International Labour Organization

Extending social health protection: Accelerating progress towards universal health coverage in the Republic of Uzbekistan

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1. Introduction

Uzbekistan is a lower middle-income country with a population of more than 37.5 million people. It is the third largest country by population size in the Commonwealth of Independent States (CIS) and the most populated country in Central Asia (UZ Statistics Agency 2025d). In 2024, close to 50 per cent of the population lived in rural areas (UZ Statistics Agency 2025b). The population is in large part young, and there has been continuous population growth over the past decades (UZ Statistics Agency 2025e). Life expectancy was estimated at around 75 years in 2024 (UZ Statistics Agency 2025a).

Since the 2000s, Uzbekistan's economy has grown rapidly, at an average rate of more than 6 per cent of GDP between 2000 and 2021 (UZ Statistics Agency 2022a). In 2023, GDP per capita by purchasing power parity (PPP) was equal to 11,107.0 international dollars (World Bank 2025). In parallel, the share of the low-income population in the country decreased by more than 2.5 times between 2001 and 2019 – from around 28 per cent to 11 per cent (UZ Statistics Agency 2025c).

Since 1996, Uzbekistan has been operating a state-run health care system with a publicly financed package of benefits (Ahmedov et al. 2014). The package guarantees free access to a list of essential health services to Uzbek citizens, foreign citizens and stateless persons permanently residing in the Republic of Uzbekistan, funded by the state budget. It also offers a list of complementary services to specified vulnerable population groups at different levels of care (Ahmedov et al. 2014). In 2020, a Social Health Insurance (SHI) scheme was launched, with a pilot initiated in the Syrdarya region in 2021 and subsequent expansion to Tashkent City and Karakalpakstan in 2023 (WHO Regional Office for Europe 2023). A phased national rollout is underway, with full implementation expected by October 2026. From 1 July 2025, free scheduled inpatient care will become available to eligible groups under the new scheme (Rödl & Partner 2025).

2. Context

Following independence in 1991, Uzbekistan inherited a centralized publicly run health system. While the legacy system performed well in tackling the main communicable diseases in the country, major improvements were necessary to respond to the shift in the burden of disease as well as changing socio-economic conditions while ensuring financial protection for all (Ahmedov et al. 2014).

In the late 1990s, Uzbekistan embarked on gradual reforms to make its health system more efficient and responsive to the evolving needs of the population. While the system remained state run, significant efforts were made to strengthen PHC, improve the distribution of resources, and strengthen medical training, management and monitoring. In this context, one of the focus areas of the reforms has been shifting emphasis from secondary to primary health to increase accessibility of services to the population and to improve health system efficiency. This was achieved through primary health capacity building (including investment in infrastructure and the workforce), consolidation of the secondary health system (including through the merging of facilities), and implementation and enforcement of patient referral procedures (Ahmedov et al. 2014).

In 1996, the Government of Uzbekistan institutionalized a state-guaranteed package of basic health benefits (SGBP) by adopting Law No. 265-I on Health Protection.[1] The Law re-affirmed the right of all citizens to health protection and the responsibility of the Government to ensure that this right is fulfilled. By introducing a defined list of available benefits, the Government sought to limit the scope of services provided while shifting some of the health costs to patients (specifically for secondary care and medicines) (Ahmedov et al. 2014; European Observatory on Health Systems and Policies and WHO 2022).

In 2018, a new set of reforms was initiated by Presidential Decree No. 5590 on Comprehensive Measures to Improve the Health care System of the Republic of Uzbekistan of 2018.[2] The Decree approved a new strategic plan for the development of the national health sector, namely the Concept on Health Development of the Republic of Uzbekistan 2019-2025 (European Observatory on Health Systems and Policies and WHO 2022). One of the overarching goals of the Concept [3] is to improve health financing and the organization of health care to achieve equal access to medical care, financial security and a fair distribution of resources. The Concept further sets an objective to gradually introduce a compulsory medical insurance scheme and to create a State Health Insurance Fund to pool and distribute financial resources for the needs of health care (WHO Regional Office for Europe 2021).

Accordingly, in 2020, the Government established a State Health Insurance Fund (SHIF) to serve as a single-payer mechanism for the purchase of health services for the entire population.[4] It is envisaged that the SHIF will accumulate, manage and distribute the funds allocated from the State budget to finance the state-guaranteed health benefits provided under the compulsory health insurance scheme. The SHIF acts as a strategic purchaser under a general tax-funded model, with a purchaser–provider split. In addition, health care institutions will start receiving payments on the basis of work performed (capitation for PHC facilities and case-based payment for hospitals), rather than on the basis of projected budgets as was the case in the legacy system (WHO Regional Office for Europe 2023).

In 2021, the Government launched a pilot project in the Syrdarya region to test the new scheme. The Syrdarya region is the smallest region of the country in terms of population size, accounting for around 2.5 per cent of the total population (Aiypkhanova 2021). An updated package of benefits has been institutionalized by Presidential Decree No. 4890 of 2020 as part of the pilot which is broader than the previous package, supplemented by an outpatient drug package. The SHIF also covers the cost of treatment for specified vulnerable population groups in pre-specified secondary and tertiary level medical facilities as well as private clinics throughout the country (State Health Insurance Fund 2024) (WHO Regional Office for Europe 2023).

