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KAZAKHSTAN MODEL OF HEALTHCARE FINANCING THROUGH PUBLIC HEALTH PRINCIPLE: EXPERIENCE AND PROSPECTS

Denis V. Panchenko[1], https://orcid.org/0000-0002-0947-1074

Assiya K. Turgambayeva[2], https://orcid.org/0000-0002-2300-0105

Zaituna A. Khismetova[3], https://orcid.org/0000-0001-5937-3045

[1]State institution «Department of Public Health of the city of Nur-Sultan», Nur-Sultan, Republic of Kazakhstan;
[2] NCJSC «Astana Medical University», Nur-Sultan, Republic of Kazakhstan;
[3]NCJSC "Semey medical university", Semey, Republic of Kazakhstan.

Abstract

Introduction. The relevance and the initial stage of the development of the issue of Kazakhstan's way of financing domestic healthcare, its theoretical and practical significance have become decisive in choosing the topic, goals and objectives of this study.

Objective. Assessment of the validity and necessity of changing the financing model of the healthcare system of the Republic of Kazakhstan, due to the introduction of compulsory social health insurance.

Materials and methods: financial aspects of the formation of new approaches to the healthcare system aimed at sustainability, efficiency and socio-economic growth. The theoretical and methodological basis of the study was the scientific works of Kazakhstani and foreign authors on the financing of healthcare systems, including domestic ones. The methods of theoretical (analysis and synthesis, induction and deduction), empirical (comparison) research, as well as statistical data processing were used.

Results and conclusion. It has been determined that the current model cannot be called fully insurance, but rather budgetary and insurance. It does not cover the entire population: at the end of 2020, the share of uninsured persons amounted to 16.2% of the total population of the country, in other words, health insurance, being de jure compulsory, is not de facto. At the same time, the state continues to bear significant costs to ensure the guaranteed volume of free medical care, their share in 2020 amounted to 66.6% of the total funding, and insurance of fifteen privileged categories of persons - 54% of all revenues fell on state contributions.

***Keywords**: health insurance, public health, financing model.*

Резюме

КАЗАХСТАНСКАЯ МОДЕЛЬ ФИНАНСИРОВАНИЯ ЗДРАВООХРАНЕНИЯ ПО ПРИНЦИПУ ОБЩЕСТВЕННОГО ЗДРАВООХРАНЕНИЯ: ОПЫТ И ПЕРСПЕКТИВЫ

Денис В. Панченко[1], https://orcid.org/0000-0002-0947-1074

Асия К. Тургамбаева[2], https://orcid.org/0000-0002-2300-0105

Зайтуна А. Хисметова[3], https://orcid.org/0000-0001-5937-3045

[1] Государственное учреждение «Управление здравоохранения города Нур-Султан», г. Нур-Султан, Республика Казахстан;
[2] НАО «Медицинский университет Астана», г. Нур-Султан, Республика Казахстан;
[3] НАО «Медицинский университет Семей», г. Семей, Республика Казахстан.

Актуальность. Актуальность и начальный этап разработки вопроса казахстанского пути финансирования отечественного здравоохранения, его теоретическая и практическая значимость стали решающими при выборе темы, целей и задач данного исследования.

Цель. Оценить обоснованность и необходимость изменения модели финансирования системы здравоохранения Республики Казахстан в связи с внедрением обязательного социального медицинского страхования.

Материалы и методы. Финансовые аспекты формирования новых подходов к системе здравоохранения, направленных на устойчивость, эффективность и социально-экономический рост. Теоретической и методологической основой исследования послужили научные работы казахстанских и зарубежных авторов по вопросам финансирования систем здравоохранения, в том числе отечественных. Использовались методы теоретического (анализ и синтез, индукция и дедукция), эмпирического (сравнение) исследования, а также статистической обработки данных.

Результаты и выводы. Было выявлено, что сегодняшнюю модель нельзя назвать полностью страховой, а скорее бюджетной и страховой. Она не охватывает все население: на конец 2020 года доля незастрахованных лиц составляла 16,2 % от общей численности населения страны, иными словами, медицинское страхование, будучи де-юре обязательным, де-факто не является. В то же время государство продолжает нести значительные расходы по

обеспечению гарантированного объема бесплатной медицинской помощи, их доля в 2020 году составила 66,6 % от общего объема финансирования, а страхование пятнадцати льготных категорий лиц - 54 % всех поступлений пришлось на государственные взносы.

Ключевые слова: *медицинское страхование, общественное здравоохранение, модель финансирования.*

Түйіндеме

ҚОҒАМДЫҚ ДЕНСАУЛЫҚ САҚТАУ ҚАҒИДАТЫ БОЙЫНША ДЕНСАУЛЫҚ САҚТАУДЫ ҚАРЖЫЛАНДЫРУДЫҢ ҚАЗАҚСТАНДЫҚ МОДЕЛІ: ТӘЖІРИБЕ МЕН ПЕРСПЕКТИВАЛАРЫ

Денис В. Панченко[1], https://orcid.org/0000-0002-0947-1074

Асия К. Тургамбаева[2], https://orcid.org/0000-0002-2300-0105

Зайтуна А. Хисметова[3], https://orcid.org/0000-0001-5937-3045

[1] Мемлекеттік мекеме «Нұр-Сұлтан қаласының денсаулық сақтау басқармасы», Нұр-Сұлтан қ., Қазақстан Республикасы;
[2] КеАҚ «Астана медицина университеті», Нұр-Сұлтан қ., Қазақстан Республикасы;
[3] КеАҚ «Семей медицина университеті», Семей қ., Қазақстан Республикасы.

Өзектілігі. Отандық денсаулық сақтауды қаржыландырудың қазақстандық жолы мәселесін әзірлеудің өзектілігі мен бастапқы кезеңі, оның теориялық және практикалық маңыздылығы осы зерттеудің тақырыбын, мақсаттары мен міндеттерін таңдау кезінде шешуші болды.

