



▶ Extending social health protection: Accelerating progress towards universal health coverage in Kazakhstan

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▶ 1. Introduction

Kazakhstan is an upper middle-income country with a population of around 19.8 million people and a GDP per capita of 38,515 current international dollars purchasing power parity (PPP) in 2023 (World Bank 2025; Qazstat, n.d.). The Human Development Index (HDI) in Kazakhstan was 0.837 in 2023, ranking the country at 60th worldwide (UNDP 2025). The poverty headcount ratio at national poverty lines was equal to 5.2 per cent of the population in 2021 (World Bank 2022). The informal economy represents a significant share of the economy, despite a decrease from 28.75 per cent in 2017 to 19.75 per cent of GDP in 2021 (QAZSTAT 2022).

Considerable improvements in health outcomes among the population have been achieved in the past couple of decades as a result of fast economic growth and continuous efforts to modernize the health system. Kazakhstan has a guaranteed volume of free medical care (GVFMC) available for all citizens and permanent residents (WHO Regional Office for Europe 2022). In addition, in 2015, Kazakhstan began taking steps towards the rollout of a mandatory social health insurance system (MSHIS) as a complement to the existing free medical care (GVFMC), with an aim to improve financing and access to health care.¹ The MSHIS was piloted in 2019 in the Karaganda region and introduced nationwide on 1 January 2020 (Panwar 2025).

▶ 2. Context

Kazakhstan previously operated a non-contributory national health service system, which provided a State-Guaranteed Benefits Package free-of-charge to all citizens. This programme was progressively expanded to include permanent residents and refugees, and most of the financing burden is borne by the State.

In 1996, a first version of mandatory health insurance was introduced but its financial viability was limited and the scheme was discontinued in 1999. In the early 2000s, the financing of social health protection was further decentralised, with funding from the rayon (village) level and later with pooling of funds

¹ Law of the Republic of Kazakhstan dated November 16, 2015 No. 405-V on Compulsory Social Medical Insurance, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/Z1500000405>

introduced at oblast (region) level (with oblast authorities playing the role of single purchasers) (Katsaga et al. 2012).

A range of important health system reforms have occurred since 2010, including enhancing the autonomy of public health care service providers. The most significant reforms involved the transfer of the economic management of state-owned enterprises, which was introduced by the State Health Development Programme for 2016-2019; improved regulation and centralization of health service procurement; strengthening of primary health care services; and active digitalization aimed at creating a unified medical records system and improved interoperability between different agencies and public databases (Republic of Kazakhstan 2020). These reforms facilitated the introduction of the MSHIS (Social Health Insurance Fund of Kazakhstan 2022a). In addition, a bundled payment mechanism was introduced to facilitate the participation of informally employed persons in the MSHIS by simplifying their contributions across multiple social protection systems (P4H 2025).

A renewed reform of social health protection in the country began in 2015-2016, through the design of a new mechanism and the establishment of the Social Health Insurance Fund (SHIF). The SHIF was tasked with managing both the GVFCM and the new MSHIS. The MSHIS was first piloted in 2019 in the Karaganda region prior to being introduced across the rest of the country in 2020 (Social Health Insurance Fund of Kazakhstan 2022a). The Law on Mandatory Social Health Insurance (No. 405-V ZRK), originally signed in 2015, was last amended in September 2024 to reflect new implementation modalities (P4H 2024c).

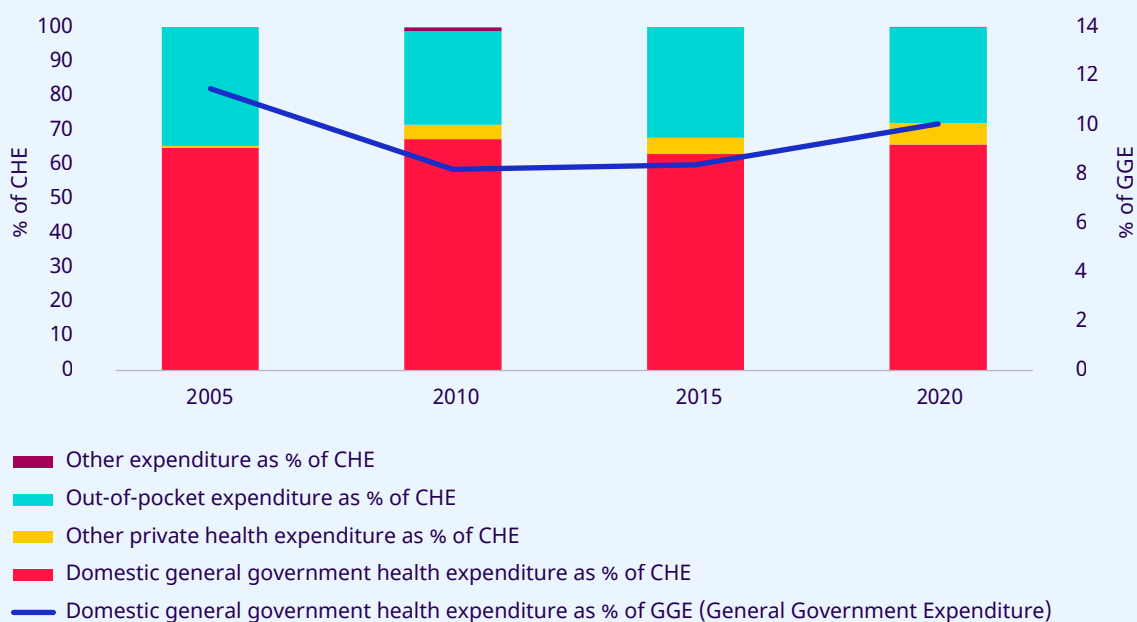
▶ 3. Design of the social health protection system

Financing

The relative level of public health financing as a share of GDP is comparatively low and stood at 2.8 per cent of GDP in 2019, which is the lowest among the Commonwealth of Independent States countries (CIS) (WHO 2020). The modest share of health expenditure has been partially offset by substantial GDP growth; although the current health expenditure (CHE) as a share of GDP has been in decline since 2000, the CHE per capita has increased (from US\$51 in 2000 to US\$273 in 2019) (WHO 2020). Nonetheless, there is a need to increase the level of health expenditure in the country, which remains below the average of the WHO European region (4.9 per cent of GDP) (WHO 2020).

