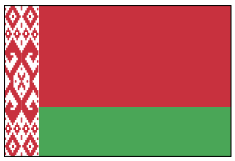
2024 Edition

Health Systems in Action

Belarus



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Health Systems in Action (HSiA) Insights

Belarus

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World Health Organization
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Editorial Team

This edition of the Health Systems in Action Insight for Belarus was written by Erin Webb.

The Health Systems in Action series

The Health Systems in Action Insights series supports Member States in the WHO European Region that are not in the European Union. The Insights for each country are intended to:

- provide core information and data on health systems succinctly and accessibly;
- outline the country health system context in which WHO Europe's Programme of Work is set;
- flag key concerns, progress and challenges; and
- build a baseline for comparisons, so that Member States can see how their health systems develop over time and in relation to other countries.

The series is co-produced by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. It draws on the knowledge and understanding of the WHO Country Offices and of the Division of Country Health Policies and Systems (CPS), the WHO Barcelona Office for Health Systems Financing and other WHO/Europe technical programmes; as well as the Health Systems in Transition series and the work of the European Observatory on Health Systems and Policies.

The Insights follow a common template that provides detailed guidance and allows comparison across countries. The series is publicly available on the websites of the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies (eurohealthobservatory.who.int).

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HEALTH SYSTEMS IN ACTION INSIGHTS: BELARUS

Key points

- The health system of Belarus is centralized and vertically organized, with the Ministry of Health setting priorities that are subsequently implemented at the district, interdistrict, regional and national levels.
- The scope of publicly covered services is quite broad and medical care is free at the point of use. Most outpatient medicines require user charges, with the exception of separate patient categories who are entitled to partly or fully reimbursed medicines at the expense of the state budget. Dental care is free of charge with the exception of dental prosthetics. There are also separate patient categories for whom dental prosthetics are partly or fully subsidized from the state health care budget.
- Three quarters of health spending was public in 2021, and the level of public spending on health was generally close to other upper middle-income countries (UMICs). More than one third of health spending was spent on inpatient curative care.
- The number of hospitals has decreased over time and the number of outpatient clinics and polyclinics has increased, reflecting a desire to move towards primary health care. Despite the decrease in the number of hospitals, the numbers of hospitals and hospital beds per population were among the highest in the WHO European Region in 2019.
- There is a continued emphasis on inpatient care and high utilization of curative care services. Opportunities remain to strengthen preventive care, in particular public health measures for reducing behavioural risk factors for noncommunicable diseases (NCDs).
- The levels of doctors and nurses in Belarus are higher than in most countries in the WHO European Region. However, the number of graduating health workers has decreased over time and staffing in rural regions remains a problem.
- Life expectancy in Belarus increased by 5.6 years between 2000 and 2018. Life expectancy in 2018 was 10 years higher for females than for males, with an average across both sexes of 74.6 years. Newer national data for 2019 suggest a life expectancy at birth of 74.4 years. Life expectancy data are not internationally available since 2018, so the impact of COVID-19 on life expectancy is not yet publicly available.
- Belarus has high levels of vaccination coverage and manages tuberculosis (TB) and HIV through vertical national programmes. Infant and maternal mortality have dropped substantially since 2000.
- NCDs cause more than 80% of deaths in Belarus, and more than half of all deaths are from cardiovascular diseases. An estimated 36% of all deaths in 2019 were related to high blood pressure, and 30% of deaths were estimated to be related to dietary risks. Premature mortality from major NCDs is three times higher for men than for women.

1 ORGANIZING THE HEALTH SYSTEM

Belarus has a centralized health system with universal population coverage

Belarus' health system retains many characteristics of the Semashko system, as the majority of health care facilities are state owned and the system has a centralized vertical structure. Patients receive health care free of charge at the point of care delivery. The majority of medicines for outpatient treatment are not reimbursed with the exception of certain categories of patients who are entitled to subsidized pharmaceuticals from the state budget. The Ministry of Health plays a key role, setting priorities, developing policies, and determining services and financing indicators, which regional health care authorities implement at their levels. The Ministry of Health also directly funds highly specialized hospitals providing high technology tertiary care at the national level. The President and the Parliament set the policy agenda and determine the share of government spending on health. The Ministry of Health and the Ministry of Finance then present an agreed budget to the government. Most public spending on health comes from taxes collected at the national and local levels.

The regional health care authorities operate all hospitals and health facilities at the regional, inter-district and district levels. Privately owned health care facilities are situated mainly in the large cities and mostly provide outpatient medical care. The services provided and capital invested are determined at the regional or district level, based on priorities and standards defined at the national level.

Supervision of the health system is driven by norms and standards

Belarus sets standards in the area of health care at the national level, with the ability for the local authorities to add their own priorities within the constraints of their own budgets. The comprehensive state programme "People's health and demographic security in the Republic of Belarus 2021–2025" covers the areas of infectious diseases and NCDs, maternal and child health, and mental health. The national standards, including public spending on health, are defined on the basis of per capita funding, the number of primary care doctors, inpatient beds, pharmacies, emergency care teams and ambulances, and the availability of medical transport at rural health facilities. As such, planning is based heavily on norms and inputs. The Ministry of Health tracks the progress of the health system along the set minimum standards, and the monitoring of the main results in health is implemented through the National Statistical Committee in the framework of the Sustainable Development Goals. The Ministry of Health also routinely audits health care facilities to assess accessibility and quality of medical care.

Patient rights are protected in the constitution and guaranteed by several laws and regulations. No single organization is tasked with the protection and promotion of patient rights, but several groups exist which focus on specific disease areas. Patient satisfaction surveys are conducted nationwide by the National Academy of Sciences and quarterly at the health care facility level.

Public revenue for health is collected and pooled by district governments

Most revenue for health is collected and pooled at the district level. Taxes are collected at the central, regional and district levels from companies and individuals. Some local revenues are sent to the national level, which then allocates them to the Ministry of Health for pooling, but a portion of revenues is retained at the district level. While this contributes to an uneven distribution of financial resources across the country, it is rectified with additional transfers of funds from the regional and national levels.

Population coverage is universal

The constitution guarantees all citizens access to health services free at the point of use, a legacy of the Semashko-style health system. Service coverage includes emergency, primary, outpatient and inpatient care. User charges are applied to most outpatient medicines, dental (if done in the private sector) and eye care (spectacles). There is also an option of conducting mostly diagnostic procedures for fixed prices at private diagnostic medical centres in Belarus. Medicines to treat diabetes, asthma, TB, HIV and some other conditions are available free of charge. In addition, certain groups of individuals, such as veterans, children under 3 years old, oncological patients and patients with certain chronic conditions do not have to pay for prescription medicines.