Мақсаты. Міндетті әлеуметтік медициналық сақтандыруды енгізуге байланысты Қазақстан Республикасының Денсаулық сақтау жүйесін қаржыландыру моделін өзгертудің негізділігі мен қажеттілігін бағалау.

Материалдары мен әдістері. Тұрақтылық, тиімділік және әлеуметтік-экономикалық өсуге бағытталған денсаулық сақтау жүйесіне жаңа тәсілдерді қалыптастырудың қаржылық аспектілері. Зерттеудің теориялық және әдіснамалық негізі денсаулық сақтау жүйесін, оның ішінде отандық денсаулық сақтау жүйесін қаржыландыру мәселелері бойынша қазақстандық және шетелдік авторлардың ғылыми жұмыстары болды. Теориялық (талдау және синтез, индукция және дедукция), эмпирикалық (салыстыру) зерттеу, сондай-ақ деректерді статистикалық өңдеу әдістері қолданылды.

Нәтижелер және тұжырымдар. Бүгінгі модельді толығымен сақтандырудан бұрын, керісінше бюджеттік және сақтандыру деп атауға болады. Ол бүкіл халықты қамтымайды: 2020 жылдың соңында сақтандырылмаған адамдардың үлесі елдің жалпы халқының 16,2% құрады, басқаша айтқанда, де-юре міндетті болып табылатын медициналық сақтандыру іс жүзінде жоқ. Сонымен қатар мемлекет тегін медициналық көмектің кепілдік берілген көлемін қамтамасыз ету бойынша елеулі шығыстарды көтеруді жалғастыруда, олардың үлесі 2020 жылы қаржыландырудың жалпы көлемінің 66,6% - ын құрады, ал он бес жеңілдікті санаттағы адамдарды сақтандыру-барлық түсімдердің 54% - ын мемлекеттік жарналарға тиесілі болды.

Түйінді сөздер: *медициналық сақтандыру, қоғамдық денсаулық сақтау, қаржыландыру моделі.*

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Introduction

The national health system is an integral part of the social policy of any country. Its reforming in modern conditions and taking into account international trends is an extremely important issue, since it is not only about what should correspond to the prevailing realities, but also about the need to meet the needs of the entire population.

In other words, health care is one of the most important sectors contributing to the development of the economy, since the availability and quality of human resources depends on it [1,2,3].

The degree of scientific elaboration: theoretical and methodological issues of the formation and reform of the health care system in Kazakhstan, including its financing, at certain stages have already been analyzed by research scientists. These include the works of *A.A. Akanov, M.A. Aliev, M.K. Kulzhanov, O.T. Zhuzzhanov, T.Sh. Sharmanov, V.N. Devyatko. Ilyasova K.K., Tuseeva M.Kh., Kim S.M., Isakhova P.B.* paid special attention to the financing of health care.

Thus, despite the contribution of researchers to the development of the model of financing the health care system

in our country, all of them were carried out at various stages of its reform, in other words, the issues of the practical implementation of the next attempt to introduce compulsory health insurance at the present stage have not yet been analyzed in detail. The population in reality felt the changes only six months after its official introduction. In this regard, there are no in-depth scientific studies reflecting the positive and negative aspects of the ongoing processes, primarily related to the timeliness of receiving the necessary treatment and the adequacy of funding for medical organizations, including the proportionality of tariffs to real costs.

The relevance and the initial stage of the development of the issue of the Kazakhstani way of financing domestic health care, its theoretical and practical significance became decisive in choosing the topic, goal and objectives of this study.

Aim of the study: Assessment of the feasibility and necessity of changing the model of financing the health care system of the Republic of Kazakhstan, due to the introduction of compulsory social health insurance.

To achieve this goal, we are supposed to solve the following tasks:

1) study the previous experience of introducing compulsory health insurance and the prerequisites for the current actions of the state;

2) identify the risks requiring revision and changes in the implemented financing model;

3) develop practical recommendations on tariff policy aimed at further successful implementation of health insurance.

Materials and methods. Financial aspects of the formation of new approaches to the health care system aimed at sustainability, efficiency and socio-economic growth.

The theoretical and methodological basis of the study was the scientific works of Kazakhstani and foreign authors on the financing of health care systems, including domestic. The methods of theoretical (analysis and synthesis, induction and deduction), empirical (comparison) research, as well as statistical data processing were used.

The information base of the study was made up of scientific literature on the available global models of financing health systems, scientific articles, normative legal acts of the Republic of Kazakhstan that are in force earlier and at the present time, statistical data, materials of periodicals and reports, as well as practical developments of the Ministry of Health of the Republic of Kazakhstan, the Fund social insurance and the Republican Center for Healthcare Development.

Theoretical significance: the study made it possible to summarize and systematize at a sufficient level a large amount of material related to the main stages in the development of the model of financing the health care system in Kazakhstan.

Practical relevance: lies in the development of a number of recommendations aimed at further successful implementation of health insurance, including in tariff policy. The assessment of socio-economic processes that determine the use of financing mechanisms for the health care system in Kazakhstan, the principles of medical care provided within this framework, as well as the trend of modernization of the industry.

The state funding model to a greater extent guarantees the observance of the principle of social justice, since it provides predominantly the entire population with equal access to medical care. In contrast to the private model, it is based on the principle of allocating funds not according to citizens' ability to pay, but according to their needs [16].

Most often, the budget model surpasses the private model in terms of the efficiency of spending, since reliance on private funding can lead to an excessively sharp increase in health care costs [3]. Moreover, this tendency also takes place when using the insurance model, subject to the active development of the voluntary health insurance mechanism.

In the insurance model, informal employment can also develop, and as a result, the shortfall in funds due to the concealment of income by the employed and self-employed. It is also susceptible to the effects of an aging population, provided that the contributions for this category are fully paid by the government.

As noted above, the budget model is extremely sensitive to financial crises and related tax shortfalls.

Thus, the choice of this or that model depends on many factors, which should be based on an analysis of the available opportunities to ensure adaptation to changing priorities as soon as possible. That is why, in its pure form, none of these models is found in any country.