The share of health expenditures as a proportion of the Government's budget has remained satisfactory, with Domestic General Government Health Expenditure representing between 7.6 per cent (lowest value) and 11.7 per cent (highest value) of general government expenditure between 2000 and 2020 (see figure 37). As a result, between 2000 and 2020, the share of government financing arrangements in CHE averaged almost two thirds (63.1 per cent)—one of the highest among the CIS countries (WHO 2020). OOP payments have been the second main source of health financing averaging one third or 34.3 per cent between 2000 and 2020, and dropping to 27 per cent in 2020 (WHO 2020). Additional financing came from the social health insurance scheme, representing 16 per cent of CHE in 2020 (WHO 2020).

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



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

The introduction of the MSHIS in 2020 created an additional source of funding for the system (see figure 38). For MSHIS contributors, the law mandated the following contribution requirements for 2022:²

- ▶ For employed persons (labour and civil-law contracts), both employees and employers have to pay contributions (employee: 2 per cent of income; employer: 3 per cent of employee's taxable income). For income/salary-based contributions, the income is capped at the 10-fold minimum monthly salary (cumulatively for all applicable sources combined), which is around US\$1,500.
- ▶ Entrepreneurs and private practitioners pay 5 per cent of the 1.4-fold minimum wage (contribution of approximately US\$10). Persons remain conditionally covered for three months after contribution payments are stopped. However, they are required to eventually pay for the unpaid periods.
- ▶ Self-payers pay 5 per cent of the minimum wage each month (contribution of approximately US\$7). Any person who is entitled to participate in MSHIS and is not eligible for non-contributory registration can obtain insurance by contributing as a self-payer. To be enrolled as a self-payer, a person must pay for each unpaid period in the previous 12 months or pay in advance for the upcoming 12 months. Paying for future months is a recent initiative to increase coverage. Since September 2022, self-payers may obtain insured status by prepaying for 12 future months, instead of repaying arrears for the past 12 months (Government of Kazakhstan 2025).
- ▶ A presumptive tax regime which includes MSHIS contributions among other sources, was put in place to encourage formalization of the self-employed. Payers of a single aggregate payment make a unified contribution (UCP) at a privileged rate. This initiative aims to include those who have informal incomes, mainly from selling agricultural goods or services to other persons (without registering as an entrepreneur). The concerned persons pay a monthly calculation index depending on residency (Electronic government of the Republic of Kazakhstan 2023).³

² Law of the Republic of Kazakhstan No. 327-VI on Compulsory Social Medical Insurance' dated May 13 2020, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/Z1500000405>

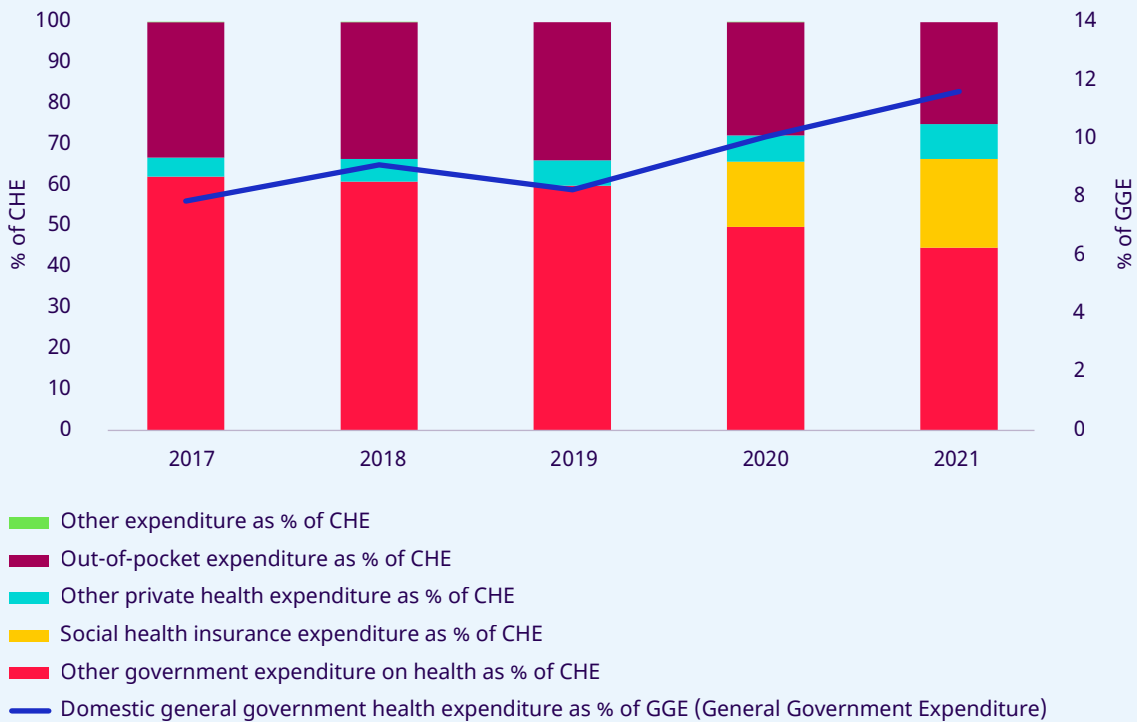
³ One monthly calculation index for those residing in the capital or in cities of republican and regional significance; 0.5 monthly calculation index for other settlements.

This payment counts towards income tax (10 per cent) and social insurance contributions for health (40 per cent), pension (30 per cent) and other benefits (20 per cent) (State Social Insurance Fund, n.d.). Unlike other mechanisms, there is a waiting period of three consecutive months of contribution payments.

As of January 2024, new contribution ceilings apply: employees contribute 2 per cent of income, capped at KZT 17,000/month, and employers contribute 3 per cent, capped at KZT 25,500/month. Independent payers contribute KZT 4,250/month (5 per cent of minimum wage), while the state pays KZT 5,800/month per insured person for 15 benefit-entitled categories (Government of Kazakhstan 2025).

For the population categories whose contributions are paid by the Government, the following rate applies as of 2022: 1.7 per cent of the average monthly salary for the period of two preceding years. The rate is scheduled to increase gradually to 2 per cent by 2025.

