11 ‘Ask us decently and then we will not reject anyone!’

Providing informal healthcare in a Kazakh medical space

Bakyt Muratbayeva and Benjamin Quasinowski

Introduction

Mobility tends to accompany new, strange and unknown contexts otherwise deemed stable and familiar, contexts characterised by taken-for-granted and approved, ‘good’ practices and ways of living. Thus, mobility can increase social contingency. As such, it also creates spaces of insecurity and fluidity, which, in turn, provide the conditions for the emergence of new forms of informality. Studying such spaces facilitates a theoretical examination of the connection between everyday aspects of mobility and informality. Vigorous debate surrounds the role and breadth of practices related to informal welfare provision in post-socialist countries (Polese et al. 2015). Is informality per se counterproductive with regard to attempts to guarantee universal welfare through the establishment of corresponding state infrastructures? Or can practices of informality take on a complementary function, existing alongside formal practices, in spaces beyond the reach of states’ formal practices related to welfare provision?

This chapter is an empirically grounded attempt to contribute to this debate. We focus on informal practices in primary healthcare (PHC) services for people occupying the margins of official regulations in rural Kazakhstan. Primarily, we argue that in post-Soviet Kazakhstan a number of practices related to the informal provision of healthcare have emerged in connection with a new mode of translocal mobility and the emergence of a new category of ‘paperless’ migrants. Alongside initiatives to reform and digitise the country’s healthcare system, these practices have recently come under pressure, although they persist today. These practices of informality tend to take on a complementary role to the formal provision of healthcare services, particularly in rural contexts where regulatory frameworks are often inconsistent or entirely absent.

Kazakhstan offers an interesting case for examining the connection between everyday aspects of mobility and informality for at least two reasons. Firstly, mobility is both a historical and contemporary constant of the country. According to the International Migration Report (2017), 20% of Kazakhstan’s population consists of international migrants. In absolute terms, this equates with over 3.5 million people, which, in turn, accounts for around 66% of the approximately 5.5 million international migrants in post-Soviet Central Asia (UN 2017: 25). The

population inhabiting Kazakhstan, the ninth-largest country in the world in terms of landmass, has long been mobile, from Kazakh nomads seeking better pastures (Olcott 1995) to the deportees sent there by Stalin (Pohl 2007), from students arriving through Khrushchev's Virgin Lands Campaign to today's Oralmandar—that is, the 'returnees' of the Kazakh diaspora (Diener 2005).

Secondly, Kazakhstan offers a paradigmatic case in mobility leading to new informal practices. In the literature on global health, the notion of PHC is often associated with the Alma-Ata Declaration (Packard 2016: 227). Although some serious efforts have been made by the Kazakh Ministry of Health towards implementing reforms (Obermann et al. 2016; Jones et al. 2017), universal health coverage and PHC remain unrealised (Lane 2018; Shukshin 2019). In particular, the '[p]rovision of healthcare in rural areas is one of the main challenges facing the Kazakh health system' (Footman et al. 2014: 190-191f). The decrease in financing available to the healthcare system after 1991 has yet not been completely reversed, leading to considerable amounts of private out-of-pocket payments for healthcare services (Shukshin 2019: 250). Rural areas and PHC facilities remain undersupplied in comparison to urban areas and hospitals (Rechel et al. 2013). Moreover, rural populations tend to have less access to pharmaceuticals (Footman et al. 2014: 190). Finally, a tradition of informal payments for health has existed for quite some time and remains widespread (Ensor 2004: 239).

In what follows, we first introduce the ethnographic field site from whence we drew our data. The structure of the chapter then proceeds in a way similar to a pair of binoculars, whereby we zoom in to focus on ever-smaller sections of the landscape at two different times: from a historical sketch of the emergence of biomedicine in Kazakhstan during the era of Soviet internal migration to its repercussions in a rural village community; then, from the flows of return migration amongst the Kazakh diaspora in the post-Soviet era back to the rural community, now undergoing some grave changes vis-à-vis its hospital, its discourses surrounding marginalised outsiders and informal practices related to healthcare provision.

Ethnographic research in a rural hospital

The research presented in this chapter was carried out within the context of two PhD projects: one focused on the role of ethnicity in medical interactions (Muratbayeva), and the other on the global diffusion of biomedical institutions (Quasinowski). We conducted ethnographic fieldwork in a village in eastern Kazakhstan and, specifically, in a local hospital. An acquaintance of ours, the director of the hospital, assisted us in gaining access to the community of Kyzylzhar¹ as well as to the hospital itself. The hospital served as our primary field site for more than 12 months between 2015 and 2017.

Kyzylzhar is located in a sparsely populated steppe area bordering China. Since the mid-twentieth century, Kyzylzhar has been home to a population of several thousand residents. A wave of out-migration followed the disintegration of the Soviet Union in 1991, when considerable segments of the village's ethnic Russians

and Germans left. Today, about 8500 people continue living in the village. Whilst the 1990s witnessed the shutdown and relocation of several factories and state-run enterprises, some important administrative and state-run infrastructure remains, including the local government office (*akimat*), a postal and telecommunications office, a police station and the local hospital. The hospital is divided into a number of functional sections. Firstly, it houses a clinic that primarily provides outpatient PHC services. Secondly, a small inpatient facility houses 15 beds. Thirdly, a small emergency department is staffed 24 hours a day with a paramedic (*fel'dsher*).

