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POSSIBILITIES OF APPLICATION OF FOREIGN COUNTRIES MEDICAL INSURANCE EXPERIENCE IN UZBEKISTAN

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ABSTRACT

This article describes how to create a health insurance system in foreign countries, as well as the work that is being carried out in our country for its application.

KEYWORDS: *Insurance, Medical Insurance, Voluntary Medical Insurance, Compulsory Medical Insurance, Insurance Market*

INTRODUCTION

In the process of institutional reforms implemented in Uzbekistan since the early years of independence, an insurance system has been formed in accordance with the principles of a market economy. In a relatively short period of time, the necessary legal framework, organizational and economic mechanisms for the regulation and management of the insurance sector of the economy have been created. As a result, in recent years, the insurance sector of the economy has been growing steadily. In the financial market of the country, the insurance system is distinguished by its importance and special significance. But the proposals show that in practice, insurance services are not efficient enough. Despite the significant measures taken by the state to stimulate and liberalize the insurance business, insurance remains a key factor in diversifying the economy and economic growth. The main reasons for this are the narrowness and low quality of the supply of services, the lack of competition, insufficient supply of insurance resources.

These cases are the main aspects of the problems of development and targeted management of insurance in Uzbekistan.

ANALYSIS OF LITERATURE ON THE SUBJECT

Today, the Action Strategy for the five priority areas of development of the Republic of Uzbekistan for 2017-2021 highlights the need to improve the insurance market, further develop the management system of insurance companies. Priority III of the Action Strategy states "... expanding the volume of insurance, leasing and other financial services through the introduction and improvement of their quality, as well as the development of the stock market as an alternative source of capital and free resources of enterprises, financial institutions and the population" [1], the function is defined.

As a result of large-scale economic reforms in our country, the financial market has been formed and its modern forms have been introduced. In particular, the insurance market is developing steadily. At the same time, the important measures are taken with the direct initiative of the President such as cultivating competition in the provision of insurance services, developing

and improving the quality of modern insurance activities, increasing the level of capitalization and financial stability of insurers, expanding their regional network, as well as improving insurance, are becoming incredibly large.

Problems of development of medical insurance in Russia are reflected in the works of A.L. Arkhipova, Yu.T. Akhvlediani, Yu.V. Volkova, N.B. Grishchenko, E.V. Kolomima, Yu.A. Lavrova, I.L. Logvinova, M.M. Morozova, E.A. Rusetskoy, G.V. Chernova, T.A. Fedorova and others. Legally described approach to the definition of medical insurance is followed by such authors as, for example, Skamay L.G., MazurinaT.Yu. [2], It should be noted that a number of researchers (for example, Shibanov I.O. [3]. LavrovaYu.A. [4], Ermasov SV, Ermasova NB [5], Arkhipov AP [6]), when characterizing voluntary and compulsory medical insurance, rely on the formulations of these types of insurance, as set out in the above law.

It should be noted that the Uzbek economists T.M. Baymuratov [7], I.Kh. Abdurakhmanov analyzed some issues of improving the insurance system and the mechanism for its implementation. In the research work of domestic scientists, the processes of self-regulation of insurance relations, analysis of market infrastructure in the insurance system are not sufficiently analyzed. Consideration of quantitative indicators of the insurance market is enough to analyze its structure and legal form. The mechanism of functioning of the insurance system in the rapidly developing insurance market, the organization of business processes in the preparation of insurance contracts are not adequately covered. This means that more research is needed on this topic.

ANALYSIS AND RESULTS

World experience shows that health insurance (both voluntary and compulsory) plays a positive role in improving the quality of medical services, attracting additional resources to the health sector, protecting the interests and rights of citizens of the country. Foreign practice has rich experience in the use of health financing mechanisms and the organization of the health insurance system. There are various models for investing in this sector of the economy, which take into account the individual development of the country and society as a whole. At the same time, different mechanisms for financing medical services have been developed around the world.

