On approval of the rules for planning the volume of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance

Unofficial translation

Order of the Minister of Health of the Republic of Kazakhstan dated December 20, 2020 No. ҚР ДСМ -290/2020. Registered in the Ministry of Justice of the Republic of Kazakhstan on December 22, 2020 No. 21844.

Unofficial translation

In accordance with subparagraph 63) of Article 7 of the Code of the Republic of Kazakhstan "On People's Health and Healthcare System", **I HEREBY ORDER:**

Footnote. The Preamble as amended by the order of the Acting Minister of Healthcare of the Republic of Kazakhstan dated 19.11.2021 No. ҚР ДСМ-120 (shall be enforced from the date of its first official publication).

1. To approve the attached rules for planning the volume of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance.

2. The Department for coordination of compulsory social health insurance of the Ministry of Health of the Republic of Kazakhstan, in the manner prescribed by the legislation of the Republic of Kazakhstan, to ensure:

1) state registration of this order in the Ministry of Justice of the Republic of Kazakhstan;

2) posting this order on the Internet resource of the Ministry of Health of the Republic of Kazakhstan after its official publication;

3) within ten working days after the state registration of this order in the Ministry of Justice of the Republic of Kazakhstan, submission of information to the Legal Department of the Ministry of Health of the Republic of Kazakhstan on implementation of the measures provided for in subparagraphs 1) and 2) of this paragraph.

3. The First Vice-Minister of Health of the Republic of Kazakhstan M.Ye. Shoranov is authorized to control the execution of this order.

4. This order comes into effect from the day of its first official publication.

Minister of health of the Republic of Kazakhstan *A. Tsoi*

Approved
by the order of the
Minister of health of the
Republic of Kazakhstan
dated December 20, 2020
№ ҚР ДСМ-290/2020

Rules for planning the volume of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance

Section 1. General provisions

1. These rules for planning the volumes of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance (hereinafter referred to as the Rules) are developed in accordance with subparagraph 63) of Article 7 of the Code of the Republic of Kazakhstan dated July 7, 2020 "On people's health and health care system" (hereinafter - the Code) and shall determine the procedure for planning the volumes of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance.

Footnote. Paragraph 1 as amended by the order of the Acting Minister of Healthcare of the Republic of Kazakhstan dated 19.11.2021 No. ҚР ДСМ-120 (shall be enforced from the date of its first official publicationя).

2. Basic concepts used in these Rules:

1) the social health insurance fund (hereinafter referred to as the fund) - a non-profit organization that accumulates deductions and contributions, as well as makes procurements and payments for the services of healthcare entities that provide medical care in the volumes and on the terms provided for by the contract for procurement of medical services, and other functions defined by the laws of the Republic of Kazakhstan;

2) the authorized body in the field of health care (hereinafter referred to as the authorized body) - the central executive body that carries out management and inter-sectoral coordination in the field of health protection of citizens of the Republic of Kazakhstan, medical and pharmaceutical science, medical and pharmaceutical education, sanitary and epidemiological welfare of the population, circulation of medicines and medical devices, the quality of medical services (assistance);

3) health statistics - a branch of statistics that includes statistical data on the health of the population, the activities of health care entities and the use of health care resources;

4) emergency medical care - a system for organizing medical care in an emergency and urgent form in case of acute diseases and conditions that threaten life, as well as to prevent significant harm to health at the scene of an accident and (or) on the way to a medical organization;

5) high-tech medical care (hereinafter referred to as HTMC) - a service provided by profile specialists for diseases requiring the use of innovative, resource-intensive and (or) unique methods of diagnosis and treatment;

6) clinical-cost groups - clinically homogeneous groups of diseases, similar in terms of the cost of their treatment (hereinafter referred to as CCG);

7) fund assets - deductions and contributions, penalties received for late payment of deductions and (or) contributions, investment income minus commission fees to support the

fund's activities, as well as other receipts to the fund not prohibited by the legislation of the Republic of Kazakhstan;

8) medical and social assistance - medical and socio-psychological assistance provided to persons with socially significant diseases, the list of which is determined by the authorized body in accordance with subparagraph 158) of Article 1 of the Code;

9) medical rehabilitation - a complex of medical services aimed at preserving, partial or complete restoration of the impaired and (or) lost functions of the patient's body;

10) primary health care - a place of the first access to medical care focused on the needs of the population, including prevention, diagnosis, treatment of diseases and conditions provided at the level of the individual, family and society, including:

diagnosis, treatment and management of the most common diseases; preventive examinations of target population groups (children, adults);

early identification and monitoring of behavioral risk factors for diseases, and training in skills to reduce the identified risk factors;

immunization;

formation and promotion of a healthy lifestyle;

measures to protect reproductive health;

observation of pregnant women and postpartum women in the postpartum period;

sanitary and anti-epidemic and sanitary-preventive measures in the foci of infectious diseases;

11) guaranteed volume of free medical care (hereinafter - GVFMC) - the volume of medical care provided at the expense of budgetary funds;

12) compulsory social health insurance (hereinafter referred to as the CSHI) - a set of legal, economic and organizational measures to provide health care to consumers of medical services at the expense of the assets of the social health insurance fund;

13) palliative care - a complex of medical services aimed at relieving pain and severe manifestations of a disease (condition) of a terminally ill patient in the absence of indications for radical treatment;

14) a complex tariff per patient of a mental health center - the cost of a complex of medical and social services to patients of mental health centers, within the framework of the guaranteed volume of free medical care, per patient registered in the subsystems "Register of mental patients" and "Register of drug addicts" of the information system "Electronic register of dispensary patients", approved by the authorized body in accordance with paragraph 2 of Article 23 of the Code;

15) screening studies - a complex of medical examinations of the population without clinical symptoms and complaints, in order to identify and prevent the development of various diseases at an early stage, as well as risk factors for their occurrence;

16) statistical information - aggregated data obtained in the process of processing primary statistical data and (or) administrative data;

17) specialized medical care in inpatient conditions - medical care provided by profile specialists and providing round-the-clock medical supervision, treatment, care, as well as the provision of a bed with meals, including in cases of therapy and surgery of "one day", providing for round-the-clock observation during the first days after the start of treatment at the secondary and tertiary levels of medical care;

18) specialized medical care in hospital-substituting conditions - a form of pre-medical, specialized medical care, including with the use of high-tech medical services that do not require round-the-clock medical supervision and treatment and provide for medical supervision and treatment during the day with the provision of a bed;

19) dental care - a complex of medical services provided to patients with dental diseases, including diagnostics, treatment, prevention and medical rehabilitation;

20) subject of digital health (in relation to the Rules) - a legal entity that carries out activities or enters into public relations in the field of digital health in terms of information and technical support of health information systems, including ensuring information security and organizational and methodological work with healthcare entities;

21) tariff - the cost of a unit of medical service or a complex of medical services, calculated taking into account correction factors, when providing medical care within the guaranteed volume of free medical care and (or) in the CSHI system;

22) rater - a list of tariffs for medical services approved by the authorized body in accordance with subparagraph 65) of Article 7 of the Code.

Section 2. Planning the volume of medical services within the guaranteed volume of free medical care and (or) in the system of compulsory social health insurance

Chapter 1. General provisions

3. Participants in the planning process are:

1) the authorized body;

2) a fund, which is a working body for formation of plans for procurement of medical services within the guaranteed volume of free medical care and in the CSHI system;

3) branches of the fund;

4) local government health authorities;

5) the subject of digital health care.

4. The process of planning the volume of medical services includes the following stages:

Local government health authorities no later than March 1 of the respective year:

1) form the forecast volume of medical services by type, forms of medical care, conditions of its provision, types of medical activities within the guaranteed volume of free medical care and in the CSHI system for the planned three-year period, taking into account the needs of the population, infrastructure and staffing;

2) submit to the branch of the fund the forecast need for the volume of medical services by type, forms of medical care, conditions of its provision, types of medical activity within the guaranteed volume of free medical care and in the CSHI system.

The branches of the fund until March 15 of the year preceding the planned three-year period provide:

1) consideration and agreement with local government health authorities of the forecast volume of medical services by type, forms of medical care, conditions of its provision, types of medical activity within the guaranteed volume of free medical care and in the CSHI system for the planned three-year period;

2) formation and submission to the fund of the application of the forecast need for the volume of medical services by types, forms of medical care, conditions of its provision, types of medical activities within the guaranteed volume of free medical care and in the CSHI system with a corresponding forecast of the volume of budgetary funds within the guaranteed volume of free medical care and the forecast volume of costs in the compulsory social health insurance for the coming three-year period.