Some state institutions or enterprises, such as the Ministry of Internal Affairs and the Ministry of Defence, run parallel health services, providing services and funding for health services for their employees. There have been ongoing efforts to integrate the parallel health service providers into the public system in order to reduce duplication of activities. With these reforms, the health system for the Belarusian Railroad was integrated in the general health care system. In the last decades, there has been substantial progress in implementing highly specialized treatment such as organ transplants and cardiovascular surgery at the national scientific and practical centres.

2 FINANCING AND ENSURING FINANCIAL PROTECTION

Belarus spends approximately US$1400 per person on health, of which three quarters is public spending

Belarus dedicated 6.6% of its GDP to spending on health in 2021, which translates to US$1389 per person, when adjusted for purchasing power. Of this, 74% was public spending, or US$1031 PPP. Approximately 22% of health spending were out-of-pocket (OOP) payments and the remaining share comes mainly from state expenses, expenses from state-owned enterprises, voluntary health insurance (VHI) prepayments and spending from donor organizations. Belarus has a higher amount of public spending than the average of UMICs, at US$967 PPP. The total amount of spending on health is around one third of the average health spending across the WHO European Region and a little below the average for the Region's UMICs (US$1646) **(Fig. 1)**.

In 2021, Belarus' public spending on health was 4.9% of GDP. Public spending on health has increased by 1 percentage point since 2018, when 3.9% of GDP was spent on health, and by nearly 2 percentage points since 2011, when 3.1% of GDP was spent on health. Public spending on health as a share of GDP is generally close to the UMIC average, with some fluctuation **(Fig. 2)**. This share was falling before the COVID-19 pandemic. The rise in the share in 2020 and 2021 reflects, as in other countries, additional funding during the pandemic.

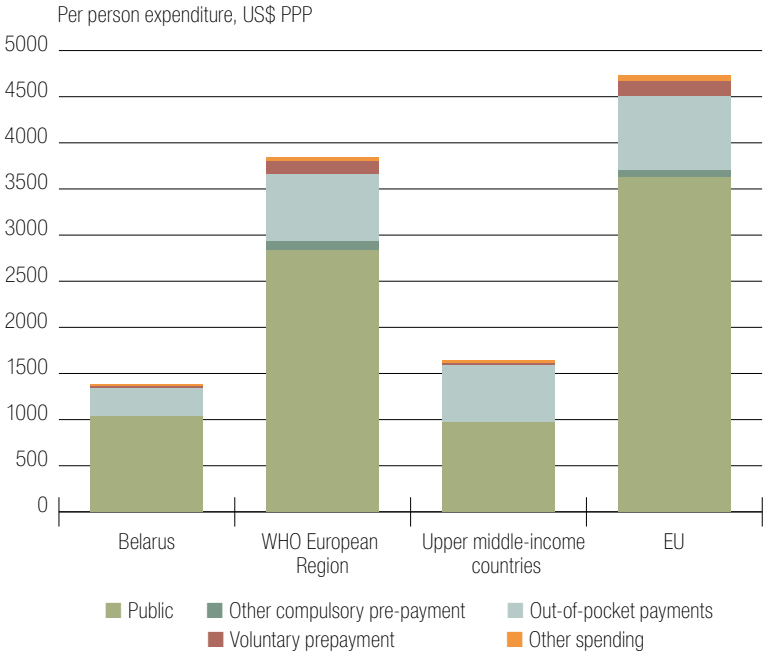
OOP payments rose as a share of current spending on health in the 2000s and 2010s, reaching a peak of 36.2% in 2015. There was a sharp drop in their share to 26.7% in 2016 and they have fallen further since then, likely related to reductions in health care utilization during COVID-19. OOP payments reached a low of 21.9% in 2021 **(Fig. 3)**, which brings their share closer to the EU average.

Most health spending goes towards curative inpatient care

In 2021, 64.7% of Belarus' current spending on health was dedicated to curative care, with 37.1% spent on inpatient curative care and 20.9% spent on outpatient curative care, which includes primary care settings. Pharmaceutical products made up the second highest category of health spending at 22.9% of spending, while ancillary services represented 4.7% of health spending. Preventive care made up 2.9% of spending, rehabilitative care 1.2% and long-term care received 0.7% of health spending. However, curative care remains the primary focus of the Belarus health system.

Fig.1

Belarus spends less on health per person than upper middle-income countries in general, but spending on health is predominantly public

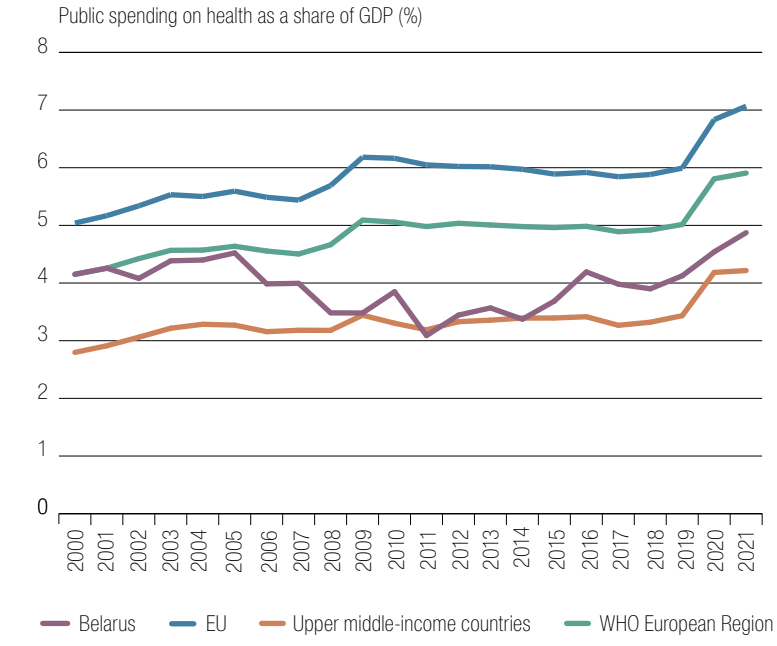


Source: WHO, 2024c.

Notes: Notes: 2021 data. Public refers to transfers from government budgets and social health insurance contributions. Other compulsory prepayment refers to premiums for mandatory health insurance schemes in Belgium, Finland, France, Germany, the Netherlands and Switzerland. Other refers to external funding and other marginal sources of funding.

