This Health System Summary is based on the *Kyrgyzstan: Health System Review* (HiT) published in 2022. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.


**Please cite this publication as:** Moldoisaeva S, Kaliev M, Sydykova A, Muratalieva E, Ismailov M, Madureira Lima J, Rechel B, Zimmermann, J (2022), *Kyrgyzstan: Health System Summary*, 2022. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen.

ISBN 9789289059268 (PDF)
How is the health system organized?

ORGANIZATION

Kyrgyzstan has a mandatory health insurance system, under the Mandatory Health Insurance Fund (MHIF), with a defined package of publicly covered services called the State-Guaranteed Benefits Programme (SGBP). The country had a population of 6.6 million in 2020, but only 69% were covered by the MHIF in 2019 and many services require co-payments.

Most health policy decisions are determined centrally. The Ministry of Health is the executive body responsible for national health policies, health protection and health insurance. External development partners have been supporting health system reform. The MHIF is an executive agency under the Ministry of Health that pools public funds at the national level, acting as a single public payer for almost all hospitals and primary care providers. Public providers are coordinated at the regional (oblast), district (rayon) and city level by administrators and oblast coordinators appointed by the Minister of Health. Most health care organizations are public, and most health workers are salaried employees.

BOX 1 | CAPACITY FOR POLICY DEVELOPMENT AND IMPLEMENTATION

Kyrgyzstan has capacity to develop national health policies and involves government bodies, international development partners, public institutions, non-governmental organizations and the expert community in the process. However, in-depth technical knowledge is lacking in some areas, which impacts the quality of health policies. Furthermore, there is insufficient interaction between governmental and non-governmental entities in areas such as environmental protection, food safety and occupational health.

Under the current Healthy Person – Prosperous Country programme of health system reform (2019–2030) the functions of the national Public Health Coordinating Council, which coordinates the activities of the Ministry of Health and its subordinate institutions, and the sub-national coordinating commissions on public health are being revised. The aim is to strengthen the role of local authorities and local self-government, improving coordination and intersectoral cooperation to successfully implement health programmes.

PLANNING

Kyrgyzstan is a presidential republic. The Government is accountable to Parliament and develops and implements national programmes, including for health. The Ministry of Health is responsible for implementing health policies, in line with national programmes, strategies and action plans. It develops annual implementation plans from higher-level strategic documents (see also Box 1). The MHIF develops annual plans for the funds that are allocated under its two programmes, the SGBP and the Additional Drugs Package (ADP), and issues annual contracts to health facilities within the single payer system. Health care providers plan their activities according to their financial and administrative autonomy.
PROVIDERS

Most primary, secondary and tertiary health care providers are public and administered by the Ministry of Health, other ministries or oblast or rayon authorities. Some health care organizations, such as haemodialysis services, are based on mixed forms of ownership and public–private partnerships. The MHIF contracts annually with all health facilities within the single-payer system. Pharmaceuticals are provided entirely by private organizations and companies. However, some pharmacies have a contract with the MHIF.

How much is spent on health services?

FUNDING MECHANISMS

Private spending, almost entirely in the form of out-of-pocket expenditure, accounted for 46.3% of health expenditure in 2019. Public revenue for health is sourced mostly from state budget funds. The Social Fund is the main social security body and collects a small volume of mandatory health insurance contributions alongside other social security funds. Currently, collection of all funds by just the tax authorities is being piloted in two districts. External development assistance used to be an important source of funding but has declined to 2.3% of current health expenditure in 2019, down from 15.7% in 2004. Voluntary health insurance is almost non-existent.

The MHIF allocates 71.9% of state budget funds to health services, while the remainder is allocated directly by the Ministry of Health. The MHIF pools state budget funds, mandatory health insurance contributions, external (donor) funds and patient co-payments before allocating funds to providers. Payment of primary care providers is largely based on capitation, while a diagnosis-related group (DRG) system has been introduced for hospital services. Results-based payments that reward quality of care have also been piloted.