Figure 2. Relative share of social health insurance and other financing scheme as percentage of CHE, 2017-2021

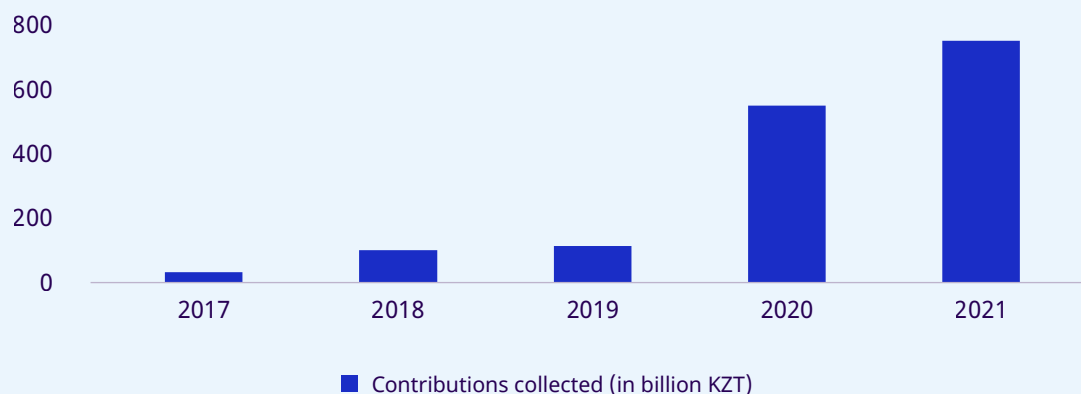


Source: Based on data from the WHO Global Health Expenditure Database.

All MSHIS contributions are made to the bank account of the State Corporation "Government for Citizens", which then transfers them to the SHIF.

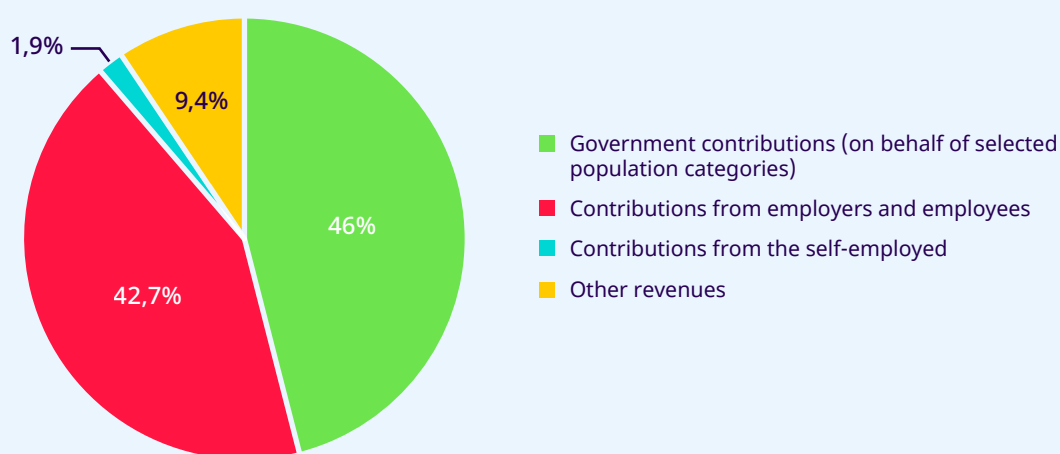
The SHIF has been collecting contributions to MSHIS since 2017, which was followed by a significant increase in contributions three years later in 2020. Figure 39 below provides further details on the funds accumulated through MSHIS, based on the data reported by the SHIF. These funds represent both revenue from contributions and state contribution subsidies (see figure 40). In 2021, these subsidies represented 346 billion Kazakhstani tenge (KZT) or 46 per cent of all funds received (see figure 40). The 2021 data reported by SHIF indicates that the funds accumulated through MSHIS have resulted in doubling the level of expenditure on publicly funded health services compared to 2019 (Social Health Insurance Fund of Kazakhstan 2022a).

Figure 3. Funds collected through MSHIS, 2017-2021



Source: Social Health Insurance Fund of Kazakhstan 2022b; 2021; 2020.

Figure 4. Structure of MSHIS financing by source (2021)



Source: Social Health Insurance Fund of Kazakhstan 2022b.

Going forward, the transition from informal to formal employment will be an important priority to strengthen the financial sustainability of MSHIS. In this respect the Government of Kazakhstan has already achieved important milestones, including the target set by the National Development Plan of the Republic of Kazakhstan of reducing the size of informal economy to 20 per cent of GDP by 2025.⁴ The Government is now planning to reduce the size of the informal economy to 15 per cent of GDP in 2050, in line with another target set by the National Development Plan (Republic of Kazakhstan 2012). This target appears to be well within reach, given that the size of the informal economy stood at 19.75 per cent of GDP in 2021 (QAZSTAT 2022). Seeking additional sources of financing for health is also an important pathway to engage in, especially since the country has raised additional excise taxes on harmful products.

⁴ National Development Plan of the Republic of Kazakhstan until 2025, dated February 2018, No. 636, available (in Kazakh) at: <https://adilet.zan.kz/rus/docs/U1800000636>

Governance

Health services are governed by the following legislation:

- ▶ Code No 360-VI of the Republic of Kazakhstan on the Health of the People and the Health Care System of 7 July 2020;
- ▶ Law No. 405-V ZRK of the Republic of Kazakhstan on Mandatory Social Health Insurance of 16 November 2015; last amended with effect from 1 September 2024 (Aiypkhanova 2024);
- ▶ Decree of the Government of Kazakhstan No. 389 of 1 July 2016;
- ▶ Decree of the Government of Kazakhstan No. 421 on Approval of the List of Medical Care in the System of Mandatory Health Insurance of 20 June 2019 (as amended in 2020);
- ▶ Decree of the Government of Kazakhstan No. 672 on approval of the list of guaranteed volume of free medical care and invalidation of some prior decisions of the Government of the Republic of Kazakhstan of 16 October 2020;
- ▶ and other relevant decrees and orders regulating the provision, management and monitoring of health care services in the country.

Code No. 193-IV of 2009, Law No.405-V ZRK of 2015 and Decree No. 421 of 2019, along with other normative acts, mandate and regulate the provision of health services under MSHIS. Decree No. 389 of 2016 institutionalizes the SHIF. Together, Decree No. 389 and the Code of 2009 establish the role of the SHIF as a single purchaser of health services (Amirova and Abilkasimov 2020).

The SHIF is responsible for accumulating funds and purchasing health services under GVFMC and MSHIS, conducting an examination of the quality of provided medical services and providing support to the population in obtaining medical services. The SHIF is governed by a Board of Directors appointed by the Ministry of Health (Social Health Insurance Fund of Kazakhstan, n.d.-b). The Board includes:

- ▶ Three independent directors, one of which is the Chairman of the Board;
- ▶ Chairman of the SHIF Executive Board;
- ▶ First Vice-Minister of Health;
- ▶ Chairman of the State Property and Privatization Committee of the Ministry of Finance of the Republic of Kazakhstan.

