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Health systems in action: Kazakhstan: 2022 edition

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1. On page 4
   - Under WHO Country Office, Samira Erkinovna Bekamanova was replaced by Zhaniya Nurgaliyeva and Nikolay Negay

This correction was incorporated into the electronic file on 9 August 2023.

2. On page 8
   - The subtitle ‘The basket of publicly paid services is relatively extensive, but there is a need for co-payments’ has been changed to ‘The basket of publicly paid services is relatively extensive, but there are substantial out-of-pocket payments’.

This correction was incorporated into the electronic file on 26 January 2024.
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This edition of the Health Systems in Action Insight for Kazakhstan was written by Astrid Eriksen, Yulia Litvinova and Bernd Rechel.
HEALTH SYSTEMS IN ACTION: KAZAKHSTAN

Key points

- A mandatory health insurance system was gradually established in recent years with the aims of increasing the coverage and quality of health services and reducing informal and out-of-pocket payments.

- The Social Health Insurance Fund was set up in 2016 and became the purchaser of publicly paid health services in Kazakhstan in 2020.

- Recent health reforms have aimed to improve health service accessibility, equity and efficiency. The state-guaranteed basic package of health services has been complemented by a package of services funded by mandatory health insurance.

- Spending on health from public sources was around 60% in 2019 but has declined from around 75% in 2009. Conversely, the share of out-of-pocket payments as a percentage of health expenditure increased to 33.9% in 2019.

- The health system in Kazakhstan is still hospital-centric, but the country is working on increasing the proportion of funding going to primary and outpatient care.

- Some hospitals were closed (primarily in rural areas) and others were restructured to become multi-profile general facilities intended to ensure better access to quality services.

- Despite overall high levels of health workers, there is a shortage in rural areas. Both national and local initiatives have been undertaken to address this problem.

- Life expectancy at birth in Kazakhstan has been increasing steadily, from 65.7 years in 2000 to 73.1 years in 2017.

- As with many other countries, the COVID-19 pandemic has temporarily impacted life expectancy since 2020 and, according to national data, life expectancy at birth decreased to 71.4 years in 2020, a decline of 1.8 years compared with 2019.

- Despite major reductions in maternal and infant mortality, regional differences remain.

- There is a high prevalence of noncommunicable diseases in Kazakhstan and the country has taken steps to address this issue.

- Primary care facilities are providing noncommunicable disease screening and treatment programmes, targeting population groups at high risk.

- Measures have been taken to address the inappropriate use of antimicrobials, but implementation of the national AMR plan is still in its early stages.

This report looks at the action Kazakhstan is taking to strengthen its health system, to achieve the Sustainable Development Goals; to address the priorities of the European Programme of Work; and to ensure that no one is left behind.
1 ORGANIZING THE HEALTH SYSTEM

Service provision in Kazakhstan is decentralized, but overall governance is centralized

Since independence, the health system in Kazakhstan has been subject to various steps of decentralization, although the central government has retained considerable authority (Amagoh, 2021). The Ministry of Health is responsible for developing national health policies and legislation and facilitating international collaboration. The regional (oblast) health departments are responsible for managing and delivering health care services in their respective jurisdictions (Amagoh, 2021). They also own and manage all state-owned hospitals and polyclinics in their regions with a relatively high degree of autonomy. The Ministry of Health is the owner of all national clinics and research centres.

A national health insurance fund is the single purchaser of publicly paid health services

Mandatory health insurance has been introduced in recent years with the aims of increasing the coverage and quality of health services and reducing informal and out-of-pocket payments (see Section 2). Funds are pooled from three sources: the government (to cover socially vulnerable groups, such as children, older people, pregnant women and the unemployed), and contributions from employers and from employees (WHO, 2016).

In 2016, a Social Health Insurance Fund was established to become the strategic purchaser of publicly paid health services. The fund began collecting insurance premiums from employees and employers in 2017. It was originally supposed to begin reimbursing medical services provided under the health insurance scheme in January 2018 (WHO, 2019d). However, this was delayed until January 2020. Since then, the Social Health Insurance Fund has been the single purchaser of publicly paid services.

