World Health Organization

European Region

Health Financing Progress Matrix assessment

Kazakhstan 2023

Summary of findings and recommendations

Abstract

This report presents the findings of the Health Financing Progress Matrix (HFPM) assessment of Kazakhstan conducted in 2023. The WHO HFPM is a standardized tool for use in evaluating the strengths and weaknesses of a health-financing system and identifying priority areas of reform to advance universal health coverage.

Acknowledging the progress Kazakhstan has made in health financing over the past two decades, with a high population coverage and a strong reliance on public funding, the report highlights related challenges, including low public health expenditure relative to government budgets, financial sustainability concerns, and inefficiencies in resource allocation. The division of public funds between two major pools — the State Guaranteed Basic Package and the Social Health Insurance Package—without cross-subsidization, poses risks related to equity and efficiency. In addition, insufficient provider-reimbursement rates and rigid purchasing mechanisms impact service quality and financial protection.

The report recommends increasing public health financing, maintaining free care at the point of use, enhancing financial management flexibility, and strengthening purchasing capacity. A strategic approach to implementing these reforms will be essential for improving financial sustainability, access to care, and overall health-system performance in Kazakhstan.

Keywords: HEALTH-CARE FINANCING, PUBLIC EXPENDITURE, KAZAKHSTAN, UNIVERSAL HEALTH COVERAGE

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Foreword

The Health Financing Progress Matrix report for 2023 marks a significant milestone in our ongoing efforts to strengthen the health sector and ensure that every citizen has access to quality health-care services. Since 2009, when the Unified National Healthcare System reform was launched, our country has made undeniable progress in improving health-financing mechanisms, which are crucial for the sustainability of the health-care system and the realization of universal health coverage. Through targeted reforms, we have enhanced financial protection for our citizens and expanded access to essential health services.

While we celebrate these successes, we also recognize that challenges remain. The full introduction of the Mandatory Health Insurance System in 2020 coincided with disruptions caused by the (COVID-19) pandemic. Therefore, 2023 – the year in which the international public health emergency ended – was the perfect moment to review progress made and lessons learned. To do so, our technical working group joined forces with WHO experts to assess the country's health-financing system against a set of evidence-based benchmarks.

The 2023 assessment identified areas where further efforts are required, particularly to increase the level of public financing for health, keep health services free at point of use, and sustain the financial resilience of our health system in the face of emerging health challenges. These challenges are not unique to our country but are part of the global struggle to maintain and improve health systems amid evolving economic and social landscapes.

The recommendations provided in this report offer a clear roadmap for the future. As we move forward, they will guide our policies and strategies, ensuring that our health system continues to evolve in a way that benefits all citizens.

On behalf of the Ministry of Health of the Republic of Kazakhstan, I would like to extend our deepest gratitude to all the experts and partners who contributed to the assessment. Their support and expertise have been invaluable, and we look forward to continuing our partnership as we work to implement the recommendations laid out in this report. Together, we can overcome the challenges that lie ahead and build a health system that truly serves the needs of our nation.

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First Vice-Minister of Health of the Republic of Kazakhstan

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Abbreviations

CHE	current health expenditure
DHS2	demographic health survey
DRG	diagnosis-related groups
DTP3	diphtheria, tetanus toxoid and pertussis vaccine
EAEU	Eurasion Economic Union
EPHS	essential package of health services
EPI	essential programme on immunization
GDP	gross domestic product
GGHE P.C	government health expenditure per capita
GGHE-D	domestic general government health expenditure
HFPM	Health Financing Progress Matrix
HSSP	health sector strategic plan
MSHI	Mandatory social health insurance scheme
NCD	noncommunicable diseases
NGO	nongovernmental organization
OECD	Organization for Economic Co-operation and Development
OOP	out of pocket
PFM	public financial management
PHC	primary health care
SCI	service coverage index
SDG	Sustainable Development Goal
SGBP	State-guaranteed basic package
SHIF	Social Health Insurance Fund
UHC	universal health coverage
VAT	value added tax

Executive summary

Background

The WHO Health Financing Progress Matrix (HFPM) is a standardized qualitative tool for use in assessing a country's health-financing system. Building on an extensive body of conceptual, empirical work, it aims to identify the main strengths and weaknesses of the system. This is achieved through a rigorous and impartial evaluation conducted by high-level experts and stakeholders, using a set of structured questionnaires and face-to-face meetings *(1)*.

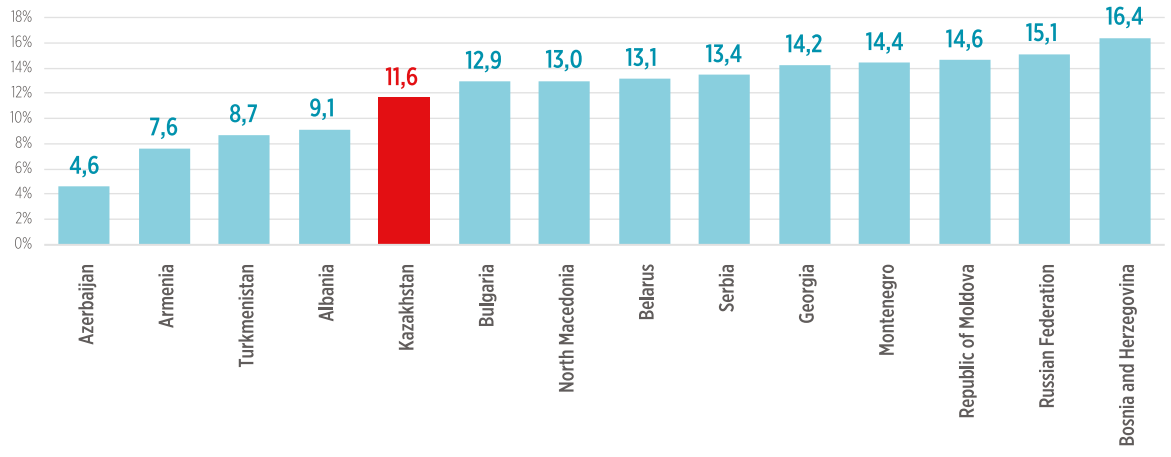
The findings and policy recommendations presented in this report are based on analyses conducted by, and discussions of the national working group established by the Ministry of Health of the Republic of Kazakhstan through a government order dated 6 March 2023. The working group comprised: nine representatives of three government agencies (the Ministry of Health, the Social Health Insurance Fund (SHIF) and the National Scientific Center for Healthcare Development named after Salidat Qaiyrbekova); two representatives of the WHO Country Office; and a joint team, comprising representatives of the WHO Barcelona Office in Kazakhstan for Health Systems Financing and the WHO European Centre for Primary Health Care in Almaty). WHO headquarters provided support.

Context: health expenditure in Kazakhstan

A high reliance on public sources of funding to pay for health care is an essential prerequisite for countries to progress towards UHC. In 2000, public expenditure in Kazakhstan accounted for 51% of the current health expenditure (CHE), which increased to a high of 76% in 2009 but fell to 65% in 2021. Despite no formal user charges, most of the remaining health expenditure is financed through out-of-pocket payments (OOP) (25% of the CHE in 2021), which could lead some households to experiencing financial hardship when using health services.

As a share of total government expenditure, health expenditure has varied over the past two decades from a low of 7.6% in 2007 to a high of 11.7% in 2006. While the priority for health in the government budget has increased in recent years compared to other upper-middle-income countries in Europe (Fig. 2), it remained low (fourth lowest) in 2021, suggesting that there may be scope for additional funding for health in the budget.

Fig. 2. Health expenditure as a percentage of government expenditure in upper-middle-income countries in Europe, 2021



Source: Global Health Expenditure Database *(2)*.

References[1]

1. Health Financing Progress Matrix [website]. Geneva: World Health Organization; 2025 (https://www.who.int/teams/health-financing-and-economics/health-financing/diagnostics/health-financing-progress-matrix, accessed 18 February 2025).

2. Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2024 (https://apps.who.int/nha/database, accessed 18 February 2025).

[1] All references were accessed on 18 February 2025.

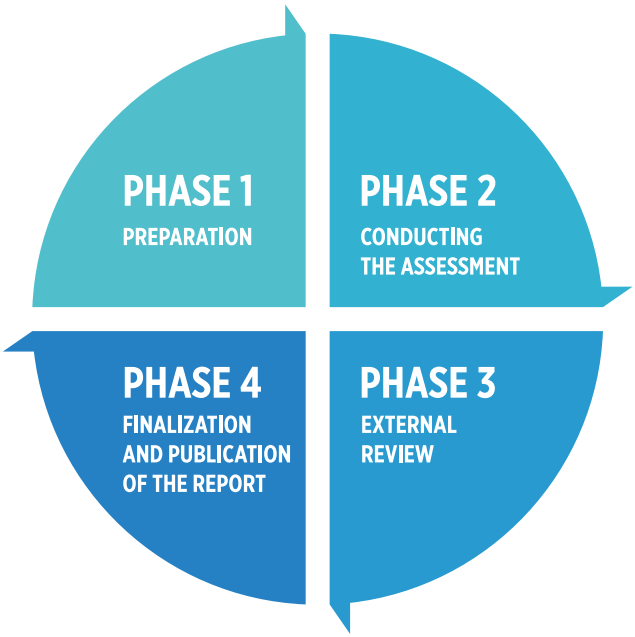
Introduction

The WHO Health Financing Progress Matrix (HFPM) is a standardized qualitative tool for use in assessing a country's health-financing system. It builds on an extensive body of conceptual, empirical work, summarizing what matters in health financing for the achievement of universal health coverage (UHC) into 19 desirable attributes, which form the basis of this assessment *(1)*.

This report identifies areas of strength and weakness in Kazakhstan's current health-financing system in relation to each desirable attribute. On this basis, it recommends relevant shifts in health-financing policy direction, specific to the context of Kazakhstan, which can help to accelerate progress towards UHC.

The qualitative nature of the analysis – along with supporting quantitative metrics – allows the provision of information to policy-makers about close-to-real-time performance. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress in the development and implementation of health-financing policies. Country assessments are implemented in four phases as outlined in Fig. 1. Since no primary research is required, assessments can be implemented within a relatively short period of time.

Fig. 1. The four phases of HFPM assessment



Phase 2 of the HFPM consists of two stages of analysis, as follows.

Stage 1 involves mapping the health-financing landscape to provide a description of the key health-coverage schemes in a country. The key design elements of each of these are mapped, such as basis for entitlement, benefits, and provider payment mechanisms, giving an initial picture of the extent of fragmentation in the health system.

Stage 2 produces a detailed assessment based on 33 questions relating to health-financing policy. Each question builds on one or more desirable health-financing attribute and is linked to the relevant intermediate objectives and final UHC -related goals.

Countries use HFPM findings and recommendations to feed into policy processes, which include the development of new health-financing strategies and a review of the existing strategies, and the routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

This report provides a concise summary of the HFPM assessment conducted in Kazakhstan in 2023, identifying strengths and weaknesses in the health-financing system and, as an extension to this, priority issues, which need to be addressed to accelerate progress towards UHC. The findings are summarized in several tables that provide varying levels of detail.

The first section provides an overarching summary of the assessment, as well as high-level summaries related to each of the seven assessment areas. These are based on the core health-financing functions and directed at senior officials interested in the broader picture of health financing. This is followed by more detailed summaries related to each of the nineteen desirable attributes of health financing. These signal what a high-performing health-financing system looks like and will be of interest to those working on the details of policy design and implementation. The annexes provide supplementary information, including contextual indicators (Annex 1), desired performance benchmarks (Annex 2), specific HPFM assessment questions (Annex 3), and a mapping of these questions to the objectives and goals of the Health Financing Progress Matrix (Annex 4).

By focusing both on the current situation and the main directions for future reforms, this report provides an agenda for priority analytical work and related technical support for the coming years. The latest information on Kazakhstan's performance in terms of UHC and key health-expenditure indicators is also presented. Detailed responses to individual questions are available on the WHO HFPM database or alternatively upon request.

This assessment is a living document and published with a view to receiving further feedback and comments from those engaged in health-financing policy development and implementation in Kazakhstan with the aim of further improving it over time.

Background

The WHO Health Financing Progress Matrix (HFPM) is a standardized qualitative tool for use in assessing a country's health-financing system. Building on an extensive body of conceptual, empirical work, it aims to identify the main strengths and weaknesses of the system. This is achieved through a rigorous and impartial evaluation conducted by high-level experts and stakeholders, using a set of structured questionnaires and face-to-face meetings *(1)*.

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Methodology and timeline

Following consultation with the WHO team (Dr David Gzirishvili and Mr Aidar Abeuov (Consulting Group Curatio Sarl), the Principal Investigators of the assessment), the Ministry of Health of the Republic of Kazakhstan issued an order on 6 March 2023, establishing a national working group, comprising nine representatives of three government agencies – the Ministry of Health, the SHIF and the National Scientific Center for Healthcare named after Salidat Qaiyrbekova – and two representatives of the WHO Country Office in Kazakhstan (henceforth, the Country Office).

The Country Office provided a Russian version of the Health Financing Progress Matrix (HFPM) country assessment guide and a data-collection template and held at least two meetings to explain the purpose and approach of the assessment, as well as the division of labour among the members of the national working group The Country Office also engaged a team of two Principal Investigators (PIs) (external contributors hired through a WHO procurement contract) and representatives of the Barcelona Office for Health Systems Financing, the WHO European Centre for Primary Health Care in Almaty, and the Country Office. The team prepared discussion materials in Russian for Stage 1 of the questionnaire, which were reviewed during a roundtable meeting.