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[1] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens, dated 29 August 1996, available (in Uzbek) at: https://www.lex.uz/en/docs/41329

[2] Presidential decree of the Republic of Uzbekistan No UP-5590 on Comprehensive Measures for improvement of the health care system, dated 7 December 2018, available (in Uzbek) at: https://lex.uz/docs/4096199#4099852

[3] The Concept sets out the following three overarching goals:

1. Increase population life expectancy by improving treatment and prevention of diseases that cause the most premature mortality and disability;
2. Improve health financing and organization of health care to achieve equal access to medical care, financial security and fair distribution of resources;
3. Enhance the capacity of health authorities, strengthening the role and responsibility of health managers to achieve the objectives set by the Concept.

[4] Presidential Decree No. 4890 on Measures to Integrate a New Model of Health System Organization and Mechanisms of State Health Insurance in Syrdarya Region, dated 13 November 2020, available (in Uzbek) at: https://lex.uz/docs/5100701

Starting from 2023, the new scheme has been expanded to other regions of the country. While a nationwide transition to the compulsory health insurance scheme (managed by the SHIF) is expected by 2025, the state-guaranteed basic benefit package (SGBP) remains, for now, the main social health protection scheme in Uzbekistan (WHO Regional Office for Europe 2023).

Starting from 2023, the new health insurance scheme has been expanded beyond the Syrdarya pilot to Tashkent City and the Republic of Karakalpakstan, with further rollout planned for additional regions. From 1 July 2025, eligible population groups will begin accessing free scheduled inpatient care through facilities participating in the scheme. While this transition is ongoing, the SGBP remains in effect and will serve as the foundation for the revised guaranteed services package to be adopted by the end of 2025 (Rödl & Partner 2025).

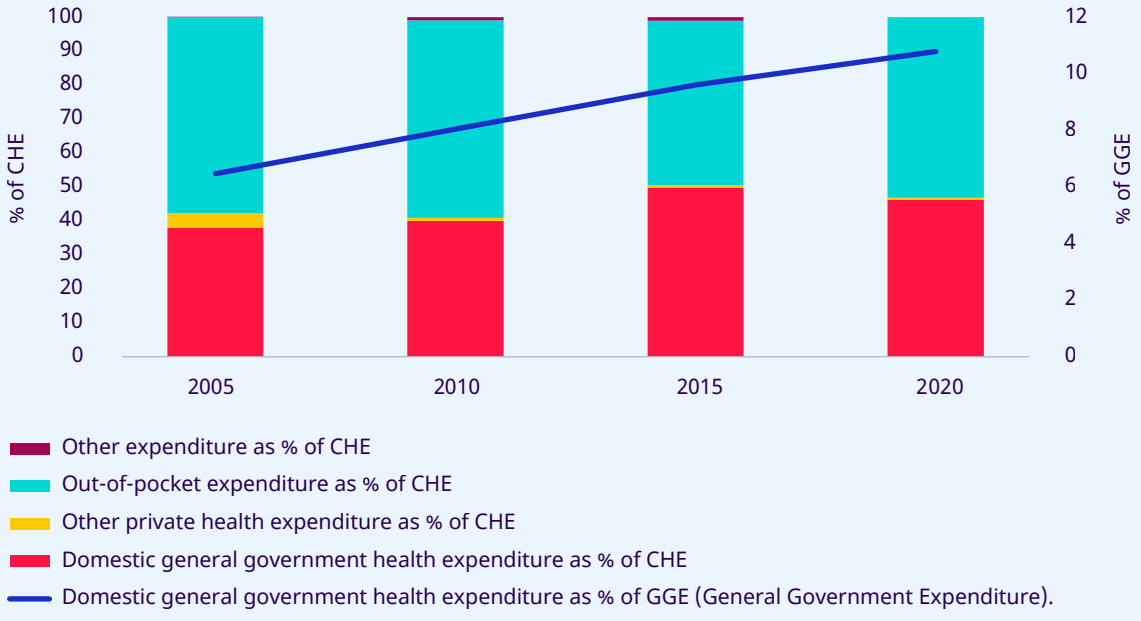
The following population groups are entitled to receive free health services under the scheme: (1) taxpayers of income tax and social contributions; (2) individuals who have paid sufficient taxes to determine employment duration; (3) minors, students, pregnant women, and caregivers of children under two; (4) officially registered unemployed individuals, pensioners, and families designated as low-income in the Unified Social Protection Register (Rödl & Partner 2025).

3. Design of the social health protection system

Financing

The composition of national health spending in Uzbekistan is characterized by a comparatively low share of public spending. Public health expenditure amounted to 39.3 per cent of CHE in 2021 (WHO, n.d.). While this is above the average among lower middle-income countries and is similar to the levels in other Central Asian countries, the current level of health funding results in exceptionally high levels of OOP spending, which amounted to 60.3 per cent of CHE in 2021 (WHO, n.d.) (see figure 46).

Figure 1. Composition of current health expenditure (CHE) in Uzbekistan, by source of financing, 2005-2020



Source: Based on data from the WHO Health Expenditure Database.

In 2021, the Government of Uzbekistan increased spending on health as part of the effort to respond to the COVID-19 pandemic (UNDP 2021). Most of the public funding originates from general tax revenues. As such, financing follow pre-set health care budgets that are determined based on past expenditures, expected input requirements and relevant policy and administrative guidelines (Ahmedov et al. 2014).