HEALTH EXPENDITURE

In total, 4.5% of Kyrgyzstan’s GDP was spent on health in 2019, a decline from levels seen in previous years (Figure 1). Health expenditure per capita is one of the lowest in the WHO European Region. In 2019, it amounted to US$ 260 PPP (= US$ 62), exceeding only Tajikistan (Figure 2). Public expenditure on health was only 2.3% of GDP in 2019, accounting for 51.4% of current health expenditure. As mentioned above, 46.3% of health expenditure in 2019 was private. While this was a lower share than in the mid-2010s, it was higher than the levels achieved in the 2000s.

OUT-OF-POCKET PAYMENTS

The majority of private spending is due to out-of-pocket payments. Almost two thirds of out-of-pocket spending goes towards medical devices and pharmaceuticals, which are either excluded from the SGBP or require large co-payments. The remaining out-of-pocket spending is due to co-payments for inpatient services and, to a lesser extent, outpatient and dental services (Figure 3). Private health expenditure also includes informal payments, which often go towards pharmaceuticals and medical personnel, particularly doctors and nurses.
**FIG. 1 TRENDS IN HEALTH EXPENDITURE, 2000–2019**

Note: PPP = purchasing power parity
Source: WHO, 2022a

**FIG. 2 CURRENT HEALTH EXPENDITURE (US$ PPP) PER CAPITA IN THE WHO EUROPEAN REGION, 2019**

Notes: CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity; UK: United Kingdom. Data for Albania are from 2018
Source: WHO, 2022a
Kyrgyzstan has not yet achieved universal health coverage. Only 69% of the population is covered by the MHIF (Box 2). Most health services require co-payments, although some clinically or socially vulnerable patients are exempt. Insured patients are fully covered for all primary care services and do not need to co-pay as long as they are registered with their local provider. Non-insured patients and those requiring services outside the SGBP have to pay entirely out-of-pocket.

**BOX 2 | WHAT ARE THE KEY GAPS IN COVERAGE?**

In 2019 only 69% of the population was covered by mandatory health insurance, a decline from 76% in 2016. Reasons for this decrease include the digitalization of enrolment, which made it easier to remove duplicates, and the migration of working-age people abroad.

Internal migrants make up an estimated 18% of the population and do not always have the necessary paperwork to enrol in the mandatory health insurance scheme. Similarly, people working in the informal sector, believed to amount to 23.6% of GDP in 2017, do not make official insurance payments. Although uninsured people can purchase mandatory health insurance separately, not all do, which affects coverage and reduces public income for the health sector.

The biggest gap in insurance coverage relates to pharmaceuticals and medicinal products. This gap is filled by private expenditure (see section on Out-of-pocket payments above).
PAYING PROVIDERS

Primary and specialized outpatient care are mostly paid for through capitation, while hospitals are paid through a diagnosis-related group (DRG) system (Figure 4). Payment for results, which takes quality of care into account, has recently been piloted under a scheme called Results-Based Funding (RBF) in hospitals and Funding for Performance (F4P) in primary care. Salaries of health workers vary across the country, but remain low, and do not reach the country’s average salary. While formal salaries of doctors in primary care are higher than those of doctors in hospitals, the latter supplement their salary with more informal payments from patients.

![FIG. 4 PROVIDER PAYMENT MECHANISMS IN KYRGYZSTAN](image)

<table>
<thead>
<tr>
<th>Primary care</th>
<th>Specialists</th>
<th>Acute hospitals</th>
<th>Hospital outpatient services</th>
<th>Dentists</th>
<th>Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>Capitation, fee-for-service</td>
<td>DRGs, fee-for-service</td>
<td>Capitation, fee-for-service</td>
<td>Capitation, fee-for-service</td>
<td>Compensation payment</td>
</tr>
</tbody>
</table>

What resources are available for the health system?

