

The University of World Economy and Diplomacy

Institute for Advanced
International Studies

Policy Report

The best international
practices for the
sustainable financing
of the immunization
programme

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I. Executive summary

We studied the cost and financing of national immunization programs in lower and middle-income 28 countries: their immunization legislation, sorting them according to responsible parties for financing, stakeholders, functioning programs, covered vaccines, promotion, donor organization and implementation processes. Based on the analysis, 6 countries have been identified as optional best practices: Sri-Lanka, Bolivia, Costa-Rica, El-Salvador, Mongolia and Vietnam. Furthermore, several other lower and middle income emerging countries immunization programs have been studied, like Moldova, Azerbaijan, Bhutan, Ghana, Armenia, Georgia and Indonesia. These countries immunization programs have covered almost all points: timeline, supply, storage, applying, prevention, monitoring, training of the staff, financing programs and circumstances of obeying the rules. In addition, the process of immunization financing is well defined in their national legislations.

The mechanism has begun from the bottom, educating and raising awareness of citizens of the essence of immunization and its importance in overall welfare. The financing process is subdivided into different sources, relying on legal supporting bodies. After transitioning GAVI support, the countries have moved to 100 percent self-financing with a little support from UNICEF. Mostly, many countries have raised funds for immunization through public health insurance, local budget, aid from foreign countries, and tiny support from international organizations. Timely monitoring, organized training, well-defined responsible parties and government support are main prerequisites for ensuring a high rate of immunization coverage.

Governments are therefore a better source of funding for immunization services because they can ensure that most vaccination services are provided free of charge to the general public and create immunization policies. The government typically covers all or a portion of the cost of the immunization program, occasionally with help from outside partners. However, access to immunization services is sometimes limited if a country's macroeconomic status is not developed, it lacks health infrastructure, and/or it has competing health priorities.

It is found that there is no single "best approach" among the various legislative methods used around the world to finance immunization. Instead, the study supports the idea that how a country approaches its legal framework for immunization financing depends on a variety of factors, including the country's context, the immunization system's capabilities, the economy, social dynamics, political realities, and the relationship that a government and its citizens have under its constitution. This study is an analysis of foreign legislations on immunization financing that will serve as an important starting point for Uzbekistan considering changes to their legislative and framework for immunization financing.

II. Introduction

Vaccines are very vital as preventing millions of death and have a positive influence like, healthier kids, higher school enrollment, increased welfare, less health related expenditure and higher productivity. The groundwork for additional crucial medical care is immunization services. Immunization must be sustained indefinitely and is therefore a long-term investment that requires stable, long-term financing as it offers a number of financial gains for every dollar invested (every dollar invested in vaccination returns 16\$ economic benefit). Governments have a chance to introduce many vaccines which are extremely important for health; however the financial challenges are main issues. Despite the fact that GAVI supported countries receive financial assistance to acquire live-vital vaccines, once the eligible time period ends, the countries have to fund their programs entirely from the domestic resources¹.

Governments must carefully plan to ensure adequate and sustainable financing for immunization programs despite the fact that the benefits of vaccines—and their cost effectiveness—are well established. Long-term planning of immunization financing is crucial due to two characteristics of vaccination.

First, immunization is a public responsibility. All children in most nations receive free immunizations through government health services or with public funding and oversight. The government is ultimately responsible for ensuring access to vaccines that are crucial for the public's health, even when private providers play a significant role.

Second, immunization must be continued indefinitely, even when the diseases that vaccines prevent have significantly decreased, unless there are exceptional circumstances where a disease can be completely eradicated (and faded from public consciousness).

Strong immunization program performance depends on funding primary care facilities and staff who provide routine immunization as part of a larger program of health services, in addition to adequate funding of immunization-specific activities at the national level, such as vaccine procurement and supply chains.

Immunization programs need sufficient funding from health budgets for managing and transporting vaccines, buying vaccines, injection supplies, and cold chain equipment, as well as providing immunization services.

To effectively plan, finance, implement, and maintain a comprehensive immunization program, nations must understand the major costs associated with immunization. Because vaccination costs occur at various levels of the health system, from the centralized coordinating agency to the point of service delivery, and because they include a number of significant components that may be funded differently, they can be challenging to separate. These include supply chain and logistics, vaccination at the point of use, and the purchase of vaccines and injection supplies.

The costs of immunization programs fall into two major categories:

1. Vaccines and injection supplies. Total costs include delivery to the country, fees associated with clearing customs, import taxes, and procurement fees, if relevant.
2. Immunization delivery. These costs, which are sizeable, include the time spent administering the vaccine, costs associated with planning, managing, and supervising, as well as costs associated with social mobilization, surveillance, monitoring, and evaluation. They also cover the expenses associated with logistics and the supply chain, such as the price of the equipment, fuel, and labor required to transport and store vaccines at points of care. The supply chain involves both ongoing and one-time costs. Recurring

¹ Domestic funding for health can come from public or private sources. Public sources include general revenue raised through broad-based taxes at the national or subnational levels and public insurance contributions. These may be complemented by “on-budget” external resources that flow through government accounting systems. Private sources commonly include private (voluntary) health insurance premiums and formal or informal user fees paid at the point of service.

costs include things like transportation fuel, using refrigerators, paying employees, and maintaining equipment used in the cold chain (which is frequently under budgeted in immunization planning). Capital expenditures include things like buying new trucks, motorcycles, and refrigeration equipment.