In recent years, further efforts have been made to increase public funding. In accordance with the Decree of the President of the Republic of Uzbekistan No. PP-5124 [5] dated 25 May 2021, since 15 June 2021, the amount of funds allocated per capita to primary health care institutions for obtaining medicines and medical products has on average tripled. In line with this resolution, in 2022, an additional 400 billion Uzbekistani som (US$36.3 million) was allocated from the state budget to expand the provision of medicines and medical products to primary health care institutions. This had a positive effect on reducing the level of OOP payments. The details of public funding for health are presented below:

▶ Table 1. Public health funding in Uzbekistan between 2018 and 2022

	2018	2019	2020	2021	2022
Public Health Expenditures (million US$)	1 161	1 354	1 487	2 333	2 537
Population (million US$)	32.7	33.2	33.9	34.6	35.3
Per capita (US$)	35.5	40.7	43.8	67.4	71.9

Source: Ministry of Economy and Finance of the Republic of Uzbekistan 2024.

As part of ongoing health financing reforms, the current input-based budgeting model is being replaced by a strategic purchasing approach under the SHIF, with phased national rollout expected to be completed by October 2026 (Rödl & Partner 2025). From 1 July 2025, inpatient services for eligible groups will begin to be funded through the SHIF, further operationalizing the new financing model (Presidential Resolution No. PP-311, 2024).. The scheme will remain primarily non-contributory (therefore tax-funded) (WHO Regional Office for Europe 2023; Rödl & Partner 2025).

The Government plans to fund the SHIF from the following sources (Norma 2019):

- Funds received from the state budget for the needs of the compulsory health insurance scheme: For this purpose, the SHIF estimates the necessary funds for providing the state-guaranteed benefit package and, together with the Ministry of Health, sends a request to the Ministry of Finance.
- Excise taxes on tobacco products, alcohol, foods high in sugar, trans fats and other unhealthy products: While the Government has recently raised the rates of these taxes to earmark funds for other health purposes, they have not yet been used to replenish the budget of SHIF.
- Funds received from the state budget to pay compensation for the execution of court decisions: Currently this is not yet implemented.
- Voluntary contributions and receipts under donor agreements: So far, the SHIF has not received any contributions or receipts from donors.
- Grants from international organizations: The SHIF is currently partnering with the WHO and the UN Multi-Partner Human Security Trust Fund for the Aral Sea Region;
- Funds received from charitable foundations, international organizations and foreign citizens;
- Other sources that do not violate national laws and regulations: In practice, this constitutes income from the placement of free funds of SHIF in financial instruments (deposits of banks, and so on).

According to comments from government officials, no additional social contributions are envisaged to help fund the SHIF.

[5] Resolution of of the President of the Republic of Uzbekistan No. PP-5124 on Additional Measures for Complex Development of Health Sector, available at: https://cis-legislation.com/document.fwx?rgn=132527

Governance

Law No. 265-I on Health Protection of 1996 is the principle legal instrument governing the health system of Uzbekistan (Ahmedov et al. 2014; Robinson 2021). The Law defines the roles and responsibilities of the key actors involved in the management of health services and sets a legal framework for the overall health system in the country (Ahmedov et al. 2014).

The health system in Uzbekistan is governed by the Ministry of Health, which plays the leading role in organizing, planning, and managing the health system (Robinson 2021). The system is dominated by the public sector and has three administrative levels, namely national, regional (oblast) and district (tuman) (Ahmedov et al. 2014):

- The national level is comprised of the Ministry of Health and republican-level facilities and institutions, including research institutions and universities and specialized centres. The Ministry of Health has the responsibility of setting and monitoring budget expenditure for national-level hospitals, specialized medical centres, emergency care centres and research institutions.
- Regional-level institutions consist of regional health facilities and regional branches of republican-level institutions and centres. They are managed by the respective health departments of regional (or city) administrations. Regional administrations are responsible for financing local and regional-level hospitals, primary health centres, sanitary-epidemiological units and other local-level facilities. A large share of funding comes from local tax revenues collected by the finance departments of local governments.
- The district level is formed of central district hospitals, district multidisciplinary outpatient clinics (polyclinics) and a network of rural physician centres, dispensaries, family health centres and obstetric centres. District institutions are directly supervised by district or city medical unions. The unions are responsible for administering funds for social assistance and for managing health and social services.

When it comes to private health care providers, both the Ministry of Health and regional health administrations have the right and the obligation to monitor and control the services provided by the private sector (Ahmedov et al. 2014).

Under the ongoing rollout of the compulsory health insurance system, the financing function of district, regional, and national-level administrations is being progressively transferred to the SHIF, which now acts as the single purchaser of health services in regions where the scheme has been introduced (WHO Regional Office for Europe 2023).

The Supervisory Board of the SHIF is chaired by the First Deputy State Counsellor, and its members include vice ministers of the Ministry of Health and the Ministry of Finance, heads of the Antimonopoly Committee, the National Association of NGOs of Uzbekistan (NANNOUz), regional health departments and regional governors.[6]

Legal coverage and eligibility

According to article 48 of the (new) Constitution of the Republic of Uzbekistan (dated 30 April 2023): "Everyone has the right to health protection and qualified medical care", institutionalizing the universal right to access qualified medical care. Accordingly, the 1996 Law on Health Protection institutionalizes a basic benefit package that is accessible to all citizens free of charge. Article 13 of the Law stipulates that the State provides citizens with health care regardless of their age, gender, race, nationality, language, religious relations, associations, beliefs, or personal and social status; and that the State should protect citizens from discrimination.[7]

According to article 14 of the Law, foreign citizens within the territory of the Republic of Uzbekistan are guaranteed the right to health care in accordance with international treaties of the Republic of Uzbekistan. Furthermore, stateless persons permanently residing in the Republic of Uzbekistan enjoy