The basket of publicly paid services is relatively extensive, but there are substantial out-of-pocket payments

Citizens and permanent residents of Kazakhstan have access to two packages of medical care: the State-Guaranteed Basic Package, which is financed by the state budget, and the Social Health Insurance package (WHO, 2019d). The Social Health Insurance Fund is the single public purchaser for both packages of services.

Services covered in the State-Guaranteed Basic Package include emergency care and transport; primary care;
specialist outpatient care for acute conditions, tuberculosis (TB), and HIV, noncommunicable diseases and contagious diseases; day care for specific diseases; inpatient care for contagious diseases and specific diseases listed by the Ministry of Health; and rehabilitation and palliative care for specific diseases. Services covered in the social health insurance package include specialist outpatient care, day care and inpatient care for a broader variety of diseases and conditions.

In 2021 the proportion of the population covered by social health insurance was 81.3%, a decline from 84% in 2020. According to national data, the 18.7% of the population that is not covered by social health insurance are people of working age who are not registered as employees or as unemployed.

**Oblast health departments are responsible for delivering primary, secondary and tertiary care**

The oblast (regional) health departments are responsible for the delivery of primary, secondary and tertiary care (excluding research centres, which are run by the Ministry of Health). Some private providers operate in both the primary care and hospital sectors, and the majority of them contract with the Social Health Insurance Fund to provide publicly paid health services. Specialized and tertiary services are provided in a range of different institutions that vary in terms of size and structure. These are polyclinics, rural hospitals, oblast and city hospitals, specialized hospitals and national republican hospitals.

2 **FINANCING AND ENSURING FINANCIAL PROTECTION**

**Health spending is comparatively low in view of Kazakhstan’s national wealth**

Per capita spending on health in Kazakhstan amounted to US$ 765 in 2019 (adjusted for purchasing power), which was higher than the average for Central Asia (US$ 552), but lower than the average for the upper middle-income countries of the WHO European Region (US$ 1 338), and the WHO European Region overall (US$ 3 226) (Fig. 1).

When measured as a percentage of gross domestic product, spending on health in Kazakhstan was only 2.8% in 2019 (the latest year for which internationally comparable data are available), which was one of the lowest levels in the WHO European Region. Since then, the government has increased public spending on health, and overall spending on health as a percentage of gross domestic product is likely to have increased as well.

**Most spending is from public sources, but the share of out-of-pocket payments has increased**

Spending on health from public sources (59.9% in 2019) is higher than in Central Asian countries on average (37.2%), but has declined in recent years, from a high of 75.9% in 2009. Conversely, the share of out-of-pocket payments as a percentage of health expenditure has increased again in Kazakhstan in recent years, to 33.9% in 2019 (Fig. 2). Yet, this was still far below the averages for Central Asia (57.1%) and upper middle-income countries (44.1%) and, following recent increases in public spending on health, the share of private spending is likely to have decreased.

Despite health being a strategic priority for the country, the share of overall government spending going to health was still low in 2019. Spending on health accounted for 8.3% of overall government spending, which placed Kazakhstan at the lower end of the spectrum for countries in the WHO European Region and was a decline from 10% in 2014. Reflecting this downward trend, public spending on health as a percentage of gross domestic product declined in Kazakhstan to 1.7% in 2019 (Fig. 3). This makes Kazakhstan one of the countries with the lowest shares in the WHO European Region and below the averages for Central Asia (1.9%), upper middle-income countries (3.4%) and the WHO European Region overall (5.0%). Public spending has increased since then and there is a shift in funding towards primary care (Box 1).
medicines and medical products and outpatient services including dental care (26%). Voluntary health insurance accounts for 1.6% of current health expenditure.

