Tajikistan

Health system **summary**

2025

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This Health System Summary is based on the *Tajikistan Health System Review* (HiT) published in 2025 in the Health Systems in Transition (HiT) series. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

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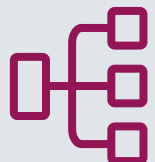
How is the health system organized?



Tajikistan's health system is largely centralized and most providers of health services are public

Organization

In Tajikistan's health system most health facilities are owned and operated by the government, but financing relies largely on private out-of-pocket (OOP) payments. Almost all citizens are eligible to access publicly funded health services. The health system is centrally organized, although health financing decisions are more decentralized, which contributes to regional variation. A small but growing private sector operates mainly in urban areas, and parallel health services run by other ministries or state companies still exist.

Health services in Tajikistan are organized according to tiers of administration. There are four main tiers: republican (or national); *oblast* (*viloyat* in Tajik) and Dushanbe City, which functions like an *oblast*; *rayon* or city-level (*nohiya*); and commune/municipality (*jamoat*). The Ministry of Health and Social Protection is the main government body responsible for health, and leads strategic planning, policy formulation, regulation and the delivery of national-level health services. Subnational authorities deliver most preventive and curative health services. There is currently very limited integration of health and other social programmes, although the plan is to see this increase.

Tajikistan's capacity for policy development and implementation is at a nascent stage, although some advances have been made in recent years (Box 1).

Box 1 Capacity for policy development and implementation

Tajikistan's capacity for policy development and implementation remains at a nascent stage. With support from external development partners, the Ministry of Health and Social Protection has created a Health Policy Analysis Group, but it is understaffed and has substantial gaps in certain skills. There are challenges facing the use of evidence for efficient and sustainable health policies and strategies. The government has access to a large amount of health data but these are not easily or consistently aggregated and analysed, which hinders their translation into policy. Most policy evidence is developed with technical support from international development partners, but it is rarely converted into legislation due to a top-down governance model. There are also issues facing the communication of key evidence needs to other parts of government. Policies that are created and approved still face obstacles to their implementation, such as a lack of available financing, insufficient staffing and limited governance around enforcement.

Planning

Health policy and planning in Tajikistan is undertaken by the state. The Ministry of Health and Social Protection is responsible for the overall planning, management and regulation of health services, and for the development and implementation of national health policies, including the current national health strategy (Ministry of Health and Social Protection, 2021). It is accountable to the government, submits annual reports about its activities, and draws up a budget of financial resources required for the following year. The national government approves and revises national health policies, programmes, laws, investment

projects and implementation budgets, all of which are developed and proposed by the Ministry of Health and Social Protection alongside other ministries and agencies. Health planning remains strongly focused on the budgetary process, which has historically prioritized input-based allocation.

Providers

Most health service providers are owned and run by the state, and receive public funding from the state budget. At the national level, health facilities are managed directly by the Ministry of Health and Social Protection, while at the *oblast* and city/*rayon* level, health facilities are managed by the respective subnational authorities. There are different models of service delivery in rural and urban areas, and parallel health systems continue to exist, run by other ministries or state companies for their employees.

The number of private health care providers is relatively low, but has grown in recent years. Most are based in urban areas, and most dentists are now private providers. The Ministry of Health and Social Protection is responsible for the regulation and management of all public providers, and for the regulation of private providers.

How much is spent on health services?

Tajikistan's public spending on health as a share of current health expenditure is one of the lowest in the WHO European Region, with a high proportion of OOP spending

Funding mechanisms

The most important source of health financing is private OOP payments from patients (both official and unofficial), followed by general government spending and external development assistance. Public spending on health is financed by both national and local level funding. Allocation of national level funding is decided annually by the Ministry of Finance, with funds provided to the Ministry of Health and Social Population, which then allocates them to the regions. Local budgets provide the majority of government health funding, which contributes to substantial regional inequalities in public per capita spending. Private health insurance is largely non-existent, and the introduction of mandatory social health insurance has been repeatedly postponed. International and bilateral agencies also play an important role in supporting the country's health system.

Health expenditure

Despite Tajikistan's socioeconomic position as the poorest country in the WHO European Region, health spending as a percentage of gross domestic product (GDP) has increased in recent years. In 2022 it amounted to 7.6% of GDP (Fig. 1), which was only slightly lower than the regional average (WHO, 2025a). However, this is largely due to high levels of OOP payments. Public spending as a percentage of current health expenditure is one of the lowest in the region, and Tajikistan's health expenditure per capita in

2022 was just US$ 364 per capita when adjusted for purchasing power – the second lowest in the region (Fig. 2). There is also substantial variation in per capita health expenditure between the country's regions (Neelsen, 2021). Private health insurance is rare and accounts for a negligible amount of health spending.

Fig. 1 Trends in health expenditure, 2000–2022 (selected years)

Notes: CHE: current health expenditure; GDP: gross domestic product; PPP: purchasing power parity.
Source: WHO, 2025a.