[6] Presidential decree of the Republic of Uzbekistan No UP-5590 on Comprehensive Measures for improvement of the health care system, dated 7 December 2018, available (in Uzbek) at: https://lex.uz/docs/4096199#4099852

[7] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens, dated 19 August 1996, available (in Uzbek) at: https://www.lex.uz/en/docs/41329

the right to health protection on an equal footing with citizens of the Republic of Uzbekistan. This is also endorsed in article 48 of the new Constitution of the Republic of Uzbekistan.[8]

Presidential Resolution No. PP-311 of 5 September 2024 further defines the groups entitled to receive care free of charge under the new state health insurance system. These include:

- Taxpayers of income tax and social contributions;
- Individuals who have paid sufficient taxes to establish employment duration;
- Minors, students, pregnant women, and caregivers of children under two;
- Registered unemployed individuals, pensioners, and families identified as low-income in the Unified Social Protection Register (Rödl & Partner 2025).

Benefits

Benefits included in the SGBP are outlined in Chapter III of the Law on Health Protection.[9] The Resolution of the Cabinet of Ministers of the Republic of Uzbekistan No. 832 of 30 September 2019 [10] approved the regulations on the procedure for the formation of the list of guaranteed volumes of cost-free medical care covered by the state budget. Decrees issued by the Ministry of Health provide further guidelines on different types of services and health care delivery.

As a result, the following categories of services are included in the SGBP:

1. Primary care:
    - Management of prevalent and emergency conditions;
    - Preventive and sanitary-epidemiological activities;
    - Initiatives in family, maternal and child health;
    - Health promotion and education.
2. Emergency care
3. Care for "socially significant and hazardous conditions" (the list is monitored and updated by the Ministry of Health), including:
    - Selected intestinal, respiratory, skin and blood-borne infectious diseases (HIV/AIDs, tuberculosis, leprosy, syphilis and poliomyelitis, among others);
    - Selected chronic conditions, including but not limited to mental health disorders and cancers.

No payments are required from the population for medical services included in the guaranteed benefit package. Services not included in the guaranteed benefit package (mainly for secondary and tertiary care) are provided on a paid basis, except for vulnerable groups (as determined by the Government).

The state-guaranteed package approved in 2021 included more than 40 medicines and more than 20 medical products provided at PHC facilities. This list was expanded in 2022 to 70 medicines and 50 medical products and consumables (Ministry of Health of the Republic of Uzbekistan 2023). Additionally, a list of medicines for inpatient and emergency care is provided for vulnerable categories of the population (Ahmedov et al. 2014). As per article 35 of the Law on Health Protection, the list of vulnerable categories of the population eligible for free outpatient medicines is defined and approved by the Cabinet of Ministers of the Republic of Uzbekistan.

A new guaranteed services package—covering outpatient medications and laboratory diagnostics for common conditions—is expected to be finalized and approved by the end of 2025(Rödl & Partner 2025).

Sickness and maternity benefits are available through employer liability and social insurance for persons in covered employment, persons on leave from employment while pursuing secondary, technical or advanced education, and registered unemployed persons. These benefits are managed by the Ministry of Labour and Social Protection and paid for by enterprises and local Departments of Social Protection.

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[8] The Constitution of the Republic of Uzbekistan was adopted by nationwide vote at the referendum of the Republic of Uzbekistan held on 30 April 2023, available at: https://constitution.uz/en

[9] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens.

[10] Resolution of the cabinet of ministers of the Republic of Uzbekistan No. 832 on Approval of the Regulation on Forming the List of the Guaranteed Amounts of Medical Care covered at the expense of the Government Budget, dated 30 September 2019, available (in Uzbek) at: https://lex.uz/docs/-4535086?ONDATE=05.04.2022%2000#

Those who are entitled to sickness cash benefits with less than eight years of uninterrupted employment are provided with 60 per cent of their monthly income, and those with more than eight years of uninterrupted employment are entitled to 80 per cent of their monthly income. As for maternity cash benefits, employers bear a portion of the financial responsibility under the current system. According to new regulations, employers are required to supplement the tax-financed maternity cash benefit to reach either 75 or 100 per cent of the woman's prior monthly earnings. Employers' liability does not apply when the benefits are equal to or less than the minimum consumer expenditure, or when the woman has worked for less than six months. In such cases, the cash benefit is fully covered by the state budget. The benefit is equal to the last full month of income, provided for 56 days prior to and 56 days after childbirth and can be extended for 70 days in cases of complicated or multiple births. Additionally, a lump sum of 405,460 som (200 per cent of the monthly minimum wage) is paid to working mothers caring for children younger than two years of age (ISSA 2019; ILO 2023)

Provision of benefits and services

Health services provided under the SGBP are delivered through a network of public health facilities, which include family doctor points (in rural areas), family polyclinics, district (city) central polyclinics, district (city) hospitals and emergency care centres.

The national State Committee on Statistics (UZSTAT) reports that, in 2022, there were 1,328 hospitals and 7,010 outpatient clinics in Uzbekistan (UZ Statistics Agency 2023a; 2023b). The vast majority of these facilities are publicly owned and operated. Health workers are salaried and paid according to state guidelines (Ahmedov et al. 2014).

To access SGBP, patients need to visit their family doctor at local physician points, family polyclinics or central multi-profile polyclinics in their registered area of residence. Upon initial contact with qualified health professionals, patients can be referred for specialized treatment in district, regional or national level institutions (Ahmedov et al. 2014).