In the hospital, we completed observations, talked with and learnt from staff members and, with their consent, made video- and audio-recordings of their daily work activities. One focus of these observations was the daily conferences (*pyatiminutka*), which take place at 9.00 each morning and which most staff members attend. These daily conferences provide an organisational space for the exchange of information and for status updates on work-related issues, such as patients' health conditions or the hospital's current medical supplies. They also serve as nodes for orders and instructions—that is, for organising the administrative and organisational work of the hospital.

Here, we primarily rely on the existing literature on biomedicine and migration to and within Kazakhstan, data from our own observations and on our interviews with hospital staff.

Mobility and medicine in Soviet Kazakhstan

In order to develop an initial understanding of the daily affairs within the village hospital, it is important to situate it within a broader historical context and within the processes that led to the consolidation of biomedical knowledge and institutions in Kazakhstan (Michaels 2003; cf. Lock and Nguyen 2018 on the notion of biomedicine). The introduction of biomedical institutions in Central Asia is a relatively recent phenomenon, deeply interwoven with the establishment of Soviet power. The first period of this process of establishment, from around 1918 to 1941, was characterised by a slow but continuous growth and the spread of biomedical institutions into the rural areas of the country. According to the plans of Soviet officials, the benefits of biomedicine were to reach every corner of this large Soviet republic (Michaels 2003: 109). During that period, 'the original emphasis was on communicable disease control and the development of a rural primary healthcare infrastructure' (Katsaga et al. 2012: 15).

However, as Michaels shows, biomedicine—compared to more traditional forms of medicine—served not only the purpose of improving the overall health conditions of the population, but also held political significance. In the Kazakh Soviet Socialist Republic (SSR), the institutionalisation of biomedicine helped to diffuse and popularise the ideas of the Soviet cultural revolution. As Michaels argues, the Soviet authorities 'saw medical educational institutions as laboratories of social engineering' (2003: 96). Having learnt about political economy in special courses included in their curricula at universities, the new medical elite was not only charged with propagating the newest standards of hygiene but were also expected

to spread the words of Marx and Lenin. Doctors often became authoritative figures in their local communities and served as models of the 'new Soviet person'.

A second important period for the development of the biomedical infrastructure in Kazakhstan was the Second World War. Throughout this time, the Kazakh SSR witnessed two large migratory flows of members of the medical profession: one into the country, and the other out of the country. On the one hand, many practitioners were drafted into the Red Army, with many sent to the frontline of the war. As a consequence, the Kazakh SSR struggled with a severe lack of medical practitioners. The Soviet government attempted to compensate for this shortage by increasing the number of trained professionals. Simultaneously, Nazi Germany's attack on the Soviet Union in 1941 led to the evacuation of a number of important medical facilities from Moscow, Leningrad and other cities at risk of being attacked. Amongst the evacuated staff were some of Soviet Russia's key professors. After the end of the war, these professors began to play major roles in establishing medical facilities in the Kazakh SSR.

One consequence of these developments was that after the war more doctors and other medical professionals had been trained than ever before. Moreover, these professionals were no longer concentrated in the country's urban areas. As Michaels writes, 'By the early 1950s, meaningful headway had been made in bringing biomedicine to even the most remote areas of Kazakhstan' (Michaels 2003: 109). Thus, these developments suggest that migratory flows have been a key feature, or even driver, of biomedical institutionalisation in the territory of what is today the Republic of Kazakhstan.

This mode of mobility was not confined to medicine, however. Instead, mobility represented an experience historically shared by large parts of the country's population—that is, it represents a collective experience. In addition to the previously mentioned events specifically affecting the medical profession, a number of other events contributed to the formation of this collective experience in more general terms. Firstly, collectivisation, relocation and *dekulakisation* (the dispossession of peasants conceived of as large property owners) decimated the Kazakh population, from 3.6 million in 1926 to 2.3 million in 1939. These events also destroyed the last remnants of the nomadic way of life in the region (Kindler 2014; Olcott 1995; Alekseenko and Masanov 2000: 380). Secondly, with the onset of Stalin's purges in the mid-1930s, the sociocultural configuration of the Kazakh SSR continued to dramatically change as the country became the new home for hundreds of thousands of deportees (Martin 2001: 328). Amongst these were approximately 449,000 Germans, 24,500 Chechens, 100,000 Koreans and 81,000 Ingushets (Alekseenko and Masanov 2000: 390). Finally, with the land reclamation programmes initiated by Khrushchev following Stalin's death, which were intended to solve problems related to supplying the USSR with agricultural products, another estimated 1–2 million settlers came to the Kazakh SSR (Pohl 2007: 238; Olcott 1995: Ch. 10). These people were mainly sent to the northern parts of the country, which likewise became the primary destinations for forced 'special emigrants' (*specpereselency*) and former inmates of the Gulag system (Pohl 2007).