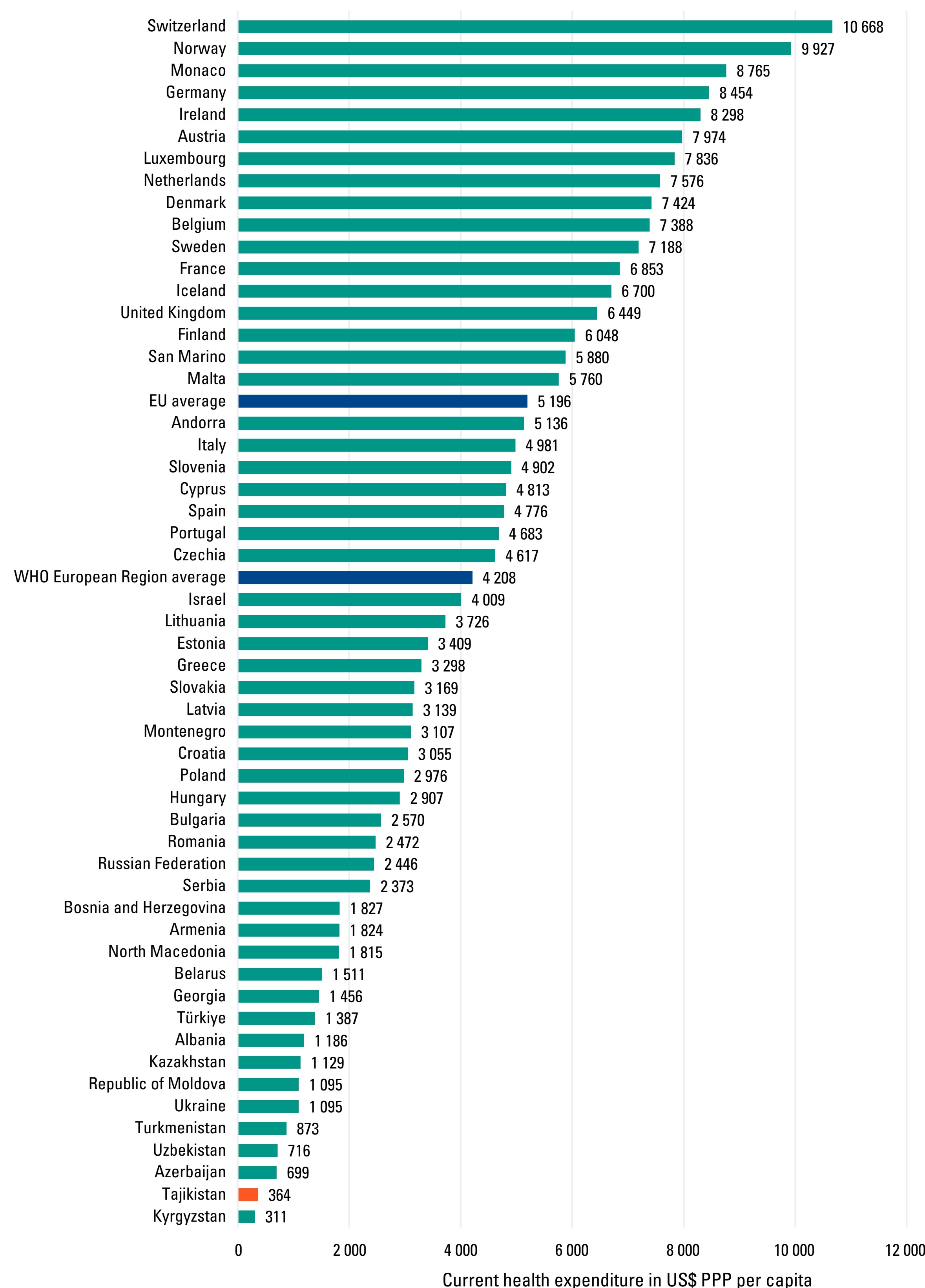
Out-of-pocket payments

In 2022 OOP payments constituted 65.2% of current health expenditure (Fig. 3). Under Decree 600 (2008) the government has established official prices for publicly provided health services, and rates of co-payments that most of the population must pay. There are also some health services that are provided free. A few population groups are exempt from co-payments. However, the official prices are not consistently enforced, and in practice patients and providers do not always understand eligibility. Use of informal payments is also widespread, although efforts are being made to address this. Between 2007 and 2023, a basic benefits package was piloted in an increasing number of *rayons* to address OOP payments, but it is unclear whether it was effective in achieving this aim. A revised basic benefits package is expected to be introduced in the future.

Coverage

Almost the entire population of Tajikistan is entitled to publicly provided health services, but not for free. Under Decree 600 certain population groups are eligible to receive publicly provided services or pharmaceuticals without the need for co-payments, including children under 1 year old, older people aged over 80 years, and low-income families. However, in practice, these exemptions are not always applied (Box 2). There are also some major gaps in scope: for example, outpatient prescription medicines are not usually covered. The 2007–2023 basic benefits package was intended to address some of these issues, such as expanding the number of services provided free to certain groups.

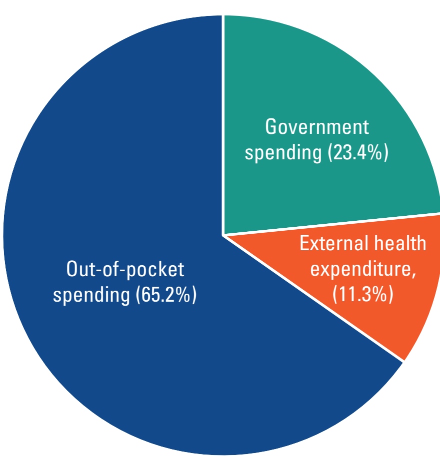
Fig. 2 Current health expenditure (US$ PPP) per capita in the WHO European Region, 2022



Notes: CHE: current health expenditure; EU: European Union; PPP: purchasing power parity.

Source: WHO, 2025a.

Fig. 3 Sources of health financing, 2022



Source: WHO, 2025a.

Box 2 What are the key gaps in coverage?