III. Key terms

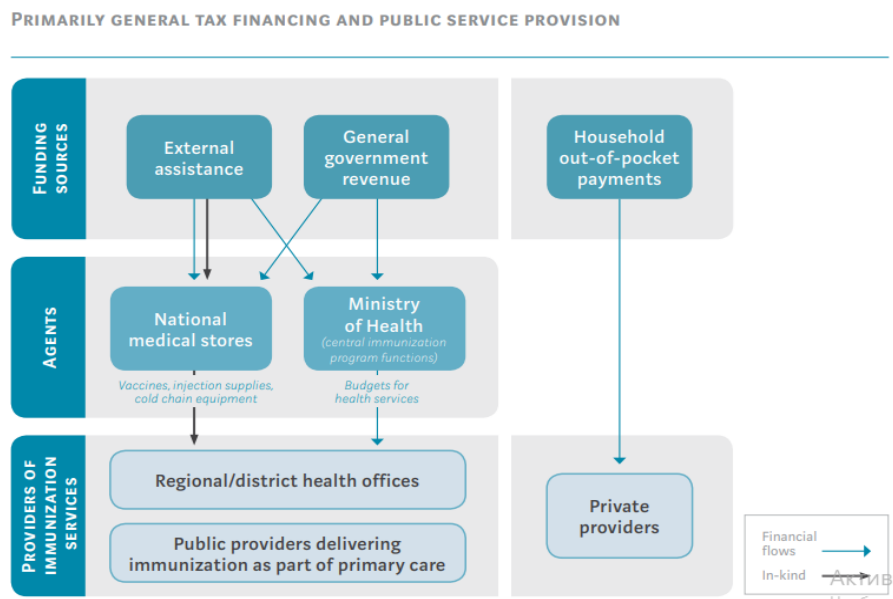
- ✓ Capital cost - The cost of assets (such as buildings and equipment) that have a working life of one year or longer and usually exceed some threshold cost. In immunization, this could include cold chain equipment, national and regional medical stores, and vehicles.
- ✓ Capitation payment - A fixed payment to a health care provider to deliver an agreed upon package of services to each enrolled person over a fixed period of time.
- ✓ Co-financing - In the context of GAVI, contributions from both GAVI and GAVI-supported countries toward the cost of vaccines. Country contributions are not paid to GAVI; rather, the required co-financing amount is converted, using the full price that GAVI pays, into the number of vaccine doses the country is responsible for financing directly
- ✓ Earmarking - Setting aside some or all revenue from a tax or group of taxes for a designated purpose.
- ✓ General revenue - Money that a government raises through personal income taxes, taxes on corporate income and profits, value-added and sales taxes, duties and import taxes, property and inheritance taxes, payroll taxes, and/or taxes on profits from the sale of natural resources. These sources are typically pooled into a consolidated fund and appropriated toward payment of public expenses through regular budgeting and planning cycles.
- ✓ Out-of-pocket payment for health - Direct expenditure by households for health care.
- ✓ Shared cost - The cost of a resource that is shared by and can be allocated to multiple health services.
- ✓ Social health insurance - A health financing model in which coverage is mandatory for the entire population or a subset of the population, entitlement to covered services is linked to a contribution made by an individual or on the individual's behalf that is not related to health risk, and coverage is provided by a government or government regulated body or bodies.
- ✓ Trust fund - A mechanism that governments can use to ring-fence, or protect, funding for specific purposes. Trust funds may receive funds from multiple streams of revenue and may be legally incorporated with policies and tax regulations that vary by country; a governing board oversees the strategy, business plan, management, and operations.

IV. Financing approaches

There are mainly three different approaches to finance the immunization programs in different countries.

Primarily General tax Financing and Public Service Provision (see Pic.1)

Some countries' health systems, like those in **Malaysia and Sri Lanka**, which rely on tax-based financing and public service delivery, perform well overall and achieve high immunization coverage rates. However, many other nations those follow the National Health Service model struggle to find sufficient funding during the annual budgeting process. These systems are frequently characterized by persistent underfunding and a lack of qualified personnel. To meet the demand for health services, a parallel, and typically unregulated, private sector frequently arises; combined with the ongoing underfunding of public facilities, this frequently results in high out-of-pocket costs for patients and insufficient financial protection.