As a consequence of these multifaceted migratory flows, many rural villages suddenly comprised a mixture of socially and culturally diverse groups. Routines related to dealing with cultural and ethnic alterity and difference in everyday life became necessary. It seems that the collective experience of being a stranger, migrant or refugee or a victim of Stalinist repression facilitated the social integration of the newly emerging diversity. Thus, we argue that this very specific kind of collective experience of mobility laid the foundation for a particular kind of conviviality, which is often mentioned by members of the country's older generation when pressed to describe Soviet times (Pohl 2007: 251). If only because they often had no other choice, people devised ways of managing their daily dealings with cultural and ethnic others, even under circumstances where almost everyone was a stranger.

Conviviality was also encouraged by the creation and propagation of a mighty bureaucratic apparatus that supported the implementation of the Soviet model of international friendship (Martin 2001: 432–461). Soviet leaders propagated a view of the Kazakh SSR as a paradigmatic case of Soviet multiculturalism, and people learned to see the country as a 'laboratory of the friendship of peoples'. This model of multiculturalism aimed to secure the harmonious coexistence of a diverse population intended to bring about a bright socialist future.

A rural hospital and its institutional biography

The institutional biography of Kyzylzhar's hospital can be traced back to the 1970s. Officials originally chose a remote location to build an administrative centre for the newly organised district (*rayon*) in the east of the Kazakh SSR. In order to foster the development of the new district and its centre, young specialists from various fields and from different parts of the Soviet Union were sent there through government programmes. Doctors with their assistants, nurses and midwives arrived in the village, all with the aim of providing healthcare to a population sparsely distributed over the large sandy semi-desert landscape of the district. These local residents included the aforementioned resettled peoples, including individuals from the Caucasus, the Volga region and the Turkmen and the Uzbek SSRs. The hospital had the official status of being a central district hospital at that time, and featured various departments and housed a relatively broad range of medical professionals.

Many of the newly arrived professionals to Kyzylzhar also shared the experience of having settled down in a distant, unfamiliar place, as indicated earlier. In addition, almost all of the older members of the hospital staff shared similar experiences of geographical mobility—that is, everyone once came here as a stranger. But, in order to make a living, people had to build trust in each other and help one another.

Kyzylzhar's infrastructure, including the hospital itself, was poorly developed at that time. In an interview, one doctor who arrived in the early 1970s recounted how the hospital lacked access to drinking water then:

Kyzylzhar was terrible. Why? First, because there was no drinking water. We had to pump up the water from the wells. ... When I arrived, the hospital

was small and in an adobe building. ... There was a kind of dormitory in the centre. Over there was the polyclinic, the treatment room and so on. In general, it was a terrible building.

(Interview with Olga Stanislavovna, June 2017)

Despite such adverse circumstances, the young professionals working in the hospital were motivated and relied on each other. Living close to one another, they helped each other out and managed to deal with the many challenges accompanying the process of starting a new life in a desolate place. Many relations amongst staff members at that time were characterised by ties of friendship, community or kinship. Amongst the medical practitioners, an emotionally invested sense of belonging exists, to the hospital and the village alike.

Therefore, in the institutional biography of the village hospital, we can find the kind of collective experience of mobility that we described as typical for many people having grown up in Soviet Kazakhstan. We argue that this experience not only affected the medical practitioners of the village but also affected the village community at large. As such, it shaped not only many individual biographies but also the identity of the village community, its image and representation of itself as well as of outsiders. Or, to state this argument in the terminology of Appadurai (1996: Ch. 9), in Kyzylzhar, mobility served as a constitutive moment in the 'production of locality'.

However, social and economic processes that have been underway in Kazakhstan since the disintegration of the Soviet Union have also left their traces in Kyzylzhar. One consequence of these transformations is that the general parameters of mobility have changed for large parts of the country's population. As previously argued, whilst mobility has been a constitutive yet rather singular (non-recurrent) factor in people's individual life histories, in more recent years mobility has become something that many people recurrently experience. Temporary migration from Kyzylzhar to the larger urban centres, like Almaty or Karaganda, represents just one instance in a range of new kinds of translocal mobilities, which have begun to restructure peoples' lives.

As another case in point, consider the shuttle traders (*chelnoki*) who started a new way of doing business resulting from the introduction of a free market economy in the 1990s. Their business consists of buying goods, often imported from China, and then selling them in one's native or neighbouring village. Shuttle traders from Kyzylzhar have used the opportunities of the newly emerging transportation infrastructure as well. Whilst during Soviet times there was only one bus travelling to Almaty each week, now a number of shuttle buses (*marshrutka*) leave several times a day for Almaty and other cities in the region. Additionally, many taxi drivers connect Kyzylzhar to Almaty and other cities. A significant part of this recently emerged transportation infrastructure caters to people working in faraway places, whilst maintaining their homes and families in their native village of Kyzylzhar.