Figure 1 shows despite recent measures in the field of health insurance, a number of problems remain unresolved. In particular, the lack of conditions for the introduction of compulsory health insurance, as a result of which health financing is carried out mainly from the budget, there are some obstacles to the cooperation of dynamically developing private and public medical institutions in the health system such as inability to effectively use additional financial resources, insufficient introduction of information and communication technologies in the health insurance system, etc.

Figure 2 shows a characteristic feature of the first model, namely Semashko-Beveridge budget model prescribes state's role as very important. The main source of funding is tax revenues, which provide free medical care to the population. The second model, known as the Bismart model, is described as an additional regulated health insurance system. This model is based on the principles of a mixed and complex economy and combines the health care market with a state-regulated and socially guaranteed advanced system. The third model of the health care system is a private model, in which medical services are provided on the basis of payment for health insurance and personal funds of citizens. The state has not formed a single health insurance system. If we analyze the experiences of the three leading countries Germany, Great Britain, USA, which most vividly describe the above models.

Below the data in Table 1, we can see that according to the sources of health financing, compulsory health insurance in Germany is 60 %, voluntary health insurance is 10 %, the state budget is 15 % and personal funds-15 %, while in the UK, the state budget is 85 %, voluntary health insurance-15 %, and in the United Statesprivate insurance – 40 %, personal funds20 %, programs for the poor and the elderly-40 %.

According to the coverage of the population with free medical care, 90 % of the population in Germany is covered by compulsory health insurance programs, while in UK, 10 % by voluntary health insurance programs, of which 3% are covered by compulsory health insurance by free health care. In the U.S., however, patients are limited by their ability to pay, and we can see that programs for the elderly and low-income do not apply to all those in need.

According to health system coverage, 73.1 % in Germany are covered by all medical institutions, public spending is 7.8 % of GDP, a total of 11.7%, and in the UK, 82.4 % is covered by all medical institutions. government spending is 7.7 % of GDP, or 9.4 % of total, and in the United States, 49 % is covered by all health facilities, while government spending is 9.1 % of GDP, or 17.2 % of total.

With regard to the distribution of funds in Germany, the state creates private funds for general health insurance (non-profit self-governing organizations), whereas in UK, it is by public self-governing organizations, and in US it is through private insurance companies, which are distributing to socially vulnerable citizens through government programs.

Methods of payment for medical services in Germany are clearly defined that includes hospital payment rates, outpatient payment (outpatient care) whereas in UK, it is through hospital-defined payment rates, outpatient payment (outpatient care) and in US, it is by means of hospital-defined payment standards and global budget, outcome directed payment (ambulance outpatient) methods.

Thus, for improving health insurance practice, the expansion of knowledge on compulsory and voluntary health insurance through the media is focused on specific aspects that have been scientifically researched by economists and revealed with relevant scientific-theoretical approaches.

Insurance products may also include services such as undergoing regular checkups to help detect illness at an early stage. This significantly increases the effectiveness of treatment. Most insurers also offer services such as getting a “second opinion” in diagnosing cancer and start treatment faster. In the picture below, we consider the situation with life insurance in Uzbekistan.

Figure 3 shows that according to the results of the insurance market of Uzbekistan in 2019, there were changes in the activities of life insurance companies, which have consistently shown high performance in terms of insurance companies. Insurance premiums increased by 34.1 % year-on-year basis to 230.6 billion soums. It increased by 33.6 % compared to the previous year. At Agros Hayot LLC, 96.3 billion soums were invested. Insurance premiums decreased by 25.7 % year-on-year to 109.8 billion soums. Soums increased by 38.8 % compared to the previous year. Uzbekinvest Hayot LLC has 95.1 billion soums. Insurance premiums decreased by 6.1% year-on-year to 110.4 billion soums. Soums increased by 62.1 % compared to the previous year. From this analysis, it can be seen that insurance in the life insurance industry is growing rapidly.