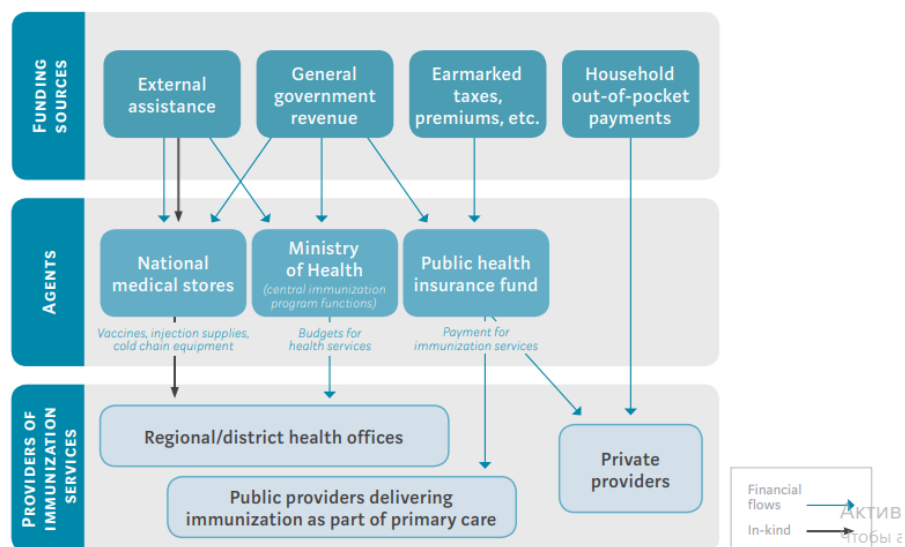


Picture-1

Mixed Public Financing and Mixed Public and Private Service Provision (see Pic.2)

Some nations, such as **Ghana, Indonesia, Peru, and Vietnam**, have implemented public insurance programs to increase funding for their healthcare systems and offer financial security against out-of-pocket expenses. As the national health insurance system has expanded, immunization coverage has increased in some nations. When a nation has several insurance programs, it can be difficult to achieve equity and expand insurance coverage to workers in the informal sector. **As in Ghana and Vietnam**, the ministry of health continues to fund health promotion and preventive services, such as immunization. Immunization is a part of the national health insurance system's benefits package in **Indonesia**. In order to prevent immunization from being neglected by the financing system and service providers, countries should make sure that immunization financing and service delivery responsibilities are clear, and that people understand where they can obtain immunization services and how they are covered. Supply and maintenance of the cold chain can be especially vulnerable in mixed systems with multiple institutional actors and hazy lines of authority.

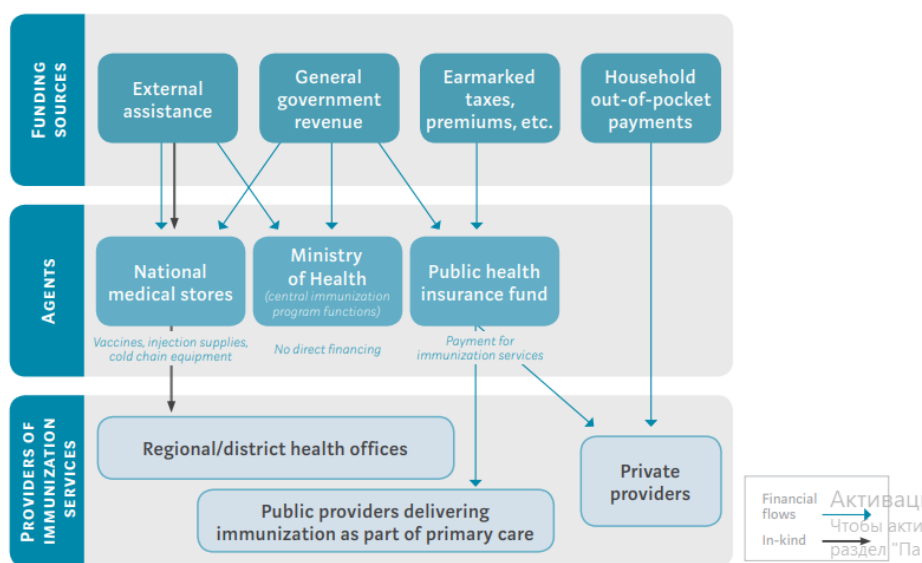
MIXED PUBLIC FINANCING AND
MIXED PUBLIC AND PRIVATE SERVICE PROVISION



Picture-2

Primarily Public health Insurance Financing and Mixed Public and Private Service Provision (see Pic.3)

PRIMARILY PUBLIC HEALTH INSURANCE FINANCING AND
MIXED PUBLIC AND PRIVATE SERVICE PROVISION



Picture-3

Some nations pay for almost all health services either through a public purchasing agency that receives the majority of its funding from general taxes or from a social health insurance system (**as in Thailand**) and is primarily funded by an earmarked payroll tax² (**as in Moldova and Estonia**). "Primarily public insurance financing and mixed public and private service provision" are the names given to these strategies. In these systems, providers are compensated for providing immunization services, which are also a part of the benefits package. Although in **Thailand**, the purchasing agency is in charge of acquiring vaccines and distributing them to healthcare providers, the procurement of vaccines and other national functions are typically carried out by the ministry of health using budget funding. Usually, the Ministry of Health no longer provides funding for services. Social health insurance programs frequently distinguish between

² The budgeting practice of dedicating tax or other revenues to a specific program or purpose. This practice typically involves depositing tax or other revenues into a special account from which the legislature appropriates money for the designated purpose.