HEALTH PROFESSIONALS

Kyrgyzstan had 203 physicians and 498 nurses per 100,000 population in 2021, which was below the average of the WHO European Region (Figure 5). The distribution of doctors across the country is uneven. Physicians are concentrated in Bishkek and Osh (225 and 246 per 100,000 population, respectively), while some rural areas only have 70 physicians per 100,000 population. This is partially compensated by postgraduate medical trainees working in rural areas. There is a looming staffing crisis in primary care, as there is no formal training pathway for family doctors and 79% of current family doctors are around pension age. A further challenge is that health workforce planning is underdeveloped. To support the COVID-19 pandemic, doctors and other employees of inpatient facilities, laboratories and other related services received a bonus payment and blanket pay rise in 2020.

Health workers who supported the treatment of COVID-19 patients received a bonus payment and pay rise in 2020.
HEALTH INFRASTRUCTURE

The public sector has 204 health facilities. There were 126 hospitals with a total of 25,787 hospital beds in 2021 (equivalent to 385 per 100,000 population). Acute hospital capacity is below regional averages (Figure 6). Between 1997 and 2021 the number of public hospitals and the ratio of hospital beds per population declined rapidly, but capacity could potentially be reduced further in view of the country’s generally young population and its stage of socioeconomic development. The bed occupancy rate in acute hospitals in 2019 was above 85% (Figure 7).

Most hospitals (85%) are over 50 years old, but some new buildings are being built with financing from the national government and international donors. Likewise, most expensive equipment is procured through donor funding. Maintenance of equipment and buildings is not clearly regulated and national resources to maintain and renew equipment are insufficient. Therefore, most modern diagnostic and treatment technologies, including MRI and CT scans, are only available in private health facilities in Bishkek, Osh and some oblast centres.
FIG. 6  ACUTE HOSPITAL BEDS PER 100 000 POPULATION IN KYRGYZSTAN AND COMPARATOR REGIONS, 2000–2021

FIG. 7  BED OCCUPANCY RATE IN ACUTE CARE HOSPITALS IN KYRGYZSTAN AND SELECTED COUNTRIES, 2000–2020

Source: WHO, 2022c
Public sector health facilities are geographically well distributed, but there are still remote areas with limited access to health services. Primary care services are provided by a mix of family medicine centres (FMCs), family group practices (FGPs) and feldsher-obstetrical points (FAPs). The latter are present in almost 90% of villages, including remote rural areas. The hospital network consists of 22 tertiary care facilities located in Bishkek and Osh, seven oblast and 40 rayon hospitals providing secondary care, eight rehabilitation centres, six psychiatric hospitals and 21 TB hospitals. While nurses are considered geographically well-distributed, the distribution of doctors is uneven.

Primary care facilities are the most accessible provider of health services. FGP are the main primary care unit responsible for initial consultation and check-up. They act as gatekeepers to higher levels of care. If a consultation with a specialist is needed, the family doctor refers the patient to an FMC, which usually has some beds and specialists, or to a hospital. In rural or remote areas FAPs, run by a feldsher and a regularly visiting FGP doctor, have been established to improve access. Primary care providers offer several public health services including health promotion, vaccinations, family planning and antenatal care.

The Government and the Ministry of Health have recognized primary care as a priority, demonstrated by the Healthy Person – Prosperous Country programme (2019–2030) and the allocation of additional funds in 2018 and 2019. In addition, Kyrgyzstan is implementing various pilots aiming to improve the efficiency of primary care services. The Government’s 2021 Plan for Improving Healthcare Delivery resulted in the merger of primary care organizations and district-level hospitals (Box 3). It remains to be seen whether this will strengthen or weaken primary care (Box 4).