Fig.2

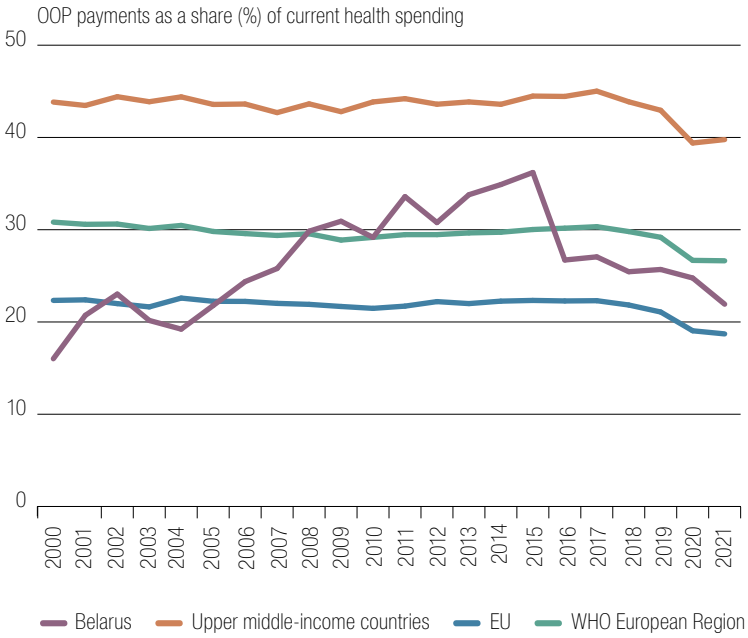
Public spending on health as a share of GDP is higher than in other upper middle-income countries



Source: WHO, 2024c.

Fig.3

The share of OOP payments has declined in recent years



Source: WHO, 2024c.

Lack of coverage for pharmaceuticals likely contributes to financial hardship

According to the National Statistical Committee of the Republic of Belarus, 16.1% of the population in Belarus spent more than 10% of their incomes on health in 2023, up from 6.5% in 2014 (National Statistical Committee of the Republic of Belarus, 2024). There is an ongoing trend that is related to increasing costs in dental care, outpatient pharmaceutical care and other health care services provided at private health care facilities. This indicates that Belarus needs to boost efforts in reducing the proportion of the population with large household expenditures on health. According to the recently conducted STEPS survey, 8% of the population did not fill a pharmaceutical prescription due to its price and around 5% of the population had missed a medical consultation or test because of cost (WHO, 2020).

3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

The number of hospitals has decreased by a third since 1990

The number of hospitals in Belarus declined from 874 in 1990 to 585 in 2022 (National Statistical Committee of the Republic of Belarus, 2024). During the same time period, the number of outpatient facilities and polyclinics increased from 1468 to 2660. Minsk city has the largest number of outpatient facilities and Minsk region has the largest number of inpatient facilities, reflecting not only their population size, but also the concentration of facilities in the capital. Despite the decrease in the number of hospitals, Belarus continues to have a high rate of health care facilities in international comparison **(Box 1)**.

Belarus has the second highest number of hospital beds per population in the WHO European Region

The number of hospital beds per 100 000 population was 969 in Belarus in 2019, higher than any other country in the WHO European Region aside from Monaco, despite decreasing from 1170 in 2000 **(Fig. 4)**. The rate of beds was much higher in Belarus than in most other countries, including neighbouring countries such as the Russian Federation (703 in 2020), Ukraine (626 in 2020) and Poland (611 in 2020), and also much higher than in the WHO European Region overall (470 in 2020).

Box 1

Health system efficiency efforts have been implemented through gradual reforms

In international comparison, Belarus has a higher rate of health care facilities, hospital beds, health workers and service utilization than most other countries, suggesting surplus capacity in the system. The existence of parallel health systems also indicates potential inefficiencies. However, reforms in both of these areas indicate a move to more health system efficiency. The numbers of health care facilities and hospital beds have dropped substantially in the last decades. In addition, parallel health services are gradually being integrated into the main health system of Belarus.

Substantial progress has been achieved in introducing electronic medical records in Belarus in many hospital facilities and primary care settings. However, parallel paper-based reporting continues, because electronical medical records are not viewed as official documents that could be requested by health authorities.

The rate of doctors and nurses is high, but concentrated in the capital region

According to WHO's National Health Workforce Accounts database, Belarus had 447 practising physicians and 1005 nurses per 100 000 population in 2020. This rate was higher than the averages in the WHO European Region of 389 and 803, respectively **(Fig. 5)**.

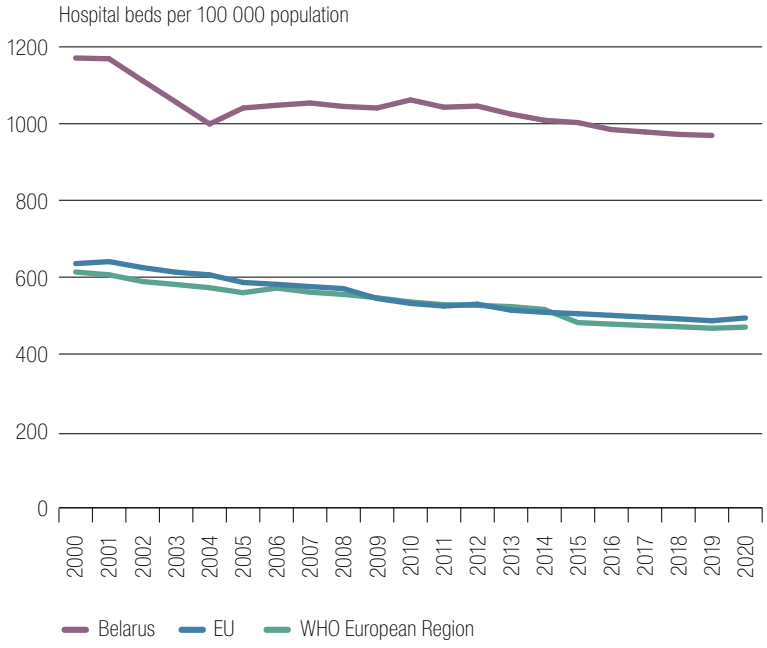
Data from the National Statistical Committee of the Republic of Belarus indicate that there were 522 practising physicians per 100 000 population in 2022, up from 405 per 100 000 population in 2010. Of the physicians in 2022, 9.3% had expertise in paediatrics, 37% in therapeutics and 29% in surgery, with physicians having expertise in multiple areas.

The paramedical personnel category includes professions such as nurses, midwives, and medical and laboratory assistants. According to national statistics, there were 1354 paramedical personnel per 100 000 population in 2022, of which 908 were nurses, 112 were medical assistants, 99 were laboratory assistants and 93 were midwives. The rate of nurses per 100 000 population has increased from 768 in 2000 to 908 in 2022, but the rate of midwives over the same time period has decreased from 119 to 93.

The number of practising physicians per 100 000 population had a wider variation in 2022 across different parts of the country (from 380 in Minsk Region to 722 in Minsk City) than paramedical personnel (from 1180 in Minsk Region to 1424 in Gomel region).

Fig.4

The rate of hospital beds in Belarus has declined only slightly since 2000



Source: WHO, 2024d.