In accordance with its governing legislation, the SHIF has an overarching mission of providing financial protection to every citizen of Kazakhstan and increasing health care accessibility and quality. As part of this mandate, the key goals of the SHIF are as follows (Social Health Insurance Fund of Kazakhstan, n.d.-a):

- ▶ To ensure universal coverage of the population under MSHIS;
- ▶ To strengthen its role as a strategic purchaser of health services;
- ▶ To protect the rights of patients;
- ▶ To ensure its sustainable functioning.

The Fund's development strategy for 2020–2025 includes objectives to strengthen proactive monitoring of medical service quality, improve patient feedback systems, enhance digital infrastructure, and increase coverage among the economically inactive population (P4H 2024a).

On the provision side, health service providers are mostly owned by local governments, though a few are also owned by the Ministry of Health. There are also many private providers that provide the GVFMC and MSHIS services (WHO 2018; WHO Regional Office for Europe 2022).

Legal coverage and eligibility

According to Kazakhstan's Constitution of 1995, article 29, "citizens of the Republic of Kazakhstan shall have the right to protection of health. Citizens of the Republic shall be entitled to free, guaranteed, extensive medical assistance established by law."

GVFMC comprises essential health services that are accessible to all citizens of Kazakhstan, permanently residing foreigners, stateless persons and refugees, while MSHIS covers an expanded package of services that is accessible to those who are registered into the scheme either on a contributory or on a

non-contributory basis (Electronic government of the Republic of Kazakhstan 2023). Citizens, permanently residing foreigners and stateless persons are eligible to participate in MSHIS, but not refugees or asylum seekers (UNHCR 2021a). In 2021, 81.3 per cent of the population was insured by MSHIS (WHO Regional Office for Europe 2022). As of 2023, this share has remained at 84 per cent, reflecting a stable proportion despite population growth (P4H 2024b).

According to Code No 360-VI of the Republic of Kazakhstan on the Health of the People and the Health Care System,⁵ the GVFMC is available to all residents, including:

- ▶ All citizens of Kazakhstan;
- ▶ “Kandas” – ethnic Kazakhs who might not have Kazakh citizenship as per the regulations provided under the Law on the Introduction of Amendments and Additions to Some Legislative Acts of the Republic of Kazakhstan on the Regulation of Migration processes of 2020;
- ▶ Persons who are granted refugee status;
- ▶ Foreigners who permanently reside in Kazakhstan and have appropriate residence permits;
- ▶ Stateless persons who permanently reside in Kazakhstan and have appropriate residence permits;

Temporarily visiting foreigners, stateless persons and asylum seekers do not have the right to access the GVFMC package, unless they seek treatment for a disease or condition that poses a risk to the health of others, or unless urgent life-saving treatment is required (medical emergency) according to the terms of CIS⁶ and EAEU treaties.⁷

Eligibility for the GVFMC is determined based on documentation certifying the legal status of the person seeking to access services under GVFMC.

In the case of MSHIS, there are both contributory and non-contributory affiliation mechanisms. To become insured through MSHIS, persons need to have Kazakhstani citizenship or a permanent residence permit and to make regular contributions to MSHIS as obligated by law, unless they belong to one of the population categories that are exempt from paying contributions. Contributions are paid to the fund for at least three consecutive months preceding the date of receipt of medical care.⁸ Since September 2022, persons without a 12-month contribution history can acquire insured status by paying contributions for the upcoming 12 months (Government of Kazakhstan 2025). Additionally, labour migrants from EAEU countries and their family members are eligible to participate in MSHIS based on the terms of the international treaty.

The main categories of MSHIS contributors, as identified by the Law of 2015 (article 14):

- ▶ Workers (both in the public and private sector);
- ▶ Individuals implementing works (services) under civil-law contracts;
- ▶ Individuals who are payers of a single aggregate payment in accordance with Article 774 of the Code of the Republic of Kazakhstan "On taxes and other obligatory payments to the budget" (Tax Code);
- ▶ Entrepreneurs;
- ▶ Self-employed and private practitioners;
- ▶ Other eligible individuals who contribute as self-payers.

Several vulnerable population categories are affiliated to MSHIS on a non-contributory basis, with the equivalent of their contributions paid by the government from the general budget on their behalf. These population categories are defined by Article 26 of the Law of 2015 and include:⁹

⁵ Code of the Republic of Kazakhstan on Public Health and Health care System No. 360-VI dated 7 July 2020, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/K2000000360>

⁶ Resolution of the Government of Kazakhstan No. 320 on Ratification of the Protocol on the Implementation of the Agreement on the Provision of Medical Care to the Citizens of the Commonwealth of Independent States, dated 29 February 2000, available (in Kazakh) at: https://adilet.zan.kz/kaz/docs/P000000320_

⁷ Treaty on the Eurasian Economic Union of 2014, available at: https://docs.eaeunion.org/docs/en-us/0017353/itia_05062014_doc.pdf

⁸ Law of the Republic of Kazakhstan No. 405-V on Compulsory Social Health Insurance, dated November 16 2015 (amended and supplemented 1 July 2023), available (in Kazakh) at: https://online.zakon.kz/Document/?doc_id=32908862

⁹ Law on Compulsory Social Health insurance.

- ▶ Children;
- ▶ Individuals registered as unemployed;
- ▶ Pregnant women who are not engaged in any type of labour activity (this requires that they do not receive any formal income and are not registered as entrepreneurs);
- ▶ Mothers of many children awarded with pendants "Altyn alka" or "Kumis alka" previously granted the title of "Mother Heroine" or previously awarded the orders of "Maternal Glory" of I or II degree;
- ▶ Persons who take care of disabled children and are not engaged in any type of labour activity;
- ▶ Persons who are not engaged in any type of labour activity and raise children (under the age of three);
- ▶ Kandas who are not engaged in any type of labour activity;
- ▶ Prisoners and detainees;
- ▶ Students who pursue secondary special education, higher education or some other form of recognized full-time education;
- ▶ Disabled persons;
- ▶ Recipients of official social aid;
- ▶ Pensioners (including war veterans).