To summarise, the experiences and practices of geographical mobility typical for Soviet times have undergone significant changes since 1991. Importantly

for our research, these changes led to a new kind of collective experience, one analytically worth distinguishing. In contrast to the collective experiences shared by many people who arrived in Kyzylzhar before 1991, the post-Soviet collective experience of mobility seems to be much more translocal, dynamic and in flux.

Kazakhstan's repatriation programme and the Oralmandar

To a considerable extent, this new form of collective experience of mobility is associated with the repatriation and migration of the Kazakh Oralmandar. Following the disintegration of the Soviet Union, Kazakhstan was the only successor state to the USSR in which the 'titular nation'—that is, the ethnic Kazakhs of Kazakhstan—was not the demographic majority. However, this situation changed in subsequent years when Kazakhs again became the country's demographic majority. This was partly due to the emigration of people belonging to ethnic minorities, for instance, many Russians and Germans emigrated to their 'ancestral homelands'. But it also resulted from the immigration of Oralmandar, that is, Kazakh repatriates born outside of Kazakhstan. According to Kaiser et al. (2017), as of 2016, the number of Oralmandar who have returned to Kazakhstan totals just under 1 million. The overwhelming majority of them have arrived from Uzbekistan (61.5%), whilst others have migrated from China (12%), Mongolia (7.3%), Turkmenistan (3.9%), Russia (3.7%) and a number of other countries (Kaiser et al. 2017: 22).

The post-Soviet government initiated this repatriation programme with the declared aim of fostering the return migration of the Kazakh diaspora in 1992. By showing a clear preference for a right to immigration based on blood ties and ethnic heritage (*jus sanguinis*), in comparison to rights based on the place of birth (*jus soli*), such new migration laws in part resembled repatriation programmes adopted in Germany and Israel (Zeveleva 2014). According to the Kazakhstani law 'On the Migration of the Population' (*Zakon Respubliki Kazachstan o migracii naseleniya* 2011), an Oralman is

an ethnic Kazakh who permanently resided outside the borders of the Republic of Kazakhstan at the time of the acquisition of sovereignty, and her/his children of Kazakh nationality who were born and permanently resided after the acquisition of sovereignty by the Republic of Kazakhstan outside its borders, and who arrived in the Republic of Kazakhstan for the purpose of obtaining permanent residence in the historic homeland and who received the corresponding status in the manner established by this Law.

(§1, section 13; translation by the authors)

The repatriation programme was in part motivated by the government's interest in rebalancing the demographic situation mentioned above. Initially, the programme was accompanied by an optimistic spirit and an official rhetoric that served to legitimate ethnic immigration (Bonnenfant 2012). Proponents of the repatriation programme employed the discourse of victimisation and demographic rebalancing,

pointing to the prospective revival of Kazakh culture and traditions. This discourse has semantically underlined what is understood as ties of blood and historical kinship (Bonnenfant 2012: 33–34). A legislative and institutional framework was established, and Kazakhs born abroad could apply for inclusion in a quota system that provided social and financial benefits to them as returnees. At the same time, it was possible to immigrate as an Oralman outside of the quota system, with the overall rate of this second approach greatly exceeding that of those immigrating within the quota system (Kaiser et al. 2017: 22). The quota is defined annually by the government, and the rate of people included has changed considerably since 1992. In this regard, Bonnenfant (2012: 38) summarised the trend as follows:

While the number of households included in the quota in 1993 was 10 000, during the period of the economic crisis in 1999, this number dropped to as low as 500. Between 2005 and 2008, 15 000 families have enjoyed benefits as 'quota Oralmandars' each year; since 2009, this number has increased to 20 000 families annually.

However, in 2009, for the first time since the system was launched, the number of Oralman families actually immigrating to Kazakhstan fell below the quota (Zakon 2010).

The dynamics of the quota system clearly reflect changes in the country's migration policies and political discourses, since 'Kazakhstan adjusted its repatriation policies as its political needs changed' (Werner et al. 2017: 1569). Whilst at the beginning of the repatriation programme official rhetoric was optimistic, in later years, when the perceived demographic problems had been solved, the initial optimism gave way to a discourse pointing to the social problems associated with immigration, such as an unwillingness amongst the Oralmandar to adapt to their 'historic homeland' (Bonnenfant 2012: 34–35; Werner et al. 2017: 1578).

A public statement by Timur Kulibayev, one of Kazakhstan's most powerful businessmen, and son-in-law of former President Nursultan Nazarbayev, illustrates how these dynamics are reflected in the country's political climate. When, in 2011, oil field workers went on strike in the town of Zhanaozen, the government of Kazakhstan announced a state of emergency and several people were shot by the police. According to Kulibayev, the strikes were instigated by Oralmandar coming from Uzbekistan and Turkmenistan. Kulibayev eagerly singled out problems that these migrants allegedly had with integrating into Kazakhstani society (Tengrinews 2011). His statement is striking, because in the political culture of the country public denigrations specifically referring to another's ethnicity or nationality are usually frowned upon, whereby an unwritten ethics of 'politically correct' language is common.