Fig.5

Belarus has a higher rate of physicians and nurses per 100 000 population than most European countries

Source: WHO, 2024b.

Note: Densities were multiplied by 10 to calculate the density per 100 000 population. Averages are based on latest available years.

Primary care is developing, but specialist care still dominates

While the number of doctors per population has increased, a smaller share is working in primary care despite general practice-oriented reforms. Since 2018, all primary care physicians in Belarus have been officially qualified as general practitioners (GPs). Academic chairs of general practice were established in each of the four medical universities of the country and the Ministry of Health approved a standard scope of practice. In accordance with the national standards in the area of health care there are GPs providing primary care exclusively to the adult population and also GPs providing primary care to both adults and children who work mostly in rural areas. Since 2018, new legislation has been passed allowing GPs to diagnose and treat common mental health conditions. As mentioned in Section 1, all primary care providers and hospitals are publicly owned, with staff directly employed by the state.

Ambulance care is an important part of the patient pathway. The ambulance system in Belarus covers out-of-hours primary care and provides the first point of contact for patients during these times. As such, it is considered part of the primary care system. Approximately one third of the population calls the ambulance every year, often after hours.

Belarus has high utilization rates of its health system

In Belarus, the average person had 12.3 outpatient visits in 2020 (WHO Regional Office for Europe, 2024). This compared with 3.7 in Georgia, 4.5 in Kazakhstan and 6.9 in the Russian Federation, and was higher than any other country in the WHO European Region with data available. Inpatient facilities also have high levels of utilization. In 2020, there were 24.6 discharges per 100 population, a decrease from around 30 discharges per 100 population seen in every year since 2010 and 30.9 discharges per 100 population in 2019 (WHO Regional Office for Europe, 2024). In comparison, Georgia had 14.8, Kazakhstan had 14.5 and the Russian Federation had 20.2 discharges per 100 population in 2019. The high utilization of the Belarus health system is partially due to the large number of routine check-ups and mass population screenings.

Similar to most other countries, the delivery of routine care in Belarus decreased temporarily during the pandemic. For example, inpatient surgical procedures per 100 000 population dropped from 9442 in 2019 to 6945 in 2020 (WHO Regional Office for Europe, 2024). The number of outpatient visits also decreased, from an average of 13.6 outpatient contacts per person in 2019 to 12.3 outpatient contacts per person in 2020.

Belarus has extensive vaccination coverage and virtually no incidence of measles

Belarus has high vaccination rates for routine childhood vaccinations, with 98% of infants receiving the first and second dose of the measles vaccine in 2022. This has remained consistent over time and exceeds the average in the WHO European Region of 94.2% of infants for the first dose in 2021 and 90.8% for the second dose in 2022. Belarus correspondingly has

Fig.6

Belarus provides antiretroviral treatment to all people living with HIV who know their status

Source: Republican Centre of Hygiene, Epidemiology and Public Health, 2023.

Notes: ART: antiretroviral therapy; UNAIDS: Joint United Nations Programme on HIV/AIDS.

reported a low incidence of measles in the last few years, with 2.7 and 2.1 cases per 100 000 population in 2018 and 2019 and no cases in 2020 and 2022.

The percentage of infants receiving the DTP3 vaccine was also at 98% coverage in 2022, compared to the average in the WHO European Region of 94% in 2021. Children under 1 year of age are seen twice by all the main specialists and then annually after 1 year of age, providing ample opportunities for check-ups during childhood (Richardson et al., 2013).

Belarus addresses public health issues such as HIV/AIDS and TB through vertical national programmes

The Ministry of Health manages vertical programmes for significant public health issues such as HIV/AIDS and TB. These vertical programmes operate parallel to the rest of the health system and receive funding from both the Ministry of Health and regional district health authorities.

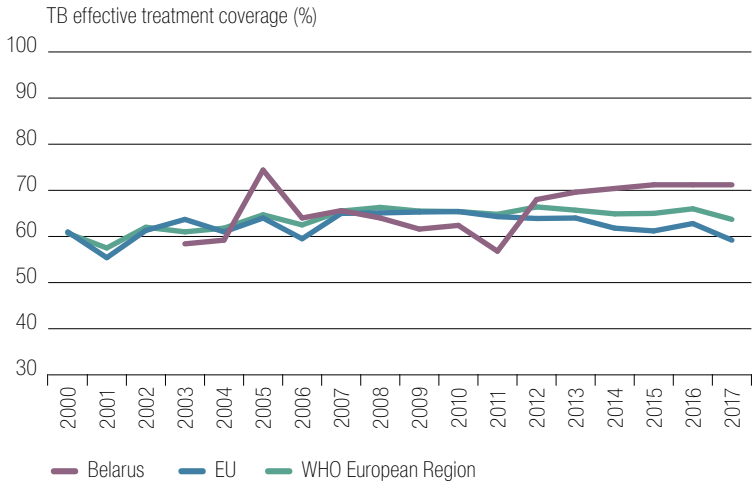
The number of new HIV infections per 100 000 population has increased in recent years, from 11.4 in 2009 to 22.6 in 2019. The number of new cases dropped by a third in 2020 and slightly increased again in 2021 and 2022 against the backdrop of pandemic-related barriers. According to the Republican Centre of Hygiene, Epidemiology and Public Health, an estimated 88% of people living with HIV in Belarus in July 2023 knew their status, and 92% of these individuals were receiving antiretroviral treatment (ART) **(Fig. 6)**. In 2018, the HIV treatment protocols changed so that every HIV-positive person is entitled to free ART from the moment they are diagnosed (UNAIDS, 2024) and in 2022 the clinical protocol for HIV was updated in accordance with WHO recommendations Of those receiving ART, 82% achieved viral suppression in July 2023. Starting from 2018, Belarus has transitioned to almost fully financing the procurement of HIV medications from the state budget.

Belarus is one of the priority TB countries in the WHO European Region, as well as one of the 30 high multidrug/rifampicin-resistant TB (MDR/RR-TB) burden countries globally (WHO, 2021a, 2021b). The incidence rate in 2021 was 16.1 per 100 000 population, down from 68.0 per 100 000 population in 2000. Once a case is identified, Belarus has over 70% effective treatment coverage, above the averages in the EU and the WHO European Region **(Fig. 7)**. Improvement of the effectiveness of the treatment of MDR/RR-TB was supported due to the opening of a WHO Collaboration Centre on the introduction of new MDR/RR-TB medicines and treatment regimens in 2019.

On average, the TB incidence rate in the WHO European Region was 18 cases per 100 000 population in 2021, although the number of cases reported may have been lower than the actual number of cases due to the COVID-19 pandemic **(Box 2)**.

Fig.7

Belarus has a higher TB effective treatment coverage rate than the average in the WHO European Region



Source: WHO, 2024d.

