margilan City in Ferghana pilot urban primary health care (polyclinic) did not use density or any other adjusters in 2007. The population density factors used in the pilot polyclinics in Samarkand oblast reflect the significantly increased population densities in these larger centers.

7. **Central Rayon Hospitals.** Most CRHs are financed through the traditional budget process. However, a case-based hospital payment system is being developed by a National Technical Group (NTG) with technical assistance from the Health II reforms to be implemented progressively through pilots. The NTG proposal is before the Council of Ministers for approval. It envisages that hospitals will be reimbursed on a predetermined fixed rate for each case. This will encourage efficiency and improve hospital management, using an output-based system in place of the traditional input-based (normative) budget approach. It employs the purchaser-provider model wherein oblast health authorities act as the “purchaser” and CRHs as the “providers” of inpatient care.

8. For the system to function efficiently and effectively, hospital funds pooled at the oblast level will be allocated to hospitals under a capitation formula similar to those employed for the

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41 That is, all except SVPs and pilot polyclinics
42 As of August 2007.
43 See Case-Based Hospital System in Uzbekistan, Power Point Presentation to Hospital Payment Seminar. USAID, October 2005.
SVP financing and the budget preparation process. Thus, capitation-financed hospitals would have to make the appropriate changes. Further, a hospital database for health statistics and financial management will have to be set up and supported by a cost-based accounting system linked to the clinical treatment database in each hospital. The cost accounting system will enter the costs of treating each type of case from all the hospitals’ clinical databases; determine a standard cost for each type of treatment, based on the average treatment cost across the entire hospital system; and refine and use the costing formulas for setting hospital budgets. In this way, efficient hospitals—with costs below system averages—will benefit from their internal efficiencies; the less efficient will not.

9. One additional effect of health sector reforms has been a nascent review of available hospital facilities for overlaps and duplication. Because current hospital financing is based on inputs such as bed number, any rationalization activity that reduces the number of beds automatically reduces the number of medical staff and support personnel. Although this is reflected in a corresponding reduction in the financing a hospital in a particular oblast receives, the oblast still has an opportunity to cut its costs below the reductions in government support payments. Box 5 provides details on a review carried out in Ferghana oblast in 2005.

<table>
<thead>
<tr>
<th>Box 5: Hospital Rationalization in Ferghana Oblast</th>
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<tbody>
<tr>
<td>1. Ferghana oblast reviewed all general hospitals and their facilities for proximity and overlapping services.</td>
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<tr>
<td>2. Where duplications in departments were discovered, patients were reassigned to one hospital and the other hospital’s department was closed.</td>
</tr>
<tr>
<td>3. Some hospitals were closed, and patients were reassigned to the remaining facility.</td>
</tr>
<tr>
<td>4. Hospitals cut their losses from 40 percent of budget norms to 20 percent.</td>
</tr>
</tbody>
</table>

Source: Oblast Project Implementation Bureau

10. The strategy tested in Ferghana oblast was successful. The existing budget provided only 60 percent of the required budget using hospital resourcing standards, and thus a 40 percent shortfall in financing. After the rationalization, despite the reduction in financing due to the reduction in the number of hospital beds, the deficit was reduced to 20 percent. In that interval, 2004–06, the number of doctors in Ferghana dropped from 6,241 to 6,173, and the ratio of doctors per 1,000 people decreased from 21.9 to 21.2. In the same period, the number of doctors in Samarkand oblast increased from 8,203 to 8,290. The formula budget reductions from fewer beds were more than offset by cost savings that allowed a reduction in the 40 percent of budget requirements to 20 percent after rationalization."
2. **SVP Financial Manager Responsibilities and Accountabilities**

1. **Responsibilities**

   The SVP Deputy Head is responsible for SVP financial, economic, organizational, and administrative activities. Responsibilities include:

   - Maintaining accounting records and reports for the SVP.
   - Determining payments and charges and performing other requirements of the Law on Accounting and Reporting.
   - Preparing the SVP staffing table, calculating payroll, and paying salaries to employees.
   - Managing all SVP reports on internal orders and regulations, personnel issues, and financial and economic activities.
   - Preparing financial statements for signature by the SVP Head and submitting them to the relevant authorities.
   - Organizing storage, control, proper use, and timely purchasing of Chapter IV items.
   - Advising SVP staff on financial, economic, and personnel rules and processes.
   - Assisting in collecting information on the SVP's catchment population and analyzing this information to support its capitation financing.
   - Analyzing and recommending proposals to improve SVP financial and economic activities.
   - Drafting SVP income and expenditure budget, developing business plan, and requesting financing.
   - Every five years, the Financial Manager is to undergo re-certification of his / her qualifications in line with the current MOH rules.

2. **Accountabilities**

   The Financial Manager is personally accountable for: the proper performance of the responsibilities specified above; compliance with current laws and legal and regulatory documents; accurate processing of financial documents; observing SVP financial discipline as established by law; verifying the reliability of accounting records, financial, economic and personnel-related documents; ensuring the timely and accurate development and submission of business plan and cost estimates; ensuring the timely execution of bank documents; implementing financial activities, including timely salary payments to employees, transfer of funds to the SVP account and to other organizations' accounts; and identifying non-targeted and inefficient use of budgetary and extra-budgetary funds.