The national working group and the WHO team agreed that, on completion of Stage 1, six roundtable meetings would be conducted to discuss the 33 questions included in the HFPM before convening a two-day workshop in Almaty on 28–29 August 2023.

A poll was organized, using AhaSlide.com, to gauge opinions and understand the complexity of the questions. The resulting diverse perspectives revealed moderate progress.

The WHO team shared a simplified version of Stage 2 of the questionnaire in Russian online to allow the members of the national working group to contribute to the discussion and comment on each other's viewpoints. Six roundtable meetings were held between June and August of 2023, one at the SHIF in Astana and five via Zoom.

Before the final roundtable meeting, which was held online, the WHO team distributed a consolidated version of Stage 2 of the questionnaire to allow for final contributions before the Almaty workshop. During the workshop, which was led by the Vice-Minister of Health, the national working group and the WHO team discussed each question thoroughly. Progress made in health-care financing was reviewed through rich and honest debate, which is reflected in the subsequent sections of the report. The PIs prepared a draft report, which was reviewed by the WHO team before being forwarded to two experts engaged to conduct an external evaluation. The report was finalized, taking their comments and suggestions into consideration.

It was agreed to prioritize the findings before seeking solutions or planning further consultations to identify root causes and recommend action.

Findings of the HFPM assessment

Overall, the HFPM *(1)* evaluation found that Kazakhstan has made considerable progress in health financing over the past two decades; however, there is scope for further improvement. Some of the key takeaways from the evaluation are described below.

Coverage levels

Coverage levels are high. All permanent residents are eligible for care through the Government's State Guaranteed Basic Package. SGBP. Approximately 83% are covered through the SHIF, which provides access primarily to some additional specialist services. All publicly financed care is provided without formal user charges. However, many people are unaware of their entitlements, and it is likely that informal payments are high, though relevant data are not available.

Low health expenditure

While public funds are the predominant source for coverage of health expenditure, the latter is low both as a share of the government budget and as a share of the economy. Budget allocations to the health sector are based on macroeconomic conditions; although they are predictable, they are regularly 10% to 15% below the budget levels requested by the Ministry of Health for the SGBP. The Government also allocates funds to the SHIF to cover contributions for specific groups; however, these funds do not fully cover the cost of the statutory entitlements defined by law. Social-insurance contributions from employers (3% of the payroll) and employees (2% of the payroll) also finance the SHIF to some extent. Chronic underfunding and increased demand for care raise concerns about financial sustainability across the health system.

Lack of cross-subsidization across risk pools

Public funds are divided across the two large risk pools, namely, the SGBP and the SHIF. While these are both administered by the SHIF, there is no cross-subsidization across the pools, which may have implications for equity and efficiency.

Purchasing-related challenges

The SHIF is responsible for all purchasing, which includes contracting service providers, determining the volume of services required and setting prices. While the capacity of the Fund appears high, it faces certain challenges. Due to strict budgetary constraints, the prices paid to providers are often low and do not always cover their costs, which can have implications for quality and availability, and lead to informal payments. In addition, the volume of care purchased from providers is based largely on historical patterns, which may not accurately reflect actual population-health needs, or the quality of the care provided.

Lack of health-financing vision

No single strategy document explicitly outlines the Government's vision for the health system, including its goals, approach to monitoring health-system performance and, not least, sources of financing. The existence of such a document to guide policy development is common in developed health systems.

Policy recommendations

Based on the above observations of the national working group, adherence to the following policy recommendations would further improve the health-financing system and contribute to progress towards universal health coverage (UHC).

Increase the level of public financing for health

Kazakhstan's priority for health in the government budget is low relative to that of other upper-middle-income countries in Europe. More public spending would help to address the misalignment between the budget allocation and the benefits package, allowing the SHIF to relax volume control and allow prices to more accurately reflect costs. This would contribute to advancing progress towards UHC by increasing access to care, reducing the risk of financial hardship due to out-of-pocket payments (OOPs), and improving the quality of care provided.

Keep health care charge-free at the point of use

Addressing sustainability challenges by implementing user charges would lead to greater financial hardship for households using the services and reduce access to care for those who cannot afford to pay. Maintaining health-care access free at the point of use should be a key objective of the health system in any future health-financing strategy.

Consider making the public financial management of health funds more flexible

Since the two risk pools are large, any fragmentation of funding has consequences for equity and efficiency. Public funds can be put to better use if they are combined or if there are mechanisms that allow cross-subsidization across the pools.

Strengthen the capacity of the purchaser

Any additional public funding for the health system should come with assurances that it will be well spent. This suggests the need not only for regular and publicly available financial and performance monitoring to hold health-system actors to account, but also for transparency in decision-making regarding the content of the benefits package. This could be achieved, for example, using tools that are not limited to cost-effectiveness analyses, such as stakeholder consultations. In addition, while the overall view of the national working group is that the SHIF performs well, it could improve the decision-making processes regarding providers of care: for example, which provider should they use? what and how much should they purchase? and how much care should they pay for? To this end, the collection of quality-of-care-related information to support the contracting and monitoring of providers, as well as the adjustment of payment, could be useful. Conducting needs assessment could also support planning and would be beneficial to making the case for more funding for the health system.

Develop an explicit health-financing strategy

Without a single agreed health-financing strategy, there is a risk of ad hoc decision-making that jeopardizes progress towards UHC. Such a strategy should clearly define the objectives of the health system, including realistic milestones, linking operational results with desired outcomes. Health-system performance assessment can be an effective tool for monitoring progress and holding the health system to account.

Future action

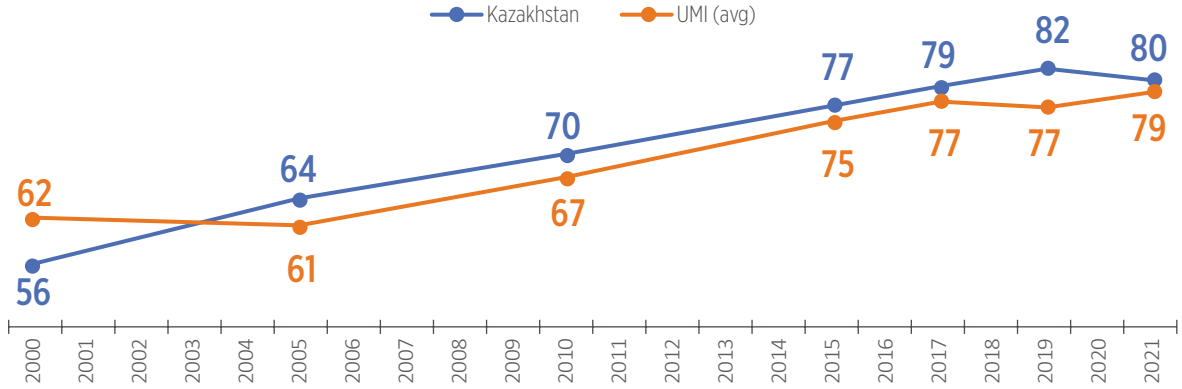
Any future decisions on moving ahead with the above recommendations will require strong support from and regular dialogue with and among key stakeholders, including government agencies, market actors, professional associations and interest groups. The roles of each actor involved need to be clearly defined, and a monitoring and evaluation framework developed to measure progress. Mechanisms for holding all actors accountable should also be established.

UHC in Kazakhstan

The goal of UHC is to ensure that all people receive the health services they need without facing financial hardship.

Indicator 3.8.1 of the Sustainable Development Goals (SDGs) pertains to the average coverage of essential services, based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases (NCDs) and service capacity and access *(2)*. In Kazakhstan, the service coverage index, ranging from 0 to 100, has shown a consistent increase since 2000 (Fig. 3).

Fig. 3. Service coverage index trend, Kazakhstan, 2020–2021 (%)



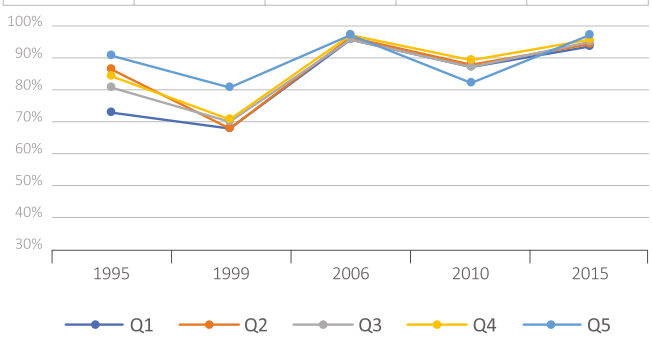
Note. UMI (avg) = unique molecular identifiers (average).
Source: Global Health Observatory 2023 *(2)*.

Disaggregated information for certain components of the index, such as antenatal-care visits and diphtheria, tetanus toxoid and pertussis containing immunization (DPT3) coverage, reveal a decreasing trend in access-related inequalities over time (Fig. 4).

Fig. 4. Antenatal care and DPT3 coverage by quintile, Kazakhstan, 2015

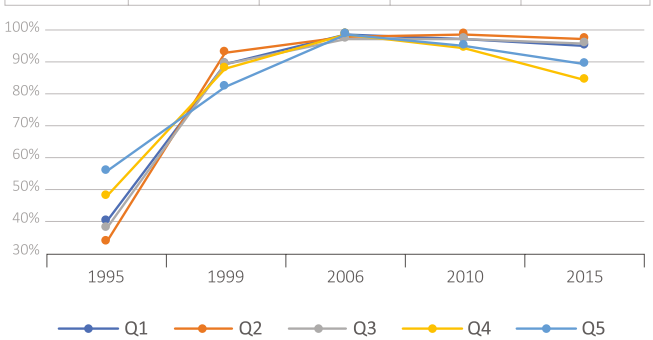
Antenatal care +4 visits
National average (2015): 95.3%
Value by quintile (2015)

Q1 (poorest)	Q2	Q3	Q4	Q5
93.7%	94.3%	95.4%	96.0%	97.4%



DTP3 coverage 1 year
National average (2015): 92.7%
Value by quintile (2015)

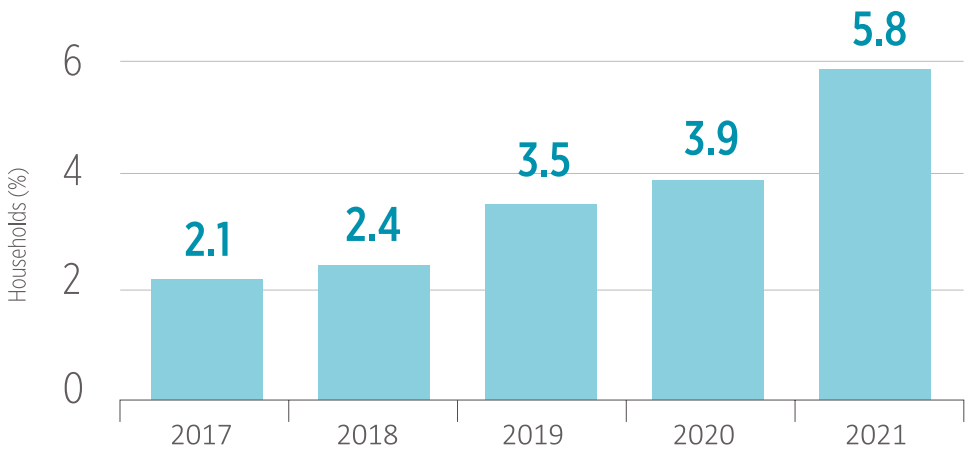
Q1 (poorest)	Q2	Q3	Q4	Q5
95.2%	96.8%	96.0%	84.1%	89.2%



Source: Global Health Observatory indicator views *(3)*.

The second measure of UHC relates to financial protection measured in terms of catastrophic spending. It is defined in the WHO European Region as the proportion of households with OOPs greater than 40% of a household's capacity to pay for health care. "Capacity to pay" is calculated by considering only the income remaining after accounting for essential household expenditures on food, housing, and utilities. Using this method, the percentage of households facing catastrophic health spending increased consistently in the period 2017–2021, though it remained relatively low at 5.8% in 2021 (Fig. 5).

Fig. 5. Trend in catastrophic health expenditure, Kazakhstan, 2017–2021

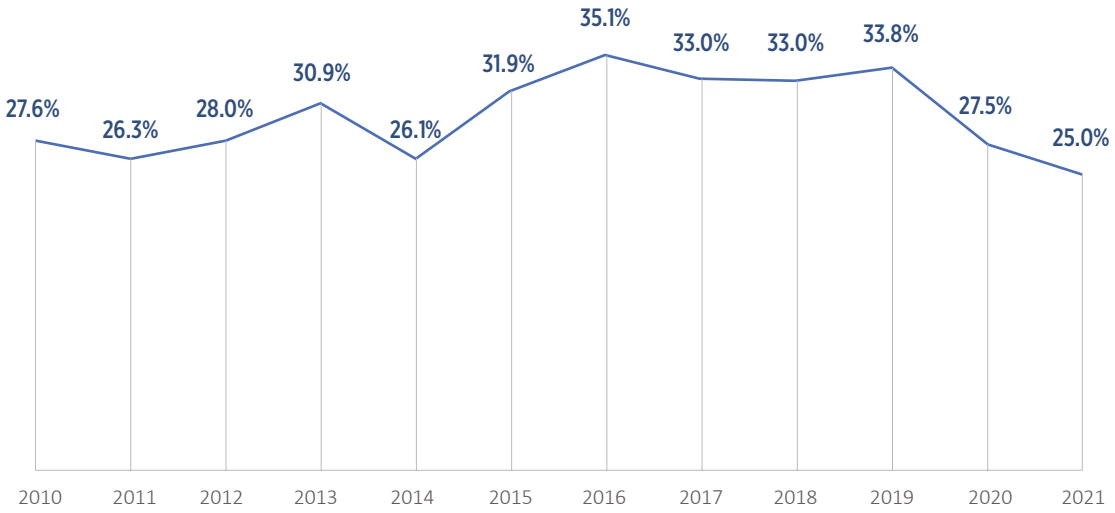


Source: Preliminary figures calculated by national experts.