A revised state-guaranteed basic package of health services was enacted in 2019 to accompany the health insurance fund package starting in 2020 and one of the aims of these reforms was to lower out-of-pocket payments. However, no specific studies on the affordability of pharmaceuticals in Kazakhstan are available, and there is a lack of information on impoverishing or catastrophic health spending in general.

### 3 Generating Resources, Providing Services and Ensuring Access

Despite reductions in hospitals and beds, capacity remains higher than in many other countries

The number of hospitals in Kazakhstan has fluctuated since 2000 (OECD, 2018b), increasing from 938 in 2000 to 1,085 in 2006 and then declining to 773 in 2020. Closure of hospitals has mostly occurred in rural areas and around 56% of rural hospitals were closed between 2013 and 2018 (OECD, 2018b). Hospital closures were often accompanied by the strengthening of central district (rayon) hospitals and upgraded technology. Some hospitals were also restructured to become multi-profile general facilities intended to ensure better access to quality services (OECD, 2018b). In 2020, 492 hospitals were run by the regional (oblast) health authorities, 39 were run by other state departments and 242 were private hospitals.

Hospital closures have resulted in an overall reduction in the number of hospital beds in Kazakhstan. Between the early 2010s and 2019, the number of hospital beds per 100,000 population decreased, before increasing again to 574 in 2020, reflecting the additional hospital capacity required to respond to the coronavirus disease 2019 (COVID-19) pandemic (Fig. 4).

Many hospitals are in poor condition, especially in rural areas

Investments have facilitated a modernization of the hospital infrastructure in Kazakhstan, although renovations have mostly benefited larger hospitals and facilities (OECD, 2018b). Tertiary care hospitals have received a lot of attention in terms of investments and renovations and are largely new builds. In contrast, rural hospitals have received much less investment,

**Box 1**

Increased spending on primary care has improved allocative efficiency

Kazakhstan is working on improving the efficiency of its health system. An increasing share of spending is devoted to primary care. According to national data, 52.4% of health spending in 2020 went to primary care, outpatient specialized care and outpatient medicines, and the aim is to increase this share to 60% by 2025. This ongoing shift in funding helps to improve the allocative efficiency of health spending and is partly a result of incentives that have been introduced to shift cases from inpatient to day and ambulatory care (OECD, 2018a). There is scope for further efficiency gains in payment mechanisms for health care providers, such as through case-based funding for hospital care which have now been introduced for rural hospitals, complemented by some additional coefficients.
and many are outdated (OECD, 2018b). Furthermore, existing medical equipment is not fully utilized, with only 55% of all medical equipment being used optimally (WHO, 2021a).

The number of physicians is higher in Kazakhstan than in many other countries in the WHO European Region

In 2020, there were 407 physicians per 100 000 population in Kazakhstan, which was a 24% increase from 329 per 100 000 population in 2000 (Fig. 5). The number of nurses per 100 000 population has also increased in Kazakhstan since 2000, from 446 per 100 000 population to 676 per 100 000 population in 2015 (the latest year for which there are internationally reported data). According to national sources, the share had increased further to 752 nurses per 100 000 population in 2020.

Despite overall high levels of health workers, there is a shortage in rural areas. Both national and local initiatives have been undertaken to address this problem. Local governments have introduced social benefit packages for new specialists arriving in rural areas, including start-off funds for transportation and accommodation, allocation of land at beneficial terms, and benefits related to utility costs, transportation and children’s nurseries (Katsaga et al., 2012). National initiatives have sought to strengthen the health workforce through a revision of medical education and training (OECD, 2018b).

Access to health services has improved

The universal health coverage (UHC) service coverage index – a global indicator that monitors progress towards Sustainable Development Goal 3 target 3.8.1 on coverage of essential health services – increased from 38.7% in 2000 to 75.9% in 2019, almost reaching the average of the WHO European Region (77.1%) (Fig. 6). This improvement is due to the increased policy emphasis in Kazakhstan in recent years on extending public coverage of services and improving equitable access.