*Source: MOH Order 535, December 2004.*
3. **HIGHLIGHTS OF THE DEVELOPMENT FUND (COM DECREE 414)**

1. Development Funds can be established only by "legal entities," a designation the MOF can confer on budget entities.

2. A budget entity can transfer unspent cash balances at the end of each quarter to an off-budget Development Account for future use, instead of returning unused funds at the end of the fiscal year to the MOF.

3. The Development Account can be credited with revenues from the sale of goods and services resulting from the normal conduct of the entity’s activity, 50 percent of the revenues from leasing building space to other entities and grants or donations from entities and individuals.

4. Accumulated expenditure arrears in on-budget operation have first priority in spending from these accounts.

5. Capital investments funded from the account must be in accordance with the approved Public Investment Program.

6. Expenditures from the Development Accounts are also used for employee bonuses and social benefits, food, pharmaceuticals, utilities, and other expenditures (in that order).

7. The MOF may reduce budgetary allocations for the next year if at year-end there is a net positive balance of accrued revenues and expenditures and inventories exceed the norm.

8. Managers are held personally liable for mishandling the Development Funds.

*Source:* Decree 414 (September 3, 1999).
4. THE ROLES OF THE KEY AGENCIES IN HEALTH SECTOR PROCUREMENT AT THE CONSOLIDATED CENTRAL LEVEL

1. **Procuring Entities.** The MOH acts as purchaser at the central level and is responsible for centrally conducted procurement of goods exceeding US$100,000 financed from the state budget and IFI credits / loans. The central level is not involved in conducting sectoral civil works procurement.\(^{45}\) Consulting services, including advisory services and technical assistance and training, are procured under IFI-financed projects and programs. Consultant selection is governed by IFI procurement guidelines and rules.

2. As a procuring entity, the MOH may establish Expert Groups, Tender Committees, and Working Groups to participate in the procurement. Expert Groups are supervised by their respective deputy ministers of health and include representatives from the MOH, the MOF, the Ministry of Economy (MOE), and other public agencies. They are responsible for review and approval of equipment lists, specifications, quantities, terms of reference for consulting services and training, and normative acts regulating project implementation. Decisions made by these groups become effective after approval by the Minister of Health. Tender Committees\(^ {46}\) follow the implementing of prevailing procurement guidelines, depending on the source of funds (IFI or state budget). Working Groups support the work of Tender Committees and are responsible for organizing the bidding process (tender). They define applicable procurement procedures, prepare and sell bidding documents, publish procurement notices, receive the bids, carry out a preliminary evaluation of the bids, and report their recommendations to a Tender Committee.

3. For contracts less than US$1 million, the MOH forms permanent or ad-hoc tender committees and working groups. If a planned tender exceeds US$1 million, the COM establishes Tender Committees and their respective Working Groups. Participants include tender committee representatives from the MOF, the Ministry of Foreign Economic Relations, Investments, and Trade (MFERIT), and the MOH (not to exceed 30 percent representation). The above principles are common for all tenders, irrespective of the source of funds.

4. The Republican Foreign Economic Enterprise (Uzmedexport), part of the MOH system, is responsible for procurement of drugs, medical equipment, and supplies for health facilities financed by the state budget as well as international loans and credits. Uzmedexport can be authorized by the MOH to act as a working group or as a procurement agent, depending on the particular situation. When acting as a procurement agent, the working group’s responsibilities are expanded to include additional tasks like contract signing, contract administration, and customs clearance. Uzmedexport has three units specialized in procurement of medical equipment, pharmaceuticals, and “turn-key” contracts, respectively.

5. **Suppliers.** The Joint Stock Association (“Dori Darmon”) specializes in supply and distribution of pharmaceuticals to the medical facilities at all levels. Dori Darmon is a commercial entity with limited (25 percent) governmental control. The association, including its subsidiaries and branches, is the largest pharmaceutical supplier and distributor in Uzbekistan. The Center for Drug Policy estimated that Dori Darmon holds an 80 percent market share of all drugs for primary health care facilities, compared with its monopoly position during the Soviet era. It has long-term relations with facilities, a countrywide distribution network including cold chain for vaccines, a reliable quality control system, and a monopoly on narcotics and psychotropic substances. Moreover, the association remains the only guaranteed supply and

\(^{45}\) The only civil works contracts concluded at central level relate to “administrative procurement,” i.e., renovation and upgrading of the ministry’s buildings financed from the MOH budget.

\(^{46}\) This is in accordance with COM Resolution 456 (November 21, 2000).
distribution channel for pharmaceuticals to remote facilities throughout the country, a market in which private pharmaceutical suppliers are not interested.

6. **Quality Control.** The MOH Department for Drugs and Medical Equipment Quality Control\(^\text{47}\) (Quality Control Department) implements a unified public policy for distribution of drugs and medical supplies and develops and enforces quality standards for these goods. Its main activities include quality control, registration, and certification of health sector goods (including imports. The Quality Control Department performs these activities for all drug supply contracts, irrespective of the financing source and financier's procurement procedures. However, Good Manufacturing Practice (GMP) certification of drug manufactures recommended by the World Health Organization (WHO) is not part of the enforced quality standards.

