FINALLY ON TRACK? HEALTH REFORMS IN KAZAKHSTAN

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Summary: Since 2005 Kazakhstan has embarked on two comprehensive national reform programmes. These have aimed to change the provision and financing of care, place more weight on prevention, and improve the quality of care. Key changes to health care provision included the standardisation of health services and the development and implementation of clinical practice guidelines. Health financing reforms have seen the introduction of pooling at the national level (for hospital services under the State Guaranteed Benefits Package) and the oblast level (for primary health care services). However, there are still challenges in the implementation of reforms and population health indicators lag behind those of most other former Soviet countries.

Keywords: Health System Reforms, Health Care Financing, Health Care Delivery, Kazakhstan

Introduction

Due to its booming energy sector, Kazakhstan is by far the richest of the Central Asian states that became independent with the dissolution of the Soviet Union in 1991. Despite a reduction in Gross Domestic Product (GDP) between 2008 and 2009 resulting from the global economic crisis, Kazakhstan’s economy has rebounded and its GDP per capita in 2011 was at least four times higher than that of the poorest Central Asian countries – Kyrgyzstan, Tajikistan and Uzbekistan – and 50% higher than in Turkmenistan.¹

Yet, paradoxically, many of Kazakhstan’s health indicators lag behind those of other countries in the former Soviet Union. Life expectancy at birth in 2010, at 68.6 years, was one of the lowest in the WHO European Region.¹ These numbers already highlight the enormous challenges faced by Kazakhstan’s health system. Our article, based on the recently published health system review,² aims to provide an overview of recent health reforms in the country and of the challenges that remain for the future.

Recent reforms

Similar to other countries in the region, Kazakhstan inherited an oversized and inefficient health system from the Soviet period, with too much emphasis on bed and staff numbers.³ Initial health reforms in the country after independence were chaotic and volatile. Factors that impeded progress in health reforms included a general lack of trained administrative and health management personnel and frequent organisational changes. Beginning in 1996, the Ministry of...
Health changed its internal structure several times, with Ministers of Health and their teams changing on average every two years. In 1999 the Ministry of Health was abolished as an independent administrative body and subsumed under larger ministries, only to be restored in 2002.

Major changes in the structure and regulation of the health system were initiated in the mid-1990s, ranging from attempts to devolve power to the rayon (local) level to the introduction of mandatory health insurance and the restructuring of primary health care. However, not all of these envisaged changes were implemented and some, such as the experiment with mandatory health insurance, were reversed. More consistent and coherent reforms only came about in the second half of the 2000s, when two comprehensive reform programmes were adopted: the National Programme of Health Care Reform and Development for 2005–2010 and the State Health Care Development Programme for 2011–2015. These programmes greatly stabilised the previously fluid health policy environment.

In 2009 two key health policy documents were adopted that aimed to underpin further reforms: the Code on People’s Health and the Health Care System and the Concept on the Unified Health Care System. Both documents envisage country-wide measures for improving the health of the population, with a particular emphasis on prevention and the shared responsibility of the state and individuals for health. The Concept on the Unified Health Care System envisages the free choice of providers, the introduction of performance-based payment mechanisms, and a strengthening of continuous quality improvement processes.

**Health financing reforms**

Initial health financing reforms in the 1990s and early 2000s were erratic. In 1996, the national Mandatory Health Insurance Fund was set up, operating as a parallel structure along with the previous system of funding health organisations through the state budget, which resulted in the vertical fragmentation of pooling. Due to revenue shortfalls, corruption, and the impact of the Russian financial crisis in 1998, the national health insurance system was discontinued the same year and Kazakhstan returned to budgetary financing. However, problems of horizontal fragmentation emerged in 2000–2003, when, in line with broader administrative decentralisation, health financing and administration were decentralised to the rayon level. These changes resulted in the creation of inefficient and poorly manageable micro-health systems, negatively impacting on the overall efficiency of the health system and the population’s access to health services.

Beginning in 2004, a new health financing system was set up that, following similar reforms in neighbouring Kyrgyzstan, allowed pooling of funds at the oblast (regional) level, establishing the oblast health department as the single-payer for health services. Health purchasing mechanisms were also reformed, establishing capitation payment for primary health care, a case-based payment system for hospital care, and a partial fund-holding system for outpatient specialty care. Since 2010, resources for hospital services under the State Guaranteed Benefits Package have been pooled at the national level.

However, as in other countries of the region, out-of-pocket payments (coming from official user fees and informal under-the-table payments) are another important source of revenue, constituting 40.1% of total health expenditure in 2010. Recognising that this presents a major barrier to accessing services, an outpatient drug benefit has been introduced that entitles children, adolescents up to 18 years old and women of reproductive age to free outpatient pharmaceuticals. Insufficient financial protection is an issue for part of the population, with 7.4% not using health services in 2008 because of high costs.