The HIV epidemic in Kazakhstan is ongoing, but the government is expanding access to prevention and treatment

In view of the ongoing HIV epidemic, Kazakhstan has been expanding access to preventive and curative services, including testing and counselling, information and education work, access to condoms, access to needles and syringes, rapid testing among key groups, and prevention of mother-to-child transmission of HIV. Kazakhstan was the first and, for a long time, the
only country in Central Asia to provide citizens with antiretroviral therapy at the expense of the state budget. As of 31 December 2021, about 35 000 people in Kazakhstan were living with HIV, and an estimated 81% of them were aware of their positive status. Of those who knew their status, 79% were on antiretroviral therapy and, of those who were on antiretroviral therapy, 86% had achieved viral suppression (NCID, 2022) (Fig. 7).

**Tuberculosis remains a serious public health challenge**

The incidence rate of TB decreased from 171 per 100 000 population in 2000 to 69 per 100 000 population in 2020, representing a decrease of around 60% (World Bank, 2022). Through its National Tuberculosis Programme, Kazakhstan has made important advances in the fight against TB. These include the introduction of a nationwide case-based electronic surveillance system (which also includes HIV/AIDS) and the roll out of a national rapid diagnostic molecular testing scheme (WHO, 2019b). The effective treatment coverage of TB increased from 75.1% in 2000 to 91% in 2017, placing the country above the averages of the WHO European Region and Central Asia (Fig. 8). However, there is uncertainty about the accuracy of the figures provided by Kazakhstan’s surveillance system to the global TB database and whether they reflect the real TB disease burden in the country (WHO, 2019b).

**Fig. 6**

Kazakhstan has made major improvements in ensuring access to health services

**Fig. 7**

Kazakhstan is working towards UNAIDS targets for HIV/AIDS

The UNAIDS 95 : 95 : 95 vision calls by 2025 for:

- people living with HIV who know their status (95%)
- people who know their status who are on ART (95%)
- people on ART who achieve viral suppression (95%)

By 2020 Kazakhstan had achieved:

- people living with HIV who know their status (81%)
- people who know their status who are on ART (79%)
- people on ART who achieve viral suppression (86%)

Notes: ART: antiretroviral therapy; UNAIDS: Joint United Nations Programme on HIV/AIDS.

Source: NCID, 2022.
4 IMPROVING THE HEALTH OF THE POPULATION

Life expectancy is increasing, but there is a major gender gap

Life expectancy at birth in Kazakhstan has been increasing steadily, from 65.7 years in 2000 to 73.1 years in 2017 (the last year for which mortality data were reported to WHO). It remained lower than the WHO European Region average (78.3 years) but was higher than the Central Asian average (73 years in 2015) (Fig. 9). As with many other countries, the COVID-19 pandemic has temporarily impacted life expectancy since 2020 and, according to national data, life expectancy at birth decreased to 71.4 years in 2020, a decline of 1.8 years compared with 2019 (NRCHD, 2021).

Kazakhstan has a large gender gap in life expectancy, with females (77.1 years) living 8.3 years longer than males (68.8 years) in 2017, which is a larger gap than in Central Asia (5.8 years) and the WHO European Region (6.3 years). According to national data, life expectancy at birth in 2020 was 75.5 years for females and 67.1 years for males, a gap of 8.4 years (Ministry of Health, 2021).

Fig. 8
The effective treatment coverage for tuberculosis in Kazakhstan is above the WHO European Region average

Fig. 9
Kazakhstan made major life expectancy gains before the COVID-19 pandemic

Notes:
- ART: antiretroviral therapy; UNAIDS: Joint United Nations Programme on HIV/AIDS.
- TB: tuberculosis.
- Data are for 2019 or latest available year (shown in brackets). No data for 2000 for Türkiye and Bosnia and Herzegovina; data for Georgia for 2000 not shown, as only marginally lower than in 2019. CIS: Commonwealth of Independent States; SEE: South-Eastern European countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, North Macedonia, Republic of Moldova, Romania, Serbia).