**BOX 3 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?**

The Government supports the integration of health services. The Healthy Person – Prosperous Country programme (2019–2030) envisages the vertical integration of health services and increased public health interagency interaction. The “Tyunduk” system of interagency interaction plays a major role in its implementation. In addition, new information systems for health services are being developed, aiming to improve interactions with other sectors (e.g. social services, state registration and the MHIF).

As the role of primary care has increased in recent years, interactions with related services, such as TB and public health are being developed, and community-based treatment supporters help patients and interact with medical personnel.

Various pilots to improve the integration of services are currently in process, including for HIV/AIDS, TB and mental health care. While most of these programmes are in an early stage of development, efforts to integrate HIV services at primary care and community level are being hampered by lack of motivated staff and continued stigma towards HIV patients. Some regions are piloting integrated primary care services for TB patients through a case management model, supported by MHIF payments for successful treatment outcomes.
HOSPITAL CARE

In comparison to FMCs, hospitals have better equipment and hospital specialists are perceived to be more highly qualified. Emergency services do not require a referral and are provided free of charge to all citizens. Outpatient and elective inpatient services require a referral unless patients cover the full cost of treatment on a fee-for-service basis. In 2000, first steps were taken to replace inpatient with day-care services where appropriate. This has reduced the demand for inpatient stays and improved access. Paediatric short stay units were introduced in 2015 and there are plans to develop payment mechanisms for hernia and cataract day surgery, procedures currently still provided in inpatient settings.

PHARMACEUTICAL CARE

Pharmaceutical policy is set out by the Ministry of Health. The Department of Drug Provision and Medical Equipment is the national agency that regulates medicines and medical devices. It implements national policies and is responsible for market authorization and post-marketing surveillance of medicines, vaccines and medical devices. The entire pharmaceutical supply chain is private. Approximately 8% of consumed pharmaceuticals are produced domestically and there is no strict division between wholesale and retail, leading to inequitable pricing and access. Household catastrophic health expenditure is mainly driven by out-of-pocket spending on outpatient medicines and new price controls are currently being tested.
LONG-TERM CARE

Formal long-term care is provided by institutions of social protection, and the health and education systems. Nongovernmental and private organizations also provide long-term care services. However, the country lacks homes for older people in need of nursing care and there are many hospital admissions of older people with chronic diseases. Most long-term care is provided informally within families, but the exact number of informal carers is unknown. In 2019 the Government introduced a system of personal assistants to financially support families with disabled children. The new system provides state support payments (KGS 4900, approximately US$ 70, per month) to those who take care of children with disabilities. These carers are also entitled to a 50% discount on health resort treatments every five years. Additionally, the scheme provides some training for carers, although this is not systematic.

DENTAL CARE

Public dental care is provided by clinics, centres and practices in FMCs and FGPs. Emergency dental care and dental health education is free of charge for all citizens. Some patient groups also receive prophylactic and rehabilitation services free of charge. These services are covered by the SGBP and are reimbursed by the MHIF via capitation. Otherwise, providers charge according to a nationally set price list. The number of private dental practices is increasing, especially in large settlements and cities. The cost of services in these institutions is not regulated by the Government and covered by patients out-of-pocket.

What reforms are being pursued?


The World Bank project on Results-Based Funding was launched in 2014. The project covered all rayon hospitals in the country. Hospitals were divided into a control group with no assessment or additional payment, an intervention group where quality indicators were assessed and bonuses were paid, and an intervention group where indicators were assessed without payment. The results showed that it is important to monitor quality indicators, as quality indicators improved significantly even in the absence of payment.

After the Results-Based Funding Project ended, the MHIF extended results-based payment to all rayon and oblast hospitals in 2019, to a maximum of 5% of the organizations’ annual budget. However, these payments were stopped in 2020 and 2021, during the COVID-19 pandemic.

The Tuberculosis Action Plan for 2017–2026 aims to restructure the network of TB organizations and expand outpatient treatment to ensure access and safety of services. TB services are gradually being integrated with primary care, and a new primary care payment method is being piloted for treated cases of TB.