Benefits

Service coverage is primarily regulated by the Code of 2020, the Law of 2015, Decree No. 421 of 2019, and Decree No. 672 of 2020 as well as other normative acts setting the procedures for accessing, distributing and managing health care services. The GVFMC is regulated by Decree No. 672 of 2020, and the MSHIS package is regulated primarily by Decree No. 421 of 2019 along with the Code of 2009. These were last amended in 2024 to expand eligibility conditions and revise the list of covered services (Aiypkhanova 2024).

The GVFMC package aims to provide universal access to the most essential services.

The main categories of services provided under GVFMC include (but are not limited to):¹⁰

- ▶ Emergency medical care (including transportation);
- ▶ Primary health care, including (but not limited to):
 - Diagnostics, treatment and management of common diseases;
 - Preventive examinations of target population groups;
- ▶ Early screening activities to detect behavioural risk factors and to improve health literacy;
 - Preventive vaccinations;
 - Pregnancy monitoring and follow-up;
 - Sanitary-epidemiological and sanitary-preventive measures in foci of infectious diseases.
- ▶ Specialized outpatient medical care for:
 - Diagnosis and prevention of HIV and tuberculosis;
 - Treatment of injuries, intoxication (poisoning) and other conditions requiring urgent medical aid;
 - Diagnosis and treatment of socially significant diseases and conditions as defined by the Ministry of Health (MoH);
 - Diagnosis and treatment of chronic illnesses that require dynamic monitoring as defined by MoH;
- ▶ Day care for diseases and conditions defined by MoH that include socially significant diseases and chronic illnesses that require dynamic monitoring;
- ▶ Inpatient services for:
 - Quarantine and isolation of individuals who have come into contact (or suspected to have come into contact) with persons with infectious or parasitic diseases that pose risks to the health of others as defined by MoH;

¹⁰ Order of the Minister of Health No. RK HM-89 on Approval of the List of Guaranteed Volume of Free Medical Care and Invalidation of Some Prior Decisions of the Government of the Republic of Kazakhstan, dated 20 August 2021, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/V2100024069>

- Treatment of infectious and parasitic diseases, including those that pose risks to the health of others, defined by MoH;
- Treatment of diseases and conditions that require urgent medical aid for persons who are not covered by MSHIS;
- Elective treatment of diseases and conditions defined by MoH.
- ▶ Medical rehabilitation during the treatment of a disease under GVFCM and medical rehabilitation of patients with tuberculosis;
- ▶ Palliative care according to the list of diseases determined by MoH;
- ▶ Provision of blood products and their components;
- ▶ Provision of free medicines as part of emergency care, day care and inpatient care, vaccination and outpatient medicines for a list of 54 groups of diseases or conditions for certain population groups, as defined by MoH.

The MSHIS package is a complement to the GVFCM and comprises the following categories of services, in line with the law:¹¹

- ▶ Specialized outpatient medical care that includes:
 - Expanded service coverage for preventive examinations of target population groups;
 - Appointment and consultations with secondary health specialists upon referral by primary health practitioners;
 - Dynamic monitoring and follow-up for persons with chronic illnesses;
 - The list of diagnostic services, including laboratory diagnostics and procedures defined by the MoH;
 - Delivery of emergency and elective dental care to selected categories of the population according to the list defined by MoH;
- ▶ Additional coverage of day care based on extended list of diseases and conditions defined by MoH;
- ▶ Additional coverage of elective inpatient treatment based on extended list of diseases and conditions defined by MoH;
- ▶ Inpatient treatment of diseases and conditions that require urgent medical aid;
- ▶ Additional coverage of medical rehabilitation based on the list of diseases and conditions defined by MoH;
- ▶ Provision of free medicines as part of day care and inpatient care, and outpatient medicines for a list of 128 groups of diseases or conditions for certain population groups as defined by MoH.

In addition, the MSHIS package currently offers access to a preventive services package on an ad hoc basis. As of 2024, the MSHIS package also explicitly includes pathology diagnostics and services for deceased donors (Government of Kazakhstan 2025).

These benefits should be accessible without any co-payments, ceilings or deductibles (Electronic government of the Republic of Kazakhstan 2023). In 2021, a co-payment system for medicines and medical devices was established according to regulations by the Minister of health.¹² However, its implementation has been postponed until 2025 (Bukatov and Gimranova 2022).

The health care benefits presented above are complemented by some cash benefits. Cash maternity benefits are available to employed persons through social insurance supervised by the Ministry of Labour and Social Protection of Population and managed by the State Fund of Social Insurance. The amount is based on the average monthly earnings in the last 12 months and it is paid for 126 days (70 days before and 56 days after childbirth). The benefit be extended for an additional 14 days for complicated childbirths and multiple births. All women, regardless of their work status, are given a lump-sum birth grant for a newborn. Cash sickness benefits are available for employed persons through employer liability, which are based on the employee's average daily earnings and conditioned by the provision of a health certificate (ISSA 2018).

¹¹ Code of the Republic of Kazakhstan on Public Health and the Health Care System, dated 7 July 2020, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/K2000000360>

¹² Order of the Minister of Health No. ҚР ДСМ-6 on Approval of Co-payment Rules, dated July 16, 2021, available (unofficial translation) at: <https://adilet.zan.kz/eng/docs/V2100023589>

The Labour Code guarantees that pregnant women, women who have given birth to a child/children, and women and men who have adopted a newborn child/children are granted the following leave in connection with the birth of a child: maternity leave, leave for employees who adopted a newborn child/children, and leave without pay for child care until the child reaches the age of three years. The duration of maternity leave is 70 days before birth and 56 days after giving birth. In cases of complicated births or the birth of two or more children, the leave is 70 days. The leave duration is independent of the longevity of employment. After the maternity leave, optional leave for child care can be granted for up to three years. Such leave can be received by the father or mother of the child, and if the child is left without parental care, then by the next of kin/caregiver.¹³

Provision of benefits and services

According to the law, the SHIF purchases and pays for the services of health care entities providing medical care in volumes and in line with the conditions stipulated by the contract for the purchase of medical services and other functions.¹⁴ Both public and private health care providers are eligible to enter into contracts with SHIF to provide the MSHIS package. In 2020, the SHIF concluded contracts with 1,258 service providers of mandatory social health insurance, including 657 public (52 per cent) and 601 private (48 per cent) providers (Eskaliev et al. 2021). By 2023, private providers represented 63 per cent of all SHIF-contracted service providers (P4H 2024b).