However, when one looks at Kulibayev's public statement within the broader context of changes in political discourse that took place after the initial optimism about Oralmandar repatriation faded, his apparent transgression of political correctness makes sense—the Oralmandar had meanwhile emerged

as a problematic social category. Thus, Kulibayev's criticism simply echoed a resentment felt by many Kazakhstanis today. Not coincidentally, the quota system for Oralmandar was suspended for the two years following the strikes in Zhanaozen (Natsuko 2013: 7–9).

Who are the Oralmandar of Kyzylzhar?

We identified repercussions from these political discourses, which associated the term 'Oralman' with a range of social problems, extending to Kyzylzhar as well. Almost one-third of the village's population is Oralmandar. Oralman families have been arriving in the village since the early 1990s. Most came from Uzbekistan's Karakalpakstan republic and from the Xinjiang autonomous region in China. In Kyzylzhar, the Oralmandar seemingly occupy outsider positions, not unlike the 'newcomers' in the social configuration famously described by Elias and Scotson (1965). Through these outsider positions, the Oralmandar stand in stark contrast to 'established' community members, many of whom once came to the village as migrants themselves. Unlike the Oralmandar, however, these established community members, at least their families, have lived in the village for many decades now. Many of them share the kind of collective experiences associated with the Soviet-era mobility we described above.

This social configuration between outsiders and established community members is reflected in the social structure of the village. Kyzylzhar was a large livestock-breeding *kolkhoz* (collective farm) in Soviet times. In fact, many villagers still make a living as herders and stockbreeders. However, herding and stockbreeding are particularly common amongst the village's Oralman families. Yet, the Oralmandar are rarely engaged in small or middle-size businesses, and even less often occupy positions within municipal institutions and administration.

Moreover, this social configuration of outsiders and established community members is also reflected in the hospital's social structure. A handful of Oralmandar from Karakalpakstan work in the lower strata of the occupational hierarchy, for example, as cleaners, cooks or electricians. Amongst the medical staff, there is only one Oralman working as a paramedic. By contrast, in the higher occupational ranks, such as amongst medical doctors or medical assistants, there are no Oralmandar. In other public or state institutions such as schools, the 'house of culture', the police or the municipal administration, the situation looks quite similar.

In addition to unequal access to prestigious positions in the community's social structure, this social configuration is discursive as well. Although the Oralmandar are viewed as keepers of the Kazakh language, culture and traditions, they are often shunned by established members of the community—that is, by Kazakhs and non-Kazakhs born in Kazakhstan. From the perspective of many of the established community members, the Oralmandar are perceived as uneducated, unhygienic, either too religiously zealous or individuals who drink too much alcohol. Thus, amongst established community members, the term 'Oralman' has taken on a pejorative connotation. This is especially true with regard to those Oralmandar

who are 'paperless persons' (*dokumentter žoqtar*)—that is, people referred to as Oralmandar, but who actually lack the legally recognised status as an Oralman. From a juridical point of view, the category of 'paperless Oralmandar' is a paradox. The term 'Oralman' in the strict sense of the law signifies an individual's ownership of a special status (and, thereby, in possession of official papers). However, the same category used in everyday language and in connection with the attribute of 'paperless' denotes an understanding that the person's residence is illegal.

As Diener (2005: 334) observed, partly due to migration laws fraught with inconsistencies, the term 'Oralman' has taken on a range of different meanings since it was devised in 1994. It is, thus, analytically important to distinguish between different domains in which the term is used today. From the range of different domains, we only single out two here. Firstly, there is the juridical domain, defined in the aforementioned law 'On the Migration of the Population'. Secondly, there are situations during which people speak of the Oralman in everyday life, using ordinary language, in which they mostly do not orient towards the juridical definition of the term. In contrast to the juridical definition, in the domain of everyday life, the term carries a broad range of dimensions, such that in each individual situation its meaning may remain highly ambivalent. Unlike the official, or juridical, designation, community members use the term to refer to a number of different categories of people. Consequently, people referred to as Oralmandar are not necessarily Oralmandar in the juridical sense. For example, there are cases where families were granted the juridical status of Oralmandar but then failed to obtain Kazakhstani citizenship within the restricted time frame reserved to do so. In this case, they lost their legal status as Oralmandar. However, in everyday life, they continue to be referred to as Oralmandar, notwithstanding their actual legal status.

With regard to the origins of individual migrant families, the term 'Oralman' is primarily reserved for Kazakhs coming from China and Uzbekistan (especially from the autonomous region Karakalpakstan). Ethnic Kazakhs who migrated from Kyrgyzstan tend not to be referred to as Oralmandar. Furthermore, internally migrating Kazakhs born in Kazakhstan (i.e., Kazakhs coming to Kyzylzhar from another place in Kazakhstan) are not referred to as Oralmandar. In all of these cases, the designation of the term 'Oralman', as used in everyday life, can contradict the meaning it carries in the juridical sense.