Source: WHO, 2022b.
**Fig. 10**
Maternal and infant mortality rates declined substantially

Maternal mortality per 100 000 live births

Infant mortality per 1 000 live births

Source: WHO, 2022b.

**Fig. 11**
Overall mortality declined in recent years

SDR per 100 000 population

Notes: No data available for 2016. IHD: ischaemic heart disease; SDR: age-standardized death rate.

Source: WHO, 2022b.
Underlying these gender differences, mortality patterns are broadly similar. In 2019, both, males and females were likely to die from cardiovascular diseases, neoplasms and chronic respiratory diseases. Yet high rates of deaths due to external causes happened more often among males (120 deaths per 100 000 population) than females (32.9 deaths per 100 000 population). In contrast, mortality caused by diabetes and chronic kidney diseases rose significantly among females (26.5 deaths per 100 000 population in 2019 compared with 18.2 in 2010) (IHME, 2019).

Improved life expectancy is among the important targets for the Kazakh government. For example, in the National Project “Healthy Nation” the government has set out the goal of reaching a life expectancy of 75 years by 2025. It aims to do so by introducing a comprehensive set of actions related to increasing the availability and quality of medical care, designing a modern system for epidemiological forecasting and response, developing a local pharmaceutical industry and expanding health promotion campaigns including developing mass sports (Government of the Republic of Kazakhstan, 2021a).

Improvements in pregnancy-related care have led to major reductions in maternal and infant mortality

Downward trends in the number of maternal and infant deaths reflect the achievements of perinatal care. In 2006, an estimated 40 women died per 100 000 live births because of pregnancy or delivery-related complications. By 2017, this number had decreased to 10 deaths per 100 000 live births, lower than the average in the WHO European Region (12.7 deaths per 100 000 live births) and Central Asia (23.6 deaths per 100 000 live births). Similarly, the infant mortality rate fell from 25.6 deaths per 1 000 live births in 2006 to 9.3 deaths per 1 000 live births in 2017, which remains slightly above the average in the WHO European region (7.5 per 1 000 live births in 2017) (Fig. 10).

Despite major reductions in maternal and infant mortality, regional differences remain (WHO, 2020). Overall, Kazakhstan offers full coverage of health care services for children under 18 years of age and for services during prenatal and postnatal care provided to mothers. Yet, service delivery capacities differ between regions. Expansion of prenatal screenings has become one of the focus areas within the National Project “Healthy Nation” 2020–2025 (Government of the Republic of Kazakhstan, 2021a). Staff shortages and insufficient coordination between levels of care have been identified as other obstacles to improving prenatal care (Embergenova, 2020).

Noncommunicable diseases remain the main cause of mortality, but problems in cause of death registration preclude a more detailed analysis

There is inconsistency in coding of the main causes of deaths, particularly with regard to ischaemic heart disease, stroke and respiratory diseases, due to changes in the coding system in 2013. Although reported data suggest that there were large declines in cardiovascular diseases, these were accompanied by a proportionate rise in deaths from unclassified causes in 2009–2012, and in respiratory and other chronic conditions thereafter. Recording of cancer deaths is more consistent, and shows that age-standardized cancer mortality declined from 191 deaths per 100 000 population in 2000 to 111 deaths per 100 000 population in 2017 (Fig.11).

The high prevalence of noncommunicable diseases highlights the need for specific policy measures (Nugmanova, 2018). With the most recent national project “Healthy Nation”, the government continues promoting healthy behaviours and developing mass sports for the prevention of noncommunicable diseases. In addition, the project focuses on implementing clinical policies on assessment and management of cardiovascular risks and conditions. Primary care facilities are providing noncommunicable diseases screening and treatment programmes, targeting population groups at high risk (Farrington, 2019).