7. **Internal Control.** The Control Inspection unit was established as an internal audit unit within the MOH by COM Resolution 18 (January 14, 1999). The unit reports directly to the Minister of Health who also appoints the unit head. It includes a central office in Tashkent and branches in all regions, employing a total of 43 staff members, to enforce compliance of individual health facility compliance with health sector regulations. Among its key duties are the control of procurement transactions and distribution and rational use of drugs and medical supplies that the individual health facilities pay for out of public funds and fee-based revenues. The unit also enforces anticorruption measures and reviews complaints by bidders and suppliers against illegal health facility staff actions.

\(\text{47 See COM Resolution 181, May 25, 1995.}\)
1. **HEALTH SECTOR SALARY SYSTEM: SELECTED TECHNICAL DETAILS**

1. The main regulations defining the salary system are: Presidential Decree 229 (December 1, 2005) on improving the compensation system of health care employees; COM Resolution 276 (December 21, 2005) on the approval of the improved compensation system of health care employees; and MOF, MOH, and Ministry of Labor Joint Resolutions 1536, 1537, and 1538, respectively (January 14, 2005) governing the stimulation fund and managerial pay. In addition, supporting documents explain the new system, and periodic updates are issued for the coefficients comprising the tariff net and increases in the minimum wage.

2. **Certification:** There are four levels of certification: no category (for new graduates), second (for staff after 5 years’ experience), first (7 years), and highest (10 years). Certification must be renewed within a specified time period, or it lapses.

3. **Workloads (“stavka”):** The first full workload is generally measured in hours, a standard work day. Work in excess of one stavka is defined based on additional duties that may be carried out, at least in part, concurrently with the full stavka. Seniority pay may be awarded if staffing norms define a position as “part-time” (as opposed to an additional workload taken on by a full-time employee).

4. **Allowances:** In SVPs, staff with managerial functions (e.g., chief doctors, head nurses) receive an allowance of 25 percent of the monthly minimum wage (not base salary), or more if they serve a large population and thus manage a large number of physicians. Managers in non-PHC facilities at rayon level and higher are eligible for up to 70 percent. Resolution 276, Annex 2, lists the specific positions entitled to various amounts of hazard or hardship pay.

5. Staff generally start receiving the allowance for continuous years of service after five years, although staff of certain facilities—SVPs among them—start receiving it after three years and at an accelerated pace. For SVPs, for example, Resolution 276 (Section VI, para. 24) sets the value of the allowance, expressed as a percentage of base salary for the principal position, from 10 percent up to a maximum of 50 percent after 11 years. As with other pay system measures, this may be affected by targeted adjustments: 2006 Presidential Decree 524 increased the seniority pay for nurses holding certain credentials and positions.

6. Rules for calculating continuous length of service are in COM Resolution 276 (Annex B-2).

7. Allowances may play a greater role in non-primary health care, but such analysis is beyond the scope of this study.

8. **Material Stimulation and Development Fund:** The fund is financed from up to 5 percent of the facility’s total budget; contributions from individuals or other donors and revenues from any billable service that the facility is allowed to offer; and any budgetary savings that the facility may realize. A portion of the fund goes to staff payments; the rest is to be spent on capital improvements or operating expenses. Polyclinics and SVPs are allowed to spend 25 percent on staff payments; central rayon hospitals and central city hospitals, 35 percent.

9. Presidential Decree 229 established the concept of the “fund for material encouragement and development,” while the criteria, procedures and details of the scoring system are further elaborated in Joint Resolutions of the Ministry of Health, Ministry of Labor, and Ministry of
Finance, nos. 1536 and 1537 (January 14, 2006). A 100-point scoring system with detailed criteria is defined in a further joint resolution from 2006.

10. As specified in Joint Resolution 1537, in polyclinics and SVPs (and their affiliated units), as well as central rayon hospitals and central city hospitals, monthly premiums can be 5 to 15 percent of base salary for junior staff and 10 to 15 percent for mid-level staff (mostly nurses) and medical doctors. Awards in specialized facilities, emergency, and first aid centers can be slightly higher.
## Workloads and Length of Service

1. Table 1 below summarizes the workloads (stavkas) and credited years of service for all categories of positions in six SVPs and three polyclinics for which data were available. Because of omissions and other uncertainties in the original data, the figures below should be seen as informed estimates rather than definitive statistics. This is especially true of SVPs, where the small number of staff means that averages can be calculated on only two or three data points.