In view of the above, in our opinion, the problems in the introduction of the health insurance system are as follows:

- Issues related to the establishment of compulsory health insurance funds;
- Determining the list of services provided;
- Identification of the insured population;
- Development of cash withdrawal mechanisms;
- Creating control systems.

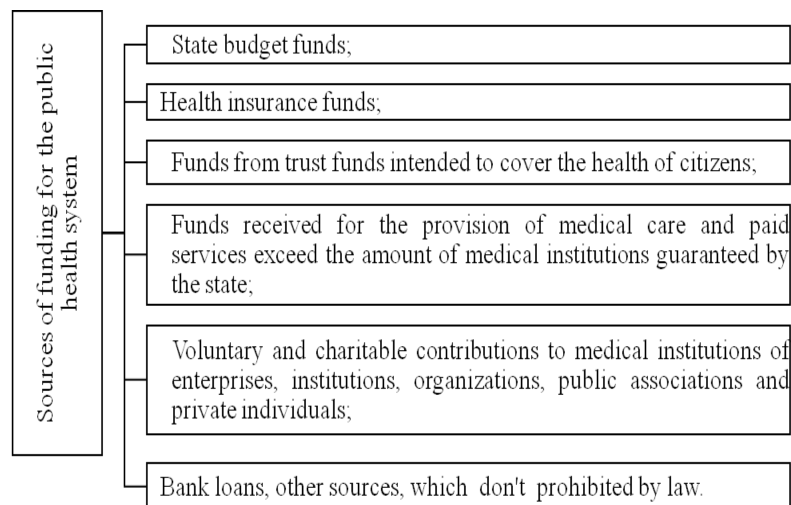

Figure 1: Sources of Funding for the Public Health System [9].

In Order to Analyze the Models of Financing and Organization of the Global Health System, we will Consider their Specific Features Below

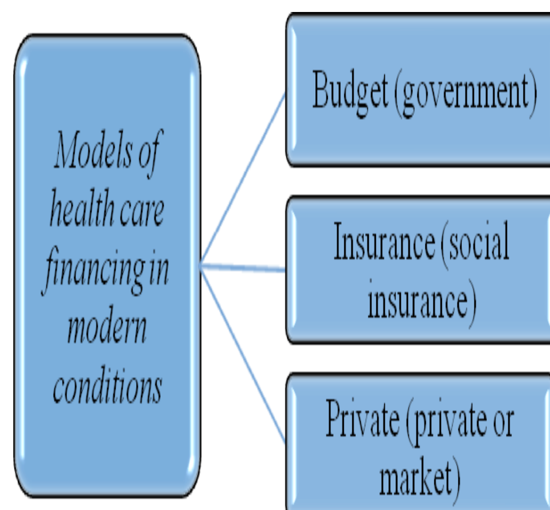

Figure 2: Models of Financing the Health Care System in Modern Conditions.

Table 1: Key Indicators of Health System Financing Models of the Leading Three Countries [10]

<table>
<tr><th>No</th><th>Indicators</th><th>Germany</th><th>Great Britain</th><th>USA</th></tr>
<tr><td rowspan="4">1.</td><td rowspan="4">Sources of health financing</td><td>Compulsory health insurance60 %</td><td rowspan="2">State budget85 %</td><td>Private insurance40 %</td></tr>
<tr><td>Voluntary health insurance10 %</td><td rowspan="2">Personal funds–20 %</td></tr>
<tr><td>State budget15 %</td><td rowspan="2">Voluntary health insurance–15 %</td></tr>
<tr><td>Personal funds–15 %</td><td>Programs for the poor and the elderly40 %</td></tr>
<tr><td rowspan="3">2.</td><td rowspan="3">Coverage of the population with free medical care</td><td>Compulsory health insurance programs90 % of the population</td><td rowspan="3">Covered with free medical care en masse</td><td rowspan="3">Patients are limited by their ability to pay, and programs for the elderly and low-income do not apply to all needs</td></tr>
<tr><td>Voluntary health insurance programs10 %</td></tr>
<tr><td>3 % of them have voluntary health insurance with compulsory insurance</td></tr>
<tr><td>3.</td><td>Coverage of health system resources</td><td>73.1 % is covered by all medical organizations, public expenditures to GDP7.8 %, total11.7 %</td><td>82.4 % is covered by all medical organizations, public spending is 7.7 % of GDP, a total of 9.4 %</td><td>49 % is covered by all medical organizations, government spending is 9.1 % of GDP, a total of 17.2 %</td></tr>
<tr><td>4.</td><td>Ways of distribution of funds</td><td>Private funds of the state general health insurance (non-profit self-governing organizations)</td><td>State self-governingorganizations</td><td>Private insurance companies, through government programs to socially vulnerable citizens</td></tr>
<tr><td>5.</td><td>Methods of payment for medical services</td><td>Clearly defined payment standards in the hospital, outcome-oriented payment (ambulance ambulance)</td><td>Clearly defined payment standards in the hospital, outcome-oriented payment (ambulance ambulance)</td><td>Hospital-defined payment standards and global budget, outcome-oriented payment (ambulance)</td></tr>
</table>