OOP expenditure in Kazakhstan

Between 2010 and 2016, OOP payments, as a percentage of CHE, fluctuated between 25% and 35%, decreasing thereafter to 25% in 2021 (Fig. 6). This decline may be attributed in part to the revised SGBP of health services, enacted in 2019, and the Health Insurance Fund package introduced in 2020, both of which aimed to reduce OOP payments by expanding service coverage *(4)*.

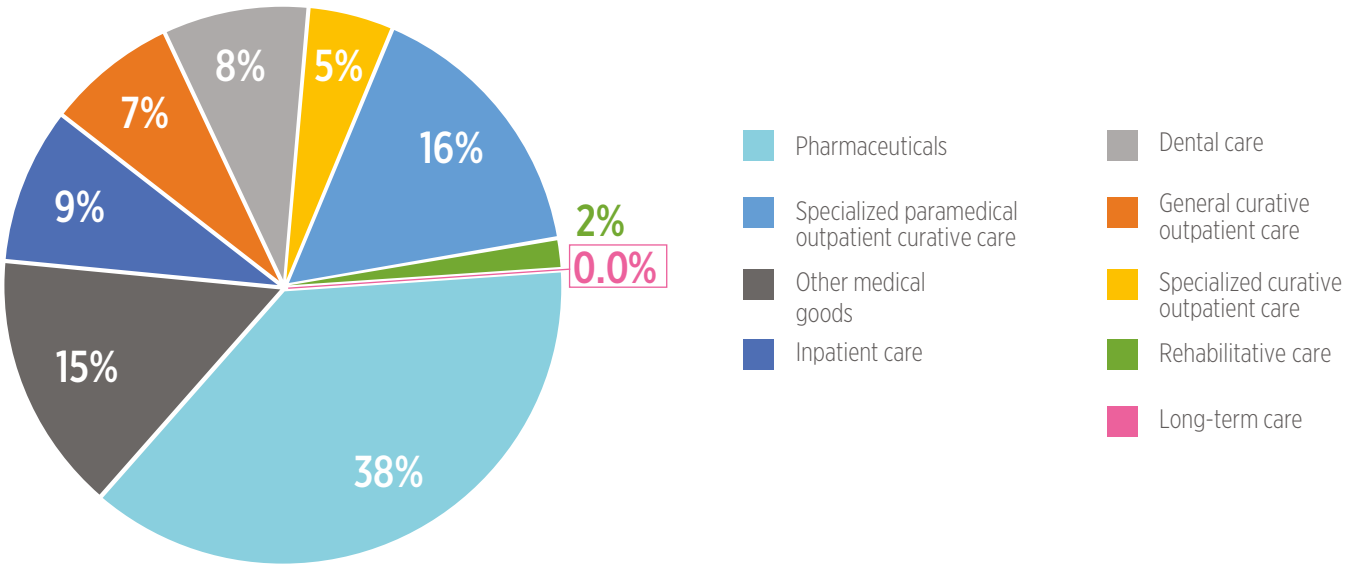
Fig. 6. OOP expenditure as a percentage of CHE, Kazakhstan, 2010–2021



Source: Health Accounts Study for 2021, Ministry of Health of the Republic of Kazakhstan *(4)*.

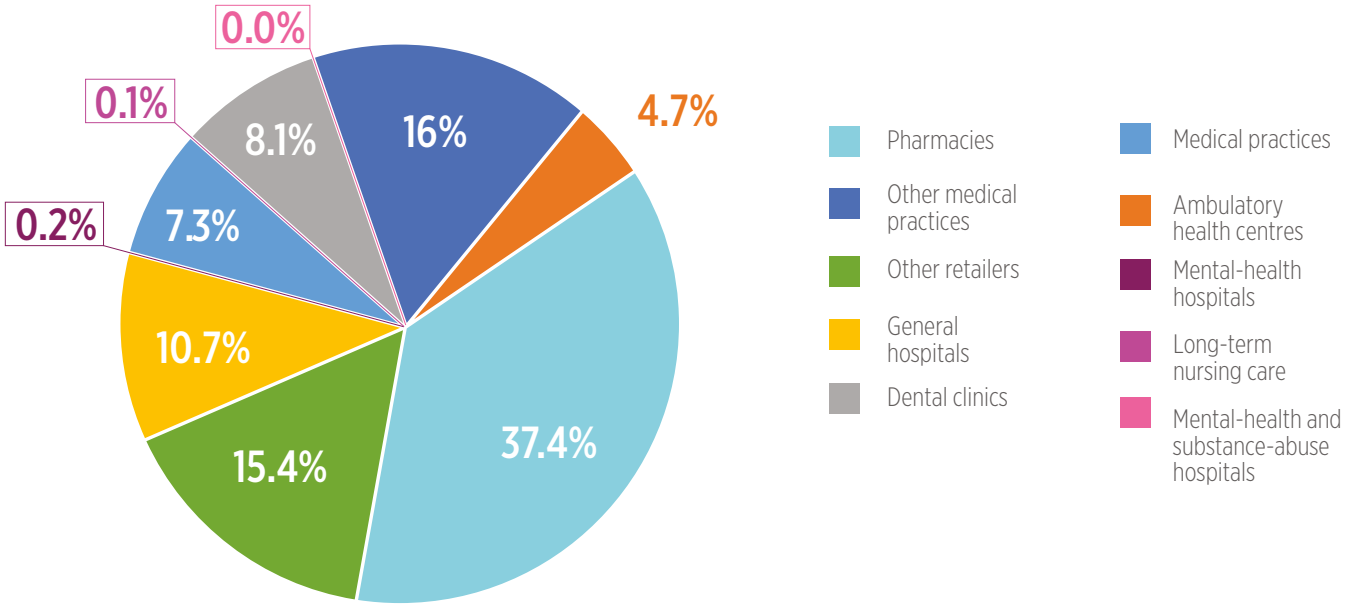
Most OOP payments are for medicines, medical products and outpatient services *(4)*. For example, in 2021, pharmaceuticals alone accounted for more than onethird of household OOP expenditure (Fig. 7). In the same year, pharmacies and retailers accounted for half of the overall OOP expenditure (Fig. 8).

Fig. 7. OOP expenditure by health-care function/consumption, Kazakhstan, 2021



Source: Health Accounts Study for 2021, Ministry of Health of the Republic of Kazakhstan *(4)*.

Fig. 8. OOP expenditure, by provider, Kazakhstan, 2021



Source: Health Accounts Study for 2021, Ministry of Health of the Republic of Kazakhstan *(4)*.

Summary of findings and recommendations, by assessment area

Based on the HPFM guidelines, the findings described in Tables 1–7 summarize the key recommendations on supporting progress towards UHC in Kazakhstan in seven assessment areas. These evidence-based recommendations draw from an extensive WHO review tailored to the context of Kazakhstan. They outline effective strategies for health-financing reform that have proven successful in other countries pursuing UHC goals.

Proposed policy shifts should be thoroughly discussed through ongoing dialogue.

Table 1. Summary of HFPM's findings and recommendations, by assessment area

Assessment area	Summary findings	Status
Health-financing policy process and governance	**Kazakhstan is committed to advancing towards UHC through various strategic initiatives and policy frameworks.** Key initiatives include: the national project, "Healthy nation for 2021–2025"; the "Health-care development concept of the Republic of Kazakhstan by 2026"; and the Ministry of Health's Development Plan for 2023–2027. These efforts focus on promoting evidence-based policy-making, using a health-in-all-policies approach, and building health-worker capacity in crucial areas, such as maternal and child health, HIV, tuberculosis, One Health and antimicrobial resistance. **The «Health-care Development Concept of the Republic of Kazakhstan by 2026» initiative and the Ministry of Health's Development Plan outline specific goals.** These include improving access to medical services, increasing social-health-insurance coverage of the population to 90% by 2026, and increasing government health expenditure to 5% of the gross domestic product (GDP) by 2027. Governance is centred on rigorous budget management. The Ministry of Health oversees the SHIF and ensures transparency in resource distribution. **Despite these initiatives, Kazakhstan's health-financing policies have several weaknesses:** • they focus narrowly on financing medical services without addressing their broader impact on people's lives or on improving the system; • their goals are vague and not specific to health financing, they are unsuitable as national policy objectives, and they fail to take the fair distribution of financial burdens into consideration; • they lack foundation based on recent performance assessments or analyses of health-financing challenges, and do not propose potential solutions; • the role of subnational governments in health-care financing, particularly concerning the SGBP and its reporting mechanisms, is unclear. **To address these weaknesses, it is recommended that Kazakhstan develop an explicit health-financing strategy with clearly defined health-system objectives and realistic milestones, linking operational results with desired outcomes.** Regular health-system-performance assessments would further help to monitor progress and ensure accountability.	**Progressing**

Table 1. contd

Assessment area	Summary findings	Status
Revenue raising	Kazakhstan finances its health-care system primarily through tax-based government budgets and mandatory insurance contributions from employers and employees. An insurance-based component was introduced in 2020 with the aim of increasing coverage and reducing informal and OOP payments. This significantly boosted health-care funding from 1 trillion tenge in 2019 to 2.6 trillion tenge by the end of 2023. The distribution of the budget between the Social Health Insurance Package and the SGBP was 1024 trillion tenge and 1565 trillion tenge, respectively. Despite these changes, the advantages of a publicly financed system and a structured budgetary process, the levels of funding allocated for health are consistently below those requested by the Ministry of Health. Contributory rates to the Mandatory Social Health Insurance scheme (MSHI) remain low with the state contributing 1.9%, employers 3% and employees 2%; approximately 3.6 million individuals remain uninsured. Currently, there are no policies mandating a minimum level of public expenditure. **It is recommended that Kazakhstan:** • increase public financing for health care to align budget allocations with the costs of the benefits packages and reduce the high reliance on private expenditure; • maintain free health care at the point of use and explore alternative public financing methods to ensure system sustainability as user charges would increase financial hardship and reduce access for those unable to pay; • clearly define excise taxes on harmful products, regularly evaluate their impact on health behaviours, model the potential effects of different tax levels on these behaviours and the revenues they generate, and create a plan to raise public awareness.	**Progressing** 
Pooling revenue	**Public funds are divided across two large risk pools: the SGBP and the MSHI scheme, both administered by the SHIF.** While these pools facilitate the distribution of funds across oblasts and health-care providers, they impose limits on reimbursement once service-volume thresholds are reached. The lack of cross-subsidization between these pools potentially affects health-service efficiency and equity, particularly if individuals at higher risk are concentrated predominantly under the SGBP. In addition, subnational-government pools and voluntary health-insurance (VHI) pools are fragmented, though their revenues are negligible compared to the national government pools. It is recommended that Kazakhstan adopt more flexible arrangements for the management of public health funds. In addition, consideration should be given to pooling resources in a single fund or creating mechanisms for cross-subsidization among existing pools to enhance efficiency and equity in health-service delivery.	**Established** 

Table 1. contd

Assessment area	Summary findings	Status
Purchasing health services	**The SHIF is responsible for all aspects of purchasing, which includes contracting providers, determining service volumes and setting prices.** The Fund uses a variety of provider-reimbursement mechanisms, based on the type of care provided, population needs and service costs, to encourage optimal service delivery. However, the impact of these payment methods on health-service utilization has not been assessed systematically; therefore, it is unclear if the prices paid for services accurately reflect provider costs. Private providers contracted by the SHIF offer publicly funded health services in primary care and hospitals, potentially encouraging competition, particularly in urban or densely populated areas *(5)*. To arrive at better-informed decisions regarding the purchase of health services (the choice of providers, what/how much to purchase, and how much to pay), it is recommended that the SHIF gather information related to the quality of care. This would support contracting, payment adjustments and provider-related monitoring. Conducting needs assessments could also contribute to planning and help justify an increase in health-system funding.	Established 
Benefits and entitlements	**All permanent residents in Kazakhstan are eligible for essential health services through the SGBP.** In addition, approximately 83% of the residents are covered under the MSHI scheme, which includes health services and medications not covered by the SGBP. The specific entitlements and services that apply under both schemes are detailed in the Government's code, «On the public health and health-care system». Despite the provision of services under both schemes without formal user charges, there is a perceived lack of awareness among the population regarding their entitlements and the distinctions between the two schemes. It is suspected that informal payments are high. The Ministry of Health oversees the design of benefit packages for both schemes, involving stakeholders, such as the Joint Commission on Healthcare Quality, the Formulary Committee and the National Scientific Centre for Health Development. The last-mentioned conducts health-technology assessments *(6)*. However, the rationale for shifting certain benefits from the SGBP to the MSHI scheme lacks clarity and transparency. Furthermore, the patient's eligibility to receive certain highly demanded services is dependent on whether the individual falls under specific disease categories, making it difficult for the population to understand whether they qualify for benefits. Despite various informational efforts, public awareness of what is covered under the MSHI scheme remains relatively low. It is recommended that Kazakhstan continue its commitment to using evidence-based and transparent approaches in developing health-benefit packages. In addition, maintaining free health care at the point of use should remain a priority to ensure equitable access for all residents.	Established 