various aspects of the healthcare system, including governance, funding, and service delivery. In contrast to a mixed budget/insurance system, this offers the chance to use strategic purchasing and payment methods to develop incentives for healthcare providers that are more extensive. **However**, this strategy runs the risk of leaving unclear who is in charge of what immunization tasks, and payment incentives could work against immunization services. To prevent the neglect of immunization services, some social health insurance programs tie specific financial incentives to immunization coverage. For instance, **Estonia's** social health insurance system combines a **pay-for-performance program**³ (Organization for Economic Co-operation and Development (OECD) countries found that P4P programs in **Estonia and New Zealand** resulted in modest increases in coverage rates for childhood immunization) with additional financial incentives for meeting immunization coverage targets in addition to **capitation payment for primary healthcare**⁴. High immunization coverage rates are typically attained by social health insurance systems that clearly define roles and responsibilities for immunization functions across the ministry of health and the health insurance agency. For instance, the National Immunization Program in **Moldova** is overseen by the Ministry of Health, but its detailed multi-year plan for immunization clearly outlines the duties of all cooperating organizations, including the National Health Insurance Fund as the provider of services. A successful program and high rates of immunization coverage are the outcomes of this. As a result of the introduction of compulsory health insurance, the funding scheme included the State Health Insurance Fund, which currently covers all maintenance and overhead costs of health facilities at the subnational level (district and municipal levels), including medical supplies such as salaries, outreach efforts and immunizations. The government has prioritized immunization through the introduction of several medium-term NIPs. They helped define goals, targets and targets for disease prevention through agreed immunization activities and commitments made by national government sectors and agencies, local governments, civil society and international partners. The last two NIPs also mention "mandatory immunization». It was recommended to improve communication about the benefits of immunization, including between health professionals and parents, and to involve government officials and parliamentarians to ensure support for immunization. More effective, accurate and timely mainstream and social media coverage of immunization is needed, including public health experts as sources for media coverage. In addition, incentive mechanisms can be explored with family physicians to increase support and support for immunization services. Finally, there is growing awareness that clear guidelines are needed to manage side effects after immunization and minimize false contraindications.

At least nine nations (**Bhutan, Bolivia, Cameroon, Costa Rica, Mongolia, Nepal, Nigeria, Senegal, and Uganda**) currently or previously have governance or legal frameworks in place that permit earmarking for immunization, but only three of those countries actually receive earmarked funding for this purpose (**Bhutan, Bolivia, and Costa Rica**). The earmarks are used to pay for vaccines and injection supplies in these three nations successfully. Other nations with broader health earmarks include **Ghana and the Philippines**. **Ghana** has no specific earmark for immunization, but the Ministry of Health used a portion of the earmarked value-added tax revenues that fund the National Health Insurance Scheme to fund vaccine purchases to meet the country's GAVI co-financing commitment in 2016.

Countries have also taken different approaches to the legislation of immunization financing. In **Vietnam**, the Law on Prevention and Control of Infectious Diseases guarantees "funds for the use of vaccines and medical bio products," while **Bolivia's** Law on Vaccines mandates that a specific share of earmarked funds for health go toward vaccines and associated syringes and operational costs. Some laws, such as **Georgia's**

³ P4P mechanisms are used in health systems in all regions of the world by countries at all income levels. The aim is to create financial incentives that encourage better quality of care and coverage of high-priority services such as immunization. For example, P4P programs in **Afghanistan, Burundi, and Rwanda** pay providers a per-service bonus on top of their line-item budgets, adjusted by a quality score, for delivering a set of priority services that includes childhood immunization.

⁴ a payment arrangement for health care services in which an entity (e.g., a physician or group of physicians) receives a risk adjusted amount of money for each person attributed to them, per period of time, regardless of the volume of services that person seeks.

Public Health Law, require the financing of vaccines in the national immunization schedule; others, such as **Panama's** Law 48, enshrine access to vaccines in the national immunization schedule as a legal right for all citizens.

Many countries combine payment methods to create a **blended payment system, or mixed model**. For example, a capitation payment system for primary care can include a small amount of fee-for-service payment for priority preventive interventions (such as immunization) to counteract the potential incentive to underprovide services. **In Romania**, primary care providers received 60% of their income from capitation payments and 40% from fee-for-service for priority services like immunization as part of a reform program to strengthen primary care and prevention.

I. Country case studies

a. Moldova (Emerging Upper-middle income economy)

The costs and financing of national immunization programs have been evaluated since the 1980s as part of the Universal Childhood Immunization Initiative. Private facilities, though growing in number, do not engage in the delivery of the routine immunization services funded by the state. Procurement of immunization supplies is funded from the centralized state budget managed by the MoH. The budget estimates for immunization supplies are approved by the Governmental Decree for a period of 5 years NIP. The MoH can reallocate the flow of resources between different national health programs based on the priority or emerging needs. The flow of financial resources allocated to public health services is quite stable and predictable, constituting around 3% of the annual total health budget. This proportion is usually used in medium-term planning within the Medium-Term Budgetary Framework (three years). In addition, resources from mandatory health insurance funds (managed by the National Health Insurance Company) are allocated annually for prevention measures. The financing of prevention activities within mandatory health insurance funds are used for the procurement of vaccines and the implementation of screening programs and some health promotion activities coordinated and managed by the National Health Insurance Company.

The government contributes to total health financing both by allocating a certain percentage (not less than 12.1%) of the total government budget to the National Health Insurance Fund and by directly financing public health services as well as national public health programs. There are currently no earmarked taxes for health, so all budgetary contributions to health financing are from general taxes.