As part of the transition to state health insurance, patients in regions covered by the SHIF can now access scheduled inpatient care using an electronic queue system, starting 1 July 2025 (Rödl & Partner 2025). Care will be delivered by both public and private providers contracted by the SHIF, based on standardized agreements. Prescriptions for medicines in the guaranteed benefit package will also be issued electronically.

Public district (city) inpatient facilities provide secondary services included in the SGBP; however, patients are responsible for covering the cost of food and accommodation (Ahmedov et al. 2014). Certain vulnerable population groups are exempt from these expenses, which the State covers on their behalf (Ahmedov et al. 2014).

Portability of benefits is limited. Public health care institutions are allowed to charge patients in cases when patients seek services outside their registered area of residence (Ahmedov et al. 2014). The price-setting process for such services is regulated, and user charges have ceilings defined by the regional health department, in accordance with the order of the Ministry of Health (order No. 293 of 3 December 2023). However, emergency care can be accessed free of charge from any provider regardless of registered place of residence.

According to statistics from the Ministry of Health, there is a trend towards the rationalization of health facilities (Open Data Portal of the Republic of Uzbekistan, n.d.-c). This translates into a decrease in the number of hospitals and an increase in the number of hospital beds. The table below shows the dynamics of changes in the number of medical institutions providing inpatient care, indicating the number of beds during the period from 2016 to 2021. The number of hospitals during this period decreased by 18 (3 per cent), while absolute number of beds between 2016 and 2021 increased by 6,281 (5 per cent) (Open Data Portal of the Republic of Uzbekistan, n.d.-b).

▶ Table 2. Number of hospital beds in Uzbekistan (absolute and relative) between 2016 and 2021

	2016	2017	2018	2019	2020	2021
Number of hospitals	582	581	574	566	570	564
Absolute number of beds	115 936	116 391	117 169	117 366	120 977	122 217
Provision of hospital beds per 10,000 population	36.7	35.9	35.6	35.3	35.0	34.7

Source: Open Data of the Ministry of Health of the Republic of Uzbekistan.

The number of medical institutions providing medical outpatient care also decreased during the period from 2016 to 2021 (Open Data Portal of the Republic of Uzbekistan, n.d.-a). The reduction in PHC facilities (by 34 per cent between 2016 and 2021) occurred due to a decrease in the number of rural medical posts (SVPs). This decision was made in order to optimize the SVP network, in accordance with the Decree of the President No. PP-2857 dated 18 March 2017.[11]

▶ Table 3. Number of PHC facilities in Uzbekistan between 2016 and 2021

	2016	2017	2018	2019	2020	2021
PHC facilities	3 758	2 377	2 374	2 368	2 374	2 478

Source: Open Data of the Ministry of Health of the Republic of Uzbekistan.

The private sector plays a minor but gradually expanding role in the country's health system. While the number of private providers grew from around 3,500 in 2017 to more than 6,000 in 2020, most of them constitute small practices (Robinson 2021). Furthermore, existing regulations require certain services to be delivered by the public sector (such as HIV/AIDS and tuberculosis) (Robinson 2021). However, it should be noted that the private sector has been contributing to an increasing share of hospital bed capacity (estimated at 23.4 per cent in 2018) (Robinson 2021). If patients choose to access services from private providers, they are usually responsible for paying the entire cost, although reimbursement mechanisms exist for vulnerable population groups (veterans, persons with disabilities, orphans and so on) (Ahmedov et al. 2014).

Under the new SHI system, private providers may be contracted by the SHIF to deliver covered services under the guaranteed benefits package. In such cases, services are paid for directly by the SHIF, and eligible patients are not charged at the point of use (Rödl & Partner 2025).

The new SHIF contracts different types of legal entities: Regional hospitals; district (city) medical unions, which consist of family doctor points (in rural areas); family polyclinics; district (city) central polyclinics; and district (city) hospitals for purchasing medical services included in the SGBP. Payment modalities include capitation for PHC services and case-based payments for inpatient services, aligned with performance indicators. The case-based mechanism currently accounts for approximately 10 per cent of the hospital budget(WHO Regional Office for Europe 2023).

[11] Decree of the Republic of Uzbekistan No. PP-2857 on Measures to Improve the Organization of Activities of Primary Health care Institutions, dated 29 March 2017, available (in Uzbek) at: https://old.lex.uz/docs/3177802

4. Results

Coverage

Under the Law on Health Protection and other legislative documents, the SGBP is accessible to all citizens of Uzbekistan, as well as foreigners and stateless persons who have permanent residence status in the country. In this context, legal population coverage of the existing scheme can be assessed as close to universal.

However, some groups of residents are not covered by the programme, most notably foreigners without permanent residence status and persons with irregular residence status. According to UN estimates, in 2015 there were close to 1.8 million immigrants in Uzbekistan (UN 2020b). A significant number of these immigrants likely had informal status and therefore were not eligible to access the SGBP (unless there was a bilateral agreement with their country of origin). Based on data sourced by the Vatican's Migrants and Refugees Section, there are approximately 100,000 people in Uzbekistan who are considered stateless, but only 50,000 of them will be granted Uzbek citizenship (Integral Human Development 2020).

In addition, some internal labour migrants and internally displaced households face challenges when accessing the SGBP because they are seeking care outside their registered area of residence (UNDP and Gender Programme of Swiss Embassy 2008). It is estimated that in Uzbekistan, there are more than 70,000 persons internally displaced by adverse climate events and disasters and around 3,500 persons displaced by conflict and violence (OCHA 2022). In addition, there is continuous internal migration from rural to urban areas linked to employment (Integral Human Development 2020).