Until the beginning of the 20th century, the population living in the territory of modern Kazakhstan, for the treatment of diseases, resorted mainly to the services of the so-called traditional healers. Taking into account the fact that officially the great sanitary awakening in the world began at the beginning of the 19th century, the imperial government sought to organize medical care for ethnic Russian settlers, creating medical centers and hospitals. However, a large-scale fight against infectious diseases began only in the early 1920s, with the establishment of Soviet power - in October 1920, the People's Commissariat of Health of the Kazakh Autonomous Socialist Soviet Republic was created, and primary health care institutions began to be created in rural settlements. Each person had an assignment to a certain city clinic or rural medical assistant's point.

In the postwar 1950s, there was a shift in priorities towards specialized medical care and hospitals. By the late 1970s, funding for primary health care had declined, and many polyclinics and hospitals were built [6]. It was during this period that key mistakes were made, based on the principles of the Semashko model - an increase in the number of hospital beds and doctors, which does not take into account the effectiveness of medical care, in other words, the financing of the system, which does not depend either on its quality or on the volume of services provided by it.

Budget funds were allocated on the basis of expenditures for the previous year, the number of beds and the number of medical personnel, which deprived any interest in their rational use, leading to an artificial increase in the number of beds and staff.

The shortcomings of the existing system became apparent already in the 80s and were associated with the deterioration of the health care situation. Its funding has significantly decreased, contributing to the fact that the volume of medical services provided has ceased to meet

the needs of the population, in other words, the norms have ceased to be observed [18]. The centralized management made it impossible to take the initiative. All this favored the emergence of the shadow economy, when medical institutions became illegal, but forced, to charge fees for the services provided.

At the end of the Soviet regime, a number of reforms were undertaken, which could no longer correct the current situation. So, in 1989, an experiment was launched in five medical institutions to introduce a new economic mechanism, which was curtailed a year later, leaving only one of the directions of health policy.

Thus, the Kazakh health care system was formed during the Soviet era and was centralized, medical services were generally available and provided to the population free of charge.

The Ministry of Health of the Kazakh Soviet Socialist Republic implemented exclusively the policy of the union ministry.

After Kazakhstan gained independence, there were no significant changes in the health care system; priorities were sharply shifted to the area of economic and political transformations. At the same time, the socio-economic conditions in the country worsened, and there were not enough funds to improve the quality of medical services and improve the material and technical base. In early 1992, the Ministry of Health of the Republic of Kazakhstan was formed.

Against the background of this situation, an experiment was carried out in a number of regions of the country, during which methods of financing medical institutions through health insurance, reorganization of primary health care and the introduction of paid medical services were tested [10].

After the first major unsuccessful attempt to introduce compulsory health insurance since 1996, the pace of reform in the industry accelerated. Since this period, the Ministry of Health has been repeatedly reorganized, in 1997 into the Ministry of Education, Culture and Health of the Republic of Kazakhstan, and since 1999 into the Ministry of Health, Education and Sports of the Republic of Kazakhstan. In November 1999, the Agency of the Republic of Kazakhstan for Healthcare was established, which, a few years later, again received the status of a ministry. From the second half of 2014, his responsibilities also included social development. The ministry has been operating in its current format since January 2017.

The further terms of the introduction of compulsory health insurance in our country have been repeatedly shifted, another practical attempt, which was preceded by a long preparatory period, has been made since 2020.

Participants in the medical services market were: the state, the Mandatory Medical Insurance Fund, policyholders, insured persons, medical organizations and individuals engaged in private medical practice [18].

In the period from 1996 to 1998, the share of state budget expenditures on health care decreased from 88% to 55%, while the fund, on the contrary, increased from 12% to 40%, the difference over the past two years was citizens' own funds for paid services [5].

Paid medical services continued to limit the availability of medical care. First of all, citizens had to pay for medicines, prostheses and other devices at the outpatient clinic level, as well as dental services and plastic surgery.

However, there were no clear criteria for identifying insured and uninsured persons.

Thus, over three years, an attempt was made in the republic to create a unified system of compulsory health insurance covering the entire population of the country, with the exception of military structures.

However, the Mandatory Health Insurance Fund failed to accumulate the planned volume of insurance premiums in its assets; at the end of 1996, their share in the health care budget was only 15%, while the plan was 25%, and in 1998 it was about 40%, it should be noted that half of these funds made up state contributions for non-working categories of persons [6].

At the same time, by the end of the same 1998, the regions' accounts payable to the fund amounted to 27 billion tenge [6].

All this led to the formation of indebtedness to medical institutions, which the fund subsequently abandoned in 1998. He was also accused of embezzlement of the collected funds and corruption.

Ultimately, in December 1998, the compulsory health insurance project was phased out. The reasons for this were the economic crisis, which affected the fact that many enterprises were not able to pay insurance premiums due to existing arrears, there was also a system of payment in kind for insurance payments, private entrepreneurs, small farmers and self-employed practically did not make contributions to health care. insurance, payment for medical services was carried out in the regions at different rates and methods, the country experienced an increase in unemployment, which increased the burden on local budgets, which simply did not have the ability to transfer the required amount of funds as contributions for this category of citizens.

In 1999, the Mandatory Health Insurance Fund was reorganized into the Center for Payment for Medical Services. The guaranteed set of medical care began to be funded by the state through the Health Committee of the Ministry of Health, Education and Sports of the Republic of Kazakhstan, medical services related to the basic set were financed from local budgets: regional, city, and since 2001 also regional budgets, as well as under contracts with the said center [5]. Decentralization of the system to the district level negatively affected its overall efficiency and the availability of health care. Paid medical services were also preserved, their lists were developed, in addition, fees were charged for visiting narrow specialists without a referral from a general practitioner. Medicines provided on an outpatient basis remained the main type of paid medical services, with the exception of some of the most vulnerable groups of the population and a number of categories of patients, in particular those with cancer.