Note: Proportion of TB cases detected and successfully treated (estimate).

Box 2

Belarus implemented protocols to identify TB cases during the COVID-19 pandemic

During the COVID-19 pandemic, Belarus experienced a decrease in TB notification rates, due to the reallocation of resources to fight the pandemic and hesitance among patients to visit health care facilities also with preventive purposes due to the risk of COVID-19 infection (WHO Regional Office for Europe, 2023). Between 2015 and 2019, Belarus saw a decrease in TB notification rates of 9%, but this reduction jumped to a 32% decrease between 2019 and 2020 (WHO, 2021a). In response, the Belarus National TB Programme and the WHO Regional Office for Europe created a pathway to test whether patients admitted for COVID-19 also had TB.

Belarus has seven TB hospitals, one in each regional capital and one in Minsk city. Between 19% and 57% of the beds in these hospitals were repurposed for COVID-19 cases when the intervention started in April 2021. Staff performed a rapid TB diagnosis test for patients admitted with COVID-19 in five of these hospitals. A study found that the procedure identified new TB cases (5.6% in the research among earlier examined), including cases at an earlier stage than would have been detected otherwise (Sereda et al., 2022), and recommended further integrated surveillance for TB and COVID-19 (WHO Regional Ofice for Europe, 2023).

Belarus has seen an increase in the UHC service coverage index

The universal health coverage (UHC) service coverage index provides an indicator for access to essential health services in the country out of 100. Belarus had a UHC service coverage index of 53 in 2000, but this increased to 79 by 2021 **(Fig. 8)**. This approached the average in the WHO European Region of 81.

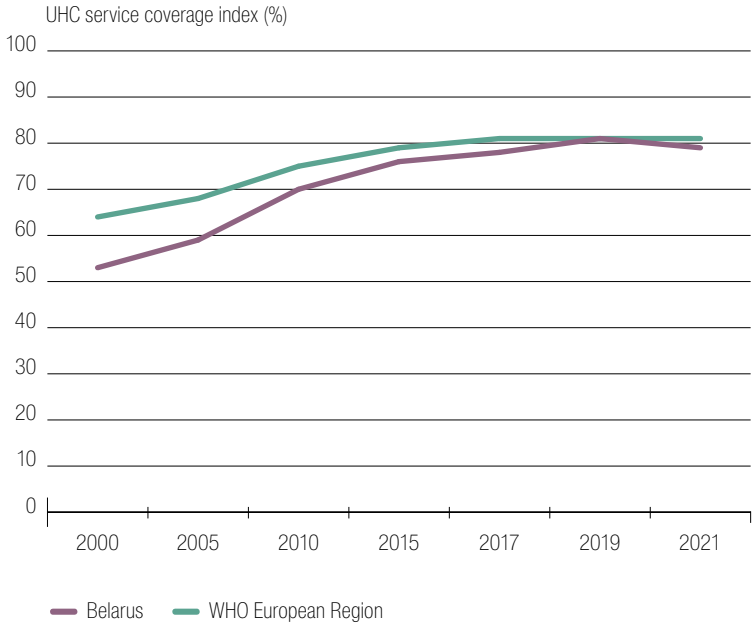
4 IMPROVING THE HEALTH OF THE POPULATION

Female life expectancy at birth is more than 10 years longer than male life expectancy

In 2018 (the latest year for which data are internationally available), life expectancy at birth in Belarus was 74.6 years, higher than in the Russian Federation (73.5) and Ukraine (73.2) in 2019. Newer national data for Belarus for 2019 suggest a life expectancy at birth of 74.4 years. Like in most other countries, life expectancy has increased since 2000, with a gain of 5.6 years in Belarus **(Fig. 9)**. In 2018, life expectancy for males was 69.3 years, lower than the life expectancy of 79.6 years for females. This 10.3 year gender gap in life expectancy exceeds the average gender gap in the WHO European Region (6.2 years), where females have an average life expectancy of 81.4 years and males of 75.2 years (in 2018). In the absence of more recent data, the impact on life expectancy of elevated mortality during the COVID-19 pandemic is not yet known.

Fig.8

The UHC service coverage index in Belarus has increased to reach the WHO European Region average



Source: WHO, 2024d.

Note: UHC service coverage index, defined as the average estimated coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; NCDs; and service capacity and access; among the general and the most disadvantaged populations.

Infant and maternal mortality have both improved markedly

Both infant and maternal mortality have decreased steadily since 2000. Estimated infant mortality fell from 10 deaths per 1000 live births in 2000 to 2.1 deaths per 1000 live births in 2021. This rate is lower than the average in the WHO European Region of 6.3 infant deaths per 1000 live births. Maternal mortality has followed a similar trend, with the estimated maternal mortality per 100 000 live births dropping significantly, from 24.3 in 2000 to 1.1 in 2021, well below the WHO European Region average of 12.6 (WHO Regional Office for Europe, 2024).

The standardized death rate for children aged 0–14 years in 2018 (31.2 per 100 000 population) is also below the average in the WHO European Region (61.8 deaths per 100 000 population) and has decreased substantially since 2000, when it was 107.5.

Cardiovascular diseases are the leading cause of death in Belarus

Of the approximately 120 000 deaths recorded in Belarus in 2018, more than half (68 095) were caused by cardiovascular diseases **(Fig. 10)**. In particular, ischaemic heart disease alone accounted for over one third of all deaths, with an age-standardized rate of 360 per 100 000 population out of 910 per 100 000 population for all causes. The second leading cause of death, cancer, led to fewer than 20 000 recorded deaths. Altogether, NCDs make up more than 80% of deaths in Belarus.

Men have a three times higher rate of premature mortality from major NCDs than women

Premature mortality due to deaths in ages 30–69 from four major NCDs (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases) has decreased over time in Belarus, although data for the full time series are not available **(Fig. 11)**. In the latest year with internationally comparable data (2018), Belarus had a premature mortality rate of 566 deaths per 100 000 population for this set of four diseases. This is substantially higher than the rate of 354 premature deaths per 100 000 population in the WHO European Region in the same year. In 2018, the premature mortality rate for Belarusian men from these four NCDs was 915 deaths per 100 000 population, while the rate for women, at 300 deaths, was much lower.

Fig.9

Life expectancy in Belarus increased by 5.6 years between 2000 and 2018

Sources: Eurostat, 2024, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye; WHO Regional Office for Europe, 2024, for all others.

Notes: * averages are based on years with data available.