Table 1. contd

Assessment area	Summary findings	Status
Public financial management	Budget administrators allocate budgets and disburse funds directly to selected health-care providers, regardless of ownership status. The providers use these funds to cover costs and fulfil contractual obligations, including reporting. **Nevertheless, the following operational challenges threaten the sustainability of the system:** • unilaterally set service tariffs, which are often adjusted to match reduced budget allocations, undermining their ability to adequately cover costs even when initially calculated for cost recovery; • poor links between sectoral priorities/policy objectives and budget programmes due to vague policy statements; • lack of clear fiscal parameters in national financial policies, which are necessary to mobilize resources effectively towards achieving national health-policy objectives. It is recommended that Kazakhstan consider introducing more flexible arrangements for the financial management of health funds. At the same time, there should be an assurance that any additional funding would be used effectively. This would require regular, publicly available financial and performance monitoring to hold health-system actors accountable.	**Established** 
Public health functions and programmes	The "Health-care development concept of the Republic of Kazakhstan by 2026" outlines the vision of and programmes for enhancing HIV-prevention services, medical aviation, mental-health services, orphan-disease care, transplantation services, sanitary and epidemiological well-being, the introduction of new vaccines, the promotion of healthy lifestyle and the prevention of NCDs. Funding for these and other public health functions and programmes is reflected in specific budget allocations. For example, in connection with the prevention and treatment of HIV, the AIDS Center (a national agency) is contracted by the SHIF to oversee preventive, curative and social-support interventions. This center manages the national AIDS programme, including the distribution of funds to other contracted service providers. Thus, while funding remains centralized at the national level, national agencies coordinate implementation, integrating the various types of preventive intervention conducted by health-care providers and other public health bodies.	**Advanced** 

Findings and recommendations, by desirable attributes of health financing

Table 2. Findings and recommendations on policy process and governance (GV)

Desirable attribute GV1	**Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services**
Key areas of strength and weakness in Kazakhstan	**Strengths** Moving towards UHC is a high priority for Kazakhstan as highlighted in various national strategy documents and reflected by several initiatives. These include: promoting evidence-based policy-making; adopting a health-in-all-policies approach; building health-worker capacity in areas, such as, mother, child and adolescent health; HIV prevention and care; the prevention and control of tuberculosis; One Health; and antimicrobial resistance *(5)*. **The Government of Kazakhstan approved the "Health-care development concept of the Republic of Kazakhstan by 2026" in connection national health-related strategies and action towards achieving the SDGs. Key health-financing goals under "Direction 7. Improving the financing of medical care" include:** • improving access to medical services; • enhancing the effectiveness of the MSHI; and • strengthening the SHIF. The Ministry of Health's Development Plan for 2023–2027 aims to increase social-health-insurance coverage to 90% by 2026 and raise health expenditure to 5% of the GDP by 2027, thus supporting UHC goals. **Weaknesses** These high-level health-financing policies fail to address the fair distribution of financial burden as a desired outcome of health-system financing. Their primary weakness is their narrow focus on funding medical services without regard to their impact on people's lives or the wider health system. Of the three goals mentioned above, only one refers specifically to health financing, one aims vaguely to improve the effectiveness of the MSHI, while the third may in itself not necessarily be appropriate as a national policy objective. Furthermore, there is no evidence that the policy statements related to these three goals were based on recent performance assessments.
Recommended policy directions	It is recommended that an explicit health-financing strategy be developed, clearly showing the vision for the health system, including objectives and realistic milestones, and linking operational results with desired outcomes.

Table 2. contd

Desirable attribute GV2	**There is transparent, financial and non-financial accountability, in relation to public spending on health**
Key areas of strength and weakness in Kazakhstan	**Strengths** The Ministry of Health and local-government executive bodies administer budget programmes according to public financial-management rules. The Ministry of Health, as the sole shareholder of the SHIF, makes the key decisions, which includes electing the Board of Directors. The Ministry also regulates the functions and responsibilities of the SHIF. Commissions within the SHIF, including representatives of local executive bodies, political parties, and nongovernmental organizations (NGOs), oversee the distribution of services to health-care providers, based on strict criteria. **Weaknesses** The role of subnational governments in financing health care, particularly in relation to the SGBP and its reporting mechanisms, requires more clarity. Further efforts are needed to ensure full transparency and accountability in public spending.
Recommended policy directions	To further enhance accountability in financial flows and the purchasing of services and goods, the following actions are recommended in addition to the SHIF's ongoing practice of publishing annual reports on corporate governance: • develop standard reporting procedures, including mechanisms for collecting feedback from end-users; • mandate the SHIF to prepare and publish additional operational and financial reports; • introduce regular public financial-management assessments to inform future budgeting reforms.
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**
Key areas of strength and weakness in Kazakhstan	**Strengths** Health-financing information is used to monitor, evaluate and improve policy development and implementation. Regularly measured indicators include CHE as a percentage of GDP, and the MSHI scheme enrolment rate. Budget administrators and financial agents conduct measurements at the operational level and the SHIF analyses the information (financial and non-financial) deriving from the contracted health-care providers and makes proposals for improvement. The Ministry of Health also requires financial reports from the SHIF for monitoring purposes. More comprehensive evaluation studies are conducted every three to five years, supported by the development partners. These include projects with the World Bank and reviews by the Insert Organization for Economic Co-operation and Development (OECD). **Weaknesses** There is no documented practice of regularly monitoring health-financing performance or using evidence in policy-making. Although some studies on health expenditure provide data on OOP spending and CHE as a percentage of GDP, none have been regular and in-depth enough to identify the problems and their root causes. In addition, there is no established practice of integrating evidence from demographics, medical statistics and financing to allow a comprehensive assessment of progress toward UHC goals, such as financial protection.

Table 2. contd

Desirable attribute GV3	There is transparent, financial and non-financial accountability, in relation to public spending on health
Recommended policy directions	**Establish health-financing objectives, which outline desired outcomes, such as improved population health and a fairer distribution of the financial burden, and propose specific indicators to assess progress.** **Institutionalize evidence generation by:** • tracking health expenditure, using the System of Health Accounts 2011 framework *(4)*; • conducting health-expenditure and utilization studies, including household surveys; • regularly analysing gaps in health financing and access to services, unmet needs, and the impact of policies on the financial protection of the population; • engaging in applied research towards maintaining an updated repository of best practice in evidence-based decision-making related to health-financing policy. Establish a knowledge-translation mechanism by engaging key national stakeholders and researchers in the development of policy briefs and conduct regular policy dialogue.

Table 3. Findings and recommendations on revenue raising (RR)

Desirable attribute RR1	**Health expenditure is based predominantly on public/compulsory funding sources**
Key areas of strength and weakness in Kazakhstan	**Strengths** Government health-care schemes are publicly financed by two main sources of revenue: the government budget and social contributions made by employers and employees. According to national health accounts data, the Government funds the SGBP fully. In 2021, the government budget covered 49% of the MSHI scheme's expenditure, the rest being funded by employment-related social contributions. Overall, in the same year, social contributions accounted for around one quarter of health expenditure across both governmental health-care schemes. The remaining funds came from the central budget, excluding local-government transfers for extended SGBP coverage, which local authorities have the option to finance from their respective local budgets. **Weaknesses** Funding from the government budget is the main source of financing government health-care schemes because revenues from social contributions are insufficient. Nevertheless, this funding from the government budget is lower than required, particularly for those who do not contribute to the MSHI scheme, such as retirees and children. In addition, while the policy of the "Health Care Development Concept of the Republic of Kazakhstan by 2026" acknowledges the importance of public funding for health care, it lacks clear targets. For example, it suggests increasing CHE to 5% of the GDP without specifying the role of public funding. It does not clarify whether alternative revenue sources, such as taxes on harmful products, should be considered for the health sector. **Recommended policy direction** • Increase public financing for health, and prioritize health in the government budget to create a closer alignment with practice in other upper-middle-income countries in Europe. • Use general tax revenues to offset low levels of social contributions.
Desirable attribute RR2	**The level of public (and external) funding is predictable over a period of years**
Key areas of strength and weakness in Kazakhstan	**Strengths** Public funding for health is somewhat predictable due to a structured budgetary process and law, according to which budgets are planned, based on socioeconomic-development forecasts, previous expenditure and budget-monitoring results. Both national and regional budgets are drawn up annually, the national budget being prepared by the Ministry of Finance and regional budgets by the local authorities for a planned period of three years. The same applies to social-health-insurance contributions, which are projected based on employment rates and average wage increases. **Weaknesses** Budget allocations to the health sector, though based on macroeconomic conditions and relatively predictable, are consistently 10%–15% below the levels requested by the Ministry of Health for the SGBP. Funding from subnational budgets is less predictable compared to central-level funding. **Recommended policy direction** • Address sustainability challenges by increasing the level of public financing for health and ensuring its predictability over a set period of years.

Table 3. contd

Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in Kazakhstan	**Strengths** The execution rate of the state health budget is high, and there are no delays in transferring funds to the budget administrators and from the budget administrators to the health-care- service providers. **Weaknesses** No notable weaknesses. **Recommended policy direction** • Budget execution should be monitored through regular public financial-management assessments (see also recommendation under "Desirable attribute GV2").
Desirable attribute RR4	
Key areas of strength and weakness in Kazakhstan	**Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms** **Strengths** Taxes are imposed on strong alcohol, beer, cigarettes and tobacco to discourage their consumption. In addition, the "Health Care Development Concept of the Republic of Kazakhstan by 2026", which emphasizes the promotion of healthy lifestyle and the development of a healthy environment, plans to introduce and gradually increase excise duties on sugar-sweetened beverages by 2025. For companies, the Government subsidizes fossil fuels significantly, although this is primarily aimed at supporting energy prices rather than directly affecting health behaviours. **Weaknesses** There is no explicit policy that includes fiscal measures aiming to reduce detrimental health behaviours and covers all aspects of potential interventions. Also, there is insufficient evidence showing that existing measures promote healthier behaviours, and that low excise-duty rates are unlikely to be effective, change behaviours or raise substantial revenues. Harmful subsidies for fossil-fuel extraction and consumption persist. **Recommended policy direction** • Clearly define excise taxes on harmful products in health-financing policy and regularly evaluate their impact on health-related behaviours, using models to assess the potential effects of various taxation levels (both on behaviours and tax revenues). • Create a plan to raise public awareness about these taxes and their intended health benefits.

Table 4. Findings and recommendations on pooling revenues (PR)

Desirable attribute PR1	**Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds**
Key areas of strength and weakness in Kazakhstan	**Strengths** Public funds are accumulated and distributed within each government health-care scheme (the SGBP and the MSHI). Local governments also accumulate funds for the SGBP in their budgets. Efforts to mitigate the impact of fragmented funding streams by reallocating funds between the SGBP and the MSHI are underway to enhance patient experience. **Weaknesses** While both funding schemes are administered by the SHIF, there is no subsidization across pools. This set-up makes it difficult for providers to meet the demand for the medical services and the goods covered by each scheme. For instance, if a provider exhausts its monthly service-volume limit under the MSHI scheme, insured individuals must either find another provider or wait until the following month, even if the original provider has funding available under the SGBP scheme. This has consequences for equity and efficiency.
	Recommended policy direction • Gather the resources in a single pool or create mechanisms to allow subsidization across pools.
Desirable attribute PR2	**Health-system and financing functions are integrated or coordinated across schemes and programmes**
Key areas of strength and weakness in Kazakhstan	**Strengths** Pooling revenues under the administration of a single financial agent (the SHIF) ensures consistency across both schemes. This includes the same application of pooling rules, such as reimbursement mechanisms, tariff structures and procedures for health-care-provider selection and contract administration. **Weaknesses** Public funds at the level of subnational government remain fragmented, which leads to weak coordination with the SGBP scheme. **Recommended policy direction** • Proceed with implementation of the policy on combining financial pools when purchasing health services under the two major schemes.

Table 5. Findings and recommendations on purchasing health services (PS)

Desirable attribute PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
Key areas of strength and weakness in Kazakhstan	**Strengths** Kazakhstan has enhanced health-system efficiency by allocating more funds to primary care and introducing incentives that encourage a shift from inpatient care to day and ambulatory care. In 2020, 52.4% of the health expenditure was dedicated to primary care, outpatient specialized care and outpatient medicines with plans to increase coverage of these areas to 60% by 2025 *(5)*. The SHIF draws up contracts for provider services based on estimated health-care needs and pre-determined service requirements. A quality-of-care component takes the following into consideration: experience in service provision; the quality and volume of medical services provided under previous or existing contracts; the absence of substantiated complaints; and accreditation level. **Weaknesses** When demand exceeds planned service volumes:, services are either postponed or redirected to another facility with available capacity. The SHIF collects health-service data, but fragmented databases and interoperability issues hinder comprehensive analyses. There is a lack of evidence of the effectiveness of quality measures for selecting services and monitoring performance, especially in areas with no provider competition. **Recommended policy direction** • Improve the setting of tariff on goods and services by: - keeping technical pricing and political budget negotiations separate; - introducing a simple, transparent mechanism for adjusting tariffs, based on health-care market inflation and service volumes required; - switching to negotiations with market actors to enhance quality and price-based competition. • Enhance resource allocation by: - reconsidering methods of estimating unmet needs and required service volumes; - mitigating the effects of monopoly on non-competitive settings through bundled procurement or antimonopoly policies.