The goal of all the reforms was the need to strengthen state control over the collection and spending of funds.

At the same time, starting from 2000, the republic again continued to study the issue of re-introduction of compulsory health insurance from the beginning of 2005 [11].

To this end, in the first half of 2000, and then in the second half of 2002, concepts were approved both for the

further development of health care and for improving its financing, the latter envisaged three stages of introducing an insurance model up to 2007 [12].

In 2004, the country adopted a program for the reform and development of health care, designed for 2005-2010, aimed mainly at further implementation of the budget financing model, within the framework of the provision of a free guaranteed package of medical services, as well as in addition to it in the voluntary health insurance system. primarily at the expense of employers. Responsibility for financing within the framework of the implementation of the new mechanism, the management of health care delivery and the ownership of most of the health facilities are consolidated at the level of regional authorities as single payers. Consideration of the issue of introducing compulsory health insurance was postponed to 2008 [18].

Since 2005, preparations have been under way for the implementation of the national health accounts planned for 2006-2007. This issue was implemented in 2010. Currently, they allow obtaining information and assessing the share of total, current, public and private expenditures on health care to the gross domestic product, in other words, on financial flows of the entire sector, and also provide an opportunity to assess the quality of health services provided.

In 2010, financing of most of the medical organizations in the country began to be carried out centrally from the republican budget by the Ministry of Health of the Republic of Kazakhstan through its department - the Committee for Payment for Medical Services [4].

Thus, the issue of transforming the model of financing the health care system, in terms of the introduction of insurance mechanisms, was worked out almost continuously a year after the first large-scale unsuccessful attempt to implement them. The greatest successes were achieved in the middle and end of the second decade of this century, which were reflected in the state program "Densaulyk", designed for 2016-2019 [11].

The World Health Organization has recommended a minimum level of health spending when using a budgetary financing model, which for developed countries should be in the range from 6% to 8% of gross domestic product and at least 5% in developing countries [17].

At the end of 2018, the share of healthcare expenditures in Kazakhstan was within 3% of the gross domestic product [18], in other words, the minimum recommended level was not met, the funds allocated by the state were not able to cover all existing needs.

The reasons for this were both demographic - an increase in life expectancy, and epidemiological changes - an increase in the number of major chronic non-communicable diseases, as well as an increase in the cost of treated cases, all of them subsequently became prerequisites for the transformation of the principles of healthcare financing in the republic.

The World Bank and independent international experts assisted in studying the world experience, primarily German, post-Soviet countries such as Russia and Lithuania, as well as the post-socialist camp in Eastern Europe - Poland, Czech Republic and Slovakia, based on the principle of the most similar health systems. including taking into account the experience of the first unsuccessful attempt to introduce compulsory health insurance. By the end of 2015, a basic law was adopted that regulates the basic principles of the functioning of the compulsory insurance part of the current model of health care financing in our country, and already in the middle of next year, the Social Health Insurance Fund was formed [14].

Mechanisms have been developed to guarantee its financial stability, namely, a non-commercial principle of operation, as in European states, non-return of made targeted contributions and deductions, audit of financial activities, ensuring separate accounting for assets and own funds: contributions, penalties, investment income and deductions , the use of these assets only in settlements with health care providers, as well as placement in financial instruments determined by the government, the formation of liabilities in strict accordance with income and a reserve to cover unexpected costs [2].

Results

In general, the financial support of the health care system consists of the following eight sources [4] (Figure 1).

It should be noted that the population of the republic is actually deprived of the opportunity to choose between insurance funds. The sole founder and shareholder of the operating fund in the organizational and legal form of a joint stock company is the Government of the Republic of Kazakhstan. Thus, there is no competitive environment with all the ensuing consequences in the form of a flexible tariff policy, promotions, bonuses, etc., but at the same time, at the initial stage, the fund, although lacking autonomy, seems to create a certain financial stability. At the same time, a large number of insurance funds are also not typical for European countries.

In the period from July 2017 to 2019, the fund managed to collect 246.9 billion tenge in the assets of the fund, of which 3.7% came as contributions from persons working under civil law contracts, as well as individual entrepreneurs, and 96.3% were deductions from employers [7,14,15].

Medical care in the voluntary insurance system is currently undergoing a stage of its formation with the aim of achieving universal coverage and ensuring the improvement of mechanisms for this type of insurance, primarily for labor migrants and foreign students studying in the Republic of Kazakhstan. Voluntary insurance mechanisms will allow them to receive not only the services included in the two main packages, but also will cover additional programs, the costs of which will be compensated by the insurance company.

To date, the minimum volume of the insurance product provided within the framework of voluntary medical insurance has not been established, the list of medical services is established by the insurance company (insurer) in agreement with the insured.

Currently, work is underway to improve the coverage mechanisms for this type of insurance, primarily to determine the volume of insurance products and the procedure for the provision of medical services.

In 2020, 1,549.3 billion tenge were allocated to medical organizations of the republic, including within the guaranteed volume - 1,031.1 billion tenge (66.6%), in the compulsory insurance system - 518.2 billion tenge (33.4%) [18]. Thus, the amount of financing increased by 49%, in 2019 it amounted to 1,039.4 billion tenge (Figure 2).