The fund provides for:

no later than May 1 of the corresponding year:

1) consideration and analysis of applications received from the branches of the fund for the forecast need for volumes of medical services by type, forms of medical care, conditions of its provision, types of medical activities within the guaranteed volume of free medical care and in the CSHI system for validity, compliance with the priorities of health care development, target indicators, performance indicators, reflected in the documents of the State Planning System and proposals of the authorized body;

2) submission to the authorized body of the forecast need of the population for medical care within the GVFMC and the system of compulsory social health insurance with a corresponding forecast of the volume of budgetary funds within the guaranteed volume of free medical care and the forecast amount of costs for payment for medical care in the compulsory social health insurance system for the next three-year period; 3) in the event of a discrepancy between the submitted forecast need with the budgetary funds limits brought up by the authorized body within the guaranteed volume of free medical care and (or) state contributions to the compulsory social health insurance, the fund, within seven working days from the day the limits are brought up, re-submits the forecast need for the volume of budgetary funds within the guaranteed volume of free medical care and the forecast volume of costs of medical care in the CSHI system to the authorized body. No later than November 1 of the corresponding year, the formation of plans for procurement of medical services within the guaranteed volume of free medical care and in the CSHI system (hereinafter - the Plans for procurement of medical services) for the coming financial year.

5. Information for planning the volume of medical services within the guaranteed volume of free medical care and in the compulsory social health insurance system are the lists of

services within the GVFMC and in the system of compulsory social health insurance, data of statistical information and health statistics, information systems, financial reports of healthcare subjects, clinical information and data, generated on the basis of paragraph 2 of Article 26 of the Law of the Republic of Kazakhstan "On State Statistics" and Article 65-1 of the Budget Code of the Republic of Kazakhstan.

6. The planning of the volume of medical services is carried out by the participants in the process by types, forms of medical care, conditions of its provision, types of medical activity.

Chapter 2. Procedure for planning the volume of medical services within the guaranteed volume of free medical care and (or) in the system of CSHI

Paragraph 1. Assessment of the forecast need of the population for medical care within the GVFMC and in the CSHI system

7. When assessing the forecast need of the population for medical care within the guaranteed volume of free medical care and in the CSHI system, local government health authorities take into account:

1) the number, density, morbidity, age and sex composition of the population, including the right to receive medical care in the CSHI system;

2) data of national statistical observation and departmental statistical observation in the field of health care;

3) target indicators, results and priorities for healthcare development, reflected in the documents of the State Planning System;

4) international practice;

5) epidemiological situation, based on the data of the digital health subject, as well as the results of epidemiological studies, if any;

6) proposals of healthcare entities, as well as the expansion, reduction, re-profiling of the bed fund, including the reorganization of the network and regional long-term plans for development of healthcare infrastructure;

7) actual consumption of medical services in previous years.

In the absence of data from national statistical observation and departmental statistical observation, data in available information systems for planning the volume of medical services, requests are sent to the relevant authorities, organizations, healthcare entities and (or) data for the previous period is used.

Paragraph 2. Determination of the amount of budgetary funds within the GVFMC and (or) fund assets in the CSHI system

8. When determining the volume of budgetary funds within the guaranteed volume of free medical care and (or) the fund assets in the CSHI system, the following are taken into account :

1) tariffs approved in accordance with subparagraph 65) of Article 7 of the Code (hereinafter referred to as the tariff), depending on the types, forms of medical care, conditions for its provision, types of medical activities;

2) additional costs provided for in program and strategic documents, including the commissioning of new healthcare facilities.

9. In the event of formation of new healthcare entities that provide targeted medical care to residents of all regions, cities of republican significance (medical organizations of the tertiary level), the redistribution of volumes between this entity and regions, cities of republican significance is carried out based on the criteria for hospitalization in this entity, or the capacity of the given health care entity, the bed capacity of the entity, the physical volume of cases subject to redistribution (direction) to this entity from regions, cities of republican significance.

In the absence of epidemiological analysis data, the required volume is formed (redistributed) in proportion to the population of a given region, a city of republican significance, or the physical volume of medical care of a given entity.

10. Determination of the amount of budget funds within the guaranteed volume of free medical care is carried out by the authorized body. Within the framework of the planned budgetary funds for the corresponding financial year, the fund forms a project for distribution of budgetary funds by types, forms of medical care, conditions of its provision, types of medical activities included in the guaranteed volume of free medical care. 11. The forecast volume of costs for medical care in the CSHI system is determined within the expected and (or) forecast amounts of receipts of the fund's assets intended to pay for the services of healthcare entities in the CSHI system, minus the fund's reserve to cover unforeseen expenses and established norms and limits that ensure financial stability of the fund.

12. Determination of the forecast volume of costs intended for payment of medical care in the CSHI system is carried out by types, forms of medical care, conditions of its provision, types of medical activities within the framework of the forecast volume of costs for the corresponding financial year and taking into account:

1) demographic forecast of the population;

2) forecast of macroeconomic indicators;

3) information on the number of persons for whom the payment of deductions and contributions to the fund is made, in accordance with the current legislation of the Republic of Kazakhstan.

13. If the planned volumes within the guaranteed volume of free medical care and in the CSHI system are exceeded by the planned budgetary funds and the forecast amounts of costs for the corresponding financial year, the distribution of volumes is carried out taking into account:

1) priority areas of health care development;

2) assessment of the needs of the population in medical care;

3) target indicators of the fund;

4) proposals of the authorized body and local government health authorities.

Paragraph 3. Formation of plans for procurement of medical services within the GVFMC and in the CSHI system

14. The formation of plans for procurement of medical services is carried out by the fund in agreement with the authorized body on the basis of the planned volumes of medical care within the volume of budgetary expenditures for paying for medical care within the GVFMC and the forecast amount of costs for medical care in the CSHI system.

15. Plans for procurement of medical services contain the following information:

1) types, forms of medical care, conditions for its provision, types of medical activities provided for by the lists of medical care within the guaranteed volume of free medical care and in the CSHI system;

2) the planned number of purchased services;

3) the planned amount of budgetary funds within the guaranteed volume of free medical care and the forecast amount of costs intended to pay for medical care in the CSHI system.

16. The authorized body considers draft plans for procurement of medical services within ten working days from the date of its receipt and notifies the fund of the results of its consideration.

17. If there are comments, the fund within five working days finalizes the draft plans for procurement of medical services and re-sends it for approval to the authorized body.

18. Plans for procurement of medical services for the coming financial year are approved by the fund annually within 3 working days after agreement with the authorized body.

19. During the year after the completion of the planning process for the volume of medical services within the guaranteed volume of free medical care and in the CSHI system, the volumes and budgets are adjusted taking into account the factors that influence consumption in medical care.

20. The fund makes changes to the plans for procurement of medical services, taking into account the results of monitoring and validity in the following cases:

1) discrepancy between the amount of funds intended for payment by the fund for the provision of services, the assets of the fund intended to pay for the services of health care entities in the CSHI system, with the actual and forecast amounts of costs for paying for services in the CSHI system provided for by the procurement plan;

2) distribution of the fund's reserve for unforeseen expenses;

3) distribution of the released funds for procurement of services within the guaranteed volume of free medical care and (or) in the CSHI system;

4) changes in the volume of budget funds for paying for medical care within the guaranteed volume of free medical care and the forecast amount of costs for medical care in

the CSHI system due to changes in tariffs, the number, number of patients and other data that are the basis for the placement of services;

5) allocation by the authorized body of an additional amount of budgetary funds to pay for medical care within the GVFMC, previously not provided for by the procurement plan for medical services within the GVFMC;

6) changes in the volume of medical services based on the results of reconciliation of the performance of the volume of medical services and financial obligations for the forecast performance of the volume of medical services, as well as monitoring the performance of contractual obligations in terms of quality and volume;

7) distribution (redistribution) of the volume of budgetary funds to pay for medical care within the GVFMC and distribution (redistribution) of the volume of costs for medical care in the CSHI system;

8) amending the names and when renaming, deleting or including types, forms of medical care, conditions for its provision, types of medical activities;

9) changes in the volume and list of purchased services; 10) the emergence of newly commissioned healthcare facilities.

21. Changes to the procurement plans in the cases provided for by subparagraphs 2) and 5) of paragraph 20 of these Rules are carried out in agreement with the authorized body.

22. The fund makes changes to the procurement plans in the cases provided for by subparagraphs 1), 3), 4), 6) -10) of paragraph 20 of these Rules, after ten working days from the date of sending the notification to the authorized body and in the absence of comments received in fixed time.