Tajikistan's low overall levels of public funding for health and limited depth of public coverage result in high levels of OOP payments, which constitute a major barrier to health care access and equity. Population groups most at risk of financial hardship are lower-income households, older people and unemployed people. Some groups, such as migrants, are ineligible for most state-provided basic health services. There are also gender inequities. Outpatient medicines are the most likely health service to lead to catastrophic health spending. In terms of scope, the breadth of diseases covered does not necessarily reflect the burden of individual diseases. For some conditions there may be formal coverage rather than effective coverage (sufficiently high-quality care). In addition, a number of cost-effective preventive services are not covered within the package, such as diabetes screening.

Paying providers

At present, there is no national mechanism for procuring health services in Tajikistan's health system. Most health facilities are government-owned, while the 'purchasers' of health services are patients, the government itself and external donors. Health financing reforms have envisaged the establishment of a clear national purchasing role for the Ministry of Health and Social Protection, but this has not yet been achieved. At the subnational level, the use of input-based norms creates barriers to improving efficiency. The lack of awareness and enforcement around established rates for publicly funded health services means providers frequently overcharge, and low physician salaries have contributed to a culture of informal payments (Fig. 4).

Fig. 4 Provider payment mechanisms in Tajikistan

Notes: *Capitation is used primarily as a norm for budgetary allocation at the national level in Tajikistan, and does not always translate into budgeting at subnational levels. [a]Data are only available for ambulatory specialists.
Source: Authors' compilation.

What resources are available for the health system?

Tajikistan is slowly improving its health care infrastructure and workforce training, but there are still shortages of fixed assets, medical equipment and medical staff

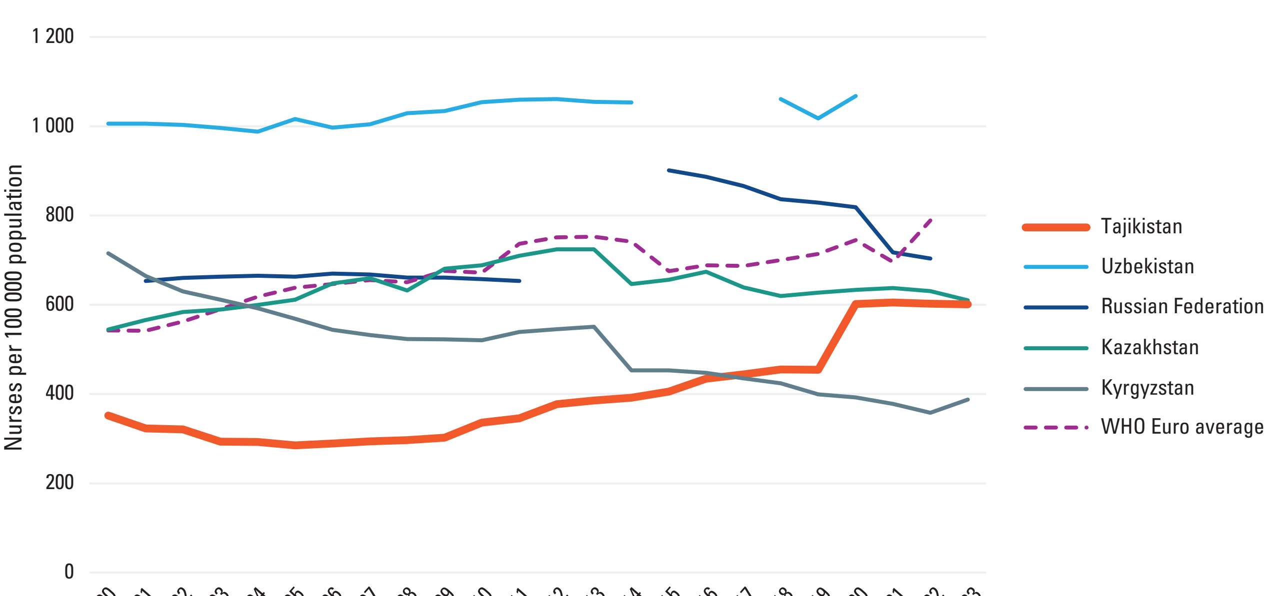
Health professionals

Tajikistan has relatively low numbers of both doctors and nurses compared to other countries in the WHO European Region (Figs. 5A and 5B). Between 2000 and 2023, the number of doctors per 100 000 population remained relatively stagnant, and the 2023 rate (187 doctors per 100 000 population) represented one of the lowest densities in the region (Fig. 5A). The number of practising nurses increased over the same period, reaching 601 per 100 000 population in 2023: below the average for the WHO European Region, but in line with neighbouring countries (Fig. 5B). There are pronounced regional imbalances in the distribution of health workers, and a lack of family doctors and staff for some specializations despite substantial investments in training, although incentives have recently been introduced (WHO Regional Office for Europe, 2024b). Health worker emigration is another major challenge. Medical education reforms continue, but family medicine has low prestige and uptake, with limited management and nursing development opportunities. Efforts are ongoing to address these issues.

Fig. 5A Practising physicians per 100 000 population in Tajikistan and selected countries, 2000–2023

Source: WHO, 2025c.