Two different procurement mechanisms:

– **UNICEF SD for NIP vaccines from 2016**

– **Self-procurement for HepA, Influenza, Antirabic**

A well-developed electronic Immunization information systems (IIS) in partnership with EPI (note: The Expanded Programme on Immunization, developed by WHO) for the public health system was developed and implemented in pilot areas. From 2021 the IIS will be used in order to increase quality of data not only for vaccination status, but for a well function stock management evidence of vaccines, in real time, at all levels, national, regional and local level. All 1380 vaccination points from Republic of Moldova will have access in 2021 to the IIS platform, so that the information technology improves efficiency and accuracy of immunization information management and reporting. The access of children to vaccines is now free of charge in Moldova and vaccination is mandatory at enrolment in educational institutions (except HPV vaccine, which is recommended for 10 years girls).

The National Immunization Program in **Moldova** is overseen by the Ministry of Health, but its detailed multi-year plan for immunization clearly outlines the duties of all cooperating organizations, including the National Health Insurance Fund as the provider of services. A successful program and high rates of

immunization coverage are the outcomes of this. As a result of the introduction of compulsory health insurance, the funding scheme included the State Health Insurance Fund, which currently covers all maintenance and overhead costs of health facilities at the subnational level (district and municipal levels), including medical supplies such as salaries, outreach efforts and immunizations.

b. Costa-Rica (Emerging Upper-middle income economy)

Costa Rica's immunization program is financed primarily by the national health insurance program, known as the Caja⁵, which provides health services to about 90% of the population. Financing for vaccines comes from three sources: the Caja, the Ministry of Health, and the national lottery. The Caja covers all immunization delivery costs. The national lottery is an innovative financing source but accounts for only about 1% of the annual cost of vaccines. Costa Rica's 2001 National Immunization Law guarantees free access to immunization for the entire population. The 2001 law also established the National Vaccine Fund and stipulates that financing to support the immunization program should come from the Ministry of Health and from the Caja. The law requires both institutions to ensure sufficient amounts in their budgets to purchase vaccines and cover other costs of the program. It also stipulates that a portion of the funds raised from the national lottery go into the National Vaccine Fund, after deducting administrative and operating costs (and the lottery payout). The law further mandates that vaccines and related materials not be taxed. The Caja finances all immunization delivery costs. Financing of vaccines is shared by the Caja, the Ministry of Health, and the national lottery proceeds. The Caja is the largest contributor to vaccine purchases, accounting for 70–85% of the total over the past five years. The Ministry of Health is the second-largest contributor, at 15–30%, and national lottery funds are a distant third, at less than 1%. The 2001 law also specified that 2% of any Caja surpluses be earmarked for the National Vaccine Fund.

c. Azerbaijan (Emerging Upper-middle income economy)

The government previously procured almost all vaccines directly. After carefully weighing this approach against the use of UNICEF Supply Division, it switched procurement of all vaccines to the UN agency in 2014. Responsibility for vaccine procurement in Azerbaijan lies with the Ministry of Health's Innovation and Supply Center. In considering the switch, the government needed to determine whether it could harmonize its own procurement regulations with UNICEF's technical rules and processes governing payment and delivery of vaccines. UNICEF requires prepayment before delivery of vaccines to countries. The Ministry of Health determined that UNICEF's requirements would be consistent with government regulations as long as the prepayment and the delivery of vaccines to Azerbaijan occurred in the same fiscal year. To accomplish this and also ensure steady vaccine supplies, the Ministry of Health and UNICEF agreed to work together to forecast vaccine requirements at the end of each year for the following year. Once the actual budget is released by Azerbaijan's Ministry of Finance the following year, the government pays UNICEF and the vaccines are delivered in the same year. Given all the positive outcomes to date, government officials have concluded that UNICEF Supply Division is the best procurement option for Azerbaijan's immunization program over at least the medium term for number reasons like Better prices. The price per dose has been considerably lower than with direct procurement; all vaccines procured by UNICEF are prequalified by WHO, guaranteeing their quality. The government trusts UNICEF's requirements for cold chain compliance during delivery; UNICEF requires payment of a 10% buffer for market and exchange rate fluctuations. If these funds are not used, they can be reprogrammed or returned to the country; Steady supply-health officials report no disruption in supply or stock-outs since the switch; transparency-UNICEF Supply Division is seen by the government as a respected organization with clear procedures.

d. Armenia (Emerging Upper-middle income economy)

⁵ Costa Rican Department of Social Security

Budget processes in Armenia clearly delineate budgets for vaccines and injection supplies and donor support. The budget line called “National Immunization Program” is specifically for vaccines and injection supplies. Financing for other immunization activities is integrated throughout the health system. All external support for immunization is accounted for in the budget. For example, the value of GAVI-supported vaccines is estimated in local currency and appears in the budget. In the past, GAVI financial support (vaccine introduction grants and health system strengthening grants) appeared in the budget in the extra budgetary account. Armenia’s immunization program has benefited from strong political commitment from the Ministry of Health, the Ministry of Finance, and Parliament. The Ministry of Health shares immunization performance data, strategies, and policies with the Ministry of Finance. During the budget cycle, Armenia’s immunization program staff works closely with budget and finance staff in the Ministry of Health to prepare the budget.

e. Georgia (Emerging Upper-middle income economy)