Cardiovascular diseases continue to be the leading cause of premature mortality

Noncommunicable diseases are also drivers of premature mortality (among those aged 30–69 years) in Kazakhstan. In 2017, four major noncommunicable diseases (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases) were accountable for 451 premature deaths per 100 000 population. This number remains significantly larger than the average for the WHO European Region (359 deaths per 100 000 population) but lower than the Central Asian average (546 deaths per 100 000 population in 2015) (Fig. 12).

Officially recorded COVID-19 deaths were lower than the WHO European Region average

The cumulative number of officially recorded COVID-19-related deaths in Kazakhstan was 101.5 per 100 000 population by the end of February 2022, which was lower than the average in the WHO European Region (196.5 per 100 000). However, the number of COVID-19 deaths in Kazakhstan may have been
undercounted. As in most other countries in Europe, the COVID-19 pandemic is expected to have affected overall mortality rates since 2020, with estimates of excess mortality indicating a peak in July 2020 (Fig. 13). The pandemic led to a disruption of essential health services and major repercussions across all areas of life, including the mental health of the population (Box 2).

Poor nutrition and smoking are major behavioural risk factors in Kazakhstan

Nearly 31% of mortality in Kazakhstan has been attributed to high systolic blood pressure (Fig. 14). Among modifiable risk factors for hypertension are unhealthy behaviours, such as diets rich in salt and fats, consumption of tobacco and alcohol, and physical inactivity. In 2019, dietary risks alone were estimated to lead to over 20% of deaths in Kazakhstan. High levels of low-density lipoprotein cholesterol were estimated to contribute to 11.6% of mortality and high fasting plasma glucose to 16.3% (IHME, 2019). Sedentary lifestyles are another challenge. In 2016, 27.5% of adults in Kazakhstan reported low levels of physical activity, which was lower than the average of 29.3% in the WHO European Region. The prevalence of overweight (with a body mass index above 25 kg/m²) among adults was 53.6% in 2016, although this was below the average of the WHO European Region (58.7%). Increasingly, children are also affected by overweight and obesity. In 2020, 20.6% of 6- to 9-year-olds were overweight or obese, reaching 24.2% among boys and 18.2% among girls (Battakova, 2019).

The government plans to improve nutrition, physical activity and other healthy lifestyles through its National Project “Healthy Nation”, which emphasizes creating healthy food and sports environments for children and people with special needs. In addition, it plans to introduce a 20% excise tax on sugary drinks and the labelling of products according to their nutritional value (Government of the Republic of Kazakhstan, 2021a).

In 2019, tobacco consumption was estimated to contribute to 16.4% of all deaths in Kazakhstan (IHME, 2019). The overall smoking prevalence in the country (21.1% of people aged 15 years and over in 2020) is lower than the average in the WHO European Region (25%). Yet, the share of males who report tobacco use in Kazakhstan (36.4%) exceeds the average in the

Box 2

Kazakhstan works on improving mental health, but suicide rates remain high

In 2017, Kazakhstan started a comprehensive reform of the mental health system, aiming to deinstitutionalize and integrate mental health into primary care. The competencies of general practitioners (GPs) were extended by giving them the mandate to diagnose and treat the most common mental disorders. In addition, approaches to screening were changed, and psychologists and social workers were introduced as a part of the GP’s multidisciplinary team. In several regions, nurses started to conduct independent appointments.

In parallel with the integration of mental health into primary care, there was a decrease in the number of psychiatric hospitals from 47 to 17 and the number of beds was reduced by 17.5%. Youth health centres were organized in all regions to provide assistance and support in reproductive and mental health. To ensure territorial accessibility of care, 204 psychiatrist’s offices were deployed at the rural level and 82 primary mental health centres at the level of urban polyclinics.