The current Healthy Person – Prosperous Country programme (2019–2030) emphasizes the importance of health for achieving economic development. It identifies a number of priority areas (see Box 5).
How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

It is Kyrgyzstan’s aspiration to establish a single health information system, but there is currently no roadmap for achieving this aim. E-health systems, such as electronic health records, are being piloted with donor support. While pilots are successful, wider implementation is slow due to lacking infrastructure and funding constraints. Transparency is a recognized challenge that the Government has aimed to address, both to provide assurance and accountability for donor and public funds and to overcome informal payments.

The national E-Health Centre collates all epidemiological data and publishes the annual statistical bulletin “Population Health in Kyrgyzstan”. Feeding into this publication, Medical Information Centres collect regional and city level data and Medical Information Departments, located in FMCs, collect district level data. The sanitary-epidemiological system, MHIF and republican centres for specific disease areas also collect information feeding into the E-Health Centre. The National Statistical Committee separately collects demographic data such as on mortality and fertility.

BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS

Den Sooluk (2012–2018): aimed to improve health outcomes in cardiovascular diseases, maternal and child health, TB and HIV/AIDS. Initiatives that formed part of this programme included:

- TB Action Plan 2017–2026 (see text above; ongoing)
- Communication Strategy for Routine Immunization 2018–2020 (implemented)
- Integration of care and expansion of primary care (implemented)
- Improved access to health promotion through newly established village health and public health committees (implemented)
- Improving regulation of medicines and their safety, efficacy and quality. Alignment with EAEU legislative framework (ongoing)
- Introducing financing for paediatric short stays (implemented)
- World Bank Results-Based Funding project (see text above; implemented)

Healthy Person – Prosperous Country (2019–2030): ongoing. Priority areas include public health, primary and emergency care, developing a rational and efficient network of hospital and laboratory services, regulation of pharmaceuticals, governance and intersectoral collaboration, health workforce, e-health, strategic purchasing and financial protection.

Population health improved prior to the COVID-19 pandemic but financial protection and quality assurance could be more effective.
ACCESSIBILITY

While health facilities are geographically well distributed, there are some remote areas with limited access. Also, not all health centres are sufficiently equipped or staffed, especially in primary care and rural or remote areas. Only 69% of the population was covered by the MHIF in 2019. Enrolment requires at least a temporary residence permit and basic identification documents, a potential barrier for internal migrants. In addition, people in informal employment may decide not to purchase MHIF insurance separately.

Co-payment exemptions covered 48% of the population in 2012 (Giuffrida, Jakab & Dale, 2013), but out-of-pocket payments, especially for secondary care, pharmaceuticals and the uninsured are a barrier to access (OECD, 2018). In 2014, 12.8% of households experienced catastrophic expenditure for health (Figure 8) (Jakab, Akkazieva & Habicht, 2018), a share that is likely to have increased since then (Iamshchikova, Mogilevskii & Onah, 2021). During the COVID-19 pandemic the provision of essential health services was affected, including services for family planning, postnatal care, vaccinations, sexually transmitted diseases and other services.

FIG. 8 INCIDENCE OF CATASTROPHIC SPENDING ON HEALTH AND OUT-OF-POCKET SHARE OF CURRENT HEALTH EXPENDITURE IN SELECTED EUROPEAN COUNTRIES, LATEST YEAR AVAILABLE FOR BOTH INDICATORS

Source: WHO, 2019; WHO, 2022b
HEALTH CARE QUALITY

Quality improvement is not yet inherent in the work of clinical teams. Patient safety incidents and adverse outcomes are not systematically collected, identified or analysed to improve services. This means that complications and adverse clinical outcomes are grossly underreported. Data on patient experience is also not collected routinely (Box 6). The World Bank is currently supporting national quality improvement systems, for example by developing information systems to collect and report quality-of-care data. A 2017 survey found low health practitioner compliance with evidence-based patient management principles (Ahmedov et al., 2020). More generally, care guidelines and protocols are not readily accessible. Where they exist, many do not provide statistical indicators or audit criteria for monitoring. For example, inpatient mortality secondary to acute myocardial infarction has recently worsened, alongside recurrent infarctions.