Table 5. contd

Desirable attribute PS2	Purchasing arrangements are tailored in support of service delivery objectives
Key areas of strength and weakness in Kazakhstan	**Strengths** The SHIF's reimbursement mechanisms vary across different types and levels of care. • Per capita is used for ambulance (emergency) care, PHC (combined with performance-based incentives), and – in rural areas –specialized outpatient, day and inpatient care. • Fee for service is used for specialized outpatient care (except in rural areas), including mobile/outreach medical teams/services. • Case-based payment per DRG is predominantly used for inpatient, day and emergency care (without admission). • Surgery and other medical interventions for specific health conditions are reimbursed, based on actual cost. • Aggregated (block) tariffs are used per treatment course for children with onco-hematological diseases. • Complex tariffs are used to reimburse health-care providers per patient with HIV or mental-health disorders (on an annual basis). • Tariffs are adjusted, taking demographic, geographic and ecological factors into consideration, whenever applicable. **Weaknesses** With respect to the DRGs, challenges remain in improving cost-accounting systems and accurately measuring clinical-activity-related resource utilization. There is no documented evidence that the current purchasing arrangements consistently promote quality of care, despite taking past performance into consideration and using financial disincentives for low-quality services. **Recommended policy direction** • Expand the routine collection of quality-related data in provider databases to analyse practice patterns and provide feedback to providers. • Develop methodology and standard procedures for SHIF to adjust reimbursements based on overall quality of care. • Assess and revise the impact of punitive damages in contract management regarding reporting practices and service quality.

Table 5. contd

Desirable attribute PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Key areas of strength and weakness in Kazakhstan	**Strengths** Monthly service volume ceilings for health-care providers prevent budget overspending and the accumulation of debt. These limits are reinforced by accountability mechanisms that monitor the actions of providers, financial agents, and budget administrators to maintain financial control. The SHIF applies a linear payment scale to enforce these limits. For specialized outpatient services, providers receive no payment for volumes exceeding 105% of the monthly cap. For inpatient and outpatient care, volumes beyond this threshold are reimbursed at only 50% of the standard rate. **Weaknesses** There is no consolidated evidence about budgetary control at the subnational level. **Recommended policy direction** • Regularly publish consolidated procurement reports to enhance transparency and support regions and health-care providers in understanding procurement decisions and payment practice. • Assess how monthly service-volume ceilings affect health-care provider performance and responsiveness.

Table 6. Findings and recommendations on benefits and entitlements (BR)

Desirable attribute BR1	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in Kazakhstan	**Strengths** Entitlements are categorized in the code "On Public Health and Healthcare System," with detailed lists specifying the services and diagnoses that are covered. Information about MSHI benefits can be accessed through a contact centre or local SHIF branches. The Ministry of Health and the SHIF conduct regular awareness campaigns on state-covered benefits; in 2021, these reached over 330 000 people. **Weaknesses** Understanding the distinctions between benefits offered by the SGBP and MSHI schemes is challenging, as both cover advisory and diagnostic services, day and inpatient care, and prescription drugs. Despite efforts, a sociological study revealed that awareness of the MSHI is low, with significant gaps in understanding the services provided under both schemes. Efforts to clarify and promote awareness of these health benefits remain insufficient. **Recommended policy direction** • Enhance public awareness of entitlements by: - establishing clear criteria distinguishing SGBP and MSHI coverage, and explaining usage; - customizing communication for retirees, children, those with chronic conditions, and low-income households. • Launch a web-based platform related to state-covered services to: - help users find nearby providers and assist with referrals; - verify provider participation and the availability of free interventions.

Table 6. contd

Desirable attribute BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
Key areas of strength and weakness in Kazakhstan	**Strengths** The Ministry of Health oversees the design of benefit packages for both schemes, involving various stakeholders, such as the JHCQ, the Formulary Committee and the National Scientific Centre for Health Development. The last-mentioned conducts health-technology assessments to determine priority health services. **The SGBP includes:** emergency care and transport; primary care; specialist outpatient care for acute conditions, TB, HIV, and noncommunicable and contagious diseases; day care for specific diseases; inpatient care for contagious and designated diseases; and rehabilitation and palliative care *(5)*. The MSHI package covers specialist outpatient care, day care, and inpatient care for a wider range of diseases and conditions *(5)*. **Weaknesses** The rationale for moving certain service benefits to the MSHI is not clear and is not publicly available. **Recommended policy direction** • Enhance the transparency of modifications to the SGBP by: - developing a clear methodological framework for reviewing proposals to amend entitlements; - engaging representatives of professional associations, think tanks, NGOs, and market players (including patient organizations) during the proposal-review stage; - communicating decisions to the public. • Adopt a unified health-benefit package, based on residency, to provide clarity and understanding of the benefits covered.

Table 6. contd

Desirable attribute BR3	**Prior to adoption, service-benefit changes are subject to cost–effectiveness and budgetary impact assessments**
Key areas of strength and weakness in Kazakhstan	**Strengths** The Ministry of Health oversees legislative revisions of benefits included in both schemes. The Joint Commission on Healthcare Quality recommends changes to benefits packages based on health technology assessments conducted by the National Scientific Centre for Health Development and other research organizations. **Weaknesses** Criteria for selecting or revising interventions are unclear, except for high-tech medical services, which are chosen based on innovation, resource intensity and uniqueness. There is inconsistency in the application of cost-effectiveness or cost-benefit analyses in decisions regarding services covered by the benefits packages. **Recommended policy direction** • Include cost-effectiveness analysis in the decision-making process and mandate its use for interventions above a certain financial threshold. • Delegate the responsibility for establishing these thresholds to the Ministry of Health. • Require health technology assessments to inform revisions of the specific services covered by the SGBP and the MSHI.
Desirable attribute BR4	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in Kazakhstan	**Strengths** The SGBP and MSHI schemes aim to provide realistic levels of free medical care within the budgetary constraints set by the Ministry of Finance. Defined benefits are aligned with available services and reimbursement mechanisms. **Weaknesses** Budget allocations often fall short of the Ministry of Health's requests by 10% to 15%, limiting the financing of required services. Despite efforts to match service volumes with population needs, tariffs have been adjusted to meet budgetary constraints, impacting reimbursements to health-care providers. **Recommended policy direction** • Increase the level of public financing for health.
Desirable attribute BR5	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in Kazakhstan	**Strengths** There are no user changes for the services and goods covered by the SGBP and MSHI schemes. This policy minimizes the financial burden on households using the services and ensures access to care for those unable to afford payment. **Recommended policy direction** • Maintain free health care at the point of use and explicitly justify the rational for avoiding user charges in health policy.

Table 7. Findings and recommendations on public financial management (PF)

Desirable attribute PF1	**Health budget formulation and structure support flexible spending and are aligned with sector priorities**
Key areas of strength and weakness in Kazakhstan	**Strengths** The SGBP budgeting process aims to ensure "a guaranteed volume of free medical care" at all levels and proposes 14 outcome indicators. **Weaknesses** There is no clear link between the outcomes of budget programmes managed by the Ministry of Finance and broader sectoral objectives. The potential for budget programmes to align resource allocations with sectoral priorities and policy objectives remains underutilized. This often results in sectoral budgets being set below the amount necessary to achieve policy targets. Governance practice prevents the Ministry of Health from adjusting the ceiling of the sectoral budget set by the Ministry of Finance. As a result, public health spending is determined more by the priorities of the Ministry of Finance than by the actual resource needs of the health sector. **Recommended policy direction** • Consider introducing more flexible arrangements for the management of health funds to ensure that any additional funding comes with assurances that will be used effectively. This requires regular and publicly available financial and performance monitoring to hold health-system actors accountable.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in Kazakhstan	**Strengths** Contracted health-care providers receive direct payment, based on the terms defined in their contracts with the SHIF. They have the flexibility to manage funds as needed, provided they meet service-volume and quality commitments. Providers report to the SHIF as required by their contracts and submit financial and non-financial (statistical) reports to their respective national authorities. **Weaknesses** No notable weaknesses. **Recommended policy direction** No specific recommendations.

Stage 1 assessment

Health-coverage schemes and health-financing arrangements in Kazakhstan

The health coverage schemes included in Stage 1 were selected according to the criteria outlined in the HFPM Country Assessment Guide. The aim is not to conduct an inventory, but rather to describe the main health schemes and programmes, which make up the health system around which health financing and other policies are made, and through which money flows to health facilities. The objective of Table 8 is to provide a detailed description of the policies within each scheme, highlight the relative financial weight of each, and identify the extent of any structural fragmentation within the health system.

Table 8. Health-coverage schemes and health-financing arrangements in Kazakhstan

Key design feature	SGBP	MSHI	Voluntary health insurance
(a) Focus of the scheme	**Citizens have the right to receive a guaranteed volume of medical services free of charge, as stated in the Constitution of the Republic of Kazakhstan (Article 29, paragraph 2).** The SGBP offers essential medical services to citizens of Kazakhsan and the following categories of people living in the country: • Kandas – repatriated ethnic Kazakhs awaiting citizenship, a status that is granted for a year and can be extended by six months; it is revoked once citizenship has been granted; • refugees; • foreigners and stateless individuals with permanent residence permits. **The scheme also provides the following population groups with a limited range of services for socially dangerous diseases:** • foreigners and people without citizenship but with temporary residence permits; • people seeking asylum.	**All permanent residents are required to enroll in the MSHI scheme, which offers key medical (health) services not covered by the SGBP.** In addition, the Eurasian Economic Union (EAEU) Treaty mandates that migrant workers and from Armenia, Belarus, Kyrgyzstan and the Russian Federation and their family members enroll in the MSHI scheme.	**The voluntary health insurance (VHI) scheme primarily covers:** • employees of certain (mostly international) companies, which include VHI in their benefits package; • citizens and residents with high incomes. VHI is complementary for these groups. Insurance companies market a standard product to groups with temporary residence status, such as migrant workers, entrepreneurs, foreign students and those reuniting with family. For these groups, the VHI serves as a substitute for the SGBP.

Table 8. contd

Key design feature	SGBP	MSHI	Voluntary health insurance
(b) Target population	**Permanent residents (no.):** • Citizens (19 844 116 as of 1 August 2023) *(7)*; • Refugees (291); • Kandas (17 700 arrived in 2019; 14 000 arrived in 2021). **Temporary residents (no.):** • asylum seekers (862); • foreigners (650 000 persons).	**Permanent residents (no.):** • Citizens (19 844 116 as of 1 August 2023) *(7)*; • Kandas: 17 000 arrived in 2019; 14 000 arrived in 2021; • Migrant workers from EAEU countries and their family members (the exact size of this population group is not published; however, as of 2022, 75 251 migrant workers from EAEU countries were registered in Kazakhstan).	**Information regarding the number of immigrants eligible for the standard VHI-coverage package is not available.**
(c) Population covered	It is presumed that the entire target population is covered. However, there is no regular administrative reporting on the number of individuals who have received at least one service under the SGBP scheme.	Coverage varies based on labour-market trends and the seasonality of certain labour categories. As of 1 May 2023, approximately 83% of the target population (16.4 million individuals) were covered.	**In 2022, 1 255 135 individuals held VHI policies:** • 665 094 individuals paid their premiums themselves; • 78 813 legal entities purchased insurance plans/ packages to cover their 590 041 employees.
(d) Basis for entitlement/ coverage	Permanent residencey permit.	Contributions to the MSHI.	**Insurance policy.**
(e) Benefit entitlements	**The population is entitled to the following benefits:** • ambulance (emergency) services; • PHC; • planned outpatient and inpatient care for socially important/dangerous diseases; • medical goods (prescribed medicines and medical appliances) for 59 groups of disease; • rehabilitative care for patients with tuberculosis; • palliative care; • urgent inpatient care (for the uninsured); • mobile brigades/home care (for the uninsured).	Specialized outpatient care, inpatient care, high-tech medical interventions and rehabilitation are primarily covered under the MSHI. **Services covered in the MSHI package include:** • specialist outpatient care and selective inpatient care not covered by the SGBP; • emergency inpatient care; • home visits by mobile teams; • prescribed medicines and medical appliances for 72 additional disease groups beyond those included in the SGBP; • dental care for children and pregnant women; • urgent dental care for ten socially vulnerable groups (such as people with disabilities, children and recipients of targeted social assistance); • medical rehabilitation (excluding patients with tuberculosis who are covered by the SGBP).	**VHI coverage for permanent residents varies by policy, but typically includes dental care, prescribed medicines and reduced waiting times.** Minimum requirements for insurance products apply to immigrants. This includes PHC and specialized emergency inpatient care, which allows immigrants access to services provided under the MSHI. For instance, the MSHI covers specialized outpatient care on referral by a PHC doctor. Access to a PHC doctor can be through either the SGBP or the VHI insurance product designed for immigrants.

Table 8. contd

Key design feature	SGBP	MSHI	Voluntary health insurance
(e) Benefit entitlements	**PHC includes:** • diagnosis, treatment and management of the most prevalent diseases; • preventive check-ups of target groups; • early detection and management of risks; • vaccination; • promotion of healthy lifestyle; • reproductive health services; • perinatal care; • response to outbreaks of infectious disease. Local authorities have the authority to expand the SGBP for their residents and finance it from the local budget.		
(f) Co-payments (user fees)	Currently no co-payments are required. The introduction of co-payments to cover the difference between reference and selected prescription-medicine market prices has been postponed until 2026.	Currently no co-payments are required. The introduction of co-payments to cover the difference between reference and selected prescription-medicine market prices has been postponed until 2026.	Varies according to the VHI policy in question.
(g) Co-payments (user fees)	**Access to services is limited to contracted health-care providers who have not exceeded the monthly service limits specified in their contracts. Referrals are mandatory for:** a) most specialized outpatient services; b) prescribed medicines and medical appliances; c) elective hospitalizations. Patients must be registered in the electronic register of specialized clinics to receive prescribed medicines for chronic diseases. Elective hospitalization is allowed only for surgical treatment in connection with certain health conditions.	**Access requires verification of enrolment status through the MSHI information system. Services can only be accessed from contracted health-care providers who have not exceeded their monthly service limits as specified in their contracts. Referrals are mandatory for:** (a) most specialized outpatient services; (b) prescribed medicines and medical appliances; (c) elective hospitalization. Patients must be registered in the electronic register of specialized clinics to get prescribed medicines for chronic diseases.	Some VHI plans limit self-referral to services and require that individuals be referred by case managers or authorized assistance services.