In order to provide GVFMC or MSHIS packages, providers need to be included in the database of SHIF suppliers. This allows the provider to apply for service provision under a direct contract or provide services as a subcontractor.¹⁵ The allocation of volumes of medical care is carried out by regional or republican commissions chaired by SHIF. An estimated 63 per cent of contracted providers in 2023 were private. The list of providers is published on the website of the SHIF (Electronic government of the Republic of Kazakhstan 2023). Purchasing mechanisms are designed to improve efficiency, cost containment and transparency. Payments are capitation-based for PHC services, while specialized inpatient and hospital care is based on diagnosis-related groups (DRGs) including more than 400 groups of inpatient cases (Mukhamedyarova et al. 2021; Chanturidze et al. 2016).

Prior to accessing health services, patients may check their insurance status through a specialized mobile application (*Qoldau 24/7*), a Telegram bot, or by visiting the national e-gov portal, or the official websites of the MoH and SHIF. SHIF also operates a hotline (1406) which can be used by patients to obtain additional information (Electronic government of the Republic of Kazakhstan 2023).

In the case of both GVFMC and MSHIS the first point of contact for beneficiaries should be at the primary health care level, where they can obtain a referral to access specialized secondary and tertiary care. The referral process can be bypassed in the case of health emergencies or elective visits to a list of specialists for certain conditions defined by the MoH (WHO Regional Office for Europe 2023).

To enable effective provision and management of services, all residents are encouraged to register with their local primary health provider. Each year, between 15 October and 15 November, a registration campaign is carried out. During this period, beneficiaries can select a clinic located close to their place of residence and register with a primary health practitioner of their choice (Electronic government of the Republic of Kazakhstan 2024).

Registration is carried out through a national e-gov portal and requires a completion of an electronic form and certification through a personal electronic digital signature (EDS). The EDS requires a valid national identity document or passport to prove citizenship (Electronic government of the Republic of Kazakhstan, n.d.). Upon submission and verification of the registration application, the newly registered

¹³ Institute of Legislation and Legal Information of the Republic of Kazakhstan, Labour Code No. 414-V ZRK of 23, dated November 2015, available at: https://natlex.ilo.org/dyn/natlex2/r/natlex/fe/details?p3_isn=102038&cs=1bzwBwsqXcZeNAWrDCxjIYoxfgxjlxLUV1KB12ezrG9dzim0kctFMqqmntjBiTOGmBr36VCgO1YxoyBtlG7iWw

¹⁴ Law of the Republic of Kazakhstan dated No. 405-V on Compulsory Social Health Insurance, dated 16 November 2015 (amended and supplemented on 1 July 2023), available (in Kazakh) at: https://online.zakon.kz/Document/?doc_id=32908862

¹⁵ Order of the Minister of Health care No. 424/2020 on Approval of the Rules for the Purchase of Services from Health Care Entities Providing Medical Care within the Guaranteed Scope of Free Medical Care and (or) Within the Compulsory Social Health Insurance System, Dated 8 December 2020, available (in Kazakh) at: <https://adilet.zan.kz/kaz/docs/V2000021744>

beneficiaries receive an electronic confirmation certified with the EDS of the health care facility of their choice.

An alternative registration procedure exists for the following categories of the population (Electronic government of the Republic of Kazakhstan, n.d.):

- ▶ Pensioners;
- ▶ Persons with disabilities;
- ▶ Caregivers;
- ▶ Prisoners;
- ▶ Students;
- ▶ Conscripts undergoing military service;
- ▶ Eligible unemployed persons who were born in foreign countries;
- ▶ Persons completing registration through the power of attorney.

Persons who fall under the above categories can register at primary health facilities without an EDS upon presentation of documents certifying their identity and their affiliation to the aforementioned categories. Registration is only possible with primary health care providers that are part of the GVFCM scheme.

▶ 4. Results

Coverage

All residents who permanently reside in Kazakhstan and whose permanent residence status is documented have access to the GVFCM. This means that, while providing coverage to the majority of the population, the GVFCM is not designed for many groups of migrants who reside in the country temporarily or whose status is undocumented, and it provides very limited benefits for these groups, primarily covering treatment for diseases or conditions that pose a danger to others (UNHCR 2021b).

Due to its geographic location and accelerated economic growth in the 2000s, Kazakhstan became a destination for many labour migrants from Central Asia. Available data suggest that Kazakhstan historically had one of the largest migrant populations in the region (relative to its population size). Modelled estimates for the 2000-2019 period suggest that the international migrant stock in Kazakhstan has been as high as 20 per cent of the population (United Nations 2020). While many of the migrants who come to the country obtain formal residency status (through work permits or otherwise), there is also a significant number of seasonal workers with temporary residence permits and many undocumented migrants. These groups are excluded from the available social security schemes, including the GVFCM, and can contract private voluntary health insurance (FIDH 2016). Some sources suggest that in 2015, between 300,000 and 1.5 million labour migrants were residing and working in Kazakhstan with an irregular status (FIDH 2016). This constitutes a notable coverage gap.

Coverage under MSHIS was estimated at 84 per cent of the population in 2023 (P4H 2024b), which is an improvement compared to the reported 81.3 per cent in 2021 and 85 per cent in 2020 (Social Health Insurance Fund of Kazakhstan 2021). In 2024, the number of insured persons surpassed 17 million, while 3.1 million people remained uninsured (Government of Kazakhstan 2025).

The decline in the number of insured persons between 2020 and 2021 was likely caused by failure to pay regular contributions to MSHIS (under the contributory pathway) among certain population groups. According to the data reported by SHIF, around 2.6 million people did not make any contributions to MSHIS in 2021 and thus were excluded from the scheme. To address this issue, a 2022 amendment to the Law on MSHIS allowed uninsured persons to acquire insurance status by paying for the upcoming 12 months rather than repaying missed contributions from the past year (Government of Kazakhstan 2025).

In collaboration with other public agencies and the media, SHIF is carrying out a widescale information campaign to encourage the population to participate in MSHIS and to improve public awareness of relevant procedures and requirements (Social Health Insurance Fund of Kazakhstan 2021).

Adequacy of benefits/financial protection

Entitlements under GVFC and MSHIS guarantee access to a broad range of health services at no cost to patients. According to the data reported by SHIF, the introduction of MSHIS resulted in a considerable increase in the utilization of many health services by the population. In particular, there has been an increase in the number of surgeries for the treatment of chronic diseases, the number of treatments for the management and prevention of disabilities, and the number of medical rehabilitation services (Social Health Insurance Fund of Kazakhstan 2021; 2020).