The fund makes changes to the plans for procurement of medical services on its own without notifying the authorized body when distributing (redistributing) the amount of budget funds for paying for medical care within the GVFMC and the distribution (redistribution) of the amount of costs for medical care in the CSHI system within one type of medical care, type of medical activities.

Chapter 3. Planning the volume of medical services by types, forms of medical care, conditions of its provision, types of medical activity

Section 1. Planning for emergency medical services

23. The planning of the volume of emergency medical services and medical care associated with the transportation of qualified specialists and (or) the patient, ambulance vehicles (hereinafter - ambulance) is carried out on the basis of the following data:

1) the average annual population in the republic and in the context of regions, cities of republican significance for the period of the previous year;

2) the number of the population by gender and age groups in the context of regional centers and (or) other settlements;

3) the number of patients with acute coronary syndrome and (or) acute myocardial infarction at the prehospital stage over the previous three years.

24. The planning of the volume of emergency medical services is carried out according to:

1) the per capita standard (hereinafter - PS), determined in accordance with subparagraph 64) of Article 7 of the Code;

2) the volume of consumption of medicines (alteplase).

25. The planned volume of PS is determined in accordance with the size of the population and age and gender groups in the context of regions, cities of republican significance, taking into account the expected population growth.

26. Budget planning for emergency medical care when paying for PS is carried out in stages:

1) at the level of regions, cities of republican significance by gender and age groups;

2) at the level of regions, cities of republican significance by correction factors.

27. When planning the budget for drugs (alteplase), the calculation is made:

1) at the level of regions, cities of republican significance by multiplying the forecast volumes of provision of medicines (alteplaza) (taking into account the form of release) with the cost of medicines determined in accordance with subparagraph 96) of Article 7 of the Code;

2) at the level of the republic by summing up regional budgets for provision of medicines (alteplaza).

28. When planning the budget for emergency medical care, the calculation is made by multiplying the assigned population by the PS, as well as summing up the costs of providing drugs (alteplase).

Section 2. Planning of primary health care services

29. Planning the volume of primary health care services (hereinafter - PHC) is carried out on the basis of the following data:

1) the average annual population in the republic and in the context of regions, cities of republican significance;

2) the number of the population by gender and age groups in the context of regional centers and (or) other settlements;

3) the number of patients with phenylketonuria in the previous three years.

30. Planning the volume of the budget for PHC services is carried out according to:

1) a comprehensive per capita standard (hereinafter - CPS);

2) the stimulating component of the per capita standard (hereinafter referred to as the SCPS);

3) the per capita standard of emergency medical care of the fourth category of urgency of calls to the assigned population (hereinafter - PS4);

4) the volume of consumption of medicinal low-protein foods and foods with a low content of phenylalanine.

31. The planned CPS volume is determined in accordance with the average number of the attached population and age and gender groups in the context of regions, cities of republican significance.

32. At the preparatory stage, the collection and formation of input data from information systems, data of national statistical observation and departmental statistical observation is carried out, on the basis of which the analysis of the actual situation over the last three years of the provision of PHC services is carried out:

1) the number of visits to PHC specialists according to ICD-10 disease codes with acute diseases (conditions) or exacerbations of chronic diseases for the period of the previous year at the urban and rural level;

2) the number of persons who received preventive vaccinations by type, taking into account age and gender, during the previous year at the urban and rural levels;

3) the number of persons who underwent preventive examinations and screenings according to their types, taking into account age and sex for the period of the previous year at the urban and rural level;

4) the number of persons who underwent antenatal observation, taking into account their age for the period of the previous year, at the urban and rural levels;

5) the number of persons who underwent postnatal observation, taking into account age and gender, for the period of the previous year at the urban and rural level;

6) the number of persons who were provided with medical and social services, taking into account age and gender for the period of the previous year at the urban and rural level;

7) the number of persons under dynamic observation with chronic non-infectious diseases (including BLS), taking into account age and sex for the period of the previous year at the urban and rural levels;

8) the number of persons under dynamic observation with socially significant diseases, taking into account age and gender for the period of the previous year at the urban and rural level.

The planned volume of PHC services is considered depending on the level of morbidity, changes in population size, in the context of age and gender groups.

CPS includes the following services:

1) preventive examinations of target population groups; 2) immunization;

3) receptions;

4) laboratory diagnostic studies;

5) observation of pregnant women and postpartum women in the postpartum period;

6) patronage of children under the age of one year;

7) medical and social assistance for socially significant diseases;

8) sanitary-anti-epidemic and sanitary-preventive measures in the foci of infectious diseases.

33. Budget planning for PHC when paying for CPS, for PS4 is carried out in stages:

1) at the level of regions, cities of republican significance by gender and age groups;

2) at the level of regions, cities of republican significance by correction factors.

34. Planning of the SCPS budget is carried out at the level of regions, cities of republican significance, taking into account the size of the attached population in regions, cities of republican significance, at a certain rate.

35. Budget planning for provision with therapeutic low-protein foods and foods with a low content of phenylalanine is carried out on the basis of calculating the need by sex and age of patients with phenylketonuria.

36. When planning the budget for primary health care services, the calculation is made by multiplying the attached population by CPS, PS4, and SCPS, as well as summing up the costs of providing therapeutic low-protein foods and foods with a low phenylalanine content.

Section 3. Planning of services for screening examinations

37. The planning of services for screening examinations is carried out on the basis of services provided in the outpatient conditions.

38. Planning the volume of services for screening examinations is carried out on the basis of the data:

1) the number of persons under dynamic observation with chronic non-infectious diseases, taking into account age and gender for the period of the last year; 2) the number of target population groups subject to screening examinations within the timeframe and frequency, established in accordance with paragraph 11 of Article 86 and paragraph 2 of Article 87 of the Code;

3) the average population in the republic, regions and cities of republican significance for the period of the previous three years at the urban and rural level.

39. Budget planning for screening examinations is carried out in stages:

1) at the level of regions, cities of republican significance for each type of screening examinations and target group;

2) at the level of regions, cities of republican significance for all types of screening examinations and for all target groups;

3) at the national level for all types of screening examinations and for all target groups.

40. When planning the budget for screening examinations, the calculation is made by multiplying the number of services by tariffs.

Section 4. Planning of services of consultative and diagnostic care (Specialized outpatient care)

41. Planning of services provided on an outpatient basis according to the list of chronic diseases subject to dynamic observation in PHC organizations, within the GVFMC (hereinafter referred to as dynamic observation at the PHC level), determined in accordance with Article 196 of the Code, is carried out in accordance with changes in the prevalence and number of age and gender groups, in the context of nosologies and age and gender groups, on the basis of which the analysis of the actual situation over the past three years is carried out.

42. Planning the volume of services of consultative and diagnostic care in the outpatient conditions for dynamic observation is carried out on the basis of the following data:

1) the number of persons under dynamic observation at an outpatient level, taking into account age and sex for a period of three years;

2) the annual increase in the number of persons undergoing dynamic observation at the outpatient level, in the republic and by regions, cities of republican significance for the period of the previous three years;

3) the average population in the republic for the period of the previous three years;

4) a list of diseases subject to dynamic observation at an outpatient level, determined in accordance with paragraph 2) of Article 88 of the Code;

5) the established mandatory minimum of diagnostic tests;

6) the frequency of these studies;

7) the number of registered patients who are under dynamic observation at the outpatient level for the reporting period in the context of age categories for this list of nosologies;

8) the number of services per year per patient for a specific disease and (or) a group of diseases by summing up services according to the standard;

9) the total number of services for a specific disease and (or) a group of diseases by multiplying the number of services per year per patient by the number of patients who are under dynamic observation at an outpatient level for this disease and (or) a group of diseases;

10) the total volume of services in the context of each region, city of republican significance by the number of patients who are under dynamic observation at an outpatient level in this region, city of republican significance;

11) the total volume of services in the republic is determined by summing up the volumes of services of each region, city of republican significance.

43. Budget planning for services of dynamic observation at the outpatient level is carried out in stages:

1) at the level of regions, cities of republican significance for a given nosology and in a given age and gender group;

2) at the level of regions, cities of republican significance for a given nosology and for all age and gender groups;

3) at the level of regions, cities of republican significance for all nosologies and for all age and gender groups;

4) at the level of the republic for all nosologies and for all age and gender groups.

44. When planning the budget for services of dynamic observation at the PHC level, the calculation is made:

1) the amount of expenses per patient who is on dynamic observation at an outpatient level for this disease per year by summing up the cost of services included in the examination standard;

2) the total amount of expenses for a specific disease and (or) a group of diseases by multiplying the amount of expenses per patient who is under dynamic observation at an outpatient level by the number of patients who are under dynamic observation at an outpatient level for this disease and (or) a group of diseases.