Fig. 5B Practising nurses per 100 000 population in Tajikistan and selected countries, 2000–2023



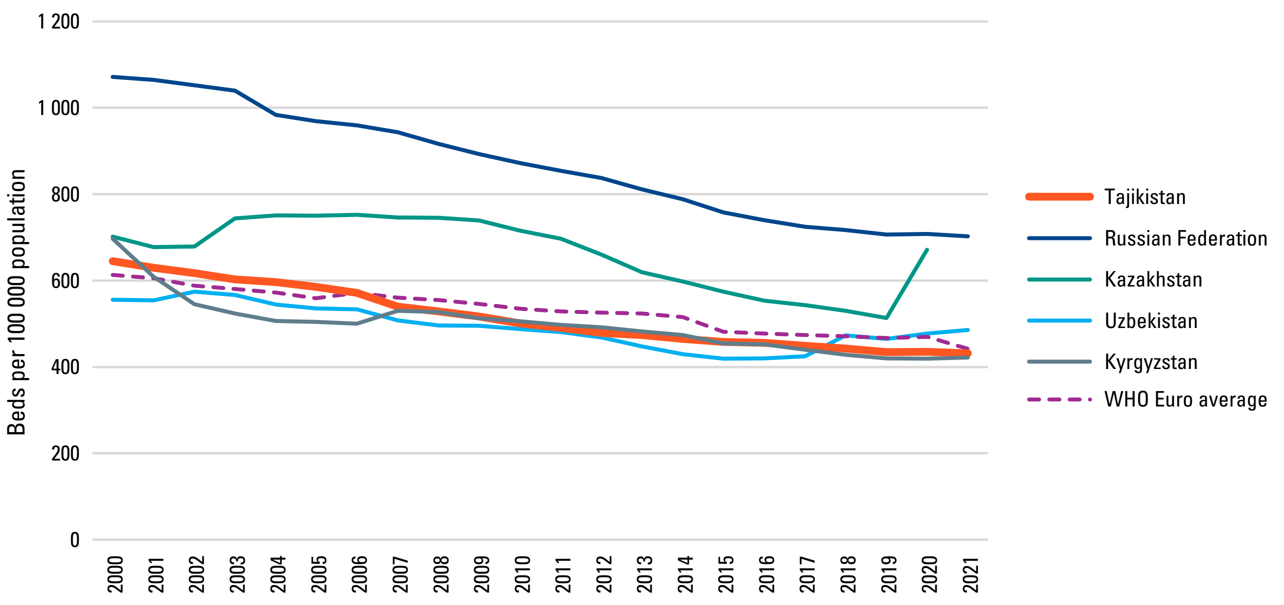
Source: WHO, 2025c.

Health infrastructure

Since independence, Tajikistan has struggled to simultaneously improve its health infrastructure while also dispensing with excess capacity. The country is working to consolidate existing hospitals and has invested in some newer institutions where needed. However, the overall distribution of hospitals remains

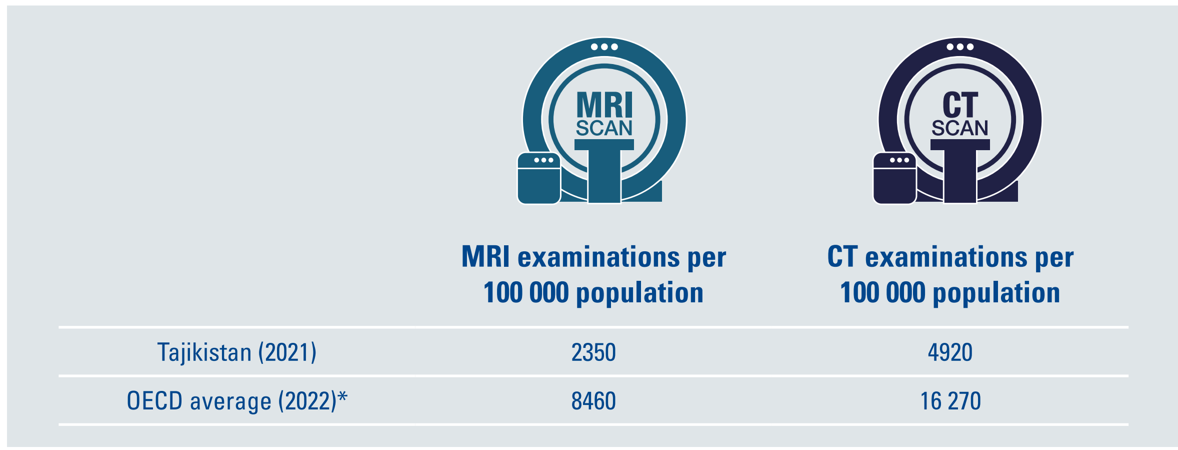
uneven and skewed towards urban areas. The ratio of hospital beds to population is not especially high compared to other countries (Fig. 6), but might be commensurate to Tajikistan's overall young population and limited financial resources. The bed occupancy rate is also comparatively low, potentially indicating oversupply (World Bank, 2021). The government and international donors have begun to address gaps in primary care infrastructure through investments in new equipment and technologies, but beneficiary facilities often struggle to cover operating costs or repairs. Private clinics play a substantial role in offering certain kinds of equipment: of the 77 computed tomography (CT) and magnetic resonance imaging (MRI) units available in Tajikistan in 2023 (Fig. 7), just 29 were owned by the state.

Fig. 6 Hospital beds per 100 000 population in Tajikistan and selected countries, 2000–2021



Source: WHO, 2025b.

Fig. 7 Number of examinations using MRI and CT scanners in Tajikistan, per 100 000 population



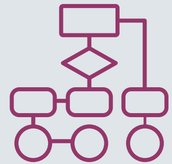
	MRI examinations per 100 000 population	CT examinations per 100 000 population
Tajikistan (2021)	2350	4920
OECD average (2022)*	8460	16 270

Note: *These figures are unweighted averages based on available data from the OECD health database.
Sources: Ministry of Health and Social Protection personal communication; OECD, 2024 for OECD average.