Similarly, governance in the public and private sector is fragmented and not adequately coordinated. This often leads to non-aligned decision-making, inconsistent application of policy, and weak management. Provider performance monitoring and inspection is duplicative, fragmented, weak and non-transparent. Some agencies that monitor services lack appropriate expertise. Providers face ineffective accountability mechanisms, a compliance-oriented culture of caution and no clear direction or support for quality assurance and improvement.

HEALTH SYSTEM OUTCOMES

Life expectancy at birth was estimated at 71.6 years in 2019 (67.6 years for males and 75.8 years for females), with recent declines in premature mortality from communicable and noncommunicable diseases. Cardiovascular diseases are the largest contributor to mortality and years of healthy life lost. As the leading cause of death for people of working age, they also account for a large share of overall mortality. Other important causes of death include cancer, respiratory disease and road traffic injuries (Fig. 9). Around two thirds of amenable deaths can be attributed to poor quality of care, and one third to non-utilization of health services. The lack of public health policies to address modifiable risk factors also likely contributes to the burden of non-communicable disease (Box 7).

While the country has achieved malaria-free status, there continues to be a high incidence and prevalence of TB and only 71% of TB cases were successfully treated in 2017. The estimated adult HIV prevalence was 0.2% in 2019, but antiretroviral treatment coverage was only around 40%. Before the COVID-19 pandemic, infant and child mortality rates steadily declined. The maternal mortality rate also improved but it remains among the highest in the WHO European Region. It is unclear how recent declines in public spending on health and the COVID-19 pandemic will affect health outcomes in the future.

BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

Data to understand patient experience is currently not collected systematically. Assessments of patient experience to date vary greatly across studies and settings.

In 2017 the MHIF interviewed 314 patients who had previously received inpatient treatment: 70% of them were satisfied and 30% were unsatisfied with the quality of treatment they had received.

The 2014–2018 Results-Based Hospital Financing Project carried out quarterly assessments of patient experience. Patient satisfaction with hospital services was low in the first year of the project, ranging from 8% to 55%. However, patient satisfaction had reached 80% by the second year and patient satisfaction exceeded 90% by the end of the project.

The World Bank-funded primary care strengthening project is supporting the Ministry of Health to collect continuous data, including on patient experience. Facility level data is expected to be publicly available and linked to MHIF payments soon, in an effort to improve quality of care and responsiveness.
**FIG. 9**

**MAIN CAUSES OF MORTALITY IN KYRGYZSTAN 2000–2016**

- Ischaemic heart disease
- Stroke
- Respiratory disease
- Cancers
- Diabetes

Deaths per 100,000 population

Source: WHO, 2022b

**FIG. 10**

**BURDEN OF DISEASE: MAIN RISK FACTORS CONTRIBUTING TO MORTALITY, 2019**

- Kyrgyzstan
- WHO European Region
- European Union

% of all deaths

Source: IHME, 2022
HEALTH SYSTEM EFFICIENCY

While there is very limited fiscal space for health, a relatively small share of funding is allocated to outpatient and primary care. However, funding allocations are being improved by a World Bank-supported project that is developing a structure, process and methodology to revise the SGBP. Similarly, the Healthy Person – Prosperous Country programme (2019–2030) aims to rationalize the health system infrastructure, although progress has stalled recently due to political instability and the COVID-19 pandemic.

The large share of out-of-pocket payments, especially for pharmaceuticals, undermines both allocative and technical efficiency. Public funds do not suffice to cover essential medicines, limiting access to highly cost-effective treatments. In 2019 price regulations were designed to lower pharmaceutical expenditure, and the new price control mechanism was tested in 2022. In addition, prescriptions are usually issued by brand name, and more generic prescription could help to improve technical efficiency.