### Table 1: Workloads and Length of Service in SVPs and Polyclinics
(January 1, 2007)

<table>
<thead>
<tr>
<th>Positions</th>
<th>Facility</th>
<th>Average stavka</th>
<th>Average</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>SVP 1</td>
<td>1.3</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>SVP 2</td>
<td>1.0</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>SVP 3</td>
<td>1.3</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>SVP 4</td>
<td>1.4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>SVP 5</td>
<td>1.5</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>SVP 6</td>
<td>1.5</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Polyclinic A</td>
<td>1.0</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Polyclinic B</td>
<td>1.1</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Polyclinic C</td>
<td>1.3</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Financial manager</td>
<td>SVP 1</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 2</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 3</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 4</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 5</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 6</td>
<td>1.0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mid-level staff</td>
<td>SVP 1</td>
<td>0.9</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>SVP 2</td>
<td>0.9</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>SVP 3</td>
<td>0.6</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>SVP 4</td>
<td>1.0</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>SVP 5</td>
<td>0.7</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>SVP 6</td>
<td>0.6</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Polyclinic A</td>
<td>1.0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Polyclinic B</td>
<td>1.1</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Polyclinic C</td>
<td>1.0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Junior staff</td>
<td>SVP 1</td>
<td>1.0</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 2</td>
<td>0.5</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 3</td>
<td>0.6</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>SVP 4</td>
<td>1.0</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SVP 5</td>
<td>0.7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>SVP 6</td>
<td>0.4</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Polyclinic A</td>
<td>1.0</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Polyclinic B</td>
<td>1.0</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Polyclinic C</td>
<td>0.9</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

*Source: Samarkand Oblast Health Department and individual facilities, and Earnings in context.*
Note: Data are for the SVPs cited above, Samarkand City Polyclinics 3 and 8, and Margilan City Polyclinic 1 in Ferghana oblast.

a. Calculations exclude dentists (who are officially grouped together with doctors) and include general practitioners (as well as in polyclinics) and specialist doctors.

b. Data for financial managers are actual rather than average since there is at most one financial manager position per SVP. The position is unique to SVPs since polyclinics have larger staffs to handle financial, personnel and procurement matters. The fact that the number of years credited for experience is zero for all cases may reflect the fact that Samarkand oblast only introduced the financial manager position in 2007 and thus records may not have been updated with data on actual staff hired into those posts.

c. Mid-level medical staff (sredniy medicinskiy personal in Russian) includes professional nurses.

d. Junior medical staff (mladshiy medicinskiy personal in Russian) includes low-ranking nursing assistants and may in some cases also include cleaners.
ANNEX C

1. HOUSEHOLDS SEEKING PHC SERVICES, AND MAIN REASONS FOR SEEKING CARE

1. In 2007 there were many more households in the cities that sought primary health care services than in rural areas (Figure 1) – 40-48 percent against 25-31 percent. The smallest percent of household members seeking primary health care services was in the villages of the Ferghana oblast.

Figure 1: Seeking Primary Health Care Services by Household Members in 2007
(Percent of the total number of household members in each region)

2. The main purpose of seeking primary health care services - both in the cities and in the rural regions - was diagnostics or treatment (45-49 percent of all the household members seeking assistance needed that service; see below). Emergency assistance was sought more often in the cities than in the villages (17-19 percent against 6-12 percent). Approximately the same per cent of patients in the cities and in the villages needed medical examination or tests to be done (21-28 percent). Vaccination only was needed by 6-13 percent of patients.

Figure 2: Main Purpose of Seeking Primary Health Care Services by Urban Households
(Percent of the total number of household members seeking services)
Figure 3: Main Purpose of Seeking Primary Health Care Services by Rural Households
(Percent of the number of household members seeking services)

- Diagnostics/Treatment
- Emergency assistance
- Vaccination only
- Pregnancy only
- Examination/Analyses

Samarqand villages

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Samarqand villages</th>
<th>Fergana villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostics/Treatment</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Emergency assistance</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Vaccination only</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Pregnancy only</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Examination/Analyses</td>
<td>28</td>
<td>21</td>
</tr>
</tbody>
</table>

Figure 4: Households Seeking Primary Health Care Services in 2007 by Presence of Children Under 16
(Percent of the total number of household members)

- Families with children under 16
- Families without children under 16

city of Samarqand

<table>
<thead>
<tr>
<th>Presence of Children Under 16</th>
<th>City of Samarqand</th>
<th>City of Margilan</th>
<th>Samarqand Villages</th>
<th>Fergana Villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families with children under 16</td>
<td>47</td>
<td>40</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Families without children under 16</td>
<td>53</td>
<td>39</td>
<td>25</td>
<td>29</td>
</tr>
</tbody>
</table>

Figure 5: Average Number of Visits to PHC Facilities in 2007 by Presence of Children Under 16 Years of Age

- Families with children under 16
- Families without children under 16

city of Samarqand

<table>
<thead>
<tr>
<th>Presence of Children Under 16</th>
<th>City of Samarqand</th>
<th>City of Margilan</th>
<th>Samarqand Villages</th>
<th>Fergana Villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families with children under 16</td>
<td>4.2</td>
<td>2.7</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Families without children under 16</td>
<td>0.6</td>
<td>0.9</td>
<td>2.4</td>
<td>0.6</td>
</tr>
</tbody>
</table>
2. **FREQUENCY OF VISITS TO PHC FACILITIES**

1. The frequency of visits to health facilities for regular examination or vaccination was lower in the city of Samarqand than in the city of Margilan (see below). 82 percent of the households in Margilan visited health facilities for these purposes at least once a year, while in Samarqand there were only 58 percent of such households. 27 percent of the households in Samarqand and 11 percent of the households in Margilan never visited health facilities for these purposes.