45. The planning of services according to the list of socially significant diseases subject to dynamic observation by profile specialists in the form of consultative and diagnostic care, within the framework of the GVFMC (hereinafter - dynamic observation of socially significant diseases), is carried out in accordance with changes in the prevalence and number of age and gender groups, in the context of nosologies and age and gender groups on the basis of which the analysis of the actual situation over the past three years is carried out.

46. The planning of the volume of services of consultative and diagnostic care in outpatient dynamic observation in socially significant diseases is based on the data:

1) the number of persons under dynamic observation with socially significant diseases, taking into account age and gender for the period of the previous year;

2) the annual increase in the number of persons under dynamic observation for socially significant diseases in the republic and by regions, cities of republican significance for the period of three previous years;

3) the average number of population in the republic for the period of the previous three years;

4) a list of socially significant diseases subject to dynamic observation;

5) the established mandatory minimum of diagnostic studies;

6) the frequency of these studies;

7) the number of registered patients under dynamic observation for socially significant diseases for the reporting period in the context of age categories for this list of nosologies;

8) the number of services per year per patient for a specific service per year per patient for a specific disease and (or) a group of diseases by summing up services according to the standard;

9) the total number of services for a specific disease and (or) a group of diseases by multiplying the number of services per year per patient by the number of patients who are on dynamic observation for this socially significant disease;

10) the total volume of services in the context of each region, city of republican significance by the number of patients who are under dynamic observation for socially significant diseases in this region, city of republican significance;

11) the total volume of services in the republic is determined by summing up the volumes of each region, city of republican significance.

47. Budget planning for services of dynamic observation for socially significant diseases is carried out in stages:

1) at the level of a region, city of republican significance for the given nosology and for all age and gender groups;

2) at the level of a region, city of republican significance for all nosologies and for all age and gender groups;

3) at the republican level for all nosologies and for all age and gender groups.

48. When planning the budget for services of dynamic observation for socially significant diseases, the calculation is made:

1) the amount of expenses per patient who is under dynamic observation for this socially significant disease per year, by summing up the cost of services included in the examination standard;

2) the total amount of expenses for a specific disease and (or) a group of diseases by multiplying the amount of expenses per patient who is on dynamic observation for socially significant diseases by the number of patients who are on dynamic observation for this socially significant disease and (or) a group of diseases at the level of the region, city of republican significance for a given nosology and in a given age and gender group.

49. The planning of the volume of services of consultative and diagnostic care at the outpatient level according to the list of chronic diseases subject to observation by profile specialists, within the GVFMC and the CSHI system (hereinafter referred to as dynamic observation by profile specialists), is carried out in accordance with changes in the prevalence and number of age and gender groups, in the context of nosologies and age and gender groups on the basis of which the analysis of the actual situation over the past three years is carried out.

50. The planning of the volume of services of consultative and diagnostic care of dynamic observation by profile specialists is carried out on the basis of the following data:

1) the number of persons under dynamic observation by profile specialists, taking into account age and gender over a period of three years;

2) the annual increase in the number of persons under dynamic observation by profile specialists in the republic and by regions, cities of republican significance for the period of the previous three years;

3) demographic forecast of the population in the republic and (or) regions, cities of republican significance for the period of the next three years;

4) the average number of population in the republic for the period of the previous three years;

5) a list of diseases subject to dynamic observation by profile specialists;

6) the established mandatory minimum of diagnostic studies;

7) the frequency of these studies;

8) the number of registered patients under dynamic observation by profile specialists for the reporting period in the context of age categories for this list of nosologies.

51. Budget planning for services of dynamic observation by profile specialists is carried out in stages:

1) at the level of regions, cities of republican significance for a given nosology and in a given age and gender group;

2) at the level of regions, cities of republican significance for a given nosology and for all age and gender groups;

3) at the level of regions, cities of republican significance for all nosologies and for all age and gender groups;

4) at the level of the republic for all nosologies and for all age and gender groups.

52. When planning the budget for services of dynamic observation by profile specialists, the calculation is made:

1) the number of services per year per patient for a specific disease and (or) a group of diseases by summing up the services determined in accordance with paragraph 3 of Article 88 of the Code;

2) the total number of services for a specific disease and (or) a group of diseases by multiplying the number of services per year per patient by the number of patients who are under dynamic observation by profile specialists in this disease and (or) a group of diseases;

3) the total volume of services in the context of each region, city of republican significance by the number of patients, who are under dynamic observation by profile specialists in this region, city of republican significance;

4) the total volume of services in the republic, summing up the volumes of services of each region, city of republican significance;

5) the amount of costs per patient, who is under dynamic observation by profile specialists in this disease per year, by summing up the cost of services included in the list of chronic diseases subject to dynamic observation, determined in accordance with paragraph 2 of Article 88 of the Code;

6) the total amount of costs for a specific disease and (or) a group of diseases by multiplying the amount of costs per patient who is under dynamic observation by profile specialists by the number of patients who are under dynamic observation by profile specialists in this disease and (or) a group of diseases.

53. The planning of the volume of services of consultative and diagnostic care within the framework of a patient's admission for an acute or exacerbation of a chronic disease is determined in accordance with changes in the incidence and number of age and gender groups , on the basis of which the actual situation is analyzed over the past three years.

54. Planning the volume of services for an acute or exacerbation of a chronic disease is based on the following data:

1) the number of registered diseases in the reporting year in the republic, regions and cities of republican significance for a period of three years;

2) the annual increase in the number of people who applied for an acute or exacerbation of a chronic disease in the republic, regions and cities of republican significance for the period of three previous years;

3) the average annual number of population in the republic, regions and cities of republican significance for the period of the previous three years;

4) the average number of population in the republic for the period of the previous three years.

55. Planning of the budget of services for acute or exacerbation of chronic disease is carried out in stages:

1) at the level of regions and cities of republican significance for a given nosology and in a given age and gender group;

2) at the level of regions and cities of republican significance for a given nosology, for all age and gender groups;

3) at the level of regions and cities of republican significance for all nosologies, for all age and gender groups;

4) at the level of the republic for all nosologies, for all age and gender groups.

56. When planning the budget for services for an acute or exacerbation of a chronic disease, a calculation is made by multiplying the planned number of calls by the estimated average cost of services (based on the number of services in the previous year and tariffs).

57. Planning the volume of services in trauma centers is carried out on the basis of the following data:

1) the average number of registered cases of visits to trauma centers in the republic, regions and cities of republican significance for the period of the previous three years;

2) the annual increase in the number of people who applied to trauma centers in the republic, regions and cities of republican significance for the period of the previous three years;

3) the average number of population in the republic for the period of the previous three years.

58. Budget planning for services in trauma centers is carried out in stages:

1) at the level of regions and cities of republican significance for a given type of service and a given age group;

2) at the level of regions and cities of republican significance, for a certain type of service, for all age groups;

3) at the level of regions and cities of republican significance, for all types of services, for all age groups;

4) at the republican level, for all types of services, for all age groups.

59. When planning the budget for services in trauma centers, the calculation is made by multiplying the planned number of services by the estimated average cost of services (based on the number of services in the previous year and tariffs).

60. The planning of the volume of services of mobile medical complexes (hereinafter - MMC) and medical trains (hereinafter - MT) is carried out in the context of each MMC, MT, taking into account consumption for one month, work schedule during the year.

61. Planning of the volume of services of MMC, MT is carried out on the basis of the following data:

1) the average number of services provided by MMC, MT in the republic for the period of the previous three years;

2) the average population in the republic for the period of the previous three years at the rural level;

3) the number of operating MMC, MT;

4) forecast coverage of the rural population and (or) the residing population at the stations ;

5) the period of operation of the MMC on the basis of special vehicles, taking into account the climatic characteristics of regions, cities of republican significance;

6) the period of operation of the MT, taking into account the approved schedule of the movement of medical trains.

62. Budget planning for services of MMC, MT is carried out in stages:

1) at the level of regions and cities of republican significance for this MMC, MT;

2) at the level of regions and cities of republican significance for all MMC, MT;

3) at the level of the republic for all MMC, MT.

63. When planning the budget for services of MMC, MT, the calculation is made by multiplying the planned number of services by the tariff.

64. Planning the volume of services for routine dental care for children and pregnant women (except for orthodontic) is carried out on the basis of the following data:

1) the average number of registered cases of visits by type to specialized dental clinics in the republic and by regions, cities of republican significance for the period of the previous three years;

2) the average population in the republic for the period of the previous three years.