Ischaemic heart disease, stroke and alcohol use disorders cause the highest disease burden in Belarus

A disability-adjusted life year (DALY) provides an indicator of the burden of disease in a population, as one DALY corresponds to the loss of one year in full health. Ischaemic heart disease has remained the leading cause of DALYs in Belarus since 2000, with an estimated 10 716 DALYs per 100 000 population in 2021 **(Fig. 12)**. In comparison, stroke, the second leading cause of DALYs in 2021 aside from COVID-19, resulted in 3 453 DALYs per 100 000 population. Alcohol use disorders and falls were the next two leading causes of DALYs, with above 1000 DALYs per 100 000 population each (WHO, 2024a).

Behavioural risk factors contribute to a large share of deaths

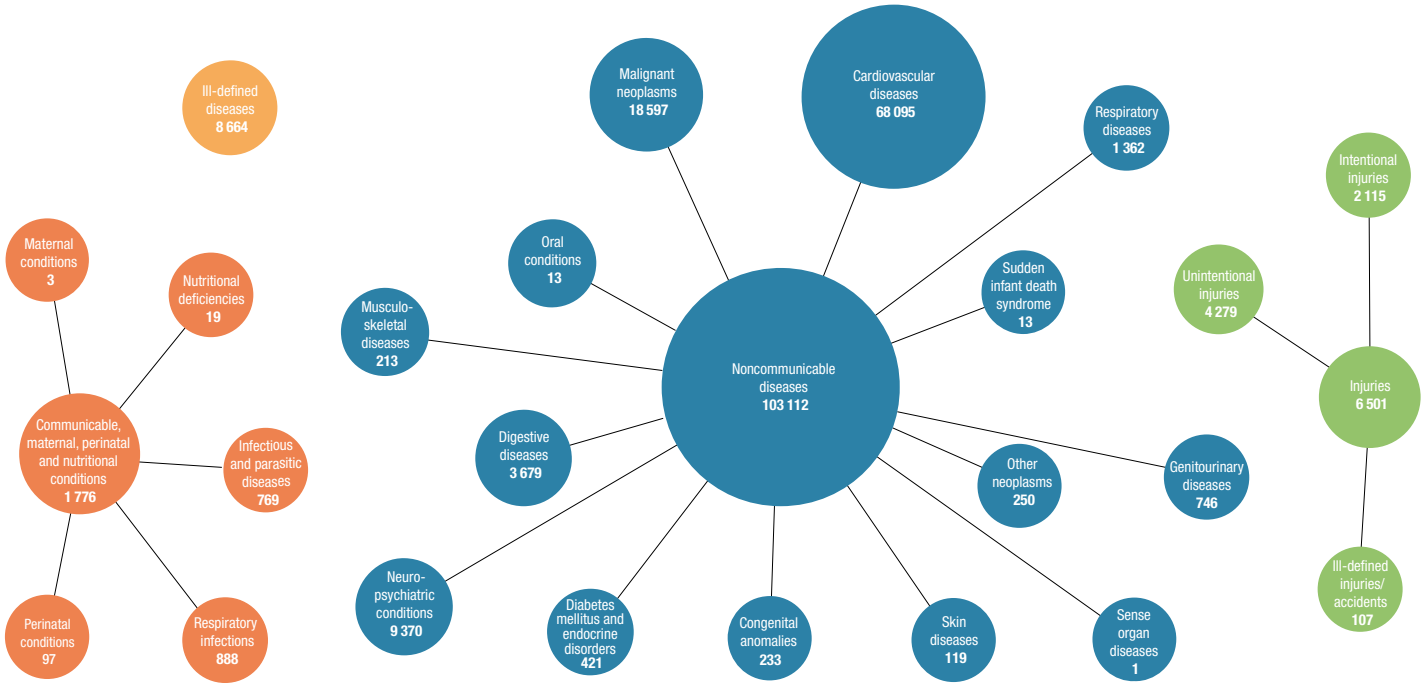
High blood pressure has been estimated to be a risk factor for 27.7% of all deaths in Belarus in 2021, followed by dietary risks (18.5%). The third highest behavioural risk factor was tobacco at 12.2% of deaths, followed by high LDL cholesterol at 12% of deaths **(Fig. 13)**.

Tobacco use has decreased over time in Belarus. In 2000, 35.2% of people aged 15 years and over were estimated to smoke on a daily basis, but this has dropped to 22.9% in 2023 **(see also Box 3)**. In contrast, the rates of overweight and obesity have risen, especially among men. In women, the prevalence of obesity has grown from 22.4% in 2000 to 26.3% in 2016, while male obesity has increased from 14.3% to 22.1% in the same time period. A similar trend can be seen for overweight, rising from 52.5% to 56.3% in women and 51.6% to 62.6% in men. Overall, 59.4% of people in Belarus were overweight in 2016 and 24.5% were obese. The prevalence of diabetes is also increasing, with 4.1% of the population having diabetes in 2020 compared with 1.3% in 2000.

In 2019, according to international data, the average amount of alcohol consumed per capita in Belarus (10.6 litres) was higher than the average in the WHO European Region (7.8 litres). Alcohol consumption per person per year has varied over time, increasing from 12.9 litres in 2000 to 14.4 litres in 2010, then dropping to 9.8 litres in 2017, before rising to 10.6 litres in 2019. According to national data, individuals over 15 years old consumed 11.7 litres of alcohol per person in 2019 (Belstat, 2024).

Fig.10

Cardiovascular diseases caused more than half of all deaths in 2018



Source: WHO, 2024e.

Note: Overview of the distribution of causes of total deaths grouped by category. Data refer to 2018.

Fig.11

Premature mortality from NCDs is higher in Belarus than in many other countries in the WHO European Region

Source: WHO, 2024b.

Note: Premature mortality among those aged 30–69 years from four major NCDs (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases). Data for Belarus only available for selected years.

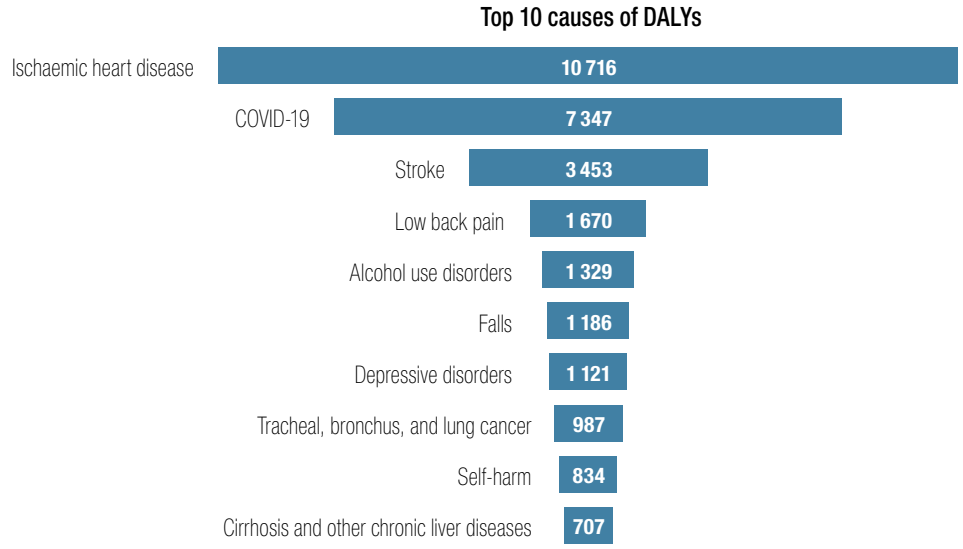
Air pollution contributes to 7% of deaths in Belarus

Environmental risk factors (such as access to water and sanitation, levels of air pollution) have varying degrees of impact on the health of the population in Belarus. In 2021, 7.0% of mortality was estimated to be due to air pollution (including outdoor and indoor pollution related to second-hand smoking and use of solid fuels for heating), but less than 1% of mortality was related to unsafe water and sanitation and other environmental risks.