Distribution of health resources

As in many countries, the distribution of health facilities in Tajikistan is uneven. Larger specialized institutions cluster around urban centres, and in rural areas health facilities are more limited in scope and equipment, with some lacking even basic utilities and infrastructure. The national hospital rationalization plan for 2011–2020 aimed to reduce the number of rural hospitals and replace them with rural health centres or *rayon* hospitals. This had partial success, but further consolidation is envisaged. Digital health and e-health are priorities to increase service access and quality, but the country's health information and communications technology (ICT) infrastructure requires substantial investment and development.

How are health services delivered?



Health service delivery is fragmented, but is slowly moving towards a more integrated approach that prioritizes primary care and disease prevention

Public health

Over the past two decades, Tajikistan has worked to transform its health system from a highly centralized model reliant on hospital and secondary care, towards one that is focused on primary care and public health. Whilst public health services were historically provided as vertically organized programmes, separate from curative services, vertical programmes are gradually being integrated into primary care. The latest national health strategy highlights the importance of providing access to essential public health services, which includes access to services beyond health care settings.

Sanitary epidemiological services are responsible for the prevention, monitoring and control of infectious diseases, occupational health, food safety and environmental health. A National Immunization Programme that is integrated into primary care has helped increase routine immunization coverage to at least 95% over the past decade. As regards noncommunicable diseases (NCDs), key issues requiring attention are reducing tobacco and alcohol use, and improving diets. Nutrition has not always been well covered by public health services, and non-governmental organizations (NGOs) regularly provide community support. Whilst overweight and obesity are less of a concern than in many other countries in the WHO European Region, rates have slowly increased in recent years (WHO Regional Office for Europe, 2023).

Primary and ambulatory care

Primary care provision is organized according to the country's administrative tiers. In urban areas, primary care is delivered by *rayon* and city health centres. These are either free-standing or associated with a hospital, and offer preventive, diagnostic, curative and rehabilitative services. In rural areas, primary care services are provided by health houses and rural health centres, and are usually more basic. Health houses are intended to be the first port of call, but in practice their gatekeeping role is limited since patients can directly access physicians for the same services at rural health centres. Concerns about quality of care can undermine envisaged patient pathways, with some users

opting to bypass locally available care or family doctors and to access higher levels of care directly (Box 3). In rural areas home visits are carried out by nurses, which contributes to challenges around staff capacity and service regulation. There also continue to be duplicated services for some issues (Asian Development Bank, 2018).

Access to specialist ambulatory care in rural settings is extremely limited. Some rural health centres have basic laboratory facilities for certain diagnostic tests, but usage rates in practice are unclear. In urban areas, certain specialized outpatient services are provided in specialist dispensaries where people are treated for specific long-term diseases.

Box 3 What are the key strengths and weaknesses of primary care?

Over the past decade, the government has introduced various reforms intended to improve health service access, quality and affordability, as well as strengthening workforce training. There have been some relative successes. The government has progressively increased overall levels of funding for primary care services. It has also made strategic investments to improve the organization and strengthen the quality of primary care services, with some vertical public health services having been successfully integrated into primary care. National immunization programmes have delivered strong results, and excess hospital bed capacity has been reduced.

However, challenges remain. Reforms around financial protection have not yet delivered the intended benefits: official (and unofficial) OOP spending on health remains extremely high, and primary care is not always financially or physically accessible. There are particular issues with primary care in rural and remote areas due to insufficient medical personnel and poor quality infrastructure, which is a concern given that most people live in rural areas (72% of the population in 2023).

Hospital care

Hospitals exist at nearly all administrative levels, but services and quality of care differ. A limited number of small rural hospitals in remote areas offer basic nursing care and some medical and obstetric services. *Rayon*, *oblast* and republican hospitals provide basic ambulance and emergency services. There are also separately functioning specialized emergency hospitals. Tajikistan has made efforts to address surplus hospital capacity, including a national hospital rationalization plan (2010–2020), but there is still some duplication, especially between city, central *rayon* and *oblast* services (Box 4). The average length of stay in acute care hospitals in Tajikistan has decreased in recent years, from 13.2 days in 2000 to 8.0 in 2021, placing it in the middle of comparator countries (WHO Regional Office for Europe, 2025). The bed occupancy rate in acute care hospitals (67.5% in 2021) is low when compared to other countries in Central Asia.

Box 4 Are efforts to improve integration of care working?

Tajikistan has historically struggled with the fragmentation of health services. Public health services have been divided into vertical structures and programmes, creating barriers to coordination of patient journeys between different levels of care or across multiple conditions. Health data collection and management is also limited as a result of the vertical programmes. To encourage a more integrated model of health care, over the past decade the government has introduced several legislative and financial reforms aimed at improving coordination and care pathways. There have been efforts to reduce duplication in hospital services, and some limited attempts to integrate certain programmes and to improve integration between primary, secondary and tertiary care. However, services are not yet fully integrated in primary care, and there continues to be a lack of integration between health services, social services and other care providers. Strengthening health care integration is deemed a priority in national health planning and policy, and there is clear interest in addressing the issue, although questions remain about how improvements will be delivered in practice.

Pharmaceutical care

Almost all state pharmacies have been privatized and there has been an increase in the number of pharmacies nationally. However, access to pharmaceuticals is frequently a challenge. Medicines are not always in stock and cost is a major issue. A national Essential Medicines List has been in use since 1994 and establishes set rates for medicine purchasing, but in reality purchasing prices vary substantially. There are also issues around quality, and the widespread trafficking and availability of counterfeit pharmaceuticals is a major area of concern. In response, the government has recently tightened oversight of pharmaceutical quality and distribution, as well as increasing funds for procurement. Most outpatient medications require co-payments, which leads to affordability barriers, exacerbated by the underuse of generic medicines. The Ministry of Health and Social Protection centrally procures a limited number of essential medicines, but facilities must individually purchase the rest, which contributes to higher costs. Pharmaceuticals for a few vertical programmes are largely donor-funded.