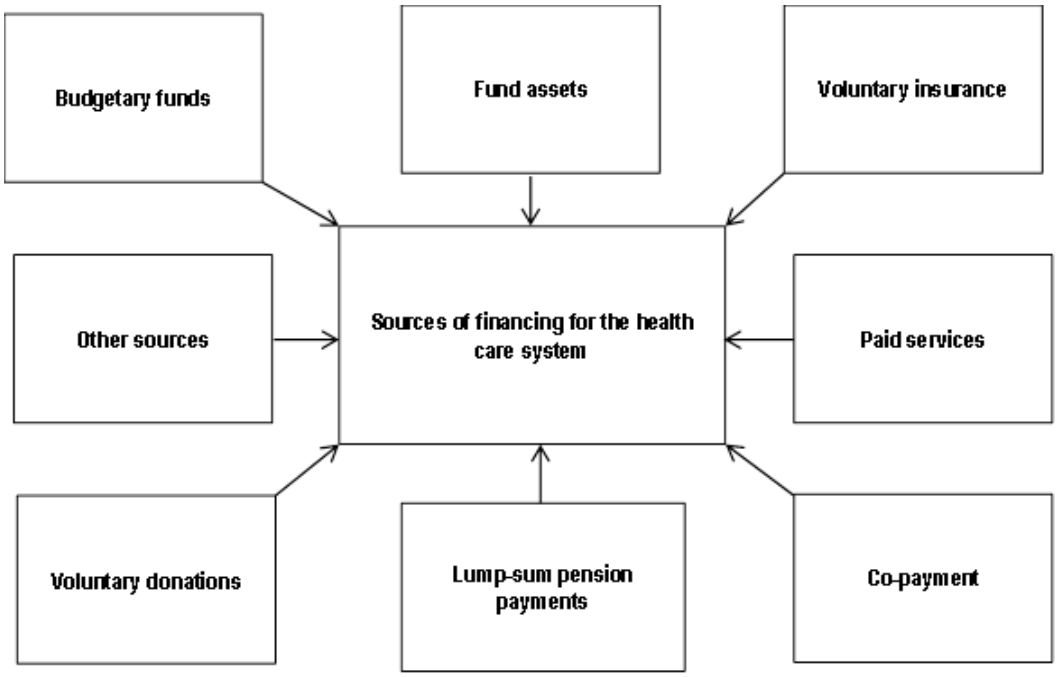

Figure 1 - Sources of funding for the health care system

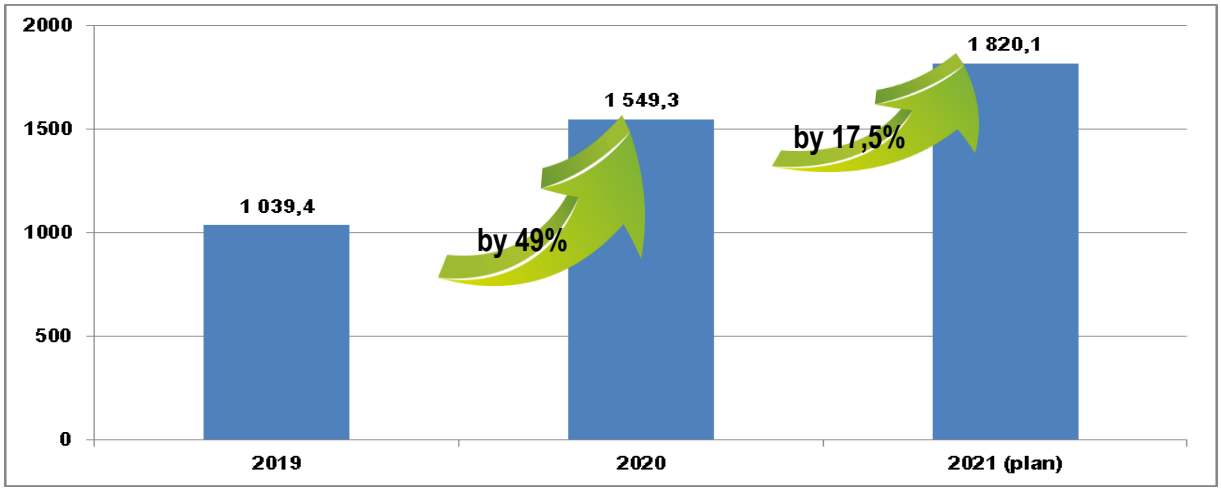

Figure 2. The volume of financing of the health care system, billion tenge.

All this made it possible to ensure the availability of all types of medical services, visits to organizations providing primary health care have doubled (2019 - 31 million visits, 2020 - 61.3 million visits), the number of consultative and diagnostic services - 2.8 times (2019 - 56.4 million services, 2020 - 159.5 million services), patient care in the admission departments of hospitals - by 7.2% (2019 - 5.1 million services, 2020 - 5.5 million services), treatment in 24-hour hospitals - by 1.6% (2019 - 2.7 million services, 2020 - 2.8 million services), medical rehabilitation in a 24-hour hospital - by 7.6% (2019 - 123.4 thousand services, 2020 - 132.8 thousand services), 25 thousand patients underwent rehabilitation in the day hospital, at the third stage at the level of organizations providing outpatient care, 2.8 million services were provided, an increase of 19.5 times, the provision of palliative care - by 1.2% (2019 - 13.6 thousand services, 2020 - 13.8 thousand services), its provision increased by 18.9% (2019 - 2.8 million people, 2020 - 3.4 million people). The number of nosologies covered by outpatient drug supply increased from 45 to 138, an increase of more than 3 times, or from 452 names of drugs to 648, in other words, almost 1.5 times.

At the end of 2020, the number of patients waiting for planned hospitalization for 10 days or more decreased by 45% from 11.9 thousand to 6.6 thousand people [7].

According to the financing plan for 2021, KZT 1 820.1 billion is provided, or an increase of 17.5% compared to last year, including within the guaranteed volume - KZT 1 114.7 billion (61.2%), in compulsory insurance system - 705.4 billion tenge (38.8%) [18].

With all the visible positive aspects, a number of problematic issues remain (Table 1).

Table 1.

The number of insured and uninsured persons, people.

Population of the country [2]	Number of insured persons [23]	Number of uninsured persons [23]
18 877 128	15 828 351	3 048 777

Thus, at the end of 2020, 83.8% belonged to the category of insured persons, and 16.2% did not have such a status, which caused difficulties in providing them with medical services in addition to guaranteed free medical care.

It should also be noted that among the insured persons, the share of those for whom the state pays contributions was 70.5% or 11,154,203 people [23].

For a more detailed analysis, the share of each privileged category of the total number of insured beneficiaries was determined, Figure 3.