Since 2015, a suicide prevention programme among minors has been implemented, developed by the United Nations Children’s Fund (UNICEF) together with the National Research Centre for Mental Health (UNICEF, 2020). The programme demonstrated its effectiveness with a decrease in the target group (15–17 years) from 210 cases in 2014 to 85 cases in 2020. However, suicides remain a serious problem for Kazakhstan, with an age-standardized rate of 18.1 cases per 100 000 population in 2019, compared with an average of 10.5 per 100 000 population for the WHO European Region (WHO, 2021b).
Fig. 13
Excess mortality increased sharply during the COVID-19 pandemic

Excess deaths per 100,000 population

Notes: Excess mortality from all causes of death, defined as the difference between the total number of deaths and the number that would have been expected in the absence of a crisis (e.g., the COVID-19 pandemic). This difference is assumed to include deaths attributable directly to COVID-19 as well as deaths indirectly associated with COVID-19 through impacts on health systems and society.

Source: WHO, 2022e.

Fig. 14
Hypertension is the largest contributor to mortality in Kazakhstan

Top 10 risk factors as a share of all deaths

Notes: LDL: low-density lipoprotein. Shares overlap and therefore add up to more than 100%.

The effect of environmental determinants of health in Kazakhstan needs further investigation

In 2019, 15% of deaths were estimated to be attributable to environmental factors, such as air pollution, non-optimal temperatures and occupational risks (IHME, 2019). Recent estimates show that levels of various air pollutants in 13 cities exceeded the permissive limits, increasing risks for acute, chronic and carcinogenic adverse events among the population (Kenessary, 2019). The Government of Kazakhstan acknowledges environmental threats to population health. In 2021 it adopted a new Environmental Code requiring the industry to implement “green” technologies (Government of the Republic of Kazakhstan, 2021b).

Box 3
The Government of Kazakhstan continues to strengthen its tobacco control policies

In 2006, Kazakhstan ratified the WHO Framework Convention on Tobacco Control. Since then, it has strengthened its tobacco control policies, helping to reduce the prevalence of smoking from 28% in 2007 to 21.1% in 2020. Measures adopted include a ban on smoking in public places, although restaurants and public transport are not yet completely smoke-free. Additional resources have been allocated for the control and enforcement of smoke-free environments and tobacco advertising restrictions for the period 2021–2025 within the project “Healthy Nation”.

Smoking cessation interventions are available in some primary care facilities, including health clinics, and are fully covered by the state. Over-the-counter nicotine replacement therapy and smoking cessation support provided at other levels of the health system, however, are only partially covered, or are not covered at all. Despite available offers, the number of smokers who sought smoking cessation services decreased from 46.6% in 2014 to 36.0% in 2019 (World Bank, 2019).

The price for a packet of 20 filter cigarettes has been increasing (from 241 tenge in 2014 to 397 tenge in 2019), of which 38% is excise tax and 10.8% is value-added tax (World Bank, 2019). Nevertheless, tobacco products remain affordable and the government plans to gradually raise the tobacco excise tax by 19% by 2025 (Government of the Republic of Kazakhstan, 2021a).

5 SPOTLIGHT ON ANTIMICROBIAL RESISTANCE

Antimicrobial consumption in Kazakhstan is below the average of the WHO European Region

Kazakhstan was among the countries in the WHO European Region with a comparatively low overall consumption of antibacterials in 2018. However, the country did not meet the WHO national monitoring target of at least 60% of total antibacterial consumption being from the “Access” category (Fig. 15). Despite a decrease in recent years, there is still inappropriate use of antibiotics, partly due to sales of antibiotics without prescription, over-prescribing, and a lack of guidance on antibiotic use at the national level (Zhussupova et al., 2021).

Measures have been taken to address the inappropriate use of antimicrobials in Kazakhstan

Based on the most recent TrACSS survey (2020–2021), a national antimicrobial resistance (AMR) plan is being implemented in Kazakhstan. Furthermore, there are multi-sectoral approaches to address AMR, such as joint work and agreements on common goals. There are regulations on the prescription and sale of antimicrobials in Kazakhstan for human use that prohibit sale without prescription in pharmacies. On the other hand, there are no laws or regulations that prohibit antibiotics for growth promotion in the absence of risk analysis.