In short, the term 'Oralman' was once devised by government officials and introduced into the public discourse with rather precise political intentions. The term held a quite specific juridical denotation. Today, it has taken on a range of different meanings depending on the contexts and domains of its usage. Thus, the use of the term in ordinary language is often independent of its juridical or official political meaning.

Registr prikreplennogo naseleniya and the emergence of new informal practices in medical treatment

One of the problematic issues within the domain of medicine in Kazakhstan concerns free PHC. It is in this domain that informal practices become analytically

salient, partly because of their existential significance for people in need of basic healthcare services. In an attempt to compensate for the decline in public funding for healthcare after 1991, many post-Soviet countries introduced a distinction between, on the one hand, free benefit packages of health and, on the other hand, health services for which a fee is charged (Rechel et al. 2013: 1151). In Kazakhstan, this distinction, first of all, concerns its citizens. By contrast, foreign citizens are guaranteed healthcare services on a pay-per-use basis (Riekkinnen et al. 2015). In this regard, it is important to remember that the Oralmandar are legally endowed with a legal status placing them on equal footing with citizens of Kazakhstan across several domains. Accordingly, the ‘Code of the Republic of Kazakhstan on the People’s Health and Healthcare System’ (*O zdorov’e naroda i sisteme zdravoochraneniya*) states that every citizen of the Republic of Kazakhstan as well as the Oralmandar are guaranteed the free benefits package—that is, the so-called state-guaranteed health benefits package (Jones et al. 2017).

In this case, the term ‘Oralmandar’ clearly denotes those persons who fall under the category ‘Oralman’ by virtue of the law ‘On the Migration of the Population’. However, cases have been reported wherein PHC, even in emergency situations, was denied to non-Kazakhstani citizens and Oralmandar alike (Zakon 2013). In the Kyzylzhar hospital, one important reason medical professionals withhold, at least formally, the provision of healthcare services is connected to a recently introduced electronic database system. This system dates back to an attempt to simplify and centralise procedures in the healthcare field in 2010. At that time, the Ministry of Health of Kazakhstan issued a law regarding the creation of a unified healthcare information system (*Registr prikrepennogo naseleniya* or RPN). RPN was intended to contain data on individual patients attached to local healthcare organisations (Katsaga et al. 2012: 29).

Prior to the introduction of RPN, a close connection existed between patients’ permanent residence and the medical organisations to which patients were attached. The idea behind tying the provision of healthcare to local residence dates back to the Soviet *propiska*, a system for managing internal migration and cutting off unregulated migration flows (Buckley 1995). With the new RPN, the government’s intention was to detach patients’ residence from the local medical organisations to which patients had been attached. This would offer citizens more opportunities in terms of individual choice in the provision of healthcare. From the perspective of lawmakers and policy experts in faraway Astana, Kazakhstan’s capital (renamed Nur-Sultan in 2019), this seemed like a reasonable decision for a country with an increasing rate of internal migration. As we argued above, since 1990, increasing numbers of people had adopted translocal and mobile lifestyles. Thus, the new migratory realities conflicted with the inherited Soviet institutions and their specific bureaucratic practices.

RPN stores information on each patient in a central, countrywide database. It enables individual medical organisations and healthcare professionals to retrieve information about a particular patient, regardless of whether the patient is already registered in that organisation or not. Moreover, the procedure of registering patients has now become centralised. Thus, from the perspective of policymakers,

it should have become much easier for patients and hospital administrators to detach patients from one hospital and attach them to another hospital in which they intend to undergo medical treatment. That is, registering new patients goes hand in hand with detaching them from the hospital to which they were previously attached. Thus, ideally a few clicks on a computer screen would achieve what previously involved much time-consuming paperwork.

But, in reality, the transition to the electronic RPN did not proceed as smoothly as planned in Astana. At least for Kyzylzhar, we find substantial evidence suggesting that the hospital's medical professionals experienced a range of problems with the new system. One of these problems resulted from a lack of technical knowledge and resources. Since the average age of staff members was relatively older, many experienced considerable problems with regard to the technical know-how and skills associated with computer-assisted administrative work, to which they were not accustomed. For instance, for Olga Stanislavovna, the hospital's oldest physician in her seventies and who still sees patients full-time, working on a computer frequently results in unpleasant experiences. We observed on one occasion that some intractable problems with the computer software literally brought her to tears. This is only partly due to her advanced age, but also due to the fact that the digitalisation of patient data only recently began in the village hospital. Previously, only a few offices and surgeries were equipped with personal computers. Even today, when most offices in the hospital are equipped with a desktop computer, the computer's hardware is outdated. Consequently, even younger medical professionals frequently experience difficulties when processing piles of patient files from paper to the new electronic database.

This lack of technical knowledge and modern equipment accounts for some of the difficulties the hospital staff experienced with the electronic RPN. But other problems emerged as well. Prior to the introduction of the new system, patients who lacked official documents, including the 'paperless' Oralmandar, were primarily treated by circumventing official regulations. With the introduction of RPN, some hospital patients who previously received treatment with hardly any bureaucratic hurdles were suddenly cut off from medical services.