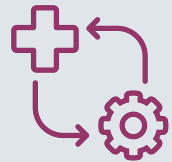
Palliative care

The development of palliative care in Tajikistan is still in its early stages, but important first steps have been taken. This is encouraging given that there is perceived to be substantial demand for palliative care for both adults and children, particularly for cancer patients. Inpatient palliative care is currently provided in cancer and tuberculosis (TB) hospitals, as well as at five regional Hospitals for Nursing Care. There are also palliative day care centres with mobile palliative care teams in two *oblasts* (Dushanbe and GBAO). A national association for palliative care has been set up, and national standards for the provision of palliative care have been developed and approved by the Ministry of Health and Social Protection. The current national health strategy also seeks to introduce mechanisms to provide palliative care to patients at home via an interdisciplinary team of professionals, in addition to maintaining a small number of dedicated hospital beds.

Dental care

Dental care is nominally provided in both public dental institutions and private clinics. In theory, certain types of dental care should be provided free of charge via publicly run health services for all citizens, such as emergency dental care, and particular services for some population groups, such as pregnant women. In reality, most dental care is provided by private providers and paid for out of pocket. The regional distribution of dental institutions is uneven, creating further access barriers: in 2024, just 1.3% of clinics were located in GBAO, compared to 50% in Sughd. Whilst to some extent this reflects population density, it nonetheless highlights disparities in availability.

What reforms are being pursued?



Over the last two decades, the government has initiated a range of reforms to advance universal health coverage and strengthen primary care, centred around health financing, governance and service delivery

Since 2001, the overall direction of health reforms undertaken in Tajikistan has focused on improving the efficiency of health spending, prioritizing spending on primary care, introducing a basic benefits package to improve financial protection, and strengthening health system legislation (Box 5).

One of the main goals of health reforms has been to improve primary care. Excess hospital capacity has been reduced, and since 2002 there have been changes to the network of primary care providers, such as the establishment of rural health centres and the merging of previously separate polyclinics. Substantial investments have also been made to strengthen the material and technical base of primary care institutions, as well as in the training of doctors and nurses in family medicine. In 2022, a Joint Statement was developed and signed by key stakeholders, which set out core priorities and actions for development partners to strengthen primary care.

In health financing, various reforms have been pursued connected to per capita financing, hospital payment systems and health insurance. Per capita financing for non-staff primary care costs has been used nationally since 2016. However, it is considered a partial capitation model, since despite setting a nominal rate, there is no mechanism for pooling funds

Box 5 Key health reforms over the last 20 years

- **Health System Financing Strategy in the Republic of Tajikistan for 2005–2015** (2005). Established new health financing models, such as strategic purchasing, pooling and measures to address informal payments (partially implemented).
- **Programme of state guarantees to provide the population of pilot regions with health care** (2007). Introduction of a basic benefits package (implemented, but ended 2023).
- **Decree No. 504 'On health insurance in the Republic of Tajikistan: resolution of the Majlisi Milli and Majlisi Oli of the Republic of Tajikistan'** (2008). Envisaged the introduction of a mandatory social health insurance system (implementation postponed in 2014, 2017, 2021 and 2022).
- **Decree of the Government of the Republic of Tajikistan No. 600 'On the procedure for the provision of health services to citizens of the Republic of Tajikistan by institutions of the state health care system'** (2008). Set a framework of fees for publicly provided health services (partially implemented, updated in 2010).
- **Government Resolution No. 827 'On the issues of introducing per capita financing in primary health care facilities'** (2015). Introduction of per capita financing in primary care (implemented).
- **Strategy for protecting the health of the population of the Republic of Tajikistan for the period until 2030** (2021). Set out the national health strategy for the period 2021–2030 (partially implemented).
- **Order 'On approval of basic standards and special funding ratios, rules for financing based on case-based financing in hospital facilities'** (2021). Set standard rates and funding allocations for case-based financing in hospitals (partially implemented).
- **Presidential Decree on measures to expand non-cash payments** (2023). Expanded the use of non-cash payment of taxes, fines and services, including for health services, to reduce informal payments (partially implemented).
- **Presidential Decree on implementation of the Sughd health financing pilot** (2024). Launched implementation of *oblast*-level pooling, capitation-based financing, and new purchasing/contracting mechanisms in Sughd region (partially implemented).

and equalizing per capita funding across providers in accordance with need. A health financing reform project in the Sughd region is piloting per capita financing combined with pooling funds at the *oblast* level. There has also been some piloting of performance-based financing, and in 2021 a legislative framework for case-based hospital payments was created. The introduction of a mandatory social health insurance system has been discussed since at least 2008, and whilst the discussion continues, its introduction has been repeatedly postponed. The piloting of a basic benefits package in 2007–2023 was a notable development, and its redesign and reintroduction is likely to be an important area of reform in the future.

How is the health system performing?

Health system outcomes have improved in some areas, but the system's efficiency is undermined by high levels of OOP spending, underdeveloped quality of care, and health workforce challenges

Health system performance monitoring and information systems

The Ministry of Health and Social Protection is largely responsible for monitoring state policy in Tajikistan's health sector. It monitors implementation of the current national health strategy using a set of selected indicators, with annual reports submitted to the government. There are few mechanisms in place for managing the performance of health workers: routine performance evaluations are not commonly used and there is no review of service outputs in terms of quality or quantity. There are also no standard tools to conduct ongoing monitoring of clinical practice.