In terms of wider socioeconomic risk factors, the poverty headcount ratio showing the share of the population living below the national poverty line has dropped noticeably, from 41.9% of the population in 2000 to 4.8% of the population in 2020. Furthermore, Belarus' Gini coefficient, which measures the equality of a country's distribution of income between 0 (perfect equality) and 100 (perfect inequality), was 24.4 in 2020, among the lowest in the world (World Bank, 2024).

Fig.12

Ischaemic heart disease is the leading cause of disability-adjusted life years in Belarus

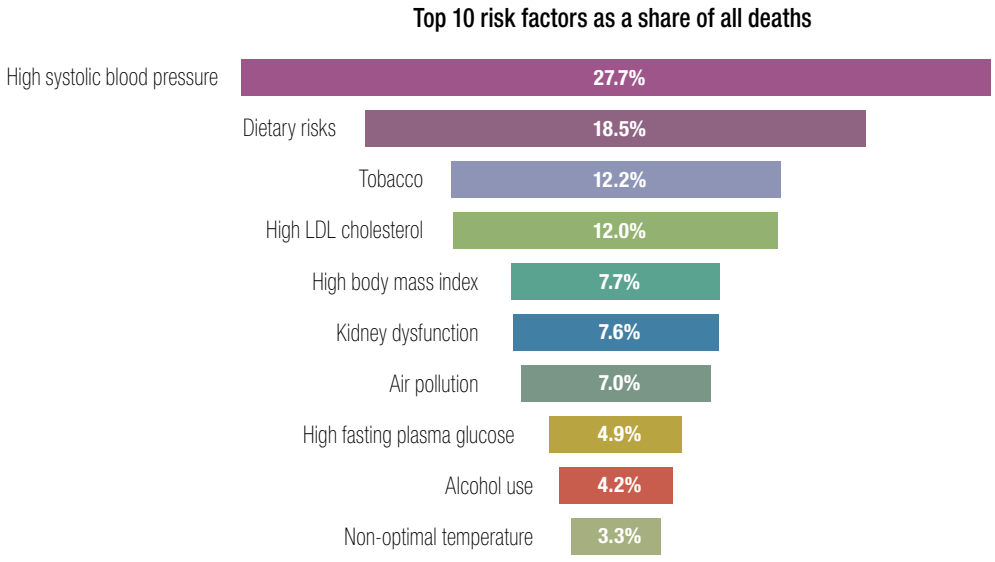


Source: IHME, 2024.

Note: Top 10 causes of DALYs per 100 000 population for both sexes and all ages. Data refer to 2021.

Fig.13

High blood pressure and dietary risks are the largest contributors to the burden of disease in Belarus



Source: IHME, 2024.

Note: Percentage of all deaths attributable to risk factors for both sexes and all ages. Shares overlap and therefore add up to more than 100%. Data refer to 2021.

Box 3

Belarus was one of the first CIS countries to implement the WHO Framework Convention on Tobacco Control

Belarus signed the WHO Framework Convention on Tobacco Control in June 2004 and ratified it in September 2005, being one of the first countries of the Commonwealth of Independent States (CIS) to do so. According to MPOWER reporting, complete measures have been implemented in monitoring and health warnings, with moderate measures in cessation programmes, mass media, advertising bans and taxation (WHO, 2023). Smoke-free environments have so far not been comprehensively implemented.

5 SPOTLIGHT ON HEALTH WORKFORCE TRENDS

The ratio of health workers has decreased slightly since 2013

As described in Section 3, Belarus has a higher rate of health workers than the average in the WHO European Region, at 447 physicians and 1005 nurses per 100 000 population, compared to 389 and 803, respectively. However, while most other countries in the WHO European Region have expanded their health workforce, according to international databases the ratio of doctors and nurses per population in Belarus has either stayed at a similar level or declined since 2013 **(Fig. 14)**. The number of nurses per population has returned to the level in 2013, when there were also 1005 nurses per 100 000 population. Meanwhile, the number of doctors per 100 000 population has decreased from 472 in 2013 to 447 in 2020. Nationally available data indicate a density of 385 doctors per 100 000 population in 2013, which may be due to methodological differences of quantifying the health workforce.