However, even before the electronic RPN was introduced, the free provision of medical services to non-citizens and 'paperless persons' had not been envisaged by Kazakhstan's legislation. As the hospital director and others explained to us, providing care to patients not officially registered by bypassing official regulations had become much harder due to the centralised electronic storage of patient data. Prior to the introduction of RPN, patient files had not been assigned unique numbers directly associated with citizen ID cards (the so-called *individual'niy identifikacioniy nomer* or IIN). Since medical cards and ID cards had previously been independent of each other, an individual's lack of Kazakhstani citizenship could not be deduced from her/his medical card. According to several medical professionals with whom we talked, in the period prior to the introduction of RPN, they had mostly tried their best to somehow provide healthcare services even to 'paperless' patients, sometimes free of charge, sometimes for a small compensation such as a good chunk of meat, goat's cheese, a bottle of milk

or a small amount of money. These kinds of informal practices can hardly be categorised as outright acts of corruption. Instead, these represent practices of gift giving, making it acceptable for physicians to transgress certain regulatory lines and for patients to reciprocate these same transgressions with an act of gratitude.

With regard to the perception of the informal practices in question here, they can be understood as in line with the aforementioned social configuration of established community members and outsiders (see the section ‘Who are the Oralmandar of Kyzylzhar?’ above). On the one hand, an ethos exists amongst the village’s doctors, who all belong to the group of established community members, according to which all patients have a right to be helped, regardless of their official status or the documents they do or do not possess. On the other hand, those same doctors may think that, when helping such patients, they actually provide a rather generous, albeit undeserved, service to patients whom they consider as outsiders and often as culturally and socially inferior to themselves. This kind of thinking has likely stabilised the previously described social configuration of established community members and outsiders, since almost all patients who fall under the aegis of informal practices for healthcare provision are also positioned as outsiders within this configuration.

Of course, apart from the Oralmandar, some other categories exist, consisting of patients who cannot be treated within the framework of official regulations. For instance, there are a handful of people in the village who still have not exchanged their Soviet passports for the new passport of the Republic of Kazakhstan. From a legal point of view, these individuals are foreigners or stateless persons. Furthermore, there are non-Kazakh migrants from neighbouring countries, who have not yet obtained permanent residence permits. Nonetheless, the bulk of the beneficiaries of the informal healthcare provision practices described here are the ‘paperless’ Oralmandar.

In view of this complex situation, it may seem surprising that the aforementioned informal practices have persisted following the introduction of the RPN system. But the new system seems to reinforce the existing differentiation between established community members and outsiders. In particular, this concerns those outsiders who have neither Kazakhstani citizenship nor the legally recognised status of Oralman. For the ‘paperless’ Oralmandar, it is impossible to register within the RPN system. As Gauhar Kayratovna, one of the doctors, explained to us, the network of official monitoring and budgeting in the healthcare system has become more closely interconnected than ever before. Furthermore, the hospital’s budget is now tightly linked to the number of officially registered patients. As she explained,

They [the ‘paperless’ Oralmandar] are not on the list of the RPN, they are not our patients. Therefore, we are not allowed to provide any medical services to them. We don’t get paid for such people and, besides, if we will treat them, we will have problems with the higher ranking medical authorities afterwards.

(Interview with Gauhar Kayratovna,
October 2015)

Throughout our time in the hospital, we observed that, despite such assertions, which appear to be accounts of how things *should* be according to official regulations, the informal practices in question have indeed persisted. That is, the 'paperless' Oralmandar continue to receive medical treatment. However, providing healthcare to them has become much more clandestine than before, whereby doctors officially deny it (but not unofficially) to the beneficiaries. Meanwhile, the Oralmandar continue to be perceived as a problematic social category in the context of the village community.

Here, we wish to provide an illustration of this perspective characteristic of healthcare professionals using an excerpt from a discourse in one of the daily case conferences. This case demonstrates how medical professionals from the hospital reflect upon the question of who will be granted PHC and under what conditions. One of the tasks of the hospital's nurses involves monitoring certain categories of people in the village, such as children and the elderly. But this monitoring also includes keeping track of the number of 'paperless persons' in the village. Each nurse working in the hospital is responsible for monitoring the population of one street in the village (usually this is the street where the home of the nurse is located). Nurses regularly brief on their monitoring duties during the daily conferences.

Immediately prior to the following discussion transcribed below, one of the nurses, Nazgul (NA), reported to her colleagues—in particular, to the doctors Gauhar Kayratovna (GK) and Kudaybergen Curbashev (KC)—about three Oralmandar living on the street she monitors. According to Nazgul's description, the three Oralmandar had a residence permit but did not intend to obtain Kazakhstani citizenship.