65. Planning of services for routine dental care is carried out according to the list approved in accordance with subparagraph 1) of paragraph 1 of Article 200 of the Code.

66. Planning of the budget for services for routine dental care is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the republican level.

67. Planning of the budget for routine dental care services is carried out by multiplying the planned number of persons to be treated by the estimated average cost of services (based on the number of services in the previous year and tariffs).

68. The planning of the volume of services for emergency dental care (acute pain) for socially vulnerable categories of the population is carried out taking into account the input data from information systems, statistical data on the basis of which the actual situation is analyzed over the past three years.

69. Planning of the budget for services for emergency dental care is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the republican level.

70. When planning the budget for services for emergency dental care, a calculation is made by multiplying the planned number of persons to be treated by the estimated average cost of services (based on the number of services in the previous year and tariffs).

71. Planning of the volume of services for orthodontic care is determined in accordance with changes in morbidity, corresponding pathologies, and the size of the child population.

72. Planning of the volume of services for orthodontic care is carried out on the basis of the following data:

1) the average number of registered cases of visits by type to specialized dental clinics in the republic, regions and cities of republican significance for the period of three previous years;

2) the average population in the republic for the period of the previous three years.

73. Budget planning for services for orthodontic care is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

74. When planning the budget for orthodontic care services, the calculation is made by multiplying the planned number of persons to be treated by the estimated average cost of services (based on the number of services in the previous year and tariffs).

75. The planning of the volume of services for observation of pregnant women (excluding medical genetic screening services) is carried out in accordance with changes in the number of pregnant women.

76. Planning the volume of services for observation of pregnant women is carried out on the basis of the following data:

1) the number of pregnant women who received observation services, taking into account their age for the period of the previous year;

2) the contingent of pregnant women in the republic, regions and cities of republican significance for the period of the previous year;

3) the average population in the republic for the period of the previous three years.

77. The planning of the budget for services for observation of pregnant women is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the republican level.

78. When planning the budget for services for observation of pregnant women, a calculation is made by multiplying the planned number of persons to be observed by the estimated average cost of services (based on the number of services in the previous year and tariffs).

79. The planning of the volume of medical genetic screening services is carried out on the basis of the following data:

1) the number of pregnant women who received observation services, taking into account their age for the period of the previous year;

2) the contingent of pregnant women in the republic, regions and cities of republican significance for the period of the previous year;

3) the average population in the republic for the period of the previous three years.

80. The planning of the budget for services of medical genetic screening is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

81. When planning the budget for medical genetic screening services, the calculation is made by multiplying the planned number of persons to be observed by the estimated average cost of services (based on the number of services in the previous year and tariffs).

82. The planning of the volume of services for health care of students (school medicine) is carried out in accordance with changes in the number of students.

83. The planning of the volume of services of school medicine is carried out on the basis of the following data:

1) the number of services provided within the framework of school medicine, taking into account age and gender for the period of the previous year;

2) the average number of schoolchildren in the republic for the period of the previous three years.

84. The planning of the budget for services of school medicine is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

85. When planning the budget for services of school medicine, the calculation is made by multiplying the planned number of students by the tariff.

86. Planning of the volume of dermatovenerological care services at the outpatient level is determined in accordance with the primary morbidity and prevalence of diseases.

87. Planning of the volume of dermatovenerological care services is carried out on the basis of the following data:

1) the average number of registered cases of diseases in the republic for the period of three previous years;

2) the annual increase in the number of patients registered in the republic, regions and cities of republican significance for the period of the previous three years;

3) the average number of patients newly diagnosed in the republic, regions and cities of republican significance for the period of three previous years;

4) the average population in the republic for the period of the previous three years at the urban and rural level.

88. Planning of the budget for dermatovenerological care services at the outpatient level is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

89. When planning the budget for dermatovenerological care services, the calculation is made by multiplying the planned number of calls by the estimated average cost of services per case.

90. The planning of the volume of services of youth centers at the outpatient level is determined on the basis of the average population in the republic for the period of the previous three years at the urban and rural levels.

91. The planning of the budget for youth centers is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

92. When planning the budget for services of youth centers, the calculation is made by multiplying the planned number of the relevant category of the population by the actual average cost of the corresponding services per person who applied.

93. The planning of the volume of services for consultative and diagnostic care at the outpatient level for republican organizations is carried out separately by categories of the population and types of services received on the basis of the following data:

1) the number of visits by ICD-10 disease codes to republican organizations by population category and types of services received for the period of the previous year;

2) the average number of registered cases of diseases in the republic for the period of the previous three years;

3) the average population in the republic for the period of the previous three years.

94. Planning of the budget for admission of complex patients is carried out at the level of republican organizations.

95. When planning the budget for provision of services in republican organizations, the calculation is made by multiplying the planned number of calls by the estimated average cost of call.

Section 5. Planning of services of program dialysis

96. When planning the services of program dialysis, the requirements of the standard for providing nephrological care to the population of Kazakhstan, approved by the authorized body in accordance with paragraph 32) of Article 7 of the Code, are taken into account.

97. If the volume of the total demand for program dialysis services by international indicators does not comply with the volume of forecast financial resources, the method of planning of program hemodialysis services is used taking into account the annual increase in patients.

98. Planning of the volume of program dialysis services is carried out on the basis of the following data:

1) the average number of program dialysis sessions in the republic for the period of the previous three years;

2) the average number of registered cases of diseases subject to program dialysis in the republic for the period of three previous years;

3) the increase in the number of patients receiving program dialysis over the period of the previous three years;

4) number of population in the republic for the period of three previous years.

99. The planning of the volume of program dialysis services is carried out separately from the planning of specialized medical care in hospital-substituting conditions, taking into account the annual increase in patients.

100. To fully determine the need for program dialysis services, planning is carried out in stages:

1) at the first stage, the planning is carried out taking into account the number of patients receiving program dialysis services;

2) at the second stage, the planning is carried out taking into account the number of program dialysis services. 101. In case of full coverage of the needs of the population in program dialysis services, the planning is carried out in accordance with changes in the total population by the number of patients over the period of the previous three years.

102. Planning of the budget in case of full coverage of the population's need for program dialysis services and within the growth of the number of patients receiving program dialysis is carried out in stages:

1) at the level of regions and cities of republican significance;

2) at the level of the republic.

103. When planning the budget for program dialysis, a calculation is made by multiplying the cost of hemodialysis services in accordance with the tariff determined in accordance with subparagraph 65) of Article 7 of the Code for the forecast number of sessions.

Paragraph 6. Planning of specialized medical care in hospital-substituting conditions

104. The planning of specialized medical care services in hospital-substituting conditions is carried out separately at the urban and rural levels.

105. The planning of the volume of specialized medical care in hospital- substituting conditions is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year at the urban and rural levels;

2) the average number of hospitalizations in the republic for the period of the previous three years at the urban and rural levels;

3) the average number of hospitalizations of nonresident patients in the republic over the period of three previous years at the urban and rural levels;

4) the average population in the republic for the period of the previous three years at the urban and rural level.

106. The planned volume of specialized medical care services in hospital-substituting conditions at the urban and rural levels is determined depending on the level of hospitalizations, changes in the population, in the context of gender and age groups.

107. Budget planning for specialized medical care services in hospital-substituting conditions is carried out in stages:

1) at the level of regions and cities of republican significance for a given age and gender group;

2) at the level of regions and cities of republican significance, according to this class of ICD-10, for all age and gender groups;

3) at the level of regions and cities of republican significance, for all ICD-10 classes, for all age and gender groups;

4) at the republican level, for all ICD-10 classes, for all age and gender groups.

108. The planned number of hospitalizations can be adjusted depending on the planned budget limit at the urban and rural levels. When adjusting, they are guided by a sample of groups according to the ICD-10 and ICD-9 codes, taking into account the priority areas of health care.

109. When planning the budget for specialized medical care in hospital-substituting conditions, the calculation is made by multiplying the average cost of one treated case for the period of three previous years for the ICD-10 class and age and gender group, taking into account changes in the base rate and payment methods for one treated case in the provision of specialized medical care in hospital-substituting conditions for previous periods for the planned number of hospitalizations in the context of ICD-10 classes and age and gender groups.

Section 7. Planning for specialized medical care in inpatient conditions

110. The planning of the volume of services for the provision of specialized medical care (hereinafter referred to as SMC) in stationary conditions is carried out separately at the urban and rural levels based on the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year at the urban and rural levels;

2) the average number of hospitalizations in the republic for the period of the previous three years at the urban and rural levels;

3) the average number of hospitalizations of nonresident patients in the republic over the period of three previous years at the urban and rural levels;

4) the number of persons who received SMC in stationary conditions for emergency indications;

5) the average number of registered cases of diseases in the republic for the period of three previous years at the urban and rural levels;

6) the average population in the republic for the period of the previous three years at the urban and rural levels.