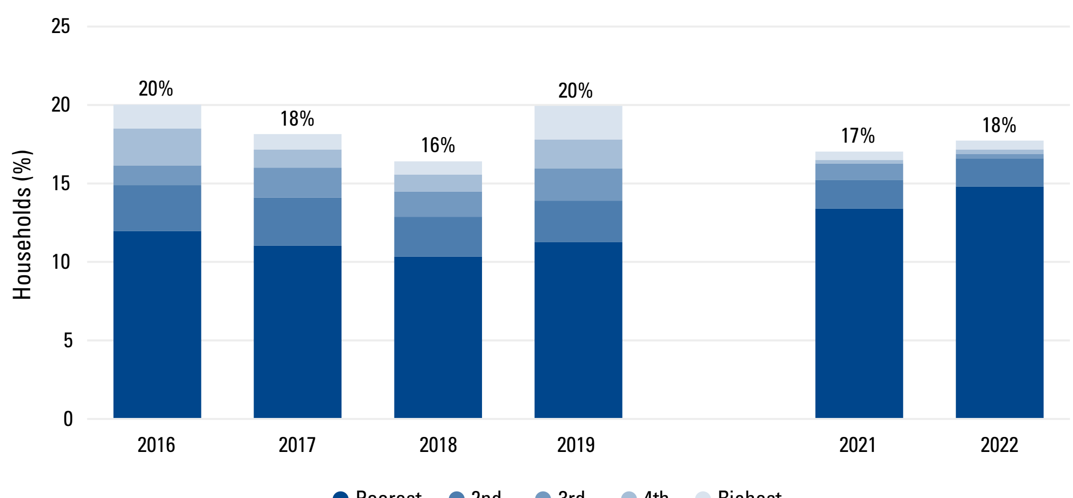
In general, the country's health ICT infrastructure is underdeveloped, with gaps in electronic data flows meaning that data cannot always be aggregated. This hinders monitoring and further analysis in policy development. To support health service delivery and improve evidence-based decision making, the Ministry has begun using health technology assessments, and plans to use a more data-driven approach to monitor progress in primary care.

Accessibility and financial protection

Almost the entire population of Tajikistan is entitled to publicly provided health services. However, the right to receive these services free was abolished in 2003, and the main barrier to accessing health services are now the required OOP payments by patients (formal and informal). The cost implications of accessing health services mean that poorer groups of the population forgo health services when in need (WHO Regional Office for Europe, 2024a). Households in the poorest consumption quintile are consistently most likely to experience catastrophic health spending (Fig. 8).

Other access challenges include limited preventive and screening services, and geographical barriers, especially in remote mountainous areas. While the government aims to provide equitable access across the country, health service coverage differs markedly between the country's regions and between urban and rural areas. Unmet need for preventive and curative care is particularly high for NCDs, which bodes poorly considering that these represent an ever-larger proportion of the disease burden.

Fig. 8 Share of households with catastrophic health spending by consumption quintile



Notes: Catastrophic health spending is defined as the share of households with OOP payments greater than 40% of household capacity to pay. Capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs (food, housing and utilities). A household is impoverished if its total consumption falls below the poverty line after OOP payments; further impoverished if its total spending is below the poverty line before OOP payments; and at risk of impoverishment if its total spending after OOP payments comes within 120% of the poverty line. The poverty line is a relative poverty line reflecting basic needs (food, housing and utilities).
Source: WHO Regional Office for Europe, 2024a.

Health care quality

Quality of care is a major concern in Tajikistan, due to: underinvestment in health facilities; a lack of modern technologies and equipment; lack of evidence-based clinical guidelines, inconsistencies and gaps in health workforce training; limited access to pharmaceuticals; and inequalities in access between different regions and population groups. One of the key challenges for improving quality of care in Tajikistan is the lack of data (Box 6). In-hospital mortality rates, which are a commonly used metric for the quality of hospital care, are not known and information on avoidable hospital admission rates (a proxy indicator for the quality of primary care) is limited. Internationally reported data on mortality in Tajikistan do not allow a detailed analysis of trends in causes of death, due to gaps in reporting. However, avoidable deaths can be attributed to poor quality of care and non-utilization of health services. In parallel with unmet needs for quality care, there is also unnecessary and potentially harmful care. Improving the quality of health care services is a strategic priority under the current national health strategy.

Box 6 What do patients think of the care they receive?

Historically, patient evaluation has played a marginal role in health services in Tajikistan. As with other areas, available data are limited. Surveys on patient satisfaction with issues such as hospital care have only been carried out occasionally, and point in contradictory directions. More recent data on patients' views on and experiences with health services are not available. The paradoxical nature of patient feedback is in line with what has been reported from poor rural areas in some other former Soviet countries, and may reflect low patient expectations. A commitment to patient-centred services is stated in the latest national health strategy, and may provide grounds for increasing the use of patient-reported experience measures in Tajikistan in the future.

Health system outcomes

Data on health system outcomes present a mixed picture. Detailed and reliable information is not available on amenable or preventable mortality. Maternal and child health have been an important focus in policy, and falling mortality rates indicate progress in health services for both. Tajikistan performs well for its income level with regard to vaccine-preventable diseases and the number of births attended by skilled health personnel. There has been progress in the control of communicable diseases: the incidence of measles is reported to be exceedingly low, and TB rates have declined although remain high. Performance on NCD outcomes is less strong. The burden of NCDs – in particular cardiovascular diseases – has been steadily increasing and the health system does not yet offer sufficient preventive and curative services for NCDs. Disease prevention is increasingly considered a priority in public health, but it is not yet embedded into primary care as robustly as it could be. For example, NCD prevention programmes are not typically covered for free under state-provided health services. Key NCD risk factors to address include tobacco and alcohol consumption, and nutrition (Box 7).