![Figure 1: Frequency of Visits to Health Facilities by Members of Urban Households for Regular Examination or Vaccination](image)

![Table: Frequency of Visits to Health Facilities by Members of Urban Households for Regular Examination or Vaccination (Percent of the total number of households in each city)]

2. In the villages of the Ferghana oblast, household members are paying more attention to regular examination and vaccination than in the villages of the Samarqand oblast (see below). In 76 percent of the households of Ferghana and in 56 percent of the households in Samarqand this was being done at least once a year, while 23 percent of the households in Samarqand and 9 percent of the households in Ferghana were never doing it. Thus, on the whole, the situation with visiting health facilities for regular examination and vaccination is significantly better in the Ferghana oblast than in the Samarqand oblast.

![Figure 2: Frequency of Visiting Health Facilities by Members of Rural Households for Regular Examination or Vaccination (Percent in Oblasts)](image)
3. Health workers in Margilan are visiting households for the purpose of regular examination and vaccination much more frequently than in Samarqand. At least once a month this is being done by health workers in 55 percent of the households in Margilan, and only in 35 percent of the households in Samarqand; several times a year and less frequently health workers are visiting 35-37 percent of the households in both cities, and 24 percent of the households in Samarqand; and 10 percent of the households in Margilan are never being visited at all.

Figure 3: Frequency of Visiting Urban Households by Health Workers for Regular Examination or Vaccination
(Percent of the total number of households in each city)

Figure 4: Frequency of Visiting Rural Households by Health Workers for Regular Examination or Vaccination
(Percent of the number of households in each oblast)
3. Consumer Opinions about Their Primary Health Care System
(Part of the households that agreed with the statement)

<table>
<thead>
<tr>
<th>Statements</th>
<th>City of Samarkan</th>
<th>City of Margilan</th>
<th>Samarkand</th>
<th>Ferghana</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents in our settlement have access to free primary health care services.</td>
<td>58</td>
<td>67</td>
<td>78</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>We do not know which health services are officially chargeable, and which are unchargeable.</td>
<td>70</td>
<td>73</td>
<td>80</td>
<td>70</td>
<td>74</td>
</tr>
<tr>
<td>Quality of health services has improved in the last three years.</td>
<td>50</td>
<td>45</td>
<td>72</td>
<td>69</td>
<td>66</td>
</tr>
<tr>
<td>There is shortage of doctors/specialists in our institutions.</td>
<td>50</td>
<td>52</td>
<td>49</td>
<td>55</td>
<td>52</td>
</tr>
<tr>
<td>From 40% to 50% of those who agreed. We do not know where to lodge a complaint if we are not receiving quality services, or if we are being refused medical assistance.</td>
<td>60</td>
<td>63</td>
<td>47</td>
<td>48</td>
<td>50</td>
</tr>
<tr>
<td>People here can receive quality medical assistance only with the help of bribes or connections.</td>
<td>53</td>
<td>49</td>
<td>35</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Local authorities are helping poor families to receive medical assistance they need.</td>
<td>36</td>
<td>27</td>
<td>40</td>
<td>51</td>
<td>43</td>
</tr>
<tr>
<td>We would like to use services of private doctors, but there are not or not enough of such doctors here.</td>
<td>33</td>
<td>32</td>
<td>37</td>
<td>48</td>
<td>40</td>
</tr>
<tr>
<td>Workers of health institutions are asking the population if they are satisfied or not satisfied, with the work of those institutions.</td>
<td>36</td>
<td>27</td>
<td>42</td>
<td>44</td>
<td>40</td>
</tr>
<tr>
<td>Less than 40% of those who agreed. Local are asking the population if they are satisfied, or not satisfied, with the work of health institutions.</td>
<td>32</td>
<td>21</td>
<td>28</td>
<td>40</td>
<td>32</td>
</tr>
<tr>
<td>Payments for health services have significantly dropped in the last three years.</td>
<td>18</td>
<td>15</td>
<td>23</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Nurses' salaries are low, that is why we are paying them.</td>
<td>45</td>
<td>21</td>
<td>17</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Doctors' salaries are low, that is why we are paying them.</td>
<td>44</td>
<td>24</td>
<td>15</td>
<td>14</td>
<td>19</td>
</tr>
</tbody>
</table>

1. An important objective of this study was to assess the primary health care system in Uzbekistan from the perspective of both the consumers and providers of primary health care services. In this regard, the study involved a service quality delivery survey (SQDS) that focused on how citizens and service providers view the accessibility, quality, and pricing of health services as well as the availability and effectiveness of mechanisms through which consumers may lodge complaints about their primary health care services and receive satisfactory resolution to their health care related concerns. The study involved a series of consultations as well as quantitative and qualitative surveys to gain an understanding of the following issues:

(a) Access to Primary Health Care. The survey investigated how consumers view the accessibility of primary health care with regard to location, cost, and other factors.

