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Editorial

Diagnosis Without Dialogue: A Rapid Analysis of Kazakhstan's New Healthcare Concept 2026–2029 and the Missing Voice of the Health Sector

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ABSTRACT

In March 2026, Kazakhstan approved a new national Healthcare Development Concept for 2026–2029. This editorial provides a rapid critical analysis of the document, comparing it with its 2022–2026 predecessor. We identify genuine advances, including expanded indicator architecture, health technology assessment tools, digital health ambitions, and an explicit adolescent health agenda alongside persistent structural weaknesses: the absence of a theory of change, limited economic evaluation, no comprehensive human resources for health strategy, and a thin monitoring and evaluation framework. We also raise a chronic governance concern: the Concept was adopted without meaningful consultation with the professional and academic health community, in tension with President of Kazakhstan Tokayev's stated commitment to a hearing state.

Keywords: Health System Reform; Kazakhstan; Primary Health Care; Universal Health Coverage; Policy Implementation; Public Health; Health Systems Strengthening; Health Policy

Introduction

In March 2026, the Government of the Republic of Kazakhstan approved a new Concept for Healthcare Development for 2026–2029, succeeding the previous Concept to 2026 adopted in November 2022 [1, 2]. The document sets out nine strategic directions, 82 target indicators, and a detailed action matrix of 168 measures spanning prevention, primary care, digitalization, biosecurity, personalized medicine, workforce development, pharmaceuticals, science, and health financing.

The aim of this editorial is to provide a rapid critical analysis of the new Concept, situating it against its predecessor and against international standards of evidence-informed health policy design. Rapid analysis of this kind is itself a response to a chronic and troubling institutional pattern: the new Concept was approved and published without meaningful prior consultation with the professional and academic health community. As with its 2022 predecessor, there is no documented evidence of structured stakeholder engagement, no published consultation rounds, no disclosed expert review process, no period for civil society input prior to adoption. This is not a procedural formality. It reflects a persistent disconnect between the Ministry of Health of Kazakhstan and the broader health sector, and it is increasingly difficult to reconcile with President of the Republic of Kazakhstan Tokayev's declared policy of a "hearing state" (слышащее государство), an approach that explicitly commits government institutions to open dialogue with citizens and professional communities before consequential decisions are made. A national health policy framework affecting 20 million people and directing billions of tenge in public expenditure warrants nothing less.

What Has Improved

The 2026–2029 Concept represents a genuine evolution in several respects. First, its indicator architecture is substantially more comprehensive than the 23 indicators of the 2022–2026 Concept [1]. New domains include AI utilization in medical organizations (Target Indicator 51: rising from 30% to 45% by 2029), AI-assisted processing of radiological studies (Target Indicator 52: from 5% to 20%), and integration of healthcare organizations with a unified medical data repository (Target Indicator 54: from 20% to 95%) [2].

Second, the new Concept introduces health technology assessment (HTA) tools that were absent from its predecessor—including QALY-based valuation of healthcare technologies (Action 115) and a cost-effectiveness threshold mechanism (Action 127) [2]. These are important institutional advances if implemented with technical rigor.

Third, the document elevates health security into a standalone strategic direction (Direction 5), with measurable targets for SPAR readiness, laboratory accreditation, and immunization coverage, [2] reflecting lessons from the COVID-19 pandemic that were articulated in the previous Concept but not given dedicated structural status.

Fourth, the new Concept introduces a structurally significant reorientation in its approach to health promotion: Direction 1 is explicitly framed as "transition to a unified integrated system for the formation of a health culture" [2]. This goes beyond the fragmented healthy lifestyle campaigns of the previous Concept. The document envisions consolidating dispersed health promotion initiatives into a scientifically grounded, life-course system that integrates health culture into education, labour, media, and the built environment—operationalized through a national "Salamatty shan'yrak" campaign, digital platforms, and a new annual population health report ("ұlt dencaulyq'y"). A national coordinator for health culture formation is to be established. This systems-level framing, embedding health promotion into all sectors rather than confining it to the health sector alone, is the most conceptually mature element of the new Concept and aligns with the WHO "Health in All Policies" approach.

Finally, children and adolescent health now receives explicit strategic attention within Direction 4, with commitments to developing youth-friendly confidential services, expanding digital mental health formats, and introducing quality assessment based on adolescent feedback [2]. This is a meaningful step toward life-course health policy design.

Key Differences from the 2022–2026 Concept

The 2022–2026 Concept contained a detailed standalone situational analysis—documenting life expectancy at 70.23 years (2021), maternal mortality at 44.7 per 100,000 live births (2021), infant mortality at 8.44 per 1,000 (2021), and a growing health workforce deficit that had reached 7,072 FTE positions by 2021. This analytical narrative grounded the policy in Kazakhstan's specific epidemiological context.

The 2026–2029 Concept largely foregoes this analytical layer, embedding epidemiological references

into the indicator tables rather than presenting them as a diagnostic foundation. This is a structural regression: while the document is more operationally detailed, it is less analytically transparent about why specific interventions were chosen and what problems they are designed to solve.

On financing, the 2022–2026 Concept set a target of raising MSHI population coverage to 90% by 2026 (from 82.4% in 2021) and identified out-of-pocket payments at 33.8% of current health expenditure as a priority concern. The new Concept sets more modest targets: MSHI coverage reaching only 85.5% by 2029 (Target Indicator 79) and out-of-pocket spending declining from 24.7% to 22.0% (Target Indicator 82). The downward revision of coverage ambitions deserves explicit justification that the document does not provide.