Table 8. contd

Key design feature	SGBP	MSHI	Voluntary health insurance
(h Revenue sources	**The SGBP is funded from the general budget. Local authorities have the option to finance additional services under the SGBP from their respective local budgets (Fig. 9).**	**The primary sources of revenue for the MSHI are contributions paid by individuals engaged in formal employment (2% of payroll taxes are paid by employees and 3% by employers).** The state budget covers contributions on behalf of 15 social categories of the population, including children (<18 years old), registered unemployed individuals, those on parental leave, retirees, prisoners, students, mothers with multiple children, economically inactive pregnant women, parents of children under 3 years of age, caregivers of children with disabilities, Kandas, and beneficiaries of targeted social assistance. In addition, the state budget finances MSHI services for military personnel and public-sector employees in the law enforcement sector.	**The primary sources of revenue are premiums; in 2022, these came to a total of 41.6 billion Tenge. However, the state budget subsidizes VHI premiums for permanent residents (individuals or employers/businesses) through tax incentives.**
(i) Pooling	**Funds are consolidated at the central level within the budget administered by the Committee of the Treasury of the Minister of Finance and the SHIF.** Additional funds for expanded services are accumulated at the local level within local budgets and managed by the respective local authorities.	**Revenues are pooled in a special account at the National Bank of the Republic of Kazakhstan, overseen by the SHIF.**	**Insurance companies manage their own pools.**
(j) Governance of health financing	**The Ministry of Health oversees health-care financing policy, which includes the content of the SGBP, establishing provider reimbursement mechanisms, and reviewing and approving service tariffs proposed by the SHIF.** The SHIF, acting as a strategic purchaser, is responsible for selecting health-care providers and determining the volume of services and goods each provider will supply.	**Identical to the arrangements for the SGBP.**	**Insurance carriers govern pools and purchasing activities.**

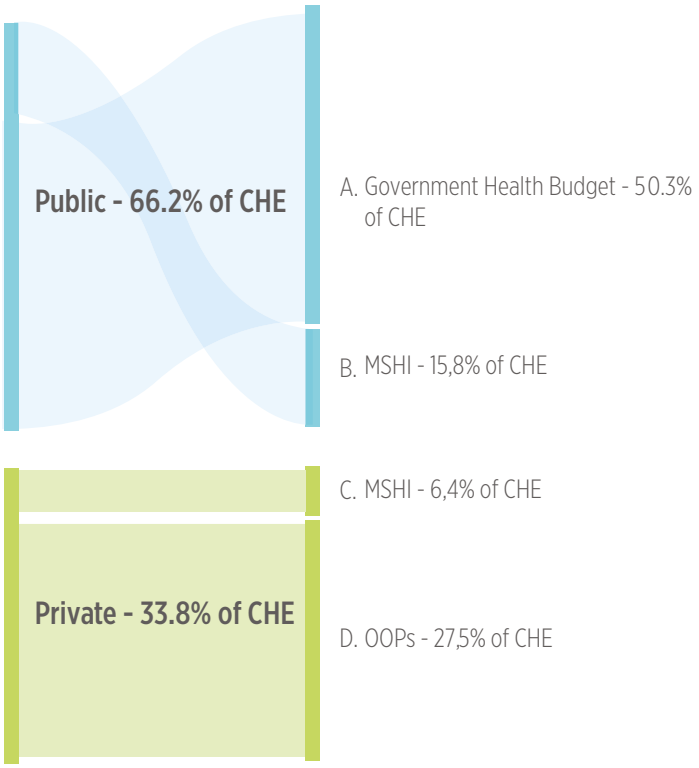
Table 8. contd

Key design feature	SGBP	MSHI	Voluntary health insurance
(k) Provider payment	**Health-care providers are reimbursed on a per-capita basis for the following services:** • ambulance (emergency) care; • primary health care, combined with performance-based incentives; • specialized outpatient, day and inpatient care in rural areas. Fee for service is used for specialized outpatient care (other than in rural areas), including mobile/outreach medical teams/services. Case-based payment per DRG is predominantly used for inpatient, day care, and emergency care (without admission). Surgery and other medical interventions for specific health conditions are reimbursed based on actual costs. Aggregated ("block") tariffs are used per treatment course (scheme) of children with onco-hematological diseases. Complex tariffs are used to reimburse healthcare providers on a per patient (per annum) basis for those with HIV and mental health disorders. Tariffs are adjusted to account for demographic, geographic and ecological factors, whenever applicable.	**Reimbursement methods for health-care providers are similar across MSHI and SGBP services. For MSHI-exclusive services:** • fee for specialized outpatient services (including diagnostics); • mobile teams receive a fixed payment per home visit; • school-based medical care is reimbursed on a per-capita basis for registered pupils. Certain inpatient or day-care cases may be reimbursed based on actual costs or through a combination of DRG payments and recovery of extra costs.	**Insurance companies reimburse health-care providers through various mechanisms.**
(l) Service delivery and contracting	**Health-care providers contracted to deliver services under the SGBP must:** • have a valid license relevant to their medical specialty; • be registered in the health-care-provider database; • undergo selection via a bidding process in public procurement and sign an agreement for service provision. The regional or national commission allocates volumes of medical services based on criteria, such as historical performance, grievances and accreditation category. As of 2023, up to 60% of the contracted providers were private entities. National regulations ensure geographic access to the health-care-provider network.	**Identical with the arrangements for the SGBP.**	**Service contracts with health-care providers vary among insurance companies and providers, which may involve payments through predefined fixed rates or fee-for-service models.** Certain services may only be available from specific providers and require advance notice and authorization from the insurance carrier.

Health expenditure, by Stage 1 coverage scheme

Fig. 9 illustrates the expenditure flows by health insurance scheme.

Fig. 9. Expenditure flows by health-insurance scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

STAGE 1 SCHEMES	PUBLIC	PRIVATE	TOTAL
A. Goverment Heaith Budget	100%		100%
B. MSHI	100%		100%
C. VHI		100%	100%
D. OOPs		100%	100%

HOW ARE REVENUE SOURCES DISTRIBUTED ACROS SCHIEMES/PROGRAMMES?

STAGE 1 SCHEMES	PUBLIC	PRIVATE
A. Goverment Heaith Budget	76%	
B. MSHI	24%	
C. VHI		19%
D. OOPs		81%
TOTAL	100%	100%

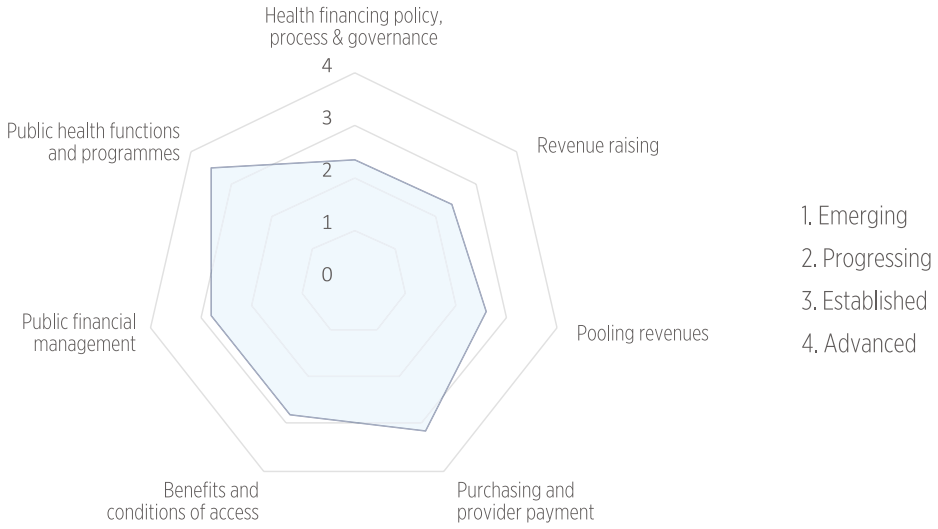
Source: Author estimates based on the breakdown of Health Financing and Financing Schemes from the 2021 Health Accounts (Ministry of Health, Kazakhstan), supplemented with the latest expenditure data for the schemes and programmes identified in Stage 1.

Stage 2 assessment

Summary of ratings by assessment area

Assessment ratings, by assessment area

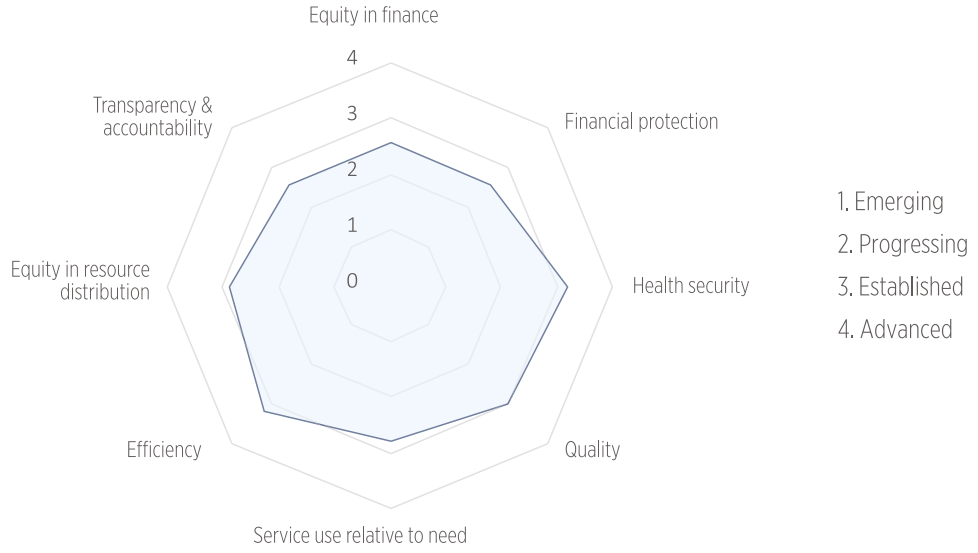
Fig. 10. Average rating, by assessment area (spider diagram)



Source: based on HFPM data collection template v. 2.0, Kazakhstan 2023.

Assessment ratings, by goals and objectives

Fig. 11. Average rating, by goals and objectives (spider diagram)

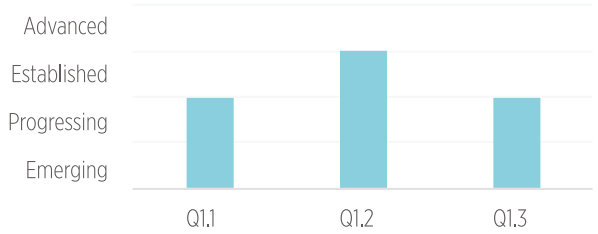


Source: based on HFPM data collection template v. 2.0, Kazakhstan 2023.

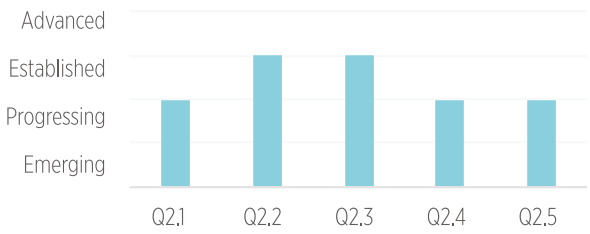
Assessment ratings, by individual question

Fig. 12. Assessment ratings, by intermediate objective and final coverage goals

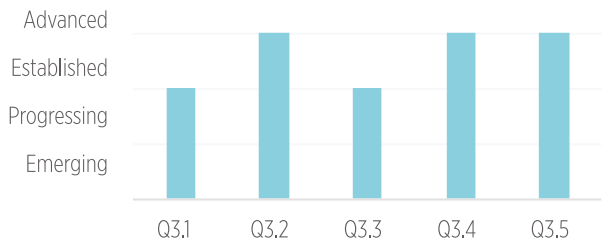
1. Health financing policy, process and governance