Box 7 Are public health interventions making a difference?

Disease prevention is one of the priorities of the current national health strategy. Focus areas include reducing tobacco and alcohol use, and increasing healthy diets. Official prevalence rates of tobacco and alcohol consumption are comparatively low, but there are reasons to suspect considerable underreporting. Tajikistan has endorsed a comprehensive tobacco control law that is aligned with the WHO Framework Convention on Tobacco Control, but no indoor public places in Tajikistan are completely smoke-free, and the relatively low cost of tobacco hinders efforts to reduce consumption. Certain policies have been introduced to reduce alcohol consumption, such as a national minimum age for off-premise sales, and regulations on alcohol promotion and sponsorship (including health warnings), but illicit alcohol production and consumption is a challenge. Poor nutrition remains a major problem. This has not always been well addressed by public health services, and the system relies on NGOs to provide community support. Overweight and obesity are less of a concern than in many other countries in the region, but rates are slowly increasing. There is potential for combining increased public spending on health with deterring unhealthy behaviours by increasing excise taxes on alcohol, tobacco products and sugar-sweetened beverages.

Health system efficiency

Health spending in Tajikistan continues to be skewed towards inpatient and specialized care, resulting in a comparatively low level of allocative efficiency. There is substantial variation across *rayons* in the share of public resources devoted to primary care (and health overall), indicating poor allocative efficiency. The technical efficiency of the Tajik health system is assumed to be low, since the country is only slowly moving towards provider payment mechanisms based on the population covered and services provided. Administrative inefficiencies and substantial disparities in allocation of health funds similarly undermine the technical efficiency of staff and services. A continued reliance on input-based budgeting at local levels further exacerbates the issue. Another obstacle for hospital efficiency is a relatively low bed occupancy rate in acute hospitals. At the same time, the average length of stay in curative hospitals is one of the longest average lengths of stay in the WHO European Region, which may indicate inefficient use of resources (Wilkens, 2023). High levels of OOP funding also incentivize some providers to provide unnecessary care (Box 8).

Box 8 Is there waste in pharmaceutical spending?

Counterintuitively, given the low absolute amounts of per capita health spending in Tajikistan, there has historically been an underuse of generic drugs. Overprescribing of expensive brand names, rather than cheaper generic drugs, risks an unnecessary financial burden for patients. Increased efforts are needed to ensure that high-quality generic pharmaceuticals are available to and affordable for the population. There are also concerns around the circulation of counterfeit or low-quality medication on the pharmaceutical market. Guidelines exist for the pharmaceutical prescription of a list of generic medicines, and over the last 10 years the number of generic medicines on this list has been expanded. However, in practice these guidelines are not widely adhered to: doctors are not legally required to prescribe generic before branded medication, and there is little evidence that many do so. The current national health strategy highlights the need for ensuring equitable access to essential medicines, and identifies several activities to be undertaken, including developing a law to regulate pricing and prices of medicines.

Summing up

Tajikistan has begun to reform many elements of its health system, but continues to face challenges in delivering universal health coverage

In the past two decades, Tajikistan has made a concerted effort to begin reforming its health system to improve coverage, quality, efficiency and financial protection. However, public spending as a share of current health expenditure is still one of the lowest in the WHO European Region, and public financing remains mostly input-based, leading to allocative inefficiencies and duplicated services. A major ongoing challenge is the high level of private OOP payments, which creates substantial inequalities in health care access between different parts of the country and different income groups, undermining the country's ambitions to achieve universal health coverage. State-funded health services exclude many types of care for most people. Hospital care continues to dominate the health care landscape, although the government has committed to improving the material infrastructure of primary care facilities and has invested in ways to incentivize medical staff to train or retrain in family medicine. The country has relatively low numbers of doctors compared to other countries in the region, and continues to struggle with an insufficient number of specialists in certain areas.

While progress in some areas has been slow, priorities for strengthening and accelerating work have been identified. The current national health strategy is focused on expanding universal health coverage, and Tajikistan has committed to addressing many of the structural, financial and technical challenges that hinder its delivery. Priorities should involve improving financial protection, introducing more efficient mechanisms for paying providers, expanding access to pharmaceuticals, and increasing the number and distribution of skilled health staff, especially in primary care. Whilst there are clear strategic directions for the future, it remains to be seen how much can be achieved in practice and at scale.

Population health context

Key mortality and health indicators

Life expectancy (years) (international estimate)	2023
Life expectancy at birth, total	71.8
Life expectancy at birth, male	69.6
Life expectancy at birth, female	74
Mortality	**2022 or 2023**
All causes (SDR per 100 000 population)	641 (2022)
Circulatory diseases (SDR per 100 000 population)	313 (2022)
Malignant neoplasms (SDR per 100 000 population)	46 (2022)
Communicable diseases (SDR per 100 000 population)	2.8 (2022)
External causes (SDR per 100 000 population)	14 (2022)
Ill-defined causes (SDR per 100 000 population)	138 (2022)
Infant mortality rate (per 1 000 live births)	22.9 (2023)
Maternal mortality per 100 000 live births (modelled estimate)	14 (2023)

Note: SDR: standardized death rate.

Sources: World Bank, 2025 (for life expectancy); WHO, 2025b (for mortality indicators).

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