Hospital day care and short stays have been introduced in the last 20 years, improving technical efficiency within the health system. To improve further, provider payment mechanisms for day surgery are currently being planned. The weak referral system and vertical structure of most disease programmes limits care coordination, another area where efficiency gains are possible.

BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?

Public health services in Kyrgyzstan have a traditional focus on the prevention and control of communicable diseases, especially TB, HIV/AIDS and diarrhoeal infections. They are much less involved in addressing noncommunicable disease or modifiable risk factors such as smoking, alcohol consumption, obesity and nutrition (Figure 10).

Despite Kyrgyzstan signing the WHO Framework Convention on Tobacco Control, the country has not implemented many of the required measures. Tax and non-tax measures are inadequate. For example, tobacco tax is among the lowest in the WHO European Region and nicotine-replacement therapy must be paid for out-of-pocket. In the 2019 Global Youth Tobacco Survey of schoolchildren aged 13–15 years, 25.5% of boys and 8.9% of girls reported smoking tobacco at least once.

Measures to reduce alcohol consumption are also inadequate. Notably, there are no control mechanisms or fines for violations for selling alcohol to children under 18 years old. Alcohol consumption per capita increased slightly from 3.6 litres in 2000 to 3.9 litres in 2018.

According to the 2014 STEPS Survey, 23% of the population was obese (BMI≥30) and 56% was overweight (BMI≥25).
Summing up

Before the COVID-19 pandemic, Kyrgyzstan’s population health outcomes had improved, with falling child and maternal mortality rates and declines in premature mortality from communicable and noncommunicable disease. However, life expectancy at birth is still one of the lowest in the WHO European Region and the COVID-19 pandemic is likely to have been a temporary but major setback. In addition, the pre-pandemic decrease of public spending on health has meant that private spending, mostly in the form of out-of-pocket payments, has increased. This undermines financial protection and access to health services, the effects of which are yet to filter through to population health outcomes.

Kyrgyzstan has demonstrated its ability to undertake sweeping reforms of its health system through several comprehensive health reform programmes. The current Healthy Person – Prosperous Country programme (2019–2030) has broad aims to strengthen primary care, restructure the hospital sector and safeguard the population from financial risk, while guaranteeing the provision of essential services. The current focus on health due to the COVID-19 pandemic could be an opportunity to resume the reform agenda, increase public investment in health and improve the efficiency of the health system, so that it is better equipped to deal with future challenges.
# POPULATION HEALTH CONTEXT

## KEY MORTALITY AND HEALTH INDICATORS

### LIFE EXPECTANCY (YEARS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Life expectancy at birth, total(^a)</td>
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<tr>
<td>Life expectancy at birth, male(^a)</td>
<td>67.6</td>
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<tr>
<td>Life expectancy at birth, female(^a)</td>
<td>75.8</td>
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### MORTALITY (PER 100 000)

<table>
<thead>
<tr>
<th>Cause</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Circulatory diseases</td>
<td>577.5</td>
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<tr>
<td>Malignant neoplasms</td>
<td>115.1</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>15.9</td>
</tr>
<tr>
<td>External causes of death</td>
<td>54.5</td>
</tr>
<tr>
<td>Infant mortality rate (per 1 000 live births)</td>
<td>16.4</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100 000 live births)</td>
<td>60</td>
</tr>
</tbody>
</table>

**Notes:** Life expectancy data are estimates for 2019. Age-standardized mortality data are for 2016. Latest infant mortality data are for 2019, latest maternal mortality data are for 2017.

**Source:** WHO, 2022c

## REFERENCES


The European Observatory on Health Systems and Policies is a partnership that supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in the European Region. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues. The Observatory’s products are available on its web site (http://www.healthobservatory.eu).