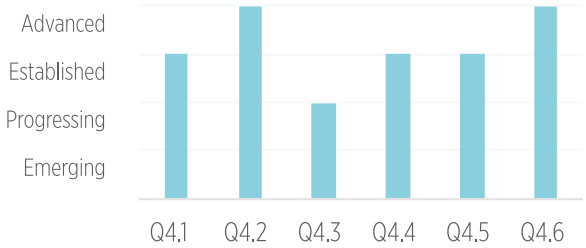
2. Raising revenue



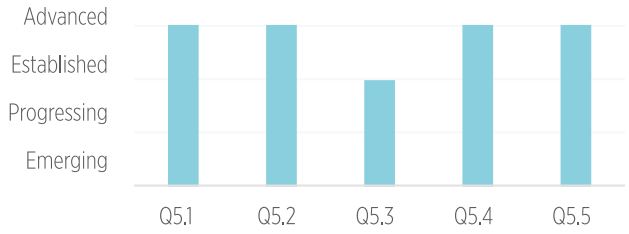
3. Pooling revenues



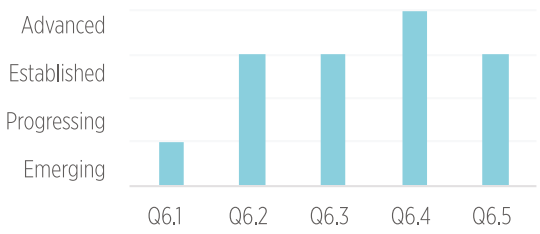
4. Purchasing and provider payment



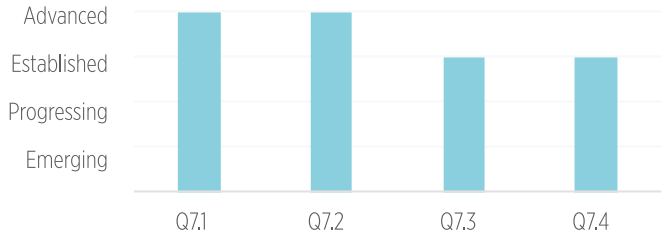
5. Benefits and conditions of access



6. Public financial management



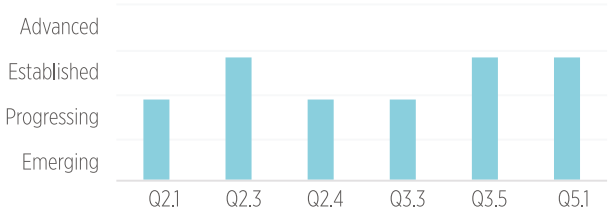
7. Public health functions and programmes



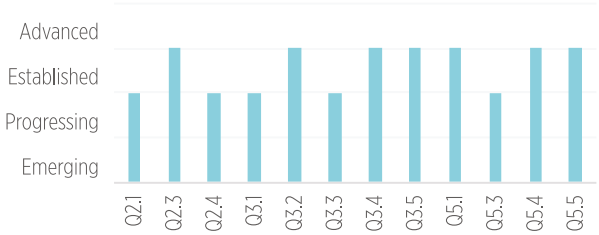
Assessment ratings, by UHC goals and intermediate objective

Fig. 13. Assessment ratings, by intermediate objective and final coverage goals

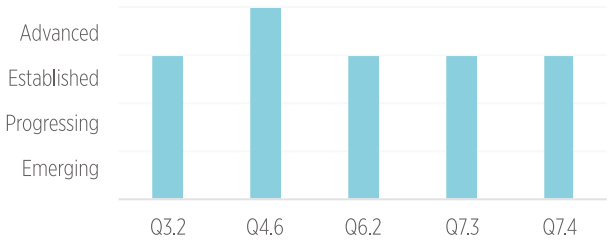
Equity in finance



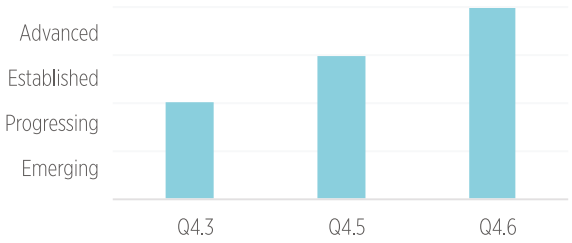
Financial protection



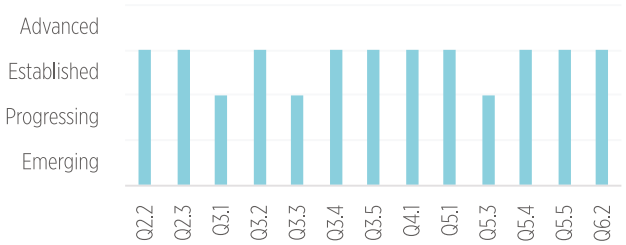
Health security



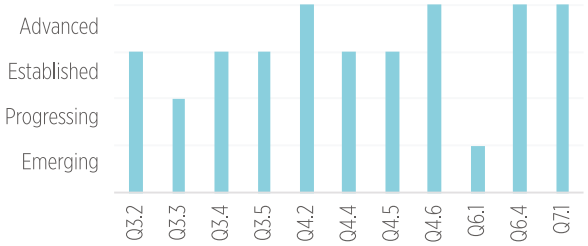
Quality



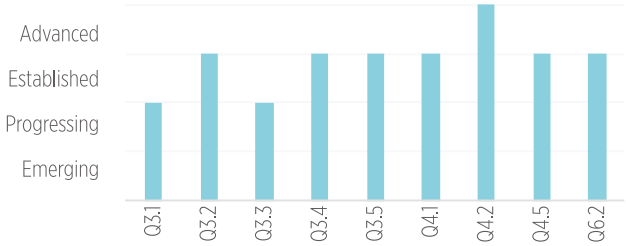
Services use relative to need



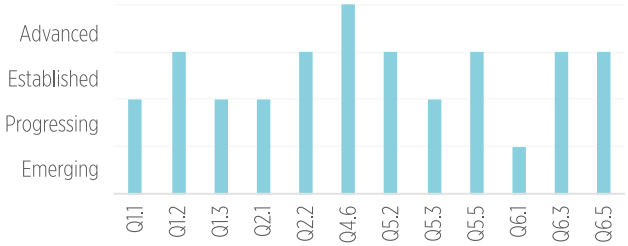
Efficiency



Equity in resource distribution



Transparency & accountability



References[1]

1. Health Financing Progress Matrix. In: Health Financing and Economics [website]. World Health Organization; 2024 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix).

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7. Bureau of National statistics of Agency for Strategic planning and reforms of the Republic of Kazakhstan [online database]. Bureau of National statistics of Agency for Strategic planning and reforms of the Republic of Kazakhstan; 2024 (https://www.gov.kz/memleket/entities/stat?lang=en).

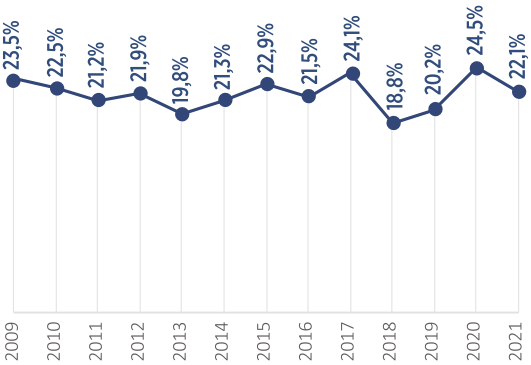
[1] All references were accessed on 18 April 2025.

Annexes

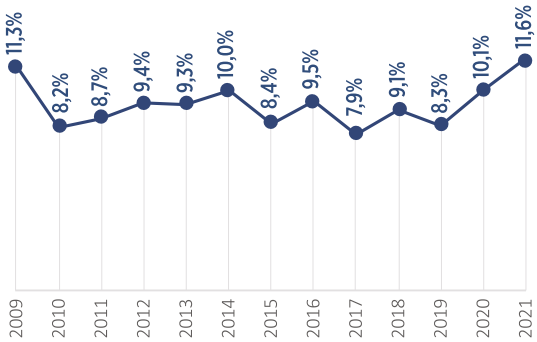
Annex 1. Selected contextual indicators

Fig. A1.1. Health expenditure indicators for Kazakhstan

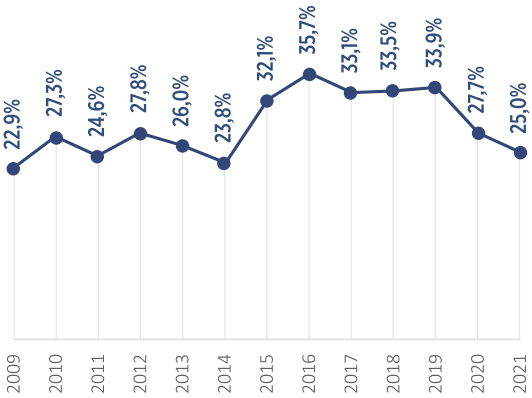
General Government Expenditure (GGE) as % of GDP



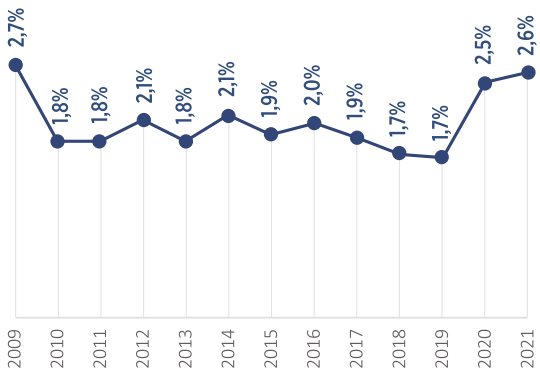
Domestic general goverment health expenditure (GGHE-D) as % of GGE



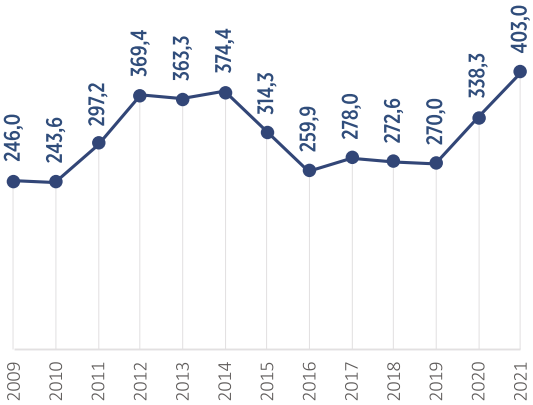
Out-of-pocket spending as % of CHE expenditure (OOPS % CHE)



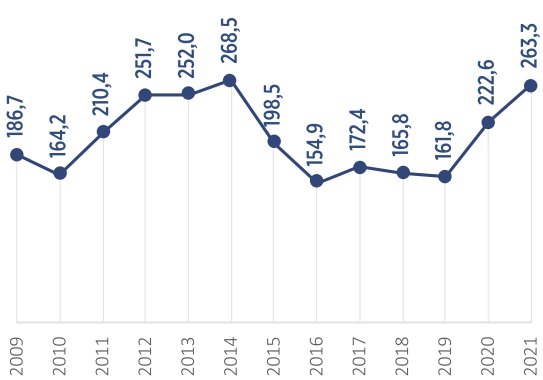
Domestic General goverment health expenditure (GGHE-D) as % Gross Domestic Product (GDP)



Total health spending (current health expenditure in PPP per capita (current intenational USD)

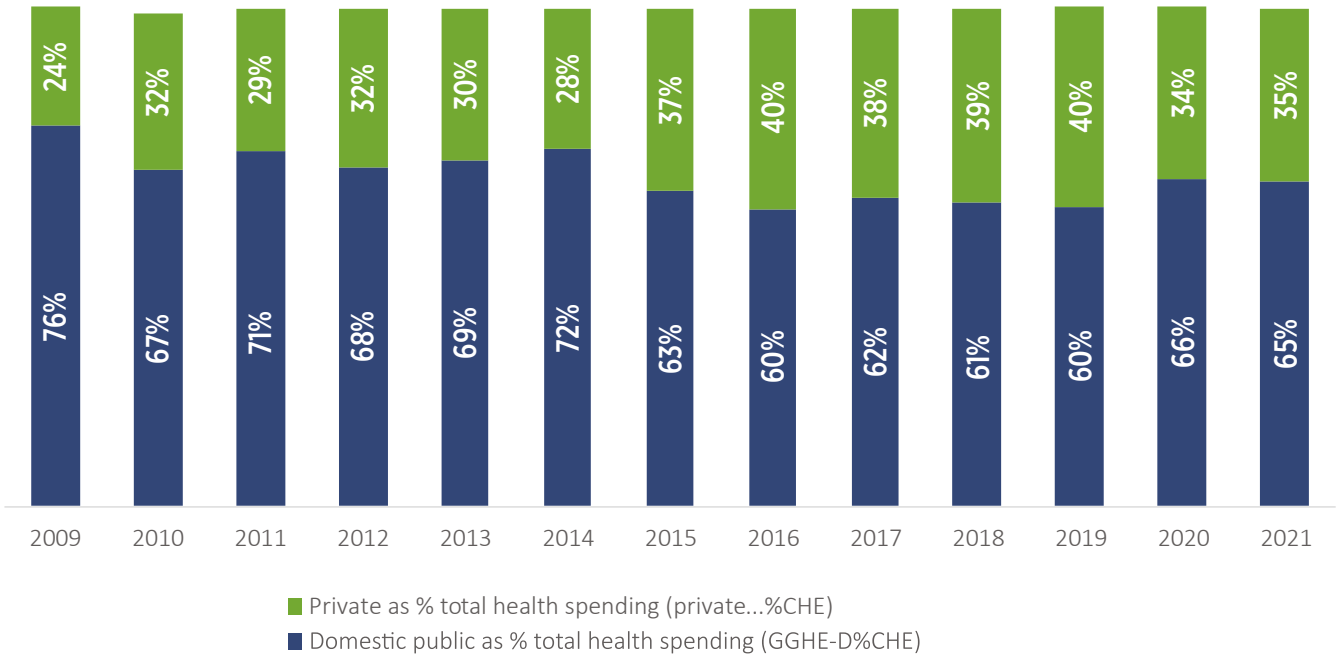


Domestic General goverment health expenditure (GGHE-D) in PPP per capita (current intenational USD)



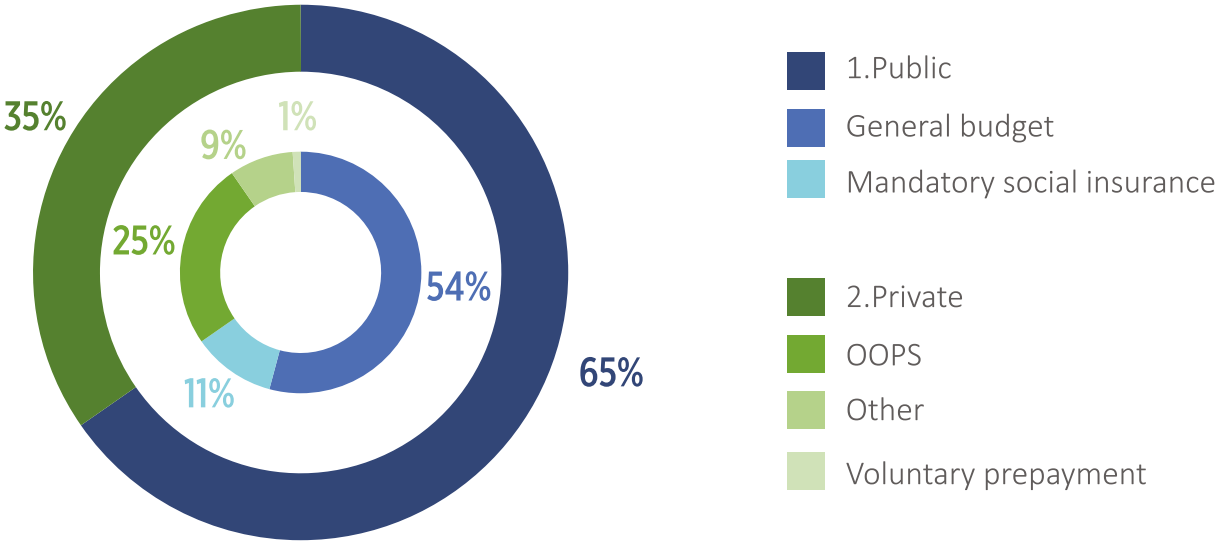
Source: WHO Global Health Observatory Database, 2023 *(1)*.