Training and professional education of health professionals on AMR are provided in some pre-service and in-service training. However, lack of guidance on antibiotic use at the national level and shortages in the number of clinical pharmacologists in medical institutions, responsible for achieving the effectiveness and safety of pharmacotherapy by health professionals, have been identified as reasons for the inappropriate use of antibiotics in Kazakhstan (Zhussupova et al., 2021).
Health Systems in Action: Kazakhstan

Implementation of the national AMR plan is in its early stages

The country has started to ensure a consolidated policy response to AMR, including by involving relevant stakeholders, starting an intersectoral coordination group and finalizing a plan of action. However, there is scope to more clearly identify targets and benchmarks, and to allocate funding to the activities outlined in the action plan. Surveillance and infection prevention and control are being strengthened and could be developed further by consolidating surveillance through a set of routine activities and special projects, an increase in the number of sentinel sites and laboratories participating, and the overall strengthening and capacity building of the laboratory component.

EUROPEAN PROGRAMME OF WORK (EPW)

Moving towards universal health coverage

Moving towards universal health coverage is a high priority for Kazakhstan and this was reiterated in the National Project “Healthy Nation” for 2021–2025. To support the country, WHO provided technical inputs into this new national health strategy and implemented a number of initiatives in collaboration with the Ministry of Health. These include activities to promote evidence-based...
policy-making and a health-in-all policies approach, as well as capacity building of health workers on mother, child and adolescent health; HIV prevention and care; tuberculosis prevention and control; One Health and AMR, case management, infection prevention and control, risk communication and community engagement, and the maintenance of safe and accessible health services throughout the COVID-19 response.

Protecting against health emergencies

The COVID-19 pandemic has brought major challenges to Kazakhstan’s health system and the government has aimed to protect the health of its population through scaling up its emergency response, improving infection prevention and control, and maintaining the provision of essential health services. WHO has been supporting these efforts with capacity building, medical supplies and equipment, and technical expertise on case management, infection prevention and control, risk communication and community engagement, and the maintenance of safe and accessible health services throughout the COVID-19 response.

Promoting health and well-being

The government aims to improve the health and well-being of its population through overarching national programmes that involve expanding primary care services, improving quality of care, and increasing health funding. WHO has supported these efforts through its Healthy Cities and Regions for Health networks, capacity building on healthy eating and nutritional standards, a review of environmental health challenges, and training and support to improve the mental health of health workers, informal carers and the general population.

COUNTRY DATA SUMMARY

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<tr>
<td>Life expectancy at birth, both sexes combined (years)</td>
<td>73.1       (2017)</td>
<td>73 (2015)</td>
<td>78.3 (2017)</td>
<td>80.9 (2018)</td>
</tr>
<tr>
<td>Estimated maternal mortality per 100 000 live births (2017)</td>
<td>10</td>
<td>23.6</td>
<td>12.7 (2017)</td>
<td>6.3 (2018)</td>
</tr>
<tr>
<td>Estimated infant mortality per 1 000 live births (2019)</td>
<td>9.3</td>
<td>17.7</td>
<td>7 (2017)</td>
<td>3.5 (2018)</td>
</tr>
<tr>
<td>Population size, in millions (2020)</td>
<td>18.5</td>
<td>72.6</td>
<td>930</td>
<td>512.1</td>
</tr>
<tr>
<td>GDP per capita, PPP$ (2020)</td>
<td>26 729</td>
<td>12 326</td>
<td>35 340</td>
<td>44 421</td>
</tr>
</tbody>
</table>

Notes: EU: the 28 EU Member States until 2020; GDP: gross domestic product; PPP: purchasing-power parity.

Source: WHO, 2022b.
References


WHO Regional Office for Europe

WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region’s future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

European Programme of Work ‘United Action for Better Health in Europe’

The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens’ expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. “United”, because partnership is an ethical duty and essential for success, and “action” because countries have stressed their wish to see WHO move from the “what” to the “how”, exchanging knowledge to solve real problems. The WHO European Region’s solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policy-makers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.