Persistent Limitations

Despite its advances, the 2026–2029 Concept reproduces structural weaknesses that characterized its predecessor and that represent the enduring implementation gap in Kazakhstan's health policy.

There is no explicit theory of change. The 168-item action plan is a catalogue of activities, not a logic model. The causal pathways linking, for example, mass health promotion events (Action 1) to rising healthy lifestyle adoption rates (Target Indicator 2), or workforce training measures (Actions 131–146) to rural staffing levels (Target Indicator 66), are unstated. Without this causal architecture, accountability for results cannot be meaningfully established [3,4].

The Human Resources for Health agenda remains reactive rather than strategic. The 2022–2026 Concept documented annual emigration of 901 health professionals (2021) and a doubling of the FTE deficit over five years. A recent system-wide analysis using the Control Knobs framework identified workforce distribution and provider incentive structures as among the most persistent weaknesses constraining equity and efficiency in Kazakhstan's health system [5]. The new Concept introduces a nurse-to-physician ratio target (Target Indicator 68: 2.2:1 by 2029) and rural retention grants (Action 136), but there is no consolidated HRH strategy, no quantified workforce projection model, and no systematic analysis of compensation or career development structures.

The full fiscal envelope of the Concept's implementation is not disclosed. Partial budget figures appear in the action matrix—31.4 billion KZT for HPV vaccination (Action 82), 13.9 billion KZT for SES modernization (Action 93), but the aggregate resource requirement is absent. This impedes fiscal accountability and raises legitimate questions about the feasibility of the 82-indicator agenda within available budget envelopes.

Despite the introduction of QALY methodology and HTA mechanisms, there is no systematic economic evaluation of the action plan as a whole. Prioritization logic, which interventions to fund first, given finite resources is implicit rather than explicit. International experience consistently demonstrates that health policy ambition without economic discipline does not translate into sustainable system improvement [4,6].

Finally, on monitoring and evaluation, the 2022–2026 Concept established a clear reporting mechanism: central and local executive bodies were required to submit annual progress reports to the Ministry of Health of Kazakhstan by April 15, with the Ministry consolidating and submitting to planning authorities by May 1. The 2026–2029 Concept preserves an action-plan-based accountability structure but does not meaningfully strengthen the evaluation architecture. The proliferation of 82 target indicators, while demonstrating analytical ambition, may in practice weaken accountability if monitoring infrastructure is not correspondingly upgraded. Strong evaluation requires not only indicators and reporting schedules, but clear attribution of responsibilities, independent verification, and mechanisms for course correction when targets are not met. These governance functions remain implicit rather than explicit in both documents.

Conclusion

Kazakhstan's new Healthcare Concept 2026–2029 signals continued maturation in health policy design, including broader in scope, richer in indicators, and more attentive to emerging priorities such as digital health, biosecurity, health promotion, children and adolescent wellbeing.

But the manner of its adoption, without meaningful consultation with health professionals, researchers, patient organizations, or civil society undermines its legitimacy and reduces the probability of successful implementation. Health sector actors who are excluded from policy design are less likely to be effective agents of its delivery. Any Ministry of Health that operates in isolation from the communities it serves and the professionals it leads cannot build the trust that sustainable reform requires [3,6].

The enduring implementation gap in Kazakhstan's health policy is not primarily a technical problem. It is a governance problem. Closing it requires not only better-designed indicators and action plans, but an institutional culture of genuine consultation, transparent economic reasoning, and accountable implementation [3,6]. President Tokayev's hearing state is an opportunity, but only if health policy becomes a domain where that commitment is visibly honored.

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References

1. Government of the Republic of Kazakhstan. Concept for the Development of Healthcare of the Republic of Kazakhstan to 2026 [Концепция развития здравоохранения Республики Казахстан до 2026 года]. Government Resolution No. 945, 24 November 2022; amended by Resolution No. 141, 29 February 2024. Astana; 2022. Retrieved from: https://adilet.zan.kz/rus/archive/docs/P2200000945/24.11.2022
2. Government of the Republic of Kazakhstan. Concept for the Development of Healthcare of the Republic of Kazakhstan for 2026–2029 [Концепция развития здравоохранения Республики Казахстан на 2026–2029 годы]. Approved 11 March 2026. Astana; 2026. Retrieved from: https://adilet.zan.kz/rus/docs/P2200000945
3. Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016. Retrived from: https://www.globalchildrenssurgery.org/wp-content/uploads/2019/03/Strategizing-national-health.pdf
4. Cylus J, Papanicolas I, Smith PC, editors. Health System Efficiency: How to Make Measurement Matter for Policy and Management. Copenhagen: WHO Regional Office for Europe; 2016. Available from: https://www.ncbi.nlm.nih.gov/books/NBK436892/
5. Yergaliyev K, Khassen U, Chaumont C, Stoyanova A. Kazakhstan's Healthcare System Through the Harvard Control Knobs: Analysis of Performance and Future Strategic Directions. Epidemiology and Health Data Insights. 2026;2(1):ehdi028. doi: 10.63946/ehdi/17861
6. Roberts MJ, Hsiao W, Berman P, Reich MR. Getting Health Reform Right: A Guide to Improving Performance and Equity. Oxford: Oxford University Press; 2004. doi: 10.1093/acprof:oso/9780195371505.001.0001