(b) Quality of Primary Health Care. The survey investigated how citizens or users of the primary health care system view the quality of their primary health care system, and from their perspective, what aspects of the existing system affect service quality and accessibility (for example, poorly trained doctors, shortage of medicines, absenteeism, regulatory or institutional changes) and were problematic.

(c) Payments. The survey examined how much consumers pay for primary health care services with regard to medical care and drugs, and whether patients are asked to make informal payments to health care providers.

(d) Accountability. The survey was designed to better understand the nature of the interactions between citizens and their primary health care service providers, and between citizens and their local institutions, as well as how these relationships and existing mechanisms of accountability affect the quality and accessibility of primary health care services. The survey also was used to identify possible mechanisms that can be introduced that may allow citizens as consumers to have a stronger voice and more influential role in securing better quality primary health care.

(e) Working Conditions for Health Care Providers. The SQDS also intended to determine how service providers view their working conditions, and from their perspective identify the main challenges they face in providing good quality primary health care (for example, low wages, lack of adequate training, mismanagement of health care facilities).

2. The SQDS involved both qualitative and quantitative methods of data collection and analysis. These methods summarized below and described in more detail in other annexes to this report allowed the study team to better understand the governance issues associated with the primary health care system from the perspective of different actors.

(a) Review of Available Literature. This involved a desk review of available project documents, social assessments, focus group discussion reports, and project monitoring reports as well as literature on health care sociology and external studies (for example, UNICEF External Evaluation of Family Education Project), and the Uzbekistan Living Standards Assessment Update (April 2007), and related literature on governance and health sector to gain an understanding of the health care system in Uzbekistan, the roles of the various institutions and health care providers in providing primary health care, and other issues relating to the governance study.
(b) **Expert Workshop.** A workshop was held at the start of the study to discuss the views and experiences of local social scientists, health care specialists, university professors specializing in this field, and representatives of NGOs knowledgeable about the social and governance issues associated with the primary health care system. Participants were asked for their views on the main issues confronting the primary health care system in Uzbekistan, the role of the mahalla committees and other local institutions (hokim, village councils, shirkat) in the health sector, and the changing formal and informal rules governing the relationships between local policy makers, the health care providers, and citizens. The results of this half day workshop were used to finalize questions that were to be further explored during the larger survey.

(c) **Semi-Structured In-Depth Interviews.** The local social scientist carried out 87 in-depth interviews with representatives of main stakeholder groups to obtain their insights and opinions covering a range of health care governance issues. The interviewees included: heads of SVPs; heads of rayon polyclinics; physicians, obstetricians, nurses, other medical staff from SVP; patients of varying ages, gender, and family circumstances; teachers from medical colleges; chairmen of mahalla committees; traditional healers; representatives of hokimiyat; and heads of any relevant health care-related NGOs.

(d) **Focus Group Discussions.** These covered a series of 16 focus group discussions in both urban and rural areas that have and have not received the benefits of the Health 1 project. The focus group discussions explored a series of issues raised during the expert group meeting and in earlier social surveys carried out at the end of Health 1. The focus groups involved rural women, rural men, urban women, urban men, elderly men, and elderly women, and clinic staff in “reformed” and “unreformed” rayons. Focus group discussion guides were prepared and used in carrying out these formal discussions.

(e) **Household Survey.** The consultant carried out a household survey involving 1,000 consumers living in both urban and rural rayons in the two study oblasts. The consultant was instructed to interview the family member responsible for making health care related decisions. The survey instrument covered a range of questions relating to: perceptions of the quality of their primary health care (qualifications of medical staff, availability of medicine), relationship to local institutions, means for securing better service, proximity to health care and access to transportation, and costs (official and unofficial) for securing good quality health care. The local consultants hired to carry out the survey were asked to pay specific attention to ensuring that the interviews cover groups of varying income levels, ethnicity, location, distances to health care facilities, gender, and age.

(f) **Exit Survey.** The consultants interviewed 300 patients as they were leaving each type of health care facility in each rayon to obtain information on service quality issues. The interviewees included those of varying ages and gender that used different types of facilities (SVPs, FAPs, SVAs, SUVs, family polyclinics, other non-specialized polyclinics, and central rayon hospitals) for their primary health care.

3. As for the other aspects of the Governance study, the SQDS was carried out in two oblasts to allow an analysis of the differences in the quality of primary health care services, pricing, and user satisfaction between Ferghana Oblast, the “advanced reformer,” and Samarkand Oblast, the “late reformer.” The survey covered three rayons: one urban and two rural rayons. In Ferghana, the rayons include the city of Margilan and the rural rayons of Yazyan, and Tashlak. In Samarkand, the urban rayon was Samarkand city; the two rural rayons were Jamboy and Tylak.
4. The survey was carried out by a team of local social scientists and a local public health care specialist under the general supervision of a World Bank social development specialist and public health specialist. It was not intended to assess the quality of primary health care delivered to patients from a medical perspective. That is, there was no attempt to assess whether a patient received the correct diagnosis or treatment, or to assess the nature or adequacy of the training received by doctors. Rather, the SQDS focused on how consumers in both oblasts view the quality of care they received based on their own perceptions, experience, and expectations, and what may be problems that need to be addressed by the authorities as they proceed with health care reform.
2. **Respondents in In-Depth Interviews with Service Providers**

1. The profile of respondents and facilities is presented below. The consultants used probability sampling for all except several in Samarkand Oblast. All specialized facilities were excluded from the sampling.