Fig. A1.2. Sources of health revenue in Kazakhstan



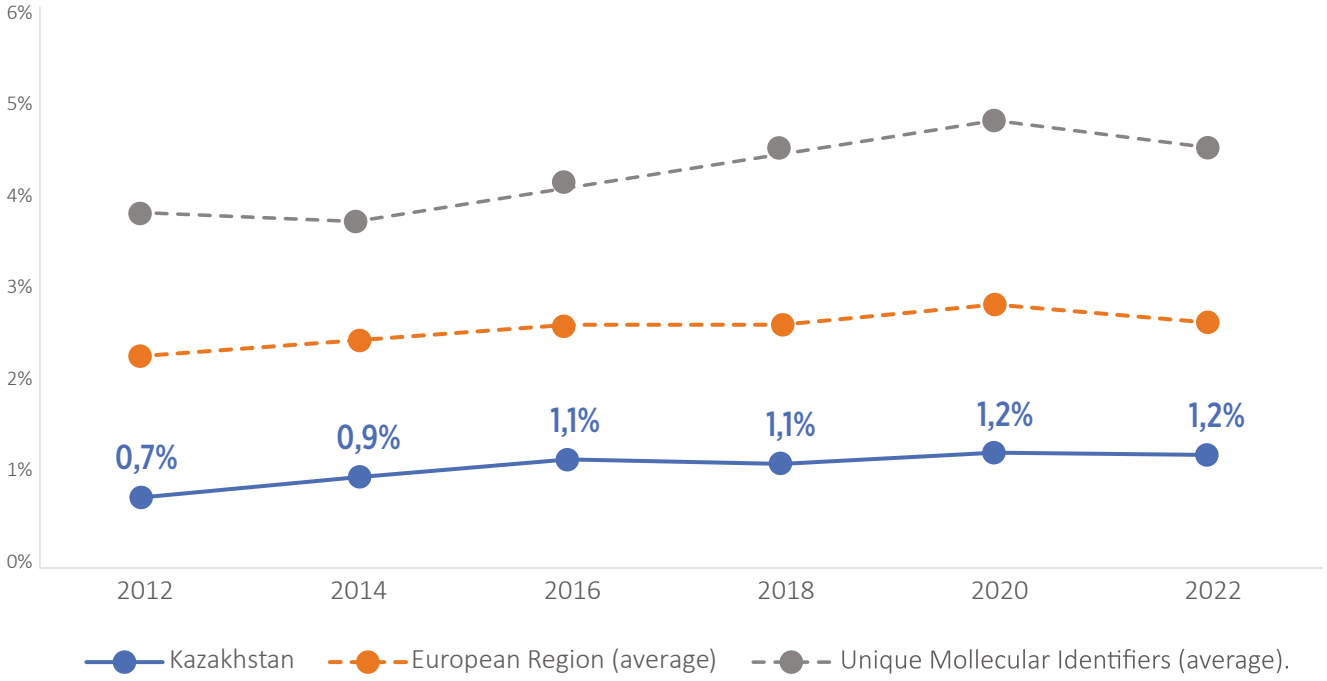
Source: WHO Global Health Observatory Database 2023 *(1)*.

Fig. A1.3. Revenue sources, disaggregated, 2021



Source: WHO Global Health Expenditure Database, 2023 *(1)*.

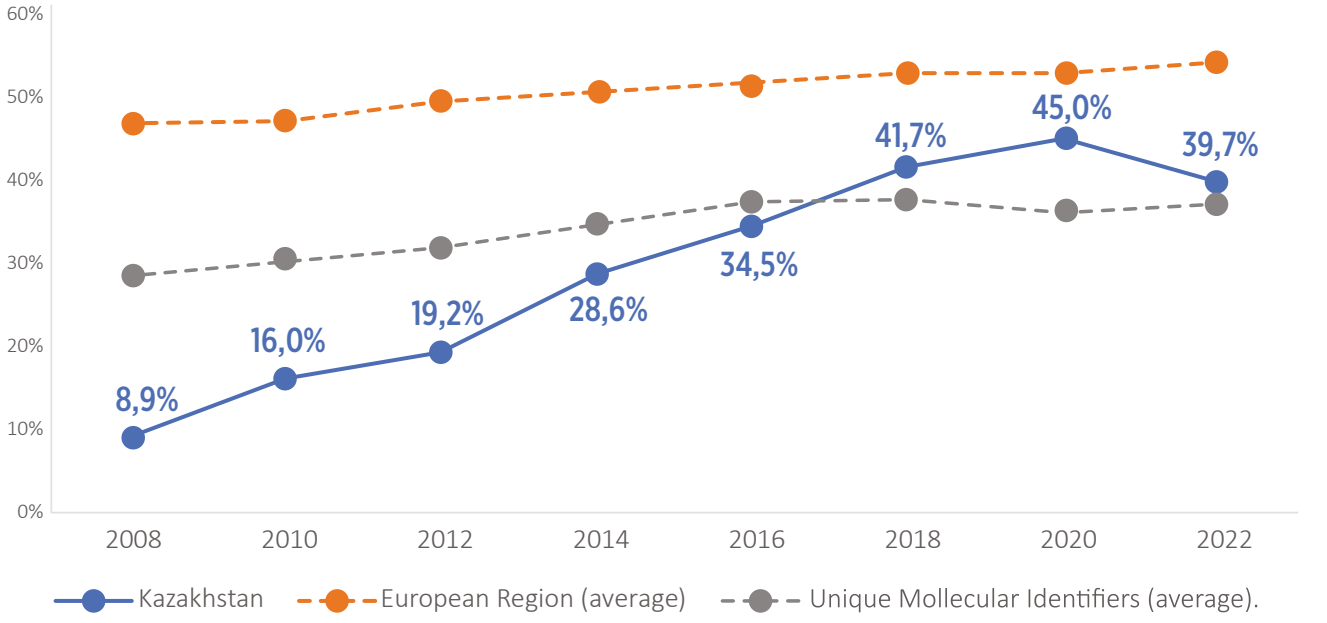
Fig. A1.4. Cigarette affordability in Kazakhstan



Notes. Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short-term changes in affordability are also presented.

Source: WHO report on the global tobacco epidemic, 2023: protect people from tobacco smoke *(2)*.

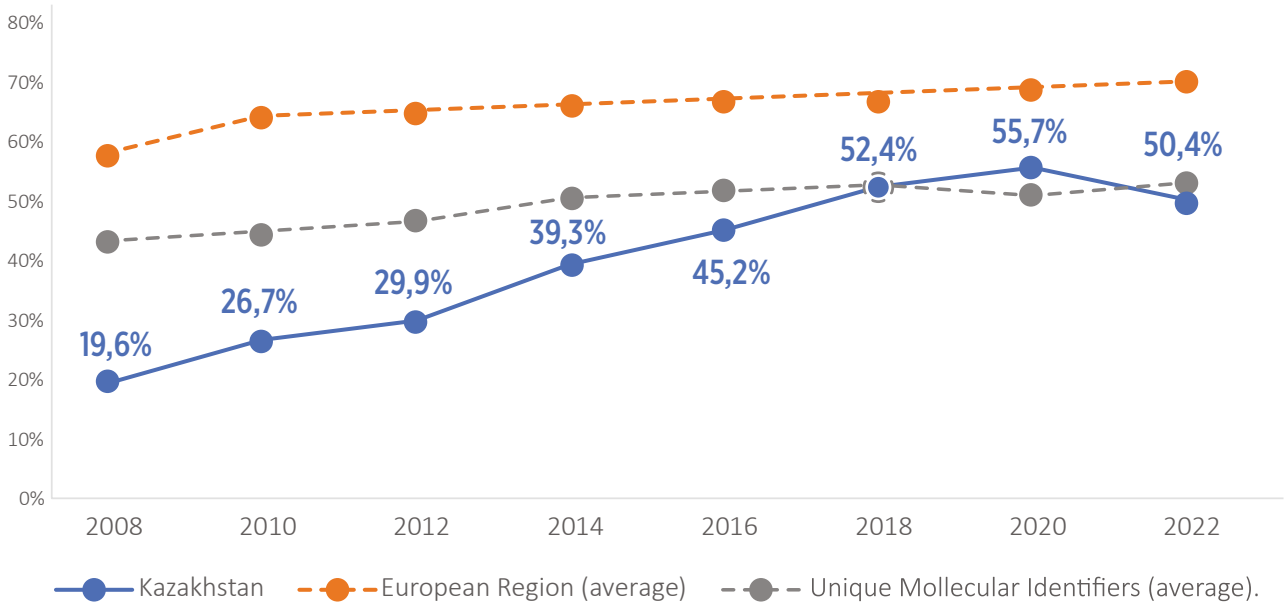
Fig. A1.5. Excise-tax share in Kazakhstan



Notes. WHO recommends an excise-tax share of 70%. The total tax share includes import duties and levies.

Source: WHO report on the global tobacco epidemic, 2023: protect people from tobacco smoke *(2)*.

Fig. A1.6. Total tax share in Kazakhstan



Notes. This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, value-added tax,/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.

Source: WHO report on the global tobacco epidemic, 2023: protect people from tobacco smoke *(2)*.

References[1]

1. The Global Health Expenditure Database [database]. Geneva: World Health Organization; 2023 (https://apps.who.int/nha/database).

2. WHO report on the global tobacco epidemic, 2023. Protect people from tobacco smoke. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/372043) License: CC BY-NC-SA 3.0 IGO.

[1] All references were accessed on 18 April 2025.

Annex 2. Desirable attributes of health financing

Policies that help to drive progress towards UHC are summarized in Table A2.1 in terms of the 19 desirable attributes of health-financing policy.

Table A2.1. Desirable attributes of health-financing systems

Assessment area	Attribute code	Desirable attribute
Health financing policy, process and governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing and provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

References

1. The Global Health Expenditure Database [database]. Geneva: World Health Organization; 2023 (https://apps.who.int/nha/database).
2. WHO report on the global tobacco epidemic, 2023: protect people from tobacco smoke. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/372043). License: CC BY-NC-SA 3.0 IGO

[1] All references were accessed on 18 April 2025.

Annex 3. HFPM assessment questions

Table A3.1. Questions asked during the HFPM assessment

Assessment	Question number/ code	Question
Health financing policy, process and governance	Q1.1	Is there an up-to-date health-financing policy statement guided by goals and based on evidence?
	Q1.2	Are health-financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health-financing information systemically used to monitor, evaluate and improve policy development and implementation?
Revenue raising	Q2.1	Does your country's strategy for domestic-resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
Purchasing and provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Benefits and conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently, using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations clear and are there functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?

Table A3.1. contd

Assessment	Question number/ code	Question
Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Are health-budget formulation and implementation support in alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Public health functions and programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health-financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of International Health Regulation (IHR) capacities to enable emergency preparedness?
	Q7.4	Are public financial-management systems in place to enable a timely response to public health emergencies?

Annex 4. Questions mapped to objectives and goals

Each question listed in Table A4.1 represents an area of health-financing policy, selected because of its influence on the intermediate UHC objectives and goals, as explicitly defined below.

Table A4.1. Questions asked during the survey

Objective/goal	Question number code	Question
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Are health-budget formulation and implementation support in alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What are the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider-payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective/goal	Question number code	Question
Transparency and accountability	Q1.1	Is there an up-to-date health-financing policy statement, guided by goals and based on evidence?
	Q1.2	Are health-financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health-financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent have providers financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparent, using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial-management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health-expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Are health-budget formulation and implementation support in alignment with sector priorities and flexible resource use?

Objective/goal	Question number code	Question
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What are the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations clear and are there functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic-resource mobilization eflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What are the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent have providers financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
	Q4.6	To what extent have providers financial autonomy and are held accountable?
	Q6.2	Are health-budget formulation and implementation support in alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

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