OOP payments dropped to 27 per cent of CHE in 2020 from 34 per cent of CHE in 2019, partly due to the expansion of MSHIS (WHO 2020). Preliminary data suggest that OOP payments declined slightly again to 26.4 per cent of CHE in 2021, but remained largely stable through 2023 (P4H 2024b). However, some of the financial risks remain unaddressed. Most notably, a large share of OOP spending in Kazakhstan is associated with the purchase of medicines (WHO Regional Office for Europe 2022). According to a 2018 Health System Review produced by OECD, households pay on average over 80 per cent of the cost of drugs out of pocket (which is two times more than in OECD countries) (OECD 2018). Although the costs of some outpatient medicines are covered by MSHIS, the number of such medicines is limited. Moreover, self-medication is an issue and some studies have observed over use of certain categories of drugs (WHO 2015; Zhussupova et al. 2020).

The practice of informal payments also threatens to undermine the level of financial protection provided through social health protection schemes. Informal payments have been commonly used by patients to circumvent certain formal procedures and/or to receive “preferential” treatment (Oka 2019). While the introduction of MSHIS will likely contribute to reducing the practice of informal payments over time, it is not yet clear what its impact will be in the short-term.

Responsiveness to population needs

Availability and accessibility

SDG target indicator 3.8.1 on UHC service coverage of essential health services increased from 39 per cent to 80 per cent over the period 2000-2020 (WHO Data 2024). Skilled birth attendance was 100 per cent in 2018 (WHO 2023).

In 2020, there were 407 physicians and 752 nurses per 100,000 inhabitants. During the same period, the number of hospital beds decreased from 719 to approximately 450 per 100,000 persons, with a slight increase to 574 in 2020 due to the COVID-19 pandemic (WHO Regional Office for Europe 2022). The average length of stay is steadily declining, having reduced from 12.3 days in 2019 to 8.6 days in 2022. The bed occupancy rate in acute care hospitals fluctuates at over 85 per cent, although it reached its lowest in 2020 (61 per cent) (WHO European Health Information Gateway 2023).

The introduction of MSHIS is believed to have facilitated access to a range of health services. The total number of providers contracted by SHIF for GVFC and MSHIS was 1,390 organizations in 2021 (2020 –1,290; 2019 – 1,417). In particular, SHIF reports that between 2019 and 2020, there was a substantial increase in the number of contracted health care providers for the delivery of rehabilitation services under MSHIS, which increased from 64 to 539 (Social Health Insurance Fund of Kazakhstan 2021). In 2023, 63 per cent of contracted providers were private (P4H 2024b).

However, one of the major challenges faced by the health care system in Kazakhstan has been the significant gap between rural and urban regions in terms of the availability of health services (Gulis et al. 2021; Government of Kazakhstan 2019). Due to the geographic characteristics of the country, the rural population is very dispersed with some communities located in remote regions where the necessary health infrastructure remains absent or underdeveloped. Understaffing of rural health facilities and clinics has been identified as a particularly significant problem (Jobalayeva et al. 2024; Gulis et al. 2021). In response, in 2009, the Government of Kazakhstan launched an incentive scheme to motivate health care

providers to relocate to rural areas. The scheme offered a one-time allowance and housing incentives. The number of rural health care providers increased significantly from 2009 to 2020, but the increase was less substantial in per capita measures (Jobalayeva et al. 2024). Between 2000 and 2018, the number of doctors, nurses and midwives per 10,000 inhabitants was 2.5 times higher in urban areas (Shaltynov et al. 2021). In 2023, SHIF reported further targeted allocations to rural providers, alongside efforts to improve telemedicine and mobile PHC units (P4H 2024a). Based on the data reported by SHIF, the introduction of MSHIS has allowed for an increase in resources allocated to day care and inpatient services for rural residents – from 72 billion tenge in 2019 to 92 billion tenge in 2020 (Social Health Insurance Fund of Kazakhstan 2020; 2021). However, further action is needed to strengthen the capacity of outpatient and primary care providers, particularly in rural areas (Gulis et al. 2021). Currently, the total number of medical personnel in rural areas is three times less than in urban areas – 16.1 vs 56.8 per 10,000 inhabitants, respectively. The average number of general practitioners per 1,000 persons is estimated at just 0.28 (OECD 2018).

Limited capacity and availability of primary health care providers often forces residents of remote rural communities to travel long distances to seek consultations and treatment at secondary- and tertiary-level facilities. This creates inefficiencies and translates into additional costs for patients (related to travel, accommodation, missed days of work, informal payments and co-payments to access secondary-level services without a formal referral, for example) (Gizaw et al. 2022).

The launch of central procurement of medicines and a “Single Distribution System” (thereby reducing instances of local commercial distributors playing the role of intermediaries) has allowed for significant savings while guaranteeing the availability of medical products at outpatient level (SK-Pharmacy LLP 2022; Bukatov and Gimranova 2022).

The main drivers of morbidity and mortality in the country are NCDs). It is estimated that NCDs account for 84 per cent of all deaths in the country and that the average person living in Kazakhstan has a 27 per cent risk of dying before the age of 70 from one of the four major NCDs (cardiovascular diseases, diabetes, chronic respiratory diseases and cancers) (Amirova and Abilkasimov 2020). The inclusion of preventive services in the design the GVFMC package plays an important role in adaptive responses to the change in demographics and disease burden. These services include annual health examinations as well as diagnostics and treatment for chronic and socially significant diseases, as defined by MoH.

Since 2010, Kazakhstan has seen a steady increase (by 39 per cent) in the number of persons affected by HIV (Mukhatayeva et al. 2022). This situation calls for a greater coordination with other social policies to reduce the social factors that create vulnerability to HIV transmission. As the first Central Asian country to provide citizens with free-of-charge antiretroviral therapy, preventive and curative services¹⁶ in Kazakhstan have been strengthened in the fight against the HIV epidemic (WHO Regional Office for Europe 2022).

Quality and acceptability

A number of studies conducted in Kazakhstan found that patients are generally satisfied with the services they receive from health care providers (Seleznev et al. 2020). However, the availability of data on the quality of patient-centred care is limited (Seleznev et al. 2020). Self-reported satisfaction rates may be affected by a range of biases that can be difficult to account for. On the other hand, it can be argued that the persistence of informal payments to health care providers is indicative of patients’ desire to receive services/ treatment that is of better quality than what is generally offered (Oka 2019). However, the context in which informal payments are made can vary significantly and may not necessarily be linked to a patient’s perception of health care quality.