<table>
<thead>
<tr>
<th></th>
<th>Head doctor / manager</th>
<th>GP</th>
<th>Doctors-specialists</th>
<th>Obstetrician</th>
<th>Patronage / district nurse</th>
<th>Other nurses</th>
<th>Chairman of the Trade Union</th>
<th>Total by rows</th>
</tr>
</thead>
<tbody>
<tr>
<td>City hospitals/</td>
<td>14</td>
<td>2</td>
<td>18</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>6</td>
<td>59</td>
</tr>
<tr>
<td>policlinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of them CRB and</td>
<td>8</td>
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2. The interviews were carried out with the following rural service providers: (i) Chief of SVP, who mostly identify themselves as doctors but not as heads of facilities and thus they spoke on behalf of doctors, (ii) doctors, and (iii) obstetricians and visiting and chief nurses.
3. Participants of Focus Group Discussions

1. The focus group discussions were carried out in the same cities and oblasts as those in the household survey and other instruments, as specified in the terms of reference. The groups for the FGD were recruited from varying social groups, gender, and age as required for the FGD groups' content homogeneity. All the criteria for recruitment are presented in the table below.

2. The participants were asked to introduce themselves using either a real or fictitious name (the latter for the sake of anonymity). The discussions were led by moderators having at least 12 years of experience conducting FGDs. The female groups were led by a female moderator; male groups were led by a male moderator. In accordance with participants' consent, their statements' were recorded with the help of a voice recording machine. The audio cassette records were transferred into full text documents. The actual quotations of participants are presented in the FGD report.

**Location of Focus Group Discussions and their Composition**

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### 4. **In-Depth Interviews with Service Providers**

#### Profile of Interviews by Type of Providers and Facilities

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<th>Obstetrician</th>
<th>Patronage/district nurse</th>
<th>Other nurses</th>
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5. The List of Interviews with Service Providers

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6. Profile of Respondents in Household Survey

1. Interviews were conducted in households using a questionnaire containing questions for each member of the household. The survey team interviewed only those household members who were responsible for making decisions related to primary health care and the primary health care facilities. Their status in households was the following:

- Head of household (38.2 percent)
- Spouse of head of household (45.6 percent)
- Son/daughter of head of household (6.4 percent)
- Mother/father of head of household (0.9 percent)
- Son-in-law/daughter-in-law of head of household (8.1 percent)
- Other relatives (0.6 percent)
- Refused to answer about the status in the household (0.2 percent)

Socio-Economic Characteristics of the Households

2. The percentage of women and men among the household members we were interviewing in the survey was approximately the same. Excluding children under the age of one year, the average age of household members was 27 to 30 years.

3. The highest education level attained by household members over 16 years was in the city of Samarkand; in the rest of the study areas the educational level of the household members was approximately the same. On the whole, 23 to 30 percent of the household members over 16 years were employed, 10 to 15 percent were retired, 7 to 10 percent were unemployed, 11 to 13 percent were housewives, 1 to 2 percent were disabled, and 1 to 7 percent were students.

4. Among those participating in the household survey and did not have piped water: 12 percent of the households were in Margilan, 52 percent of the rural households were in the Ferghana oblast, and 71 percent of the rural households in the Samarkand oblast. Interruptions in piped water supply are frequent, and occur in all the regions.

5. The quality of piped water was evaluated as good by a large percentage of the households (90 percent and over in different regions think their drinking water is of good quality). Further, 94 percent of the households in villages are consuming their own farm produce, while in the cities there are only 28 to 33 percent of such households.

6. The supply of municipal services to the households is not equal. For example, out of all of the services, it is only electricity that is supplied to all of the households. However, there are frequent interruptions in service.

7. Almost all (93 percent) of the households in Margilan and 69 percent of the households in Samarkand do not have central heating. Natural gas is not being supplied to 30 percent of the households in Margilan, 16 percent of the households in the city of Samarkand, 34 percent of the households in the villages of the Ferghana oblast, or to 39 percent of the households in the villages of the Samarqand oblast. Interruptions in gas supply also occur frequently, and for long periods in all the regions.