As can be seen from Figure 3, the largest share of the total number of fifteen privileged categories fell on children - 58.3%, followed by recipients of pension payments, including veterans of the Great Patriotic War - 20.3%, full-time students - 6.5%, non-working persons raising a child before reaching the age of 3 years - 5.9%, disabled people - 3.6%, non-working pregnant women - 2% and, finally, only 1,5%. Each of the remaining eight preferential categories was less than 1%.

Analysis of this trend in monetary terms showed that government contributions accounted for more than half of all receipts - 54%, employers 'contributions amounted to 29%, employee contributions - 13%, the share of individual entrepreneurs' contributions - only 1.9%, and self-employed - 0.4% [18].

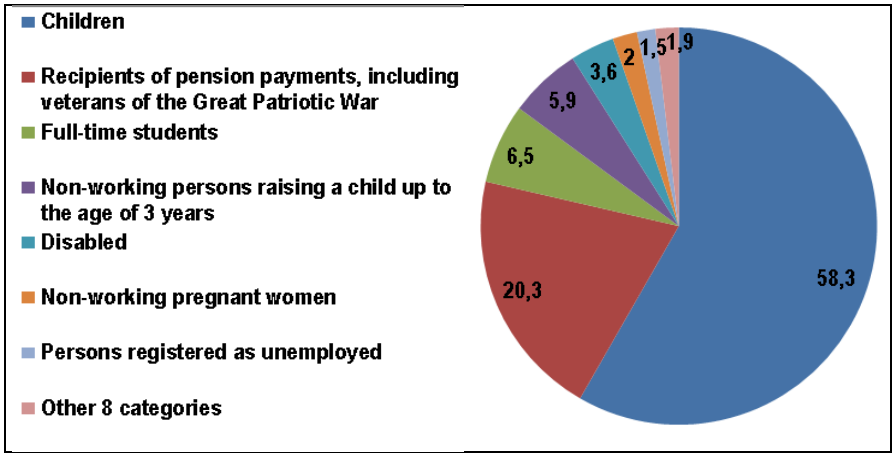

Figure 3. The share of each privileged category of the total number of insured beneficiaries, %

Thus, the current model of financing the health care system cannot be called fully insurance, rather budgetary and insurance, which continues to remain sensitive to financial crises, both domestic and international, as well as to the political priorities of the current government. It still does not cover the entire population, while the state continues to bear significant costs to provide guaranteed free assistance and insurance for fifteen privileged categories of persons.

For this reason, the addition of the existing budgetary model with insurance mechanisms is due, possibly, to the desire to expand the available sources of funding in order to obtain additional funds. This trend can be continued further.

As noted above, European pensioners are not exempt from paying contributions, paying them in full or on the principle of joint responsibility with the state. At the beginning of 2021, the average size of pension payments in our country amounted to 94,733 tenge [2,8,9].

Taking into account the fact that pensioners are the second largest benefit category, with the most frequently seeking medical care, the possibility of their involvement in the payment of insurance premiums should be considered by developing certain mechanisms, including based on the specific amount of pension payments to an individual.

For example, up to a certain amount, this category continues to be exempted from paying contributions, in excess of it, up to the established threshold, it pays on the principle of joint liability with the state, above a certain threshold it pays in full on its own. At the same time, veterans of the Great Patriotic War should continue to be exempted from paying insurance premiums.

This, at first glance, an unpopular measure from the point of view of social policy, will provide additional stability to the current model of financing the health care system.

Thus, the presented system allows medical organizations, at best, only to recoup their activities, but not to develop, and this despite the fact that some tariffs for a treated case require an upward revision.

Problematic issues of the current tariff policy. In the course of the first year of implementation of the updated model of financing the health care system of our country, the central authorized body and the fund carried out a lot of work to improve the existing tariff policy, both within the guaranteed and compulsory insurance components.

In general, tariffs include the following costs:

1) wages, taxes and other payments to the budget;
2) purchase of consumables and medicines;
3) nutrition of patients and providing them with soft equipment;
4) development of the human capital of employees, including travel;
5) utilities;
6) service maintenance of medical equipment;
7) household goods and services [15].

For the current year 2021, the Ministry of Health of the Republic of Kazakhstan has planned a number of activities, the implementation of which is determined in ten key areas [7].

Among them, it is supposed to revise the methods of payment for treated cases of oncological profile. Malignant neoplasms are socially significant diseases that require constant, systematic work to prevent and identify them at early stages. For the treatment of cancer patients, strict adherence to protocols is necessary, which imply financial costs for the introduction of modern technologies and drug therapy. The financing of the oncological service is carried out at an integrated rate. The use of chemotherapy drugs - according to the actual costs, conducting sessions of radiation therapy - according to their actual implementation. When financing cancer-related care, payments for expensive medical devices and expensive reagents must be made at actual cost. Colony-stimulating drugs, hormonal and corrective drugs should be included in the list of reimbursable

drugs at actual cost, as they are included in the protocols for the diagnosis and treatment of cancer patients.

A certain part of the services provided by specialists at the level of outpatient care has a price that is several times lower than the cost of funds spent on these services and (or) cheaper in comparison with private providers of similar medical services. In this regard, it is impossible to refer a patient to a particular service in private medical organizations, which creates the problem of queues. For example, the cost of laparocentesis or puncture of the abdominal cavity according to the current tariff is 874.51 tenge [16], while in private medical organizations the price varies from 13.5 thousand to 25 thousand tenge, and in some cases even higher. Tariffs for these medical services should be revised upward.

Another issue that did not find reflection in ten key areas, but deserves attention, is the financing of the psychiatric service, carried out at a comprehensive tariff within the guaranteed free volume, established depending on the region in the range from 10 101.38 to 15 471.34 tenge [13,16,17]. Payment is made for one patient per month registered in the registries of narcological and (or) mental patients. The change in the current legislation is aimed at excluding the group of preventive registration of drug addicts. A reduction in the number of people with borderline mental disorders registered in these registers will lead to an underfunding of the service. The current comprehensive tariff requires revision, since it does not cover all actual costs, including for laboratory tests, maintenance of temporary adaptation and detoxification centers, remote medical services, namely the development of medical and social rehabilitation in the field of mental health, services aimed at preventing mental health. and behavioral disorders (diseases), examination of the mental health of citizens who are not registered with dispensaries.