The available macro indicators suggest that health care quality in Kazakhstan has improved over time. Improvements to the delivery of health services have manifested in a significant decrease in maternal and under five mortality in the past two decades (Gulis et al. 2021; Government of Kazakhstan 2019) as well as in the reduction of mortality from diseases of the circulatory system, mortality from malignant neoplasms, and mortality from tuberculosis (Orazymbetova and Sultanbekova 2021).

¹⁶ The services range from testing and counselling; information and education work; access to condoms; and access to needles and syringes to rapid testing among key groups; and prevention of mother-to-child transmission of HIV.

Significant investments have been made in modernizing the national health system since 2000 (Gulis et al. 2021). Continuing reforms have included the optimization of inpatient care and the strengthening of primary health care services (Government of Kazakhstan 2019). Disease prevention and timely screening are currently of high importance due to the growing burden of NCDs (Farrington et al. 2019).

Nonetheless, there remains a range of challenges that complicate the provision of quality health services to the population. In particular, under-funding of primary health services and health care facilities remains a challenge (Barbazza et al. 2019). Some accounts claim that over 50 per cent of all health facilities have been in operation for more than 30 years without any major renovations, and that there is an average 30 per cent gap in the availability of medical equipment (Amirova and Abilkasimov 2020). One 2019 study that involved the collection of feedback from 198 physicians working in outpatient clinics found a range of complaints about working conditions, including insufficient amount of office equipment and supplies and inadequate workplace lighting. Around 20 per cent of physicians surveyed reported to work shifts of nine hours and longer, and around 36 per cent pointed to a lack of breaks (Aldabergenova and Turgambayeva 2021).

To improve the responsiveness of health services to patient needs, SHIF collects feedback from health care users. In 2020, nearly 720,000 requests were received and processed through the SHIF hotline, including 7,865 complaints (Social Health Insurance Fund of Kazakhstan 2021). Attention has been given to reducing waiting times for hospitalization. As reported by SHIF, the share of patients who had to wait more than 30 days before admission for inpatient treatment at hospitals decreased from 12 to 5 per cent between 2019 and 2020 (Social Health Insurance Fund of Kazakhstan 2021). In 2023, SHIF expanded its digital engagement platform and introduced a new client satisfaction dashboard that aggregates feedback data across contracted providers (P4H 2024a).

Another factor that might contribute to the improvement of health care quality in the future is the active digitalization of the national health system, which contributes to improved efficiency and can lead to substantial savings thanks to optimization, evidence-driven decision-making, and reduced coordination, monitoring and data collection costs (WHO Regional Office for Europe 2023).

► 5. Way forward

The national long-term development strategy “Kazakhstan-2050” identifies the following priorities in the area of health: Ensure affordable medical services with high standards of care, develop a better system of preventive medical care and introduce smart medical care, remote diagnosis and treatment and electronic medical care (Republic of Kazakhstan 2012). The rollout of MSHIS contributes to all of these priorities by mobilising additional resources for health financing and by providing a new means for structuring and regulating the provision of health care to the population.

Moving forward, retention of MSHIS contributors will likely be a priority to gradually make the scheme less reliant on government funding. This should come about through careful analysis and understanding of factors motivating drop-out rates. Among other measures, the expansion of the MSHIS benefits package to include a comprehensive list of outpatient medicines and efforts to decrease administrative barriers could increase the attractiveness of the scheme for contributors, especially given that the major share of OOP health spending is driven by medicine purchases. The 2024 amendment of the Law on MSHI introduced new categories of services under the MSHIS benefits package and extended access to key diagnostic and specialized care, which could help improve scheme attractiveness for paying contributors (Government of Kazakhstan 2025).

Another strategic priority should be the formalization of employment and enterprises and the provision of health coverage to temporary residents and migrant workers. Given the high share of migrants in the Kazakh labour force, expanding social health protection coverage is not only a necessity to achieve UHC, but it will also contribute to social cohesion, with the potential to facilitate increased support and integration for these groups. In 2025, the Government announced that implementation of the Unified Aggregate Payment mechanism (UCP) had enabled the gradual integration of over 300,000 informally

employed persons into the MSHIS, with forward contributions now accepted to accelerate insured status (Government of Kazakhstan 2025).

Further implementation and strengthening of MSHIS should be undertaken in conjunction with increased investments in primary health care capacity and quality, and improvement of public health policies, including those to close the gap in service quality and availability between rural and urban regions.

Timely screening, early treatment and prevention can strengthen the financial sustainability of MSHIS by facilitating a reduction of costs associated with high consumption of secondary- and tertiary-level services, which will inevitably remain high if primary health and referral systems are weak. This is particularly important given the growing burden of NCDs in the country (Farrington et al. 2019)

Moreover, further digitalization of health and optimization of health data can contribute to the efficiency and sustainability of the system, and has been identified as one of the key next steps for the achievement of SDG 3 in the latest voluntary national review of SDG implementation in Kazakhstan (Government of Kazakhstan 2019).

▶ 6. Main lessons learned

- ▶ The introduction of MSHIS has yielded a range of positive effects, including increased financing and utilization of certain categories of health services. This was made possible through significant efforts to extend coverage and make the social health protection scheme available to all including informal workers and self-employed persons, through a unified contribution system for social protection benefits. However, a gap in coverage remains which disproportionately affects this group.
- ▶ In addition to reforms aiming at improving population coverage, efforts to strengthen and optimize health care delivery, including through strategic investments in primary health care development and widescale introduction of digital health services, have been ongoing. The Government is also taking steps to address availability challenges related to health workers, including through the revision of salaries of health professionals (Social Health Insurance Fund of Kazakhstan 2021).
- ▶ Improvements in financial protection can only be achieved if the scope and the coverage of the two packages offered is improved, the adequacy of benefits is addressed and the benefits are subject to regular formalized reviews and updates.
- ▶ Health financing is comparatively low in Kazakhstan. The introduction of the MSHIS allowed for the mobilization of additional earmarked resources, but additional investments are needed to improve primary health care capacity and to further optimize the health delivery system, and should come from a diversified mix of public revenues.
- ▶ One potential challenge with the use of digital health services for the extension of health care reach in rural regions is the lack of connectivity and digital infrastructure, which might impede uptake among remote rural communities. While this challenge can be resolved, additional investment might be required to ensure successful and sustainable implementation.

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