111. The planned volume of SMC in stationary conditions at the urban and rural levels is determined in accordance with changes in the population, in the context of ICD-10 classes and age and gender groups.

112. Budget planning for the SMC in stationary conditions is carried out in stages:

1) at the level of regions and cities of republican significance for this class of ICD-10 and this age and gender group;

2) at the level of regions and cities of republican significance, for this profile, for all age and gender groups;

3) at the level of regions and cities of republican significance, for all profiles and for all age and gender groups;

4) at the republican level, for all profiles and age and gender groups.

113. The planned number of hospitalizations can be adjusted taking into account the budget limit at the urban and rural levels. When adjusting, they are guided by sampling of groups by ICD-10 disease codes and ICD-9 operation codes, taking into account priority values.

114. To eliminate the risk of deficit or excess of the planned volumes of detailed inpatient services of the SMC for disease codes according to ICD-10 and operation codes according to ICD-9, an approach of gradual equalization is used between regions and cities of republican significance.

115. When planning the budget for SMC in inpatient conditions, the calculation is made by multiplying the average cost of one treated case for the period of three previous years for the ICD-10 class and age and gender group, taking into account changes in the base rate for previous periods, by the planned number of hospitalizations in the context of ICD-10 classes and age and gender groups.

Section 8. Planning for high-tech health care

116. The planning of the volume of high-tech medical care (hereinafter - HTMC) is carried out by types of technologies provided at all levels on the basis of the following data:

1) actual indicators of the number of those who received HTMC services in the republic for the period of the previous year;

2) the average population in the republic for the period of the previous year;

3) the number of types of HTMC services provided by the operation code for the ICD - 9;

4) the number of persons who received HTMC, including for emergency indications;

5) data from the analysis of international practice in provision of HTMC services;

6) proposals of local government health authorities, scientific centers, research institutes on the forecast volumes of provision of HTMC services for the planned period in the context of healthcare entities and technology;

7) tariffs for HTMC services.

117. Calculations to determine the volume of HTMC services are carried out in the context of technologies, in the republic, taking into account the impact of HTMC services on morbidity, mortality and quality of life.

118. Comparative analysis of the level of HTMC in the Republic of Kazakhstan is carried out per one million population in comparison with international best practices.

119. Budget planning within the recommended international level and within the capacity of providers for HTMC services is carried out in stages:

1) at the level of the republic, certain services of the HTMC;

2) at the republican level, for all HTMC services.

120. If it is possible to fully cover the needs of the population for HTMC services, planning is carried out in accordance with changes in the total population at the level of the republic, for a specific HTMC service.

121. When planning the HTMC budget, the calculation is made by multiplying the forecast number of services by the tariff.

Section 9. Planning of palliative care services

122. The planning of the volume of palliative care services is carried out separately for medical care in inpatient, hospital-substituting conditions and mobile teams.

123. Planning the volume of palliative care services is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations by ICD-10 disease codes subject to palliative care for the period of the previous three years;

3) the average number of hospitalizations of patients who received palliative care services in the republic over the period of the previous three years;

4) the average population in the republic for the period of the previous three years.

124. In case of full coverage of the needs of the population for palliative care services, planning is carried out in accordance with changes in the total population in terms of the number of patients subject to palliative care over the period of the previous three years.

125. The planned volume of palliative care services in inpatient, hospital-substituting conditions is determined in accordance with changes in the population size, in terms of ICD-10 disease codes.

126. Budget planning for palliative care services when paying for a bed-day is carried out in stages:

1) at the level of regions and cities of republican significance in the form of services provision, at a certain tariff;

2) at the level of regions and cities of republican significance in the form of services provision, at all tariffs;

3) at the republican level for all tariffs.

127. When planning the volume of palliative care services in the form of mobile teams, the tariff for palliative care, the region, the number of visits, the forecast number of people in need of palliative care are taken into account.

128. Budget planning for palliative care services in the form of mobile teams is carried out in stages:

1) at the level of regions and cities of republican significance at a certain tariff;

2) at the level of regions and cities of republican significance at all tariffs;

3) at the republican level for all tariffs.

129. When planning the budget for palliative care, the calculation is made:

1) at the level of regions and cities of republican significance by multiplying the planned number of bed-days by the corresponding tariff;

2) at the republican level by summing up regional budgets of palliative care.

Section 10. Planning of anatomico-pathological diagnostic services

130. The planning of the volume of services of anatomico-pathological diagnostics is carried out taking into account the types and categories of complexity of the diagnostics and on the basis of the following data:

1) the actual number of deaths in hospitals for the period of the previous year;

2) the average number of deaths in hospitals for the period of the previous three years;

3) the actual number of anatomico-pathological autopsies for the period of the previous year;

4) the average number of anatomico-pathological autopsies for the period of the previous three years;

5) the actual number of cytological examinations of biopsy and surgical material for the period of the previous year;

6) the average number of cytological examinations of biopsy and surgical material for the period of the previous three years;

7) the actual number of intravital anatomico-pathological studies of biopsy and surgical material for the period of the previous year;

8) the average number of intravital anatomico-pathological studies of biopsy and surgical material for the period of the previous three years.

131. Planning of the full need for services of intravital anatomico-pathological studies and cytological studies of biopsy and surgical material is carried out separately in accordance with changes in the total volume of surgical cases of the round-the-clock and (or) day hospital; manipulations on the collection of biological material in a round-the-clock and (or) day hospital; outpatient procedures and manipulations in the context of the current tariffs for the corresponding anatomico-pathological services.

132. When planning anatomico-pathological autopsies (autopsies), the classification of autopsies into compulsory (maternal, infant mortality, stillborn) is taken into account and according to a written application from legal representatives.

133. When planning the budget for anatomico-pathological diagnostics, the calculation is made by multiplying a forecast number of anatomico-pathological autopsies (autopsy) and intravital anatomico-pathological and cytological examinations, compiled on the basis of requests from regional anatomico-pathological departments and (or) bureaus for tariffs.

Section 11. Planning of services for procurement, processing, storage and sale of blood and its components, for production of blood products

134. Planning of the volume of services for procurement, processing, storage and sale of blood and its components, production of blood products to provide patients hospitalized in round-the-clock and day hospitals is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations in the republic for the period of the previous three years;

3) the average number of hospitalizations of patients who received services for procurement, processing, storage and sale of blood and its components, the production of blood products in the republic over the period of the previous three years;

4) the average number of registered cases of diseases in the republic for the period of three previous years;

5) demographic indicators of population movement in the republic for the period of the previous year;

6) the average population in the republic for the period of the previous three years.

135. Budget planning for services for procurement, processing, storage and sale of blood and its components, production of blood products is carried out in stages:

1) at the level of regions and cities of republican significance for this profile (for the SMC) or the operation code for ICD-9 (for HTMC), at a certain rate;

2) at the level of regions and cities of republican significance, for all profiles (for SMC) or operation codes for ICD-9 (for HTMC), at a certain rate;

3) at the level of regions and cities of republican significance for all profiles (for SMC) or operation codes for ICD-9 (for HTMC), for all tariffs;

4) at the republican level for all profiles (for SMC) or operation codes for ICD-9 (for HTMC), for all tariffs.

136. The planned volume of services for procurement, processing, storage and sale of blood and its components, the production of blood products in terms of groups of services: accompaniment of organ transplantation from related donors, accompaniment of organ transplantation from posthumous donors, accompaniment of hematopoietic stem cell transplantation, formation of a waiting list, formation of a register of hematopoietic stem cell donors, individual selection of platelets, typing of cord blood, individual selection of erythrocyte-containing media is carried out in the context of services of this group and centers . In this case, the volumes are determined based on the forecast volumes of transplants and resources.

137. When planning the budget for procurement, processing, storage and sale of blood and its components, the production of blood products, the calculation is made by multiplying the cost of drugs and services according to the tariff for the forecast number of blood products and services.

138. In the absence of the above data, the planning of the volume of services for procurement, processing, storage and sale of blood and its components, the production of blood products is carried out on the basis of requests from regional and city blood centers agreed with the healthcare organization operating in the blood service.