Noteworthy is the situation when one of the parents or another person directly caring for a child undergoing inpatient treatment, if his age is less than five years old or he needs additional care, is with him in a medical organization [7], which is forced to take all expenses related to this: analyzes, utility bills, etc. At the same time, they are not covered by tariffs. A similar situation arises with mothers who are nursing children under one year of age, who must be provided with free meals for the entire period of their stay in a medical organization for childcare [6]. In this regard, tariffs should be developed for the costs associated with the stay of these accompanying persons.

One of the determining factors in the effectiveness of a patient's treatment in a hospital is his recovery. It should be borne in mind that in some cases the patient has more than one disease and needs complex treatment. Patients with comorbid pathology, who often have a mass of concomitant and competing diseases, as well as patients with polytrauma, require special attention.

Thus, it is most expedient to pay for the treated case, taking into account, in addition to the underlying disease, the presence of competing and severe concomitant pathologies or injuries in the tariffs for clinical-cost groups, in addition to the underlying disease.

The cost of treated cases of seriously ill patients who are in the department of anesthesiology, resuscitation and intensive care for a long time, sometimes exceeding several months, is always fixed, payment is made according to clinical-cost groups and may not cover all costs incurred. In this regard, it is necessary to consider the possibility of paying for the treatment of critically ill patients in intensive care at the actual costs per bed-days spent in the specified department.

An important problematic issue is emergency hospitalization of patients without identity documents entered into the portal of the Hospitalization Bureau as “unknown”. For payment, the case is closed on the portal "Electronic register of inpatients" only on condition that there has been a lethal outcome. If the patient is discharged, but his identity has not been established, the specified case is not accepted for payment, all the costs incurred are forced to be borne by the medical organization.

Discussion

The research work made it possible to confirm the validity and necessity of changing the model of financing the health care system of the Republic of Kazakhstan. It served as the basis for conclusions and practical recommendations for all the tasks set.

It provides an overview of three classic models of health financing, with reference to the countries where they are implemented. Conclusions are made on their main features, strengths and weaknesses, as well as a small comparative analysis.

The issues of the formation of the domestic health care system, affecting the tsarist and Soviet periods, are analyzed.

Previous attempts to introduce compulsory health insurance in Kazakhstan are studied. It should be noted that work in this direction began almost from the first years of our country's independence and led to the first large-scale attempt to implement it, which was not crowned with success, but served as prerequisites for the current actions of the state, behind which there are numerous studies and repeated postponements of the transformation of the financing model. health care during the first twenty years of this century.

The paper analyzes the modern principles of financing, based on this, the current model in Kazakhstan is classified.

The issues related to how its transformation contributed to the improvement of the provision of medical care to the population are analyzed.

The study provided an opportunity to identify unresolved issues so far, including those related to voluntary health insurance issues, and weaknesses of the Kazakh model associated with the still high share of government spending, creating risks and requiring revision.

On the basis of this, a number of recommendations have been developed for the further improvement of the considered mechanisms, including on the basis of foreign experience, in particular of Western European countries.

In addition, some issues of the current tariff policy were not left without attention. The emphasis is made on the fact that the planned work does not affect all the necessary aspects in the provision of one or another medical care. In this regard, recommendations were also developed for further improvement of tariffs.

Conclusion

Thus, consideration should be given to the possibility of paying for treated cases of “unknown” patients with an outcome of recovery or improvement.

These facts of imperfection of the applied tariff policy in the provision of assistance to cancer patients, primary health care, psychiatric and inpatient care may lead to a situation where, in some cases, it will become unprofitable for medical organizations to introduce innovative technologies and conduct research on the development of new diagnostic and treatment methods.

Based on the results of the study, the following **conclusions** were made:

1. Issues of voluntary medical insurance are not regulated at the legislative level, the minimum volume of the insurance product has not been established by the Government of the Republic of Kazakhstan, on the basis of this, the list of medical services is determined by the insurance company (insurer) in agreement with the insured.

2. The transition from one financing model to another, with the use of an insurance component, made it possible to increase spending on the health care system in 2020 compared to 2019 by 49%. Medical services and drug provision have become more accessible to a wide range of the population, in particular, visits to organizations providing primary health care have doubled, the number of consultative and diagnostic services - by 2.8 times, patient care in the admission departments of hospitals - by 7.2%, treatment in round-the-clock hospitals - by 1.6%, medical rehabilitation in a round-the-clock hospital - by 7.6%, at the third stage at the level of organizations providing outpatient care, there is an increase of 19.5 times, provision of palliative care - by 1.2%, drug provision increased by 18.9%.

The number of nosologies covered by outpatient drug provision has increased more than 3 times, or almost 1.5 times in terms of the number of drugs.

At the end of 2020, the number of patients waiting for planned hospitalization for 10 days or more decreased by 45%.

3. It has been determined that the current model cannot be called fully insurance, but rather budgetary and insurance. It does not cover the entire population: at the end of 2020, the share of uninsured persons amounted to 16.2% of the total population of the country, in other words, health insurance, being de jure compulsory, is not de facto. At the same time, the state continues to bear significant costs to ensure the guaranteed volume of free medical care, their share in 2020 amounted to 66.6% of the total funding, and insurance of fifteen privileged categories of persons - 54% of all revenues fell on state contributions.

4. The facts of imperfection of the applied tariff policy in the provision of assistance to cancer patients, primary health care, psychiatric and inpatient care have been established, which can lead to the fact that, in some cases, it will become unprofitable for medical organizations to introduce innovative technologies and conduct research on the development of new diagnostic methods and treatment.