The rollout of SHIF is expected to improve effective coverage by reducing exclusions linked to place of registration and expanding contracting across public and private providers (WHO 2023).

Adequacy of benefits/financial protection

Entitlement to SGBP provides access to a range of health services at no cost to patients, including preventive services. For instance, vaccination and immunization programmes are included in the benefit package and provided according to the approved vaccination schedule.[12] The prevention of the spread of infectious diseases is also included, with a number of programmes implemented to combat HIV/AIDS, tuberculosis, hepatitis B, C, D and others. Each of these programmes is supported at the government level and financed from public funds.

However, the current composition of the package largely excludes secondary and tertiary care as well as some outpatient pharmaceuticals for most of the population (Robinson 2021). As a result, there are substantial shortfalls in financial protection as patients are forced to pay out of pocket for the services that are not covered under the existing arrangement. Notably, while NCDs are the main cause of death in the country,[13] the basic benefits package only includes some NCDs, such as cancer, cardiovascular disease and diabetes, while other common NCDs (asthma, Chronic obstructive pulmonary disease and others) remain uncovered by preventive and screening programmes.

This situation is expected to improve with the introduction of a revised guaranteed services package. It will cover outpatient diagnostics and essential medications for common illnesses and will be financed through SHIF. Medicines will be issued via electronic prescriptions and dispensed without cost to the patient (Rödl & Partner 2025).

In general, the SGBP does not cover rehabilitation services. In family polyclinics there are exercise therapy rooms (the office of physiotherapy exercises),[14] but the level of equipment and the attendance of patients

[12] Resolution of the Sanitary and Epidemiological Welfare and Public Health Service of the Republic of Uzbekistan No. 02, dated 19 July 2021, available (in Uzbek) at: https://lex.uz/docs/5520052

[13] The share of mortality attributable to NCDs in Uzbekistan has risen from 73 per cent in 2000 to 85 per cent in 2019 (World Bank 2020).

[14] Ministry of Health of the Republic of Uzbekistan Order No.594, dated 29 December 2007, available (in Uzbek) at https://www.med.uz/documentation/detail.php?ID=9128

is low, with many turning to private clinics providing rehabilitation services (Ahmedov et al. 2014). Overall, the volume of medical services provided by private providers is estimated at 30 per cent of the total volume of medical services provided (The Government Portal of the Republic of Uzbekistan 2023).

While existing guidelines and regulations provide for referral procedures, in practice, they are loosely followed by both patients and health care providers (Ahmedov et al. 2014). Therefore, it is not uncommon for patients to access health care directly from secondary-level institutions, many of which have outpatient units, which limits financial protection. Furthermore, beneficiaries have the option to seek medical services outside of the provider network, as they can access health care at private clinics that require patients to cover their health care costs. Moreover, the SGBP does not cover compensation for transportation costs, meaning that patients are forced to pay these costs at their own expense, which reduces the level of financial protection and adversely affects well-being, especially among vulnerable people.

Persons who are not included in vulnerable groups of the population are forced to buy medicines and pay for medical devices and consumables for surgical operations (stents, endoprostheses and so on) (WHO Regional Office for Europe 2023; ILO, UNICEF and World Bank 2020). Moreover, a shortage of medicines is being reported.

With the establishment of SHIF, public financing is increasingly directed toward strategic purchasing of priority services, based on output (e.g. case-based payment), rather than historical budgets. This model is expected to reduce some out-of-pocket burdens, especially in SHIF-covered regions, but full impact will depend on implementation quality (WHO 2023).

Another challenge to financial protection is presented by informal payments (Ahmedov et al. 2014). Some reforms have been introduced to tackle this, but they have proven to be ineffective. Informal payments are common at secondary and tertiary care levels, representing an obstacle for all, primarily the most vulnerable, to access these levels of care. Despite an increase in public expenditure on health, OOP payments, informal payments and the limits of the benefit package led to large gaps in terms of financial protection (Jung Cho and Haverkort 2023; European Observatory on Health Systems and Policies and WHO 2022). As of 2025, informal payments remain a major barrier, despite digital tools and payment contracts introduced under SHIF. Targeted anti-corruption and transparency mechanisms are being discussed in ongoing policy dialogues with international partners (BMAS-GIZ 2025).

For all of these reasons, OOP spending amounted to 57.7 per cent of CHE in 2019 (WHO n.d.). WHO estimates suggest that in 2018 almost one in five households incurred catastrophic health expenditures (Robinson 2021). It is estimated that 36 per cent of CHE was spent on medical goods (mostly medicines) in 2019, and this cost was solely borne by private household spending. Similarly, domestic private expenditure on curative care represented 18 per cent of CHE, which means that households still have to pay for a major share when it comes to access to curative services (European Observatory on Health Systems and Policies and WHO 2022). In 2020, 18 per cent of households reported that at least one household member had not sought medical care because they could not afford it (World Bank 2021).

Representative surveys of Uzbekistan residents conducted in 2006 and 2010 found that among the most common challenges experienced by people when accessing health care were the need to make informal payments (27 per cent), the lack of required medicines in facilities (25 per cent) and long waiting times (21 per cent) (Habibov et al. 2019). Despite the incomplete provision of the necessary medical care within the framework of the SGBP, the demand for voluntary medical insurance is not particularly high (European Observatory on Health Systems and Policies and WHO 2022). The main reason for this is the limited services included in insurance products and the high levels of insurance premiums for obtaining this type of insurance.