Georgia graduated from GAVI support in 2018, and since then, the NIP has been fully financed from domestic sources. The UHC program receives the highest priority in the health budget, consuming about 70% of the Government’s total health allocations. The NIP is one of the state health programs approved annually by the Government. The NIP budget covers costs for routine immunization vaccines and injection supply, which constitutes more than 70% of the total program budget; vaccines and other pharmaceuticals for epidemiological indication (rabies, tetanus); influenza vaccine and service costs (from 2014); cold chain support; and communication and information system support (from 2020). However, the NIP budget is not the only governmental fund spent on immunization. Under the UHC Program, routine immunization service costs are integrated into the consolidated budget for PHC services. NIP management costs, such as EPI unit staff costs, are part of the NCDC institutional budget, while personnel costs for immunization supervision at the municipal level are covered by municipal budgets. Georgia is leveraging the opportunity to purchase vaccines through a pooled mechanism, and as such, procures all routine immunization vaccines (except Hexavalent vaccine) through the UNICEF Supply Division. This procurement arrangement became possible following legislative amendments in 2006. Since 2011, the NCDC has been responsible for the procurement of vaccines.

f. The Bhutan (Emerging Lower middle income economy)

The Bhutan Health Trust Fund (BHTF) is a flexible financial tool, the world’s longest-running national immunization financing trust fund. The government is committed to fully financing all vaccines in its national schedule from the BHTF as donor support is phased out, along with associated injection supplies and cold chain equipment. Vaccines are procured through UNICEF Supply Division. The new source of income, called the “health contribution,” is collected through a 1% salary deduction from corporate private-sector employees and civil servants, with contributions from the informal private sector also being explored. Political champions in Bhutan were essential to establishing the fund and maintaining support through nationwide activities such as the annual health walk. Robust and transparent governance will be a continued priority as the fund transitions to becoming an autonomous entity.

g. Ghana (Emerging Lower-middle income economy)

Ghana’s NHIS was established by the National Health Insurance Act (Act 650) of 2003. Ghana’s value added tax is 17.5%. Of that, 2.5 percentage points are earmarked for (dedicated to) the NHIS. Other sources of funding include an earmarked 2.5% of the total 17.5% social security contribution by formal sector workers, as well as investment income and premiums paid by nonexempt individuals (such as self-employed and informal-sector workers). The revenue from the earmarks is entirely protected for health, with 90% going to the NHIS and the other 10% to the Ministry of Health for special programs as a supplement to the ministry’s general budget. It has implemented public insurance programs to increase

funding for their healthcare systems and offer financial security against out-of-pocket expenses. Ministry of health continues to fund health promotion and preventive services, such as immunization.

h. Indonesia (Emerging Lower-middle income economy)

Indonesia fully self-finances its immunization program starting in 2018, after GAVI support ends. The central government is responsible for procuring vaccines, and district governments are responsible for service delivery. Operational costs, including the cold chain and immunization service delivery, are the responsibility of subnational governments. The Ministry of Health's National Immunization Program (NIP) oversees immunization and carries out forecasting and planning for vaccine procurement. The central government finances vaccines through a national budget line item, and regulations require that all government-procured vaccines be supplied by Biofarma, a state-owned enterprise. As with other health services, district governments are responsible for service delivery costs, including operational costs for primary health care facilities to provide immunizations. The NIP provides technical assistance, guidelines, monitoring and evaluation, quality control, training, and supplementary activities such as immunization campaigns. The NIP also uses a standardized tool for assessing supply-side readiness for immunization at the local government level. Immunization is provided free to the population through the public health service delivery network regardless of health insurance coverage status. Although most government financing for immunization comes from the government budget, some financing also comes from JKN. JKN currently covers routine immunizations for children under age 5 and tetanus immunization for pregnant women. At public health facilities contracted to provide services under JKN, individuals do not need to present their insurance card to obtain free immunizations.

i. Sri-Lanka (Emerging Lower-middle income economy)

The ACCD (Advisory Committee on Communicable Diseases)'s mandate includes not just immunization but all policy decisions related to the control of infectious disease, and assessing the introduction of new vaccines into the national program, with considering disease burden, vaccine efficacy and safety, feasibility, cost, and cost-effectiveness. The ACCD does not recommend introduction unless funding is assured. Sri Lanka has completed the transition from GAVI support and found domestic resources for all new vaccines; this makes the rigorous ACCD decision-making process even more valuable. At the end of 2015, Sri Lanka became one of the first countries to complete the transition from GAVI support. Compared to countries that introduced more vaccines, Sri Lanka faced a smaller increase in domestic vaccine financing during this transition. Nevertheless, it will now have to find domestic resources to pay for any new vaccines it introduces. The rigorous decision-making process led by the ACCD—including the requirement that assured financing be in place—puts Sri Lanka in a strong position to face these new challenges. To ensure the financial sustainability, the Government of Sri Lanka will ensure a separate budget line for the NIP within the National Budget. This budget line will be reviewed annually with a view of achieving NIP objectives.

