Tajikistan
Public Expenditure Tracking Survey (PETS)
The Health Sector

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May 5, 2009

Organization

- Context of PETS Health in Tajikistan
- Objectives
- Strategic decisions taken during the PETS
- Main Findings and Recommendations
- Lessons Learned

1. Context of PETS

- Provide inputs to PPER and DPO that focused on improving efficiency of public expenditure in the social sectors
- Complement an investment operation in primary health care
- Collaboration with HD and DEC and financed by DFID

2. PETS objectives

- To assist the government improve the efficiency of resource allocation in the health sector by identifying whether:
  - resources were spent on the wrong goods or professionals
  - public funds failed to reach frontline service providers
  - providers have weak incentives
- To understand the roles of various levels of government (central, oblast, rayon, and jamoat) in the allocation of health resources

3. Strategic decisions taken regarding design implementation once PETS underway

- PETS was launched in May 2006 but actual survey began in November 2006
- Hired a local research firm supported by WB local staff
- Developed a full list of health facilities in Tajikistan (location, rural/urban, type, # of beds, public/private)
- Focused only on the local budget (rayon and jamoat) due to fiscal decentralization and on primary health care to complement the ongoing work program

Strategic decisions – cont'd

- Decisions on sampling design and instruments
  - 5 questionnaires for randomly selected rayons (31), jamoats (104), central rayon hospitals (28), health facilities (326), and staffs (1282)
  - Purposely chosen 2 rayons (Varzob in RRS and Dangara in Khatlon oblast) that piloted per capita financing so that results could be used as a baseline for future evaluations
  - Added a jamoat questionnaire due to its budget execution role in the rural area; designed for rayon, central rayon hospitals (CRH), jamoats, facilities, and staff
  - Changed sampling strategy from randomly selecting facilities within each rayon (which would have brought about a high number of jamoats and a sharp increase in survey cost) to sampling four jamoats in each rayon

Strategic decisions – cont'd

- Triangulation of data at various levels (rayon versus CRH, and rayon versus jamoat) due to a lack of PHC facility budgets to determine leakages of goods and services
- Focused on staffing incentives (allocation of floating staff positions, absentee rate, and informal payments)
- PETS also tracked health financing by donors and local contributions

4. Main Findings

- Under-funding of the health sector. Budget allocations are low and donor assistance makes a large contribution to the overall spending on health services.
- Few resources reach front line providers – the primary health care facilities – which are expected to provide the first level of care for the population; this serves to exacerbate pressures on secondary care.
- High degree of discretion in the allocation of scarce resources. This not only applies to distribution of stavkas but also to the bulk of inputs.
- A wide variation in the availability of resources among rayons that translates into an inequitable distribution of quality health care.

a) How “under-funded” is the health sector?

- Funding
  - Low by international standards (1% of GDP)
  - Low compared to the needs of the population and the unmet demand
  - Severely under-fund at the level of rural PHCs
- Allocative and technical efficiency of the system is low
  - Biased towards hospital services instead of PHC that provide low-cost preventive care
  - Limited resources for non-wage inputs (medicine, communal services, O&M, etc)
  - A high ratio of inputs (nurse/doctor, doctors/pop, bed/pop, and length of hospital stay)

b) To what extent do resources reach health facilities?

Overall Health Budget

- Discrepancies in the data suggest potential leakages from the rayon to the CRH budget and from the rayon to the jamoat budget

Wage Fund

- Most of the wage fund reached health care facilities with some delays
- Wage fund equivalent to about 4.8 staff positions (stavkas) per health facility could not be accounted for
- Paper-based salary payments raised a fiduciary concern
- A high degree of discretions in reallocating unspent wage funds (unallocated staff positions)

Resources – cont'd

Non-wage Inputs

- Did not quantify leakages of non-wage inputs that flowed from a higher administrative level (CRH and Jamoat) to PHC due to:
  - Lack of separate budgets/smetas for PHCs
  - Poor record keeping for in-kind inputs received by PHCs

c) What kinds of “discretion” do local authorities have?

Discretion at two levels: local governments and health facility (CRH)

- Discretion of local governments (rayon)
  - Allocation of resources across sectors financed by local budgets
  - Reallocation of resources across line items
  - Allocation of excess revenues above the targets and contributions from donors and local communities
- Discretion of CRH chief doctors
  - Hiring and firing of personnel
  - Allocation of additional stavkas
  - Allocation of budgetary resources in the consolidated budget implemented by CRHs

d) What are the implications for service quality?

- Low wage (relative to the cost of living) leading to extra work for more money inside (official 1.2 staff positions compared to actual 1.6 positions) and outside health facilities
- Governance related issues: informal payments (50% of staff), and high rate of absenteeism (30%), especially in rural hospitals and polyclinics
- Spent more on food rather than drugs. Some 16% of facilities reported that they did not receive drugs and supplies
- Inadequate heating (3 hrs in the winter in rural area) reduced operating hours and thereby access to PHC
- Poor infrastructure

5. PETS Recommendations

- Increase budget allocation to PHCs in parallel with launching necessary reforms to improve efficiency, i.e rationalization of the hospital sector
  - Appropriate ratio for nurses/doctor across regions
  - Reallocate budget from food to other medical supplies
  - Reduce the number of under-utilized beds in CRHs
- Separate the PHC budgets from the CRH budgets, build capacity of PHCs in budget management, improve transparency and accountability in the health PFM, and dissemination of budget information (laws, guidelines, etc.)
- Increase transparency in budget allocation (per capita financing in PHCs) and execution
- Improve basic infrastructure of rural PHCs and increase availability of medical supplies

6. Lessons Learned from TJ PETS

- Need a good fact finding mission to thoroughly understand the flows of funds and identify availability of budget records and documents used at all levels before launching the survey
- Questionnaires should be easy to understand and include guidelines (not on a separate paper)
- Quality control is crucial in a weak capacity environment (training of the local survey team, close supervision and monitoring of survey and data entry)
- Sustained government ownership is required not only for the survey but also to implement reforms emerging from PETS