Despite the incomplete provision of necessary medical care within the SGBP, demand for voluntary medical insurance remains low. Recent reforms—especially guaranteed outpatient medicines and the inclusion of private providers under SHIF—could reduce reliance on out-of-pocket payments and lessen the need for private insurance, but the impact will depend on national rollout success (WHO Regional Office for Europe 2023; Rödl & Partner 2025).

Responsiveness to population needs

Availability and accessibility

Despite improved access to certain types of services (such as maternal, child and reproductive health services, which have been prioritised by the Government in recent years), a very large portion of the population continues to face major barriers when seeking health care. In 2019, the health service coverage index (health service indicator 3.8.1) was equal to 71, which is below the value of Kazakhstan and Turkmenistan but above that of Tajikistan and Kyrgyzstan. The sub index on reproductive, maternal, newborn and child health was indicated at 83.61 (WHO 2021).

Several factors affect service availability in Uzbekistan:

- Geographic remoteness of some rural settlements poses a challenge to health care accessibility. Even when medical facilities are present, staffing remains low (Ahmedov et al. 2014). To access some villages located on the territory of Kyrgyzstan, it is necessary to cross the State border, which creates obstacles in the provision of doctors and medical equipment (Baizakova 2017).
- One of the main challenges to tackle is the brain drain and migration of health professionals to neighbouring countries where there are better financial conditions (Dronina and Nam 2019). This has led the country to face a shortage of physicians. However, the number of nurses per 100,000 persons continued to remain stable at between 1,000 and 1,200 and remained the highest in Central Asia during the period 1990-2012 (Ahmedov et al. 2014). According to the national Statistics Agency, in 2020, the number of nurses was estimated to be 3,656 per 100,000 persons (UZ Statistics Agency 2022d).
- The distribution of the health workforce in the country remains unequal, with the majority of health professionals located in urban areas, leading to shortages in rural areas. Since half of the population lives in rural areas, this phenomenon affects a large share of citizens (Robinson 2021). Health workers are salaried and paid according to state guidelines, yet the salaries are low and insufficient to cover the cost of living. This explains why many professionals tend to emigrate to neighboring countries (Ahmedov et al. 2014).
- Differences in competencies between rural and urban areas and low enrolment in higher education contributes to shortages of highly qualified personnel (UN 2020a).
- Water services and sanitation infrastructure require extensive rehabilitation and renewal, since they were built predominantly under the Soviet Union (Robinson 2021).

Since 2021, efforts to improve service accessibility have included expanding primary care infrastructure and developing new contracting mechanisms with both public and private providers under the SHIF. According to Presidential Decree No. UP-6110 of 2020, 315 family doctors and 85 family polyclinics were created by 2023, with continued expansion underway. (WHO Regional Office for Europe 2023; Rödl & Partner 2025).

Since 2023, the use of telemedicine and eHealth systems has expanded beyond pilots. These developments aim to reduce geographic disparities and improve continuity of care (WHO 2023).

Quality and acceptability

In recent years, much attention has been paid to improving the quality of medical care, especially in the field of maternal and child health (European Observatory on Health Systems and Policies and WHO 2022). As a result of consistent health resource commitment to maternal and child health, 100 per cent of births were attended by skilled health personnel in 2020, and maternal and child mortality have decreased significantly (WHO Data 2024). However, these rates are higher than the average for the Europe and Central Asia region, highlighting the need for further progress in this area (World Bank 2023; UNDP 2022). National standards have been developed for the management and provision of medical care to pregnant women, which are based on evidence-based medicine and approved by orders of the Ministry of Health (Republican Specialized Scientific and Practical and Medical Center for Maternal and Child Health, n.d.).

According to studies conducted by the National Committee for the Confidential Study of Maternal Deaths during the period from 2018 to 2020, over the past 25 years, the maternal mortality ratio (MMR) in Uzbekistan has decreased by more than 3 times: In 1990, it was 65.5 per 100,000 live births, and in

2015, this figure was -18.9. The studies revealed that the main cause of maternal mortality in Uzbekistan are direct obstetric causes, which accounted for 77.3 per cent of cases. In most cases, these causes are preventable, which indicates that there is still room for reducing maternal mortality (National Committee on Confidential Maternal Mortality Research 2022). For example, analysis of maternal mortality indicators shows that most cases of maternal mortality occur in district level facilities (RMO) due to risk factors that should have been the basis for referral or transfer to a higher level of perinatal care (National Committee on Confidential Maternal Mortality Research 2022).

The organization and management of the health system is not sufficiently optimized, which leads to congestion in certain areas, which can affect the quality of medical services. In addition, there are significant regional disparities both in terms of specific indicators and in assessing the quality of medical institutions. In order to monitor the activities of medical institutions and the quality of medical care provided, regular monitoring visits are carried out, problems are identified and measures are taken to eliminate them. Licensing of the activities of medical organizations is carried out by the Ministry of Health.[15] State medical organizations typically receive licenses automatically, while non-governmental providers must meet all standard conditions. With the inclusion of private providers in SHIF contracts, stricter enforcement of licensing and quality controls is expected (Rödl & Partner 2025).

However, a range of significant issues persist that affect the quality of health care and the willingness of the population to access services offered by the public health system. Despite the orders approved by the Ministry of Health indicating measures for prevention and the timing of their implementation, prevention activities [16] are not carried out regularly or efficiently. As such, the level of preventive measures taken can be assessed as unsatisfactory (European Observatory on Health Systems and Policies and WHO 2022; WHO Regional Office for Europe 2023).