**Health service provision reforms**

Similar to other countries of the former Soviet Union, the provision of health services in Kazakhstan has evolved on the basis of the legacy of the Soviet health system, with its overemphasis on hospital services and its neglect of primary health care, disease prevention and health promotion. This delivery system is still in the process of being reorganised.

Health care provision and financing have been largely devolved to the oblast administrations and their health departments. The 14 oblast and Almaty and Astana city health departments are the key bodies administering health services in Kazakhstan and run most hospitals and polyclinics. In addition, parallel health systems run by some ministries and government agencies have been inherited from the Soviet period and are still largely in place.

Although Kazakhstan was the setting of the Alma-Ata Declaration of 1978, which emphasised the centrality of primary care to the operation of effective, efficient and equitable health services, this principle was neglected for a long time, with a higher priority allocated to inpatient facilities. In the 1990s a dramatic reduction of outpatient services occurred, following the introduction of user fees for most diagnostic services and the necessity to purchase outpatient pharmaceuticals. This situation changed significantly in the 2000s, when primary health care facilities were legally and financially split from hospitals, providing them with greater autonomy to manage their resources and increase efficiency. Furthermore, the infrastructure of primary health care was upgraded, particularly in rural areas. However, the shortage of qualified personnel remains one of the major problems in this sector. Rural and remote areas continue to experience a shortage in primary care personnel, while larger cities are much better staffed. There
is also an imbalance towards specialist services, to the detriment of primary health care facilities.

In the hospital sector, Kazakhstan has significantly reduced the number of hospitals and hospital beds and also started to renew its health infrastructure, but the ratio of hospital beds per capita is still high and also differs greatly across oblasts. Furthermore, inpatient facilities continue to consume the bulk of health financing. In 2008 public expenditure on hospital care was 2.6 times higher than expenditure on outpatient services and only 0.17% of oblast health expenditure was devoted to health promotion.\[1]\n
Quality of care was another focus of reform efforts. After 2005 the principles of evidence-based medicine were increasingly introduced to policy-makers, academics and health care providers, leading to a gradual recognition of evidence-based medicine as a core prerequisite of clinical practice, education and research, and of the importance of its institutionalisation and implementation. The Health Care Development Programme 2011–2015 envisages a comprehensive set of measures to improve the efficiency and quality of hospital care. Key areas include improving hospital performance, development of general hospitals with specialty departments, and expansion of diagnostic and treatment technologies.

Another challenge is that linkages between primary and secondary care are poor, and many services are organised in parallel vertical structures, such as tuberculosis services, sanitary-epidemiological services, or the health systems operated by other ministries and government agencies. The resulting poor horizontal integration of services leads to duplication and inefficiencies. In light of this, the standardisation of health services across the country is one of the key objectives pursued by current health reforms. In 2009 the Ministry of Health approved standardised types and volumes of health services at five levels of care.\[2]\n
Main challenges for the future

As this brief overview has highlighted, there are still many elements of Kazakhstan’s health system that need to be developed further. Crucially, the ultimate objective of the health system – improving the population’s health – has not yet been sufficiently achieved. While information on mortality amenable to health care interventions is not readily available, five-year survival rates for patients with a primary diagnosis of cancer are low, amounting to 50.2% in 2009.\[3]\n
One of the main areas of future efforts will have to be stepping up public health and primary health care. The allocative efficiency of Kazakhstan’s health system is undermined by a continued reliance on inpatient care, which consumed 53.4% of total public expenditure on health in 2008, whereas primary health care only received 16%.\[4]\n
There is also much scope for improving technical efficiency, in view of a high ratio of hospital beds per population, poor performance indicators for inpatient care, and many narrowly specialist health facilities.

Financial protection of the population is another area that requires more attention, as widespread out-of-pocket payments undermine access to services. There are also pronounced regional inequities in health financing, health care utilisation and health outcomes, although some improvements have been achieved in recent years. Residents of Almaty and Astana cities still have advantages in accessing health services, as these two cities host the most advanced national clinical centres, whereas the geographical accessibility of health services in remote areas is much more challenging, due to the country’s vast and sparsely populated territory. In 2010 life expectancy at birth varied between 66.3 in North-Kazakhstan oblast and 73.2 in Astana city. There were also strong regional variations in infant and maternal mortality.\[5]\n
Finally, quality of care has been recognised as another area in need of major improvement and Kazakhstan has embarked on promoting evidence-based medicine and developing and introducing new clinical practice guidelines based on WHO standards, as well as facility-level quality improvement. Preliminary results of the State Health Care Development Programme 2005–2010 indicate progress in quality improvement, in particular with regard to maternal and child health and tuberculosis, but also a strong need for further efforts.

References