Paragraph 12. Planning of medical and social assistance to persons with HIV infection

139. The planning of the volume of services of medical and social assistance to persons with HIV is carried out separately for persons who are under dynamic observation, persons who have applied to friendly offices, and persons tested for HIV infection on the basis of the following data:

1) the average number of registered cases of HIV infection over the period of the previous three years;

2) the annual increase in the number of patients registered in the republic, regions and cities of republican significance for the period of the previous three years;

3) the average number of patients newly diagnosed in the republic, regions and cities of republican significance for the period of the previous three years;

4) the average number of patients subject to examination for the disease in the republic, regions and cities of republican significance for the period of the previous three years;

5) the average population in the republic for the period of the previous three years at the urban and rural levels.

140. When determining the forecast number of persons under dynamic observation and budget planning, the calculation is made:

1) the average growth rate of patients over the past three years in the context of each region and city of republican significance for the planned period;

2) the amount of expenses by multiplying the complex tariff by the forecast number of persons under dynamic observation;

3) the volume of services in the republic, summing up the volumes of services of each region and city of republican significance.

141. When determining the forecast number of persons who applied to friendly offices and budget planning, calculations are made:

1) the average growth rate of patients over the past three years in the context of each region and city of republican significance for the planned period;

2) the amount of expenses by multiplying the tariff by the forecast number of persons who applied to friendly offices;

3) the volume of services in the republic, summing up the volumes of services of each region and city of republican significance.

142. When planning the volume of services for testing the presence of HIV infection and planning the budget, the calculations are made:

1) the average growth rate of the number of services over the past three years in the context of each region and city of republican significance for the planned period (data from tertiary organizations);

2) the amount of expenses by multiplying the tariff by the forecast number of services for testing the presence of HIV infection (data from tertiary organizations);

3) the volume of services in the republic, summing up the volumes of services of each region and city of republican significance.

143. When planning the volume of services of the republican organization and budget planning, calculations are made:

1) the forecast number of persons under dynamic observation;

2) the forecast number of services per patient, who is under dynamic observation;

3) the amount of expenses is calculated by multiplying the cost of services according to the reference book of medical services and the forecast number of services. 144. When planning the budget for provision of antiretroviral drugs, the calculation is made:

1) at the level of regions and cities of republican significance by multiplying the forecast volumes of drug supply with antiretroviral drugs (taking into account the form of release) with the cost of drugs determined in accordance with subparagraph 96) of Article 7 of the Code;

2) at the republican level by summing up regional budgets for provision of antiretroviral drugs.

Section 13. Planning of medical and social assistance to persons with tuberculosis

145. The planning of the volume of services of medical and social assistance to persons with tuberculosis is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations in the republic for the period of the previous three years;

3) the average number of registered cases of diseases in the republic for the period of the previous three years;

4) the annual increase in the number of patients registered in the republic, regions and cities of republican significance for the period of the previous three years;

5) the average number of newly diagnosed tuberculosis patients in the republic, regions and cities of republican significance for the period of the previous three years;

6) the average number of patients examined with suspected disease in the republic, regions and cities of republican significance for the period of the previous three years.

146. The planning of the volume of medical and social assistance to persons with tuberculosis is carried out at a comprehensive tariff per patient with tuberculosis, with the exception of:

1) provision of anti-tuberculosis drugs;

2) republican organizations, which are paid for provision of specialized medical care in inpatient and hospital-substituting conditions at a rate per one bed-day (hereinafter - a health care subject providing medical and social assistance to persons with tuberculosis).

147. When planning the volume of medical and social assistance to persons with tuberculosis, the calculation is made:

1) the average rate of change in the number of persons with tuberculosis by determining the arithmetic mean number of registered patients at the beginning and end of the period for the previous three years in the context of regions, cities of republican significance;

2) the forecast annual average number of persons with tuberculosis by multiplying the number of patients registered with the average rate of change in the number of patients in the context of regions, cities of republican significance.

148. When planning the budget for medical and social assistance to persons with tuberculosis, the calculation is made:

1) at the level of regions, cities of republican significance by multiplying the complex tariff by the annual average number of persons with tuberculosis;

2) at the republican level by summing up regional budgets for medical and social assistance to persons with tuberculosis.

149. When planning the volumes of drug supply with anti-tuberculosis drugs, the calculation is made:

1) the total physical volume of consumption of anti-tuberculosis drugs for the period of the previous year in the context of regions and cities of republican significance, taking into account the form of production of drugs;

2) the forecast annual average number of persons with tuberculosis.

150. When planning the budget for provision of anti-tuberculosis drugs, the calculation is made:

1) at the level of regions, cities of republican significance by multiplying the forecast volumes of drug supply with anti-tuberculosis drugs (taking into account the form of release) with the cost of drugs determined in accordance with subparagraph 95) of Article 7 of the Code;

2) at the level of the republic by summing up regional budgets for the provision of anti-tuberculosis drugs.

Paragraph 14. Planning of medical care in the field of mental health for persons with mental, behavioral disorders (diseases)

151. Medical care in the field of mental health for people with mental and behavioral disorders (diseases) is provided at the primary health care level, in outpatient, inpatient and hospital-substituting conditions (voluntary and compulsory).

152. The planning of the volume of services of medical care in the field of mental health for persons with mental, behavioral disorders (diseases) is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations in the republic for the period of the previous three years;

3) the average number of registered cases of diseases in the republic for the period of three previous years;

4) the annual increase in the number of patients registered in the republic, regions, cities of republican significance for the period of the previous three years;

5) the average number of patients newly diagnosed in the republic, regions, cities of republican significance for the period of three previous years;

6) the average number of patients examined with suspected disease in the republic, regions, cities of republican significance for the period of the previous three years.

153. Budget planning of medical care in the field of mental health to persons with mental, behavioral disorders (diseases) is carried out at a comprehensive tariff per patient in a mental

health center, with the exception of republican health care organizations providing specialized medical care in inpatient and hospital-substituting conditions, which are paid for the treated case at the estimated average cost and per bed-day.

154. To determine the volume of services of medical care in the field of mental health to persons with mental, behavioral disorders (diseases), the calculation is made:

1) the average rate of change in the number of persons with mental, behavioral disorders (diseases), by determining the arithmetic mean number of registered patients at the beginning and end of the period for the previous three years in the context of regions, cities of republican significance;

2) the forecast annual average number of persons with mental, behavioral disorders (diseases) by multiplying the number of registered patients with the average rate of change in the number of patients in mental health centers in the context of regions, cities of republican significance.

155. When planning the budget for medical care in the field of mental health for persons with mental, behavioral disorders (diseases), the calculation is made:

1) at the level of regions, cities of republican significance by multiplying the complex tariff by the forecast annual average number of patients with mental and behavioral disorders;

2) at the level of the republic by summing up regional budgets for medical and social assistance to persons suffering from mental disorders (diseases).

Section 15. Planning of medical care for persons with infectious and parasitic diseases in stationary conditions

156. The planning of the volume of services of medical care to persons with infectious and parasitic diseases is based on the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations in the republic for the period of the previous three years;

3) the average number of hospitalizations of nonresident patients in the republic for the period of the previous three years;

4) the average number of registered cases of infectious diseases in the republic for the period of the previous three years;

5) the average population in the republic for the period of the previous three years.

157. The planned volume of inpatient services for persons with infectious and parasitic diseases is determined in accordance with the forecast morbidity in the context of infectious nosologies.

158. Planning of the budget for inpatient services to persons with infectious and parasitic diseases is carried out in stages:

1) at the level of regions, cities of republican significance by disease codes according to ICD-10;

2) at the level of the republic for all nosologies according to ICD-10 codes.

159. In order to increase the accuracy of planning infectious diseases in cases of an imminent change in the epidemiological situation according to the list of ICD-10 codes of infectious diseases (an infection that exceeds the incidence rate usually registered in a given territory and can become a source of an emergency) towards an increase in the epidemic threshold, an analysis of the past epidemiological season for this infection is made.

160. Information on morbidity and (or) the rate of forecast increase in incidence (for the total population and each age group) is provided by the authorized body in charge of sanitary and epidemiological welfare of the population, indicating the increase in infectious morbidity according to the list of ICD-10 codes.

161. If there are factors indicating the beginning of an epidemic, the planned number of cases of this infection increases by the growth of the incidence of this infection.

Paragraph 16. Planning of cancer care for population of the Republic of Kazakhstan

162. The planning of the volume of services of oncological care to the population of the Republic of Kazakhstan is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the number of registered patients in the republic for the period of three previous years, with the exception of patients with malignant neoplasms of lymphoid and hematopoietic tissue and children under the age of 14 years.

3) the average number of registered cases of oncological diseases in the republic for the period of the previous three years;

4) the annual increase in the number of patients registered for the dynamic observation of cancer patients in the republic, regions and cities of republican significance for the period of the previous three years, with the exception of patients with malignant neoplasms of lymphoid and hematopoietic tissue and children under the age of 14;

5) the average number of patients examined with suspected disease in the republic, regions and cities of republican significance for the period of the previous three years;

6) the number of patients newly diagnosed in the republic, regions and cities of republican significance for the period of the previous three years.