It should also be noted that the prevalence of self-medication in Uzbekistan is high. One 2014 study observed that close to 80 per cent of schoolteachers in cities used non-prescribed antibiotics for self-treatment (Belkina et al. 2014). The frequent use of self-medication is often indicative of challenges with accessibility and acceptability of health services, but can also be linked to cultural beliefs. It also highlights the need for stronger regulation and monitoring to avoid the negative effects of excessive antibiotics usage and health-harming use of medicines.

Information on the satisfaction of patients is scarce and seems to be conflicting. Available surveys suggest that patients are usually satisfied with the services provided by health care workers at polyclinics and hospitals (Akhmedov et al. 2022; Madrakhimov and Karimov 2021). However, these results are difficult to extrapolate to the overall health system, since the surveys in question were conducted in specific locations (facilities) and concern specific procedures. Furthermore, anecdotal evidence suggests that, when their financial situation allows, many patients prefer to seek treatment overseas or in private health facilities (Ahmedov et al. 2014).

The success of SHIF in contracting private providers and implementing electronic systems is expected to improve transparency, reduce waiting times, and raise perceived quality. Still, further investment in provider accreditation, community engagement, and patient feedback is needed to strengthen trust in the system (WHO Regional Office for Europe 2023; Rödl & Partner 2025).

[15] Resolution of the Cabinet of Ministers in the Republic of Uzbekistan No. 92 on Enhancement of Procedure for Licensing of Medical Activities dated 29 March 2012, available at https://cis-legislation.com/document.fwx?rgn=50991

[16] This includes activities such as screening for oncohematology among children aged 3-18 years; cervical cancer among women aged 35-55 years; breast cancer among women aged 45-65 years; helminthiases in children aged 2-10 years (according to the order of the Ministry of Health of the Republic of Uzbekistan No. 210 dated 27 July 27 2022); phenylketonuria and congenital hypothyroidism in newborns; early diagnosis of congenital and hereditary diseases in the fetus by conducting a mass prenatal ultrasound examination of women; and biochemical prenatal (prenatal) screening for the detection of neural tube defects and chromosomal syndromes in the fetus; CVD risk stratification; early detection of tuberculosis; and monitoring of growth and development of children under 5 years of age (according to Presidential Decree No/ PP-3440, dated 25 December 2017, available at: https://lex.uz/docs/3471753

5 Way forward

In recent years, particular attention has been paid to strengthening the financial protection of the population, and expanding the coverage and types of health services provided to citizens by the State. However, problems related to the inadequacy of the benefit package in meeting the needs of the population are reflected in very high OOP payments nationwide, with large exclusions (including secondary and tertiary care as well as outpatient pharmaceuticals) leaving the population with very limited financial protection. Limited government allocation to health is also of concern, particularly given that the financing of the new SHIF is supposed to rely exclusively on taxation. Options to diversify sources of revenues should therefore be explored. Moreover, continued improvement of PHC and the availability of providers, specifically in rural areas, should be prioritized. A WHO-led feasibility study on the introduction of mandatory health insurance conducted in 2020-2021 recommended that the Government should focus on efficiency gains in the service delivery system, by introducing modern clinical and professional managerial practices underpinned by strong digitalization and performance monitoring to use limited resources more efficiently (WHO Regional Office for Europe 2021).

Through the continued implementation of the Concept on Health Development of the Republic of Uzbekistan 2019-2025 adopted in 2018, the main actions to address current gaps should involve (i) expansion of the benefit package; (ii) increased levels of public funding for social health protection; and (iii) capacity building and improved resource availability.

The Government has started to use intersectoral approaches to tackle social health protection-related issues. During COVID-19 for example, the Ministry of Health collaborated with a variety of sectors, including employment, transport and tourism to respond to the effects of the pandemic (European Observatory on Health Systems and Policies and WHO 2022). Prior to COVID-19, an area of intersectoral collaboration that yielded positive results was addressing risk factors related to NCDs. Furthermore, tobacco control could be an area in which an intersectoral approach could be used to strengthen existing policies (Robinson 2021).

6. Main lessons learned

- Enshrining the universality of social health protection coverage in the Constitution and related laws is the first necessary step towards guaranteeing social health protection for all, institutionalizing state liability for providing social health protection.
- Many health services are currently not covered by the SGBP, which hinders effective financial protection and access to care for the majority of the population (Robinson 2021). In addition, while service availability has improved over recent years, challenges remain, especially in remote rural areas.
- Low levels of health funding, underpinned by insufficient allocations to the health sector, should be addressed in order to guarantee the sustainability of the new SHI scheme. To this end, additional sources of revenue should be investigated.
- The introduction of a purchasing mechanism for medical services made it possible to monitor the system of referrals from family doctors, as well as to control the provision of medical care within the SGBP (WHO Regional Office for Europe 2023). Accordingly, in regions not covered by state health insurance, there may be gaps. Gradual consolidation of financial resources, first at the regional level (Syrdarya and other regions) and then at the national level, will make it possible to cover the population with a package of state guarantees, regardless of the place of permanent residence.
- The improvements in maternal and child health in Uzbekistan are commendable, and maternal and child mortality have decreased significantly as a result of consistent health resource commitment to this area. However, the rates are higher than the average for the Europe and Central Asia region, highlighting the need for further progress in this area (World Bank 2023; UNDP 2022).

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