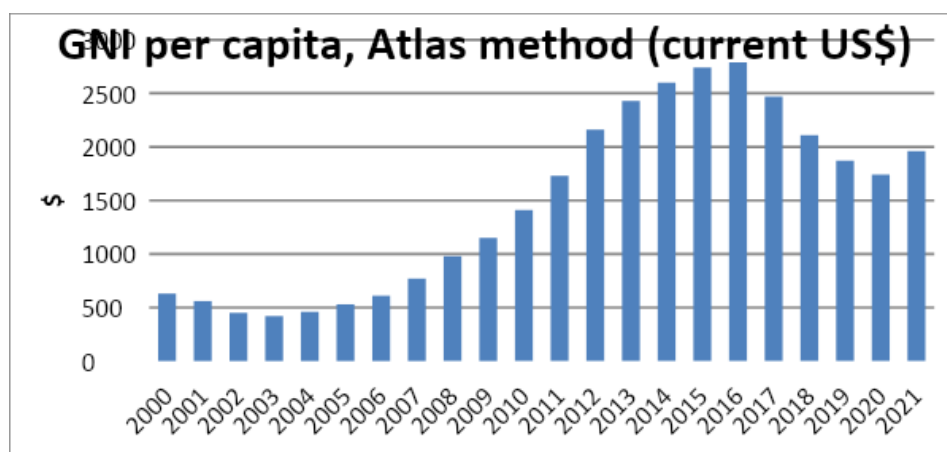
j. Vietnam (Emerging Lower-middle income economy)

Financing for immunization is mainly generated through central government revenues (taxes, loans, grants); though efforts to further decentralize the system could increase provincial inputs over time. Decentralized provincial programs generally rely on national transfers to fund programming. Some provinces do contribute additional funds for immunization campaigns, minor repairs to facilities, trainings, and allowances for health workers. Operational funding is especially in need. Currently, 70% of the central NIP budget is spent on vaccines and this percentage is set to increase as GAVI co-financing decreases through 2019. Operational expenses are meant to be split 50%-50% between central and local governments, but inputs at the local level are highly variable and often absent. The MoH has identified the

delivery incentives program as an area of opportunity for co-financing. A third of provinces already cover 50% of their incentive programs and the MoH hopes to have all provinces doing so in the near future. Stakeholders should support provincial prioritization of immunization to increase fiscal space for the program. Vietnam’s immunization program is autonomous of its national health insurance mechanism though the MoH is pushing for inclusion of prevention services within the benefits package. Performance-Based Payments for Fully Immunized Children Drives High Coverage (Innovative Financing Box). The incentive program, which began in 2014, offers 3,000 VND for each fully immunized child. Payments are calculated monthly and paid directly to facilities. Facilities have full autonomy in how these funds are used and most either split them amongst staff or host parties for staff and families. The program has been well received, but efforts are underway to have provinces cover at least half of the program costs. About 1/3 of provinces already do so through local revenue (immunization program coverage: see Appendices).

VI. Conclusion

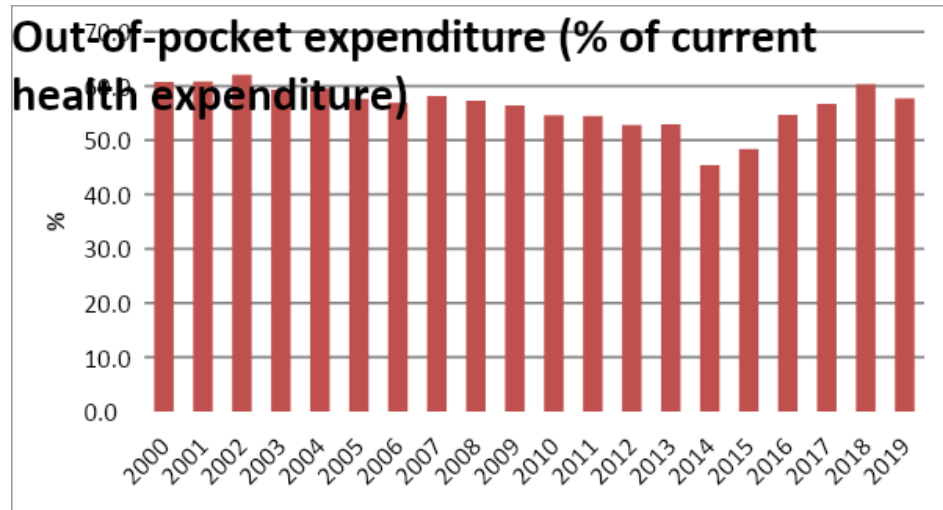
GAVI income status of Uzbekistan is “Non-GAVI middle income countries” and has entered the final phase of the transition process and started phasing out from GAVI support, as it has surpassed GAVI eligibility threshold GNI per capita \$1857 (See Pic.-4).



Picture-4

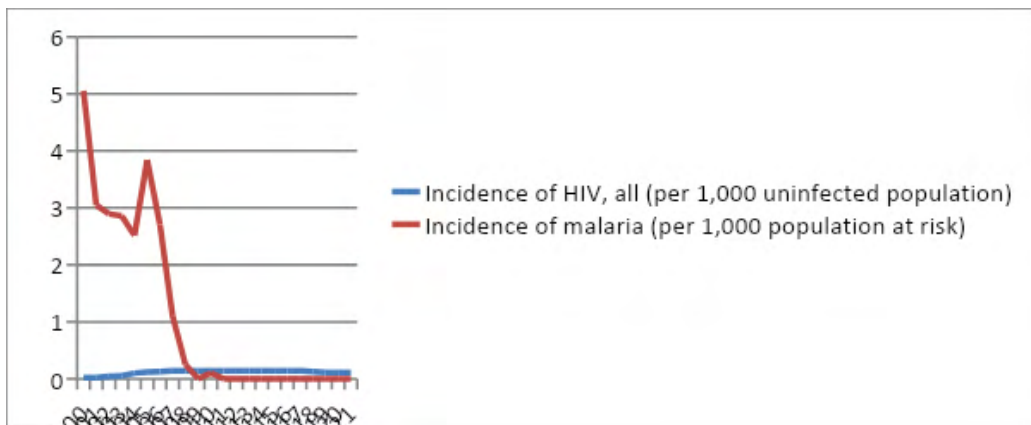
$$3 - \text{yearaverage} = \frac{1870+1740+1960}{3} = \$1857$$