163. When determining the volume of services of oncological care to the population of the Republic of Kazakhstan, the calculation is made:

1) the average rate of change in the number of cancer patients by determining the average number of registered patients at the beginning and end of the period for the previous three years in the context of regions and cities of republican significance;

2) the forecast annual average number of cancer patients by multiplying the number of cancer patients registered in the electronic register of cancer patients for the period of the previous year by the average rate of change in the number of cancer patients in the context of regions and cities of republican significance.

164. When planning the budget for cancer care to the population of the Republic of Kazakhstan, the calculation is made:

1) at the level of regions and cities of republican significance:

for the provision of specialized medical care on an outpatient basis by multiplying the predicted number of services by tariffs;

for the provision of specialized medical care in hospitals by multiplying the average cost of one treated case for the past period according to the ICD-10 class by the planned number of hospitalizations in terms of ICD-10 classes;

for the provision of specialized medical care in hospital-replacing conditions by multiplying the average cost of one treated case for the past period according to the ICD-10 class by the planned number of hospitalizations in terms of ICD-10 classes;

2) at the level of the Republic by summing up regional budgets for medical and social assistance to cancer patients.

Footnote. Paragraph 164 as amended by the order of the Acting Minister of Healthcare of the Republic of Kazakhstan dated 19.11.2021 No. ҚР ДСМ-120 (shall be enforced from the date of its first official publication).

165. When planning the volumes of provision of oncological patients with chemotherapy and targeted drugs, the calculation is made:

1) the total physical volume of consumption of chemotherapy drugs and targeted drugs for the period of the previous year in the context of regions, cities of republican significance, taking into account the form of production of drugs;

2) forecast annual average number of cancer patients.

166. When planning the budget for provision of chemotherapy and targeted drugs, the calculation is made:

1) at the level of regions and cities of republican significance by multiplying the forecast volumes of provision with chemotherapy drugs and targeted drugs (taking into account the form of release) with the cost of drugs determined in accordance with subparagraph 96) of Article 7 of the Code;

2) at the level of the republic by summing up regional budgets for provision of chemotherapy drugs and targeted drugs.

167. The planning of the volume of services of radiation therapy for cancer patients is carried out on the basis of requests from regional dispensaries and centers, agreed with the specialized republican organization in the field of oncology and radiology. To plan the forecast volume of radiation therapy, the calculation is carried out by multiplying the tariff by the forecast volume of services.

Paragraph 17. Planning of medical care for hematological cancer patients

168. The planning of the volume of medical care services for hematological cancer patients is carried out on the basis of the following data:

1) actual indicators of the number of hospitalizations in the republic for the period of the previous year;

2) the average number of hospitalizations in the republic for the period of the previous three years;

3) the average number of registered hematological cancer patients in the republic for the period of the previous three years;

4) the average population in the republic for the period of the previous three years.

169. The planned volume of inpatient care services for patients with oncohematological diseases is determined in accordance with the forecast morbidity in the context of ICD-10 codes.

170. Budget planning for inpatient care for patients with hematological cancer diseases is carried out in stages:

1) at the level of regions, cities of republican significance for all codes of oncohematological diseases according to ICD-10;

2) at the republican level for all codes of oncohematological diseases according to ICD-10

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Section 18. Planning for medical rehabilitation services

171. The planning of the volume of medical rehabilitation services is carried out separately for persons receiving the second and third stages of medical rehabilitation, depending on the nosology, based on the following data:

1) actual indicators of the number of hospitalizations according to ICD-10 disease codes, which form the need for medical rehabilitation of the second and third stages, in the republic for the period of the previous year;

2) the average number of hospitalizations of patients who received medical rehabilitation services in inpatient and hospital-substituting conditions in the republic for the period of the previous year;

3) the average number of hospitalizations of patients who received medical rehabilitation services on an outpatient basis in the republic over the period of the previous three years;

4) the actual number of the child population with chronic diseases according to ICD-10 disease codes subject to medical rehabilitation for the period of the previous year;

5) the average population in the republic for the period of the previous three years.

172. When planning the volume of medical rehabilitation services of the second stage in inpatient and hospital-substituting conditions, the calculation is made:

1) the number of hospitalizations by disease codes according to ICD-10, provided for medical rehabilitation of the second stage, taking into account the change in population in the context of each region, city of republican significance for the planned period;

2) the volume of medical rehabilitation services of the second stage by determining the proportion of patients by disease codes according to ICD-10, provided for medical rehabilitation of the second stage, in the context of each region, city of republican significance;

3) the amount of expenses for medical rehabilitation of the second stage by multiplying the cost of services according to the CCG code for the forecast volume of medical rehabilitation of the second stage;

4) the volume of services in the republic, summing up the volumes of services of each region, city of republican significance.

173. When planning the volume of medical rehabilitation services of the third stage in inpatient and hospital-substituting conditions, the calculation is made:

1) the number of hospitalizations by disease codes according to ICD-10, provided for medical rehabilitation of the third stage, taking into account the change in population in the context of each region, city of republican significance for the planned period;

2) the number of the child population with chronic diseases according to the ICD-10 disease codes provided for medical rehabilitation, taking into account the change in the population in the context of each region, city of republican significance for the planned period ;

3) the volume of medical rehabilitation services of the third stage by calculating the frequency of consumption of medical rehabilitation services of the third stage, the forecast number of hospitalized patients and the number of children with chronic diseases according to ICD-10 disease codes provided for medical rehabilitation of the third stage, in the context of each region, city republican significance;

4) the amount of expenses for medical rehabilitation of the third stage by multiplying the cost of services per bed-day and the forecast volume of bed-days of medical rehabilitation of the third stage;

5) the volume of services in the republic, summing up the volumes of services of each region, city of republican significance.

174. The calculation of the volume of medical rehabilitation of the third stage for republican organizations is carried out in the same way as the calculation of the volume of rehabilitation services of the third stage in inpatient and hospital-substituting conditions, except for the application of tariffs for medical organizations that have a certificate of accreditation according to the standards of the Joint Commission International (JCI), USA.

175. Calculation of the volume of medical rehabilitation services of the third stage in the outpatient conditions is carried out in the same way as the calculation of the volume of medical rehabilitation services of the third stage in inpatient and hospital-substituting

conditions, except for determining the amount of expenses, which is determined by multiplying a tariff for the service according to the rater and the forecast number of medical rehabilitation services of the third stage in outpatient conditions.

Paragraph 19. Planning the volume of services when sending citizens of the Republic of Kazakhstan for treatment abroad and (or) attracting foreign specialists for treatment in domestic medical organizations

176. The planning of the volume of services when sending citizens of the Republic of Kazakhstan for treatment abroad and (or) attracting foreign specialists for treatment in domestic medical organizations is carried out on the basis of the following data:

1) the actual number of persons who received treatment abroad over the period of the previous year;

2) the actual number of persons who received treatment abroad over the period of the previous three years;

3) the actual number of persons who received treatment in the conditions of domestic medical organizations with the involvement of foreign specialists during the previous year;

4) the actual number of persons who received treatment in the conditions of domestic medical organizations with the involvement of foreign specialists over the period of the previous three years;

5) the average number of patients newly diagnosed in the republic and by region over the period of the previous three years;

6) demographic indicators of population movement in the republic for the period of the previous year at the urban and rural levels;

7) the average population in the republic for the period of the previous three years at the urban and rural levels.

177. For budget planning when sending citizens of the Republic of Kazakhstan for treatment abroad and (or) attracting foreign specialists for treatment in domestic medical organizations is carried out on the basis of the following data:

1) the actual amount of expenses when sending citizens of the Republic of Kazakhstan for treatment abroad for the period of the previous year;

2) the actual amount of expenses when sending citizens of the Republic of Kazakhstan for treatment abroad for the period of three previous years;

3) the actual amount of expenses for receiving treatment in the conditions of domestic medical organizations with the involvement of foreign specialists for the period of the previous year;

4) the actual amount of expenses for receiving treatment in the conditions of domestic medical organizations with the involvement of foreign specialists for the period of three previous years;

5) the actual amount of expenses for the patients who are transferred for treatment abroad for the period of the previous year;

6) the actual amount of expenses for passing patients who received treatment in the conditions of domestic medical organizations with the involvement of foreign specialists for the period of the previous year.

178. In the event of fluctuations in the exchange rate, an adjustment is made to the amount of expenses.