Based on the results of the study, the following practical recommendations were developed:

1. It is required to adopt an appropriate package of normative legal acts in order to regulate the issues of voluntary health insurance. First of all, this should affect the interests of labor migrants and foreign students studying in the Republic of Kazakhstan, giving them the opportunity to receive not only services included in two main packages - guaranteed and insurance, but also to cover additional programs, the costs of which will be compensated by the insurance company.

2. In order to reduce the burden of spending on the guaranteed volume of free medical care and insurance of fifteen privileged categories of persons, in other words, the shift of priorities from the budget component towards the insurance component, the state should revise the existing approaches. The measures taken should provide the current model of financing the health care system with additional stability in order to reduce its sensitivity to financial crises, both domestic and international, as well as reduce dependence on the political priorities of the current government.

3. It is necessary to consider the possibility of involving pensioners in the payment of insurance premiums, according to the experience of European countries, with the development of appropriate mechanisms that allow up to a certain amount to exempt this category from the payment of contributions, in excess of it, up to a set threshold, to be obliged to pay on the principle of joint liability with the state, above a certain threshold pay in full yourself. At the same time, veterans of the Great Patriotic War should continue to be exempted from paying insurance premiums.

4. It is necessary to revise the current tariff policy both within the framework of the existing plans of the Ministry of Health of the Republic of Kazakhstan and outside them, including for the psychiatric service.

When financing cancer-related care, payments for expensive medical devices and expensive reagents must be made at actual cost. Certain drugs should be included in the list of reimbursable drugs at cost, as they are included in the protocols for diagnosing and treating cancer patients.

Tariffs for a number of medical services provided at the level of outpatient care should be revised upward, since they differ many times from those actually available on the market and implemented by private medical organizations. The current comprehensive tariff for mental health services requires revision, since it does not cover all actual costs, including laboratory tests, maintenance of temporary adaptation and detoxification centers, remote medical services, namely the development of medical and social rehabilitation in the field of mental health, services aimed for the prevention of mental and behavioral disorders (diseases), examination of the mental health of citizens who are not registered with dispensaries.

It is necessary to develop tariffs for the costs associated with the stay of parents or other persons directly caring for a child under five years of age or in need of additional care, as well as food for mothers feeding children under one year of age, for the period of their stay in a medical organization.

It is more expedient to pay for the treated case of patients with comorbid pathology or polytrauma, taking into account, in addition to the main disease, the presence of competing and severe concomitant pathologies or injuries in the tariffs for clinical-cost groups.

It is necessary to consider the possibility of paying for the treatment of critically ill patients in the department of anesthesiology, resuscitation and intensive care for a long time at the actual cost per bed-days spent in the specified department.

Consideration should be given to paying for inpatient cases of "unknown" patients with an outcome of recovery or improvement.

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Turgambayeva A.K. - this author takes responsibility for all aspects of the reliability and freedom from bias of the data presented and their discussed interpretation

Panchenko DV- data collection, analysis, methodology, writing original draft.

Khismetova Z.A.- scientific management of the study, writing - review & editing.

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14. *Prikaz Ministra zdravookhraneniya Respubliki Kazakhstan ot 21.12.2020g. № ҚR DSM-309/2020 «Ob utverzhdenii pravil i metodiki formirovaniya tarifov na meditsinskie uslugi, okazyvaemye v ramkakh garantirovannogo ob"ema besplatnoi meditsinskoi pomoshchi i (ili) v sisteme obyazatel'nogo sotsial'nogo meditsinskogo strakhovaniya»* ["Order of the Minister of Health of the Republic of Kazakhstan dated December 21, 2020 No. KR DSM-309/2020 "On approval of the rules and methodology for the formation of tariffs for medical services provided within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance"]. [in Russian]

15. *Prikaz i.o. ministra zdravookhraneniya Respubliki Kazakhstan ot 30.10.2020 g. № ҚR DSM-170/2020 «Ob utverzhdenii tarifov na meditsinskie uslugi, predostavlyaemye v ramkakh garantirovannogo ob"ema besplatnoi meditsinskoi pomoshchi i v sisteme obyazatel'nogo sotsial'nogo meditsinskogo strakhovaniya»* [Order of the Acting Minister of Health of the Republic of Kazakhstan dated October 30, 2020 No. KR DSM-170/2020 "On approval of tariffs for medical services provided within the guaranteed volume of free medical care and in the system of compulsory social health insurance"]. [in Russian]

16. *Sistemy zdravookhraneniya v perekhodnyi period. Kazakhstan. – Evropeiskoe regional'noe byuro VOZ / Evropeiskaya observatoriya po sistemam zdravookhraneniya* [Health systems in transition. Kazakhstan. - WHO Regional Office for Europe / European Observatory on Health Systems], 1999. – 75 p. [in Russian]

17. *Ukaz Prezidenta Respubliki Kazakhstan ot 15.06.1995 g. № 2329, imeyushchii silu Zakona, «O meditsinskom strakhovanii grazhdan». Utratil silu Zakonom RK ot 17 dekabrya 1998 goda № 324* [Decree of the President of the Republic of Kazakhstan dated June 15, 1995 No. 2329, which has the force of Law, "On medical insurance of citizens"]. [in Russian]

18. *Ukaz Prezidenta Respubliki Kazakhstan ot 13.09.2004 g. № 1438 «O Gosudarstvennoi programme reformirovaniya i razvitiya zdravookhraneniya Respubliki Kazakhstan na 2005-2010 gody»* [Decree of the President of the Republic of Kazakhstan of September 13, 2004 No. 1438 "On the State program of reform and development of healthcare of the Republic of Kazakhstan for 2005-2010" became invalid]. [in Russian]

Corresponding Author:
Turgambayeva Assiya - PhD, Associate professor, NJSC «Medical University Astana» Head of the Department of Public health and Management;
Mailing Address: 010002,Nur-Sultan, Kazakhstan, Tashenov str 17.
E-mail: tak1973@mail.ru
Phone: +7 701 887 62 73