8. The structure of monthly expenses for an average household is approximately the same in all the regions: 61 to 66 percent of the expenditures are for food and clothes, 5 to 7 percent are for municipal services, and 4 to 8 percent are for health services. Health services in the cities make up 6 to 8 percent of a monthly budget, while in the country it is 4 percent.
9. Primary food items, such as meat and milk, are being consumed in 83 to 90 percent of the households; 11 to 13 percent of the households do not consume any meat and meat products or consume them very rarely. The average daily consumption of meat and meat products per household member (including children less than 1 year) is from 24 grams in the villages of the Samarkand oblast to 44 grams in the city of Samarkand. The most significant difference between the structure of meals in the cities and in the villages is the amount of consumed meat/meat products and milk/milk products (with the exception of cheese, kaymok and sour cream). The respondents living in the cities are consuming more of the first, while the villagers are consuming more of the second.
7. **Household Survey Sample Design**

1. The target population covered individuals of all ages living in the two oblasts (Samarkand and Ferghana) covering one city and two rural rayons each. The sample included 1,000 households. The population of Ferghana oblast is 2,729,800 people, and the population in Samarkand oblast is 2,749,800 people. Within Ferghana oblast, the population of Yazayavan rayon is 60,500 people, and in Tashlak rayon the population is 118,600 people. The population of Margilan city is 153,800 people. Within Samarkand Oblast, the population of Jamboy rayon is 98,600 people, and in Taylak rayon the population is 124,500 people. The population of the Samarkand city at the time of the survey was 362,100 people.

**Sampling Frame**

2. The sampling frame was developed from the lists obtained from two types of units (primary sampling units—PSUs): (i) the MK (“Mahallinskiy Komitet”) or town makhalla committee; and (ii) the SSG (“Selskiy Skhod Grazhdan”) or Rural Citizen Council, which has been used for rural areas in all recent surveys. Both the MKs and SSGs are self government bodies based on the traditional neighborhood.

3. The MK has good up-to-date lists of households. The geographical boundaries of each MK are clearly defined without any territorial overlaps. Approximately once a year, the makhalla committee representatives inventory all of the households in order to revise the lists. The lists are also updated when members of the household apply to the MK for certificates. The MK is usually of an appropriate size, but in some cases the social research firm merged two or more MKs in order to obtain a new unit with the overall number of households increased.

4. In the SSG, the situation is similar to that in the MK. The SSG comes from the village soviets, which existed in the Soviet period. They combine several villages, and after the revival of the makhalla system some SSG combine rural makhallas instead of villages. Traditionally, lists and accounting are quite detailed and accurate. For convenience, we use the word “SSG” instead of villages and rural makhallas. In the report, MK and SSG are sometimes called “makhalla”.

**General Sampling Scheme**

5. The sampling scheme has the following three-stage stratified clustered sampling:

   - Equal allocation of all interviews between Samarkand and Ferghana regions;
   - PPS-sampling of PSUs within urban/rural strata (see Annex 1 above for explanation of PSU types);
   - Sequential random sampling of households (Secondary Sampling Units—SSUs) in selected PSUs;

6. Six strata were formed. All interviews (1,000) were allocated equally among the strata thereby attaining the following advantages:

   - The strata-provinces represent relatively homogeneous groupings of units which makes the resulting sample more efficient, i.e. leads to reducing sampling error as compared with the entire unstratified sample;
   - Stratification ensures inclusion of all the provinces into the sample with certainty, not relying on chance;
• Stratification permits the treatment of each province as a "population" in its own right, when data are required separately for provinces, and select a sample of the required size and design from each independently.

Sequential Random Sampling of Households

7. Interviewers during the fieldwork implemented a sequential random sampling in which they were given a special form with random numbers to draw a sample of households. The lists of households are obtained from either the makhalla committees or village councils. The sequential random sampling procedure consisted of the following:

• Selection by means of random numbers associated with serial numbers of households in the list;
• Households having been already selected cannot be selected again;
• Selection and interviewing of households strictly according to the order of generating the random numbers;
• Households that failed to be interviewed (not found, refusal, etc.) are replaced with the next ones, according to the order of the random numbers;
• Selection repeated until a required number of interviews is reached.
Sample Design

1. The selection of respondents for the exit survey was based on random sampling at the time of a respondent's exit from a facility. Only those who had received some medical assistance or service were interviewed. Prior to the survey, the interviewers confirmed the facility's working hours on the day of the survey, and divided those hours into half-hour periods. For example, if the working hours of the facility were from 9:00 am to 18:00 pm, the total number of hours was divided into 18 periods (segments). The first patient was interviewed within the period from 9:00 to 9:29, the second patient from 9:30 to 9:59, and so on. Each patient was interviewed for approximately 15 to 20 minutes, which accounts for the segments being divided up into half hour periods. After the first patient was interviewed, the interviewer waited for the second patient to leave the building, and so forth. In case the patient did not meet the criteria (for example, a person had come to the facility just to visit a friend or family member), or if the patient refused to be interviewed, the interviewer filled out a "refusal from interview" form. A "Patient Selection" form was developed for registering all cases of refusals and interviews. Based on the results, there were only 9 "refusals" in the Ferghana oblast, and 20 such cases in the Samarqand oblast.

Access to Services

2. As shown in the bar graphs below, most facility visitors (hereafter referred to as "visitors") represent the population strata with low income, unemployed people, and women. The well-being of consumers according to their self assessment is based on how they view their own circumstances. The population groups with low income are shown in the first two columns of the graph below.

Well-Being of Consumers Based on Self-Assessment

[Bar graph showing well-being categories]
Profile of Visitors' Employment

![Graph showing the profile of visitors' employment.

Profile of Visitors Based on Employment Status

![Graph showing the profile of visitors based on employment status.

Gender of Visitors

![Graph showing the gender of visitors.

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