Overview

The Republic of Tajikistan was classified as being highly exposed to the effects of the economic crisis with a low capacity to respond to the crisis according to a methodology developed by Cord et al., 2010. The Gross Domestic Product (GDP) measured in constant 2006 prices rose during the pre-crisis period (2006–2008) but declined by 9.5% between 2008 and 2009. The GDP per capita declined by 11.2% in 2009. In 2009, the country faced a budget deficit for the first time, and debt accounted for 35.8% of GDP. Also in that year, the country faced a 21% devaluation of the local currency relative to the US dollar.

For Tajikistan, remittances are an important source of foreign exchange and comprise about 20% of GDP. Remittances began to decrease at the end of 2008 and continued to decline into 2009. Ministry of Finance officials believed the first sign of the impact of the economic crisis was reduction of remittances, which was expected to affect total household income.

The case study on Tajikistan represented a unique opportunity to explore then potential effects of the crisis on household health expenditures.

The Case

A rapid assessment of the impact of the global economic crisis on health spending in Tajikistan was conducted between March and June 2010 following a methodology developed for a multi-country study. The assessment examined to what extent real public, household, and donor health expenditures changed between pre- and post-crisis periods; the pathways through which changes were affected; and, policies and actions taken by government and stakeholders to possibly mitigate these effects. The results below reflect a descriptive comparison of trends before and during the crisis period.

The period of the economic crisis was associated with a slow-down in government health spending in Tajikistan

While government health expenditures rose from 105 million somonis (US$48.9 million) in 2007 to 137 million somonis (US$82.78 million) in 2009, the average annual expenditure growth rate during the crisis period was much lower (3.4% compared to 17%). The expenditures for the State Investment Program (SIP) declined between 2008-2009. Total and per capita government health spending remained, relatively, flat during the crisis period.

Sub-national health expenditures were less affected during the crisis period than those at the central level

Between the crisis years of 2008 and 2009, there was a 24% decline in national-level government health expenditures that was offset by a 12% increase in sub-national level expenditures for health. Consequently the national/regional pattern of public health financing changed over this period, with the share of regional expenditures rising from 76.5% to 81.2% of government health expenditures. These patterns were not the result of changes in allocation rules during the period.

The composition of health spending changed during the period of the economic crisis

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1 This case draws from Potapchik E. and Brenzel L. Rapid Assessment of the Impact of the Economic Crisis on Health Spending in the Republic of Tajikistan. HDNHE, World Bank, February 2011. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author and should not be attributed to the World Bank, its affiliated organizations, or members of its Board of Executive Directors or the countries they represent.


4 Health expenditures are those related to personal health services, primary health care, hospital services, and priority health, nutrition, and population programs made at various levels of the health system, including the community level. Expenditures for water and sanitation will not be included in this analysis.
Salaries and pension represent the largest share of total government health expenditures, followed by purchase of goods and services, and new equipment. Purchase of goods and services includes travel allowances, food, medications, and salaries of outside specialists. These were reduced by 18% during the crisis period.

Declines in expenses on travel, medicines, and other critical components of health care suggest that fewer services and lower quality of services were provided during this period. In addition, the ratio between expenditures on new equipment and maintenance of assets declined by 5%, suggesting that general upkeep may have been jeopardized.

Primary health care expenditures continued to increase during the crisis period, but expenditures for secondary/tertiary levels and other services declined during the crisis period.

Primary care grew 240% in the pre-crisis period and continued to grow during the crisis period to 81.8 million somonis in 2009. The lion’s share of this growth was at the sub-national level. Secondary and tertiary care accounted for over 50% of total government expenditures at sub-national level, and increased over this period to 157.2 million somonis. By contrast, government central-level expenditures on secondary and tertiary care declined during the crisis period by 6%.

Budget execution may have been affected during the crisis period.

Budget execution rates were relatively high at 95% or higher. Budget execution rates increased for the central level during the pre-crisis period (3%), but declined by nearly 7% during the crisis-period. The opposite trend was observed at the sub-national level, with a 3% decline in budget execution rates before the crisis, and a slightly better execution rate during the crisis period. Budget execution rates might be related to timely purchase of equipment and medical supplies. The Ministry of Finance reduced capital expenditure and purchase of equipment and transport vehicles.

Households reduced spending on medical services but increased spending on pharmaceuticals during the crisis period.