Still having high ratio of out of pocket expenditure on health with average 57.7% (see Pic.-5), developing a sustainable government financing scheme (fully-funded vaccination-introduce high-quality, life-saving vaccines) will lower the cost of health, as lessening the incidence of dangerous, infectious diseases.

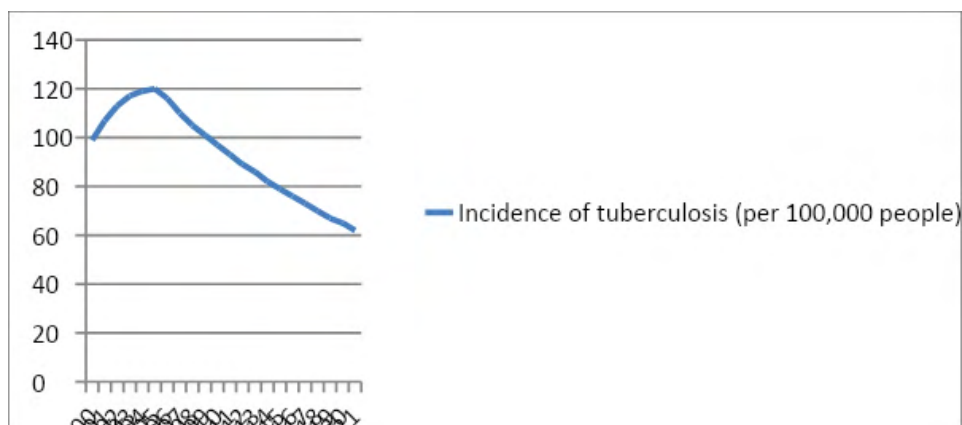


Picture-5

Developing transition plan facilitated through partners including short to medium term needs and activities will reduce substantially the incidence of being infected with serious diseases (see Pic.- 6 and Pic.- 7).



Picture - 6



Picture - 7

Proposals to develop the immunization process in Uzbekistan

In the case of Uzbekistan, immunization practices of different countries could be implemented: (Moldova, Ghana, Estonia, and Sri Lanka);

1. Implement ID cards of all individuals from birth which contains information about
 - ✓ The person: date of birth, place of birth, health status;
 - ✓ The date, place of all vaccinations: what they are oriented towards, what they are against;
 - ✓ In the case of not receiving the vaccine: the cause and intended date of being vaccinated.(IDs must be implemented and monitored by Ministry of health and distributed by maternity hospitals, this card should be for a life-long period with QR code which work in all organization: from kindergartens to employment agencies)
2. One single e-platform should be developed, containing all population's medical info regarding vaccination and this platform should connect all distribution channels and education and work institutions where individuals belong to. Access to this platform should be done through individual login and password. Furthermore, the section regarding the vaccinations should be integrated into the system: aim, period, possible incidental case, their treatment, health requirement of patients during vaccination. Individuals should also have access to the e-platform.
3. Promotional, educational trainings, shows should be translated through media: TV, radio and newspapers, leaflets should be placed and distributed in medical, educational, work institution; entertainment places to increase people's awareness.
4. Medical staff should be trained properly: from suppliers to vaccine applying professionals. Literacy on supply, storage, distribution should be educated in depth explaining the severe consequences of not meeting the requirement.
5. The whole process of receiving the vaccinations should be monitored by separate agency under the Ministry of health. This agency should be responsible for appropriate supply, storage transportation and on-time receiving and entering all related information into the e-platform.
6. A special group of medical staff have to be created to fully check-up the patient's medical condition: pediatrician, neuropathologists, therapists, ENT doctors and etc. They have to be trained separately and periodically, to have trainings. They should be directed to the process fully during the vaccination.
7. Heads of all medical institutions, pre-schools, schools, high-educational institutions, employment places must be responsible for proper receiving the vaccinations.

Funds to implement aforementioned proposals:

The state budget:

- ✓ To buy vaccines,
- ✓ To transport,
- ✓ To store,
- ✓ To distribute,
- ✓ To medical staff trainings;
- ✓ To implement e-platform and monitor it, employ specialists to work on it;
- ✓ To promote the importance of vaccination via media to increase people's awareness;

Donor international organization: for special periodical international trainings for staff;

Employers: to implement allocation of the percentage of yearly revenue to mandatory and optional vaccines: against special cases, against inappropriate work conditions, unexpected disease spread.

Financing:

- Covering from the state budget;
- Funding through a social health insurance system funded primarily by earmarked payroll tax;
- (P4P) and additional financial incentives to achieve immunization coverage targets. P4P, also called Quality System (QS) as a voluntary financial incentive system based on quality;
- Capitation;
- A pay-for-performance program