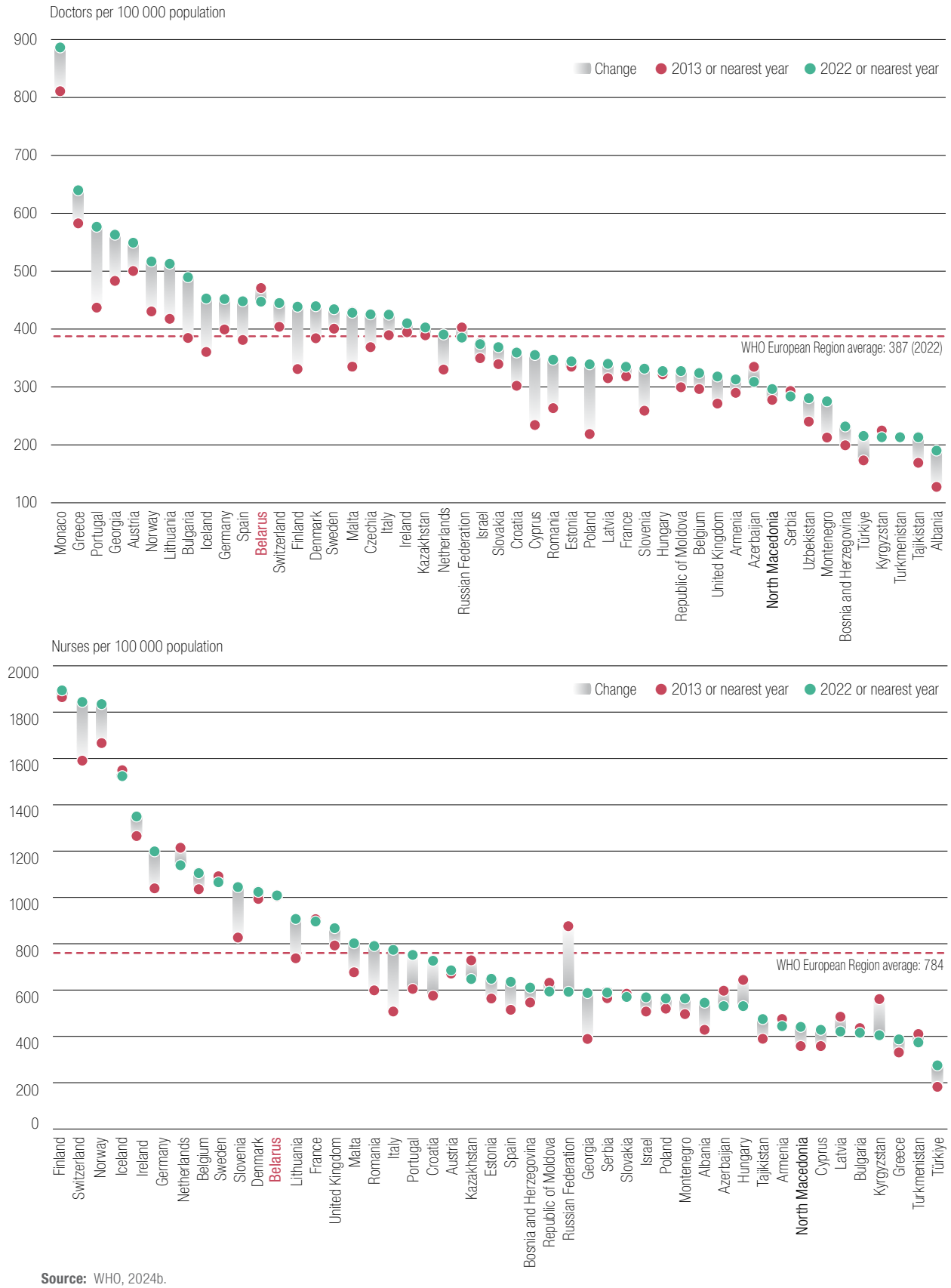
The number of graduating health workers has also fallen. The absolute number of medical graduates has dropped from 2767 graduates in 2016 to 2480 graduates in 2021, representing a decrease of 11.6%. The number of nursing graduates has decreased by 21.7% since 2012, from 2493 to 2048 graduates in 2020.

Most doctors in Belarus are women

In 2020, 73.5% of doctors in Belarus were women. Women have consistently made up at least 70% of the share of medical doctors since 2011. This is higher than in most other countries in the WHO European Region, with the exception of Latvia, with 73.9% of doctors being women in 2020. Reliable and up-to-date international data on other aspects of the health workforce in Belarus are currently not available.

Fig.14

The rates of doctors and nurses in Belarus have remained fairly stable in the last decade



Source: WHO, 2024b.

Note: The data plotted for nurses in Austria have to be treated with caution, due to breaks in the time series and switching between "licensed to practise" and "practising" workforce numbers.

6 EUROPEAN PROGRAMME OF WORK (EPW)

Moving towards universal health coverage

Objectives of the EPW are at the centre of the Biennial Collaboration Agreements between the Ministry of Health and the WHO Regional Office for Europe and they are implemented by the WHO Country Office in Belarus. With the support of WHO, the capacity of primary care workers was strengthened by developing and implementing the WHO-recommended mental health gap (mhGAP) approach in primary care. After passing national legislation allowing GPs to diagnose and treat common mental health conditions, clinical guidelines on depression, dementia, autism, harmful use of alcohol and smoking cessation were developed and training was conducted between 2021 and 2023. WHO provides further support in enhancing monitoring of the System of National Health Accounts and learning of good practices in health financing. There is ongoing technical collaboration with the Ministry of Health in the areas of MDR-TB and HIV control as part of the ongoing Global Fund (GFATM) grant implementation in Belarus. In 2023, comprehensive reviews of national TB and HIV programmes were conducted and recommendations were provided for the new Global Fund grant on MDR-TB and HIV for 2025–2027. WHO provides additional technical support in introducing e-health and ICD-11 in Belarus by implementing the WHO assessment mission on health information systems.

Protecting against health emergencies

The COVID-19 pandemic was met with collaboration at the highest levels. In 2020–2021, WHO provided support to strengthen the COVID-19 response in Belarus. This included procurement of emergency PPE, laboratory supplies, oxygen supportive treatment equipment, vaccination preparedness support, and technical assistance and capacity building activities. As part of strengthening health emergency preparedness, WHO supported enhancing infrastructure for vaccine preventable diseases that included procurement of cold chain specialized equipment and training.

Promoting health and well-being

Promoting health and well-being plays an important role in collaboration between WHO and the Ministry of Health in Belarus. Strengthening surveillance of NCDs and risk factors in Belarus was improved with WHO support by conducting nationally representative STEPS surveys on the prevalence of the risk factors of NCDs in Belarus in 2016 and 2020. Results of the STEPS survey have been used in preparation of the state programme "People's health and demographic security in Belarus 2021–2025". In the framework of the joint project with UNDP, UNICEF and UNFPA "Supporting the efforts of the Republic of Belarus in the nationalization and localization of the Sustainable Development Goals", WHO contributed to the development of educational videos for patients on the prevention of NCDs to support primary care workers in conducting motivational counselling and brief advice in promoting healthy lifestyles.

COUNTRY DATA SUMMARY

	Belarus	WHO European Region	European Union
Life expectancy at birth, both sexes combined (years)	74.6 (2018)	78.2 [a] (2022)	79.9 [a] (2022)
Estimated maternal mortality per 100 000 live births (2020)	1.1	12.6	6.4
Estimated infant mortality per 1 000 live births (2021)	2.1	6.3	3.2
Population size, in millions (2022)	9.5	929.1	512.7
GDP per capita, PPP$ (2021)	21 698	38 936	48 615
Poverty rate at national poverty lines, % of population	4.8 [b] (2020)	14.9 (2018)	17.0 (2018)

Sources: WHO Regional Office for Europe, 2024;

[a] Eurostat, 2024, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye; [b] World Bank Group, 2024.

Note: This table reports data that are publicly available from international sources. The latest national statistics for some indicators are included in the text.

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WHO Regional Office for Europe

WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region's future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

European Programme of Work 'United Action for Better Health in Europe'

The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens' expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. "United", because partnership is an ethical duty and essential for success, and "action" because countries have stressed their wish to see WHO move from the "what" to the "how", exchanging knowledge to solve real problems. The WHO European Region's solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policy-makers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.

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