Transcript 20160414 (simplified version, translated from Kazakh and Russian)

-
1	GK	Because they are citizens of China and they receive certain social benefits there.
2		(3.0)
3	KC	No, a residence permit, for example—
4	NA	They have it, they have it.
5	KC	One can have a residence permit for their whole life!
6		(1.2)
7	KC	But they should not ask us for anything!
8		OK, tell all of them, 'Those who don't have legal documents for
9		the Republic of Kazakhstan are served on a fee basis.'
10		'Go to the district centre, pay your fee and then come back!'
11		(0.4)
12	KC	All of them have to learn this!
13		(2.0)
14	KC	No, if it is for children, they are innocent, we don't mind.
15		But there are those who trample over you, damnit!
16	ST	Right.
17	KC	The Karakalpaks and the Turkmens. I'm talking about these people.
18		Ask us decently, and we won't reject anybody.
19		They play the boss, but actually they don't have any rights!
-

In line 1 of this transcription, Gauhar Kayratovna explains the motives underpinning the Oralmandar's decision to retain their Chinese citizenship. Since they are unwilling to relinquish their Chinese citizenship, they cannot obtain Kazakhstani citizenship. However, it turns out that they have residence permits and, thus, reside in the village legally (lines 3–4). Hospital director Kudaybergen Curbashevich, then, reflects upon how to deal with these Oralmandar and instructs his subordinates accordingly (lines 5–19).²

This discourse shows how the mode of translocal mobility we described as a characteristic feature of post-Soviet times is framed as a highly problematic issue here. Kudaybergen Curbashevich refers to presumably official regulations in the provision of healthcare services (lines 7–10). Simultaneously, he specifies the conditions under which the official rules should be circumvented (lines 14–19). Importantly, he mentions the possibility of circumventing the official regulations not merely as a discursive statement. That is, his discourse is consistent with ethnographic observations we repeatedly made throughout our fieldwork: in almost all cases where, from an 'official' point of view, the provision of healthcare services would not be possible, due to, for example, the lack of citizenship or another suitable legal status, medical professionals from the hospital actually did provide the healthcare services deemed necessary. The excerpt above, thus, exemplifies how medical professionals create room to manoeuvre, which exists despite the official regulations regarding providing healthcare services. In other words, there is a discrepancy between, on the one hand, the official discourse and legal regulations and, on the other hand, the actual provision of healthcare services under practical circumstances.

For people at risk of being excluded from PHC, like some of Kyzylzhar's 'paperless' Oralmandar, this may turn out to be favourable. However, the informality created through this means of providing healthcare services introduces an element of arbitrariness into medical practitioners' decision-making when determining who they will or will not treat. Thus, the kind of informal provision of healthcare we observed in the hospital of Kyzylzhar is likely to reinforce existing inequalities, which can be conceptualised according to Elias and Scotson's (1965) social configuration of outsiders and established community members.

Our own observations are confined to one rural village in the east of Kazakhstan. Thus, we can only make educated guesses regarding the situation in other rural communities, let alone other regions of the country. However, the provision of healthcare services seems to remain an unsettled issue, especially in Kazakhstan's 'remote, loosely populated countryside areas' (Riekkinnen et al. 2015: 127). The precarious situations of the Oralmandar, particularly those who are 'paperless', have been described for other regions of Kazakhstan as well. We would, therefore, expect to find social configurations similar to that we have described in this chapter, with their specific problems related to practices of informality existing throughout the country.

Conclusions

In this chapter, we evaluated a selection of data from our fieldwork in one rural hospital in Kazakhstan. In doing so, we have attempted to contribute to the growing subfield of informality studies in post-socialist countries. We situated the ethnographic site of our research within the broader historical scope of biomedicine in Kazakhstan. We argued that many of the biomedical institutions and their practitioners during the Soviet era were characterised by a specific mode of mobility associated with collective migratory experiences, such as that of 'being sent' far away.

Following the disintegration of the Soviet Union in 1991, a different mode of mobility emerged. This mode is translocal, much more dynamic than the typical Soviet mode of mobility and is characterised by its recurrence over individual lifespans. Kazakhstan's Oralmandar represent one of the social categories particularly affected by this post-Soviet form of mobility. As people whose family networks and mobile lifestyles are often spread across several countries, healthcare systems, labour markets and jurisdictions, they are also especially affected by the respective regulatory frameworks in each of these contexts.

We examined the emergence and persistence of informal practices vis-à-vis the provision of PHC using the example of one rural hospital. Whilst from a strictly juridical point of view the 'paperless Oralmandar' are not legally entitled to treatment, they have actually been provided with free PHC services here. Following the introduction of a new healthcare information system, the informal provision of healthcare services became more difficult. However, these informal practices have actually persisted. For the 'paperless' Oralmandar, this persistence is favourable in a certain sense. However, in the long term, the persistence of informal treatment practices may become a barrier to the integration of the Oralmandar—and other vulnerable minorities—into local communities, such as Kyzylzhar. Without the possibility of claiming their rights to PHC on a substantial legal basis, these groups will depend upon the arbitrary decisions of local healthcare providers.

Notes

- 1 We have used pseudonyms for all names of places and persons used in this chapter.
- 2 He refers to the Oralmandar from Karakalpakstan and Turkmenistan as Karakalpaks and Turkmens, respectively.

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