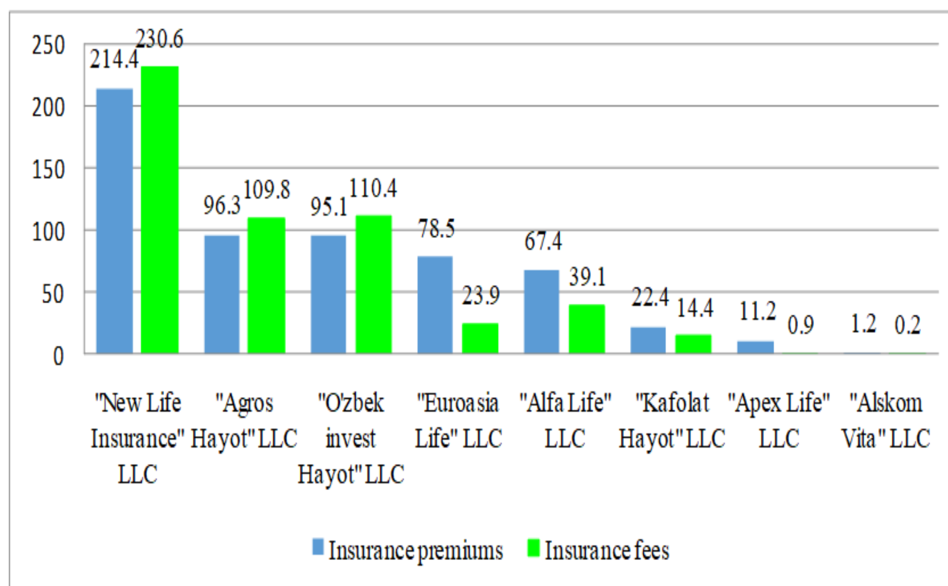

Figure 3: Information on the Insurance Market by Insurance Companies in 2019 [11](in the Life Insurance, in Billion Soums).

CONCLUSIONS AND RECOMMENDATIONS

Taking into account the above, in our opinion, in order to further develop the health insurance system, it should be noted that the ongoing market reforms in our country require development of a competitive environment in the market of medical services. It is expedient to change the method of direct (i.e with the participation of citizens) in the direct allocation of state budget funds in the financing of the activities of state medical institutions.

In the scientific work, we would like to make our proposals for further development of health insurance in Uzbekistan:

- Gradual introduction of new financing mechanisms in the transition to the model of health insurance;
- Development of health insurance infrastructure in the insurance market;
- Establishment of a compulsory health insurance fund and ensuring a phased coverage of health insurance coverage;

In the current situation, it is possible to restore citizens' health in a timely manner and at affordable prices with the citizens' participation in health insurance. This, firstly, reduces the likelihood of contracting dangerous diseases, prolongs the average life expectancy in the country, and secondly leads to the development of the insurance market.

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