Between 2006 and 2008, nominal per capita household expenditures rose by 135%. However, during the crisis period (2008–09), growth in per capita household expenditures slowed to 4%, reaching a total of 134.43 somonis ($32.44). Per capita purchase of drugs increased by 20% in the crisis period, while per capita expenses on medical care decreased by 19.4%.

The rise in per capita drug expenditure might be explained by rising drug prices as a result of devaluation of local currency, or reflect a substitution or preference for drug purchases over medical treatment during this period. Expenditures on pharmaceuticals rose 80% during the crisis period (2008–09), compared to an 11% rise previously. The average annual growth rate of the drug price index was 0.8% during the pre-crisis period and jumped to 12% during the crisis period. By contrast, all other price indices declined during the crisis period, including indices for food, consumer purchases, and medical care.

The rise in drug price index during the crisis period is probably a reflection of the devaluation of thesomoni that occurred in 2009. Increasing drug prices will pose challenges for the government to provide high quality services, and for households to afford medical treatment.

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5 The State Investment Program (SIP) is a program designed to implement the construction of new medical facilities and the purchase of expensive medical equipment.
There is some evidence to suggest that households substituted lower cost medical services in the public sector during the crisis period.

Expenditures for private medical services rose by 11% during the crisis period, while expenditures for government medical services increased by 42%. Out-of-pocket expenditures for private medical services accounted for more than 90% of total medical service expenditures.

Changes of medical care expenditure share could be seen as indirect measure of medical care consumption. It is not known whether and to what extent households are delaying medical treatment, seeking less expensive sources of care, or benefitting from more primary care provided by governments. The number of visits per capita was declining in the pre-crisis period, and increased nearly 8% during the crisis period. On the other hand, the hospital admission rate declined slightly during the crisis period. These data might suggest that more expensive hospitalizations were postponed.

The period of the economic crisis did not seem to affect donor commitments to the health sector in Tajikistan.

Our estimates suggest that donor assistance to the health sector did not decline during the crisis period. The bulk of support in financial terms comes from UN organizations (70% of support in 2009). Some key health programs, such as immunization, are heavily donor dependent (upwards of 90% of funding comes from external sources).

The Government implemented programs during the crisis period in order to maintain the level of social expenditures.

In 2009 and 2010, the Government adopted an anti-recessionary program that included measures to protect social expenditures, encourage development of the industrial sector, and establish new work opportunities. Measures to protect social spending included maintaining salaries in education and health sectors, and allocating additional funds to social services to provide retraining for returning labor migrants.

The Ministry of Finance also ensured protection of priority recurrent expenditure items in the 2009 budget related to implementation of various reforms (e.g., public sector wage reform), and all other socially-oriented expenditure items (transfers, compensations, allowances, pensions), as well as fully-financed the social protection budget to create new employment opportunities for returning migrants and implement new projects in social protection in accordance with the allocated amount in the amended state budget for 2009.

Among other new socially oriented projects for protection of the population, which were not initially included in the budget at the beginning of 2008, rural rayons’ financing program is, especially, important to protect existing jobs and create new employment opportunities for returning migrants. In this regard, about 30,000 households received monetary compensation, including micro-financing opportunities.

In response to crisis, the Ministry of Health issued an administrative order in April 2009 that established a working group comprising of the Ministry of Health representatives and representatives of the regional health authorities to develop measures to decrease the impact of the economic crisis on national health system.

Summary

This rapid assessment has demonstrated the potential effects of the economic crisis on government and private health spending in the Republic of Tajikistan. Government expenditures for the State Investment Program (SIP) were reduced during the crisis period. The purchase of goods and services, which includes travel allowances, food, medicines, and specialist services, experienced an 18% decline during the crisis period. Declines of these critical components of health care suggest that access to quality health care may have been affected during the crisis.

Data shows that households reduced their spending on medical services, but increased spending on pharmaceuticals. There is evidence to suggest that households increased their utilization of outpatient services, while decreased their use of hospital inpatient care.

There appears to be no effect of the economic crisis on donor commitments to the health sector. Unfortunately, there was insufficient information to evaluate whether disbursements were delayed.

In short-term, the Government of Tajikistan took steps to reduce potential negative impact of the economic crisis on the health system by maintaining the level of public health expenditures and certain items within the budget allocation, particularly at the sub-national level.