

Assessment of compulsory health insurance abroad and the prospects for implementation in the Republic of Uzbekistan

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Abstract. *This article provides an overview of compulsory insurance in developed countries such as Germany, Israel, the United States of America and the possibility of applying this type of insurance in the Republic of Uzbekistan. The risks and ways of overcoming them are assessed, as well as the costs required to create a perfect model of health insurance based on the gross domestic product produced in the Republic of Uzbekistan.*

Key words: *insurance; finance; advanced technologies; Republic of Uzbekistan*

The relevance of the research topic is due to the need to study the experience of developed foreign countries in the development of the financing system and legislative regulation of medical services in order to be able to use it in the Republic of Uzbekistan. This is due to the fact that there is an urgent need in the country to move to the health insurance system as a type of health insurance for citizens, to develop a health care financing system through taxes and fees paid by working citizens to the budget and compulsory medical insurance funds, especially in the provision of emergency and emergency medical care.

The aim of the study. Assess compulsory health insurance abroad and, based on advanced technologies, create an own insurance system in the Republic of Uzbekistan

However, the development of the health insurance system is constrained by a number of reasons, where the main ones are a decrease in state funding for health care, an outdated material base, a shortage of drugs, indicators of the demographic development of the state and the level of morbidity among citizens, and many others. There are many contradictions and problems in the development of the health insurance system, one of which is that only 0% of outpatients receive medicines at the expense of health insurance funds, and the availability of medical care is reduced.

It should be noted that to this day there is a practice of rewarding doctors with expensive gifts, a kind of (optional) additional payment for services rendered. This practice is usually criticized and viewed as a bribe, but in principle it is vital and is quite consistent with the official Western systems of payment for medical care.

Based on the analysis carried out in the article, important points of the experience of the functioning of health insurance in foreign countries were identified, which can contribute to the formation and development of the system of financing health insurance in the country [1].

The question of the possibility of building the correct model for financing health care in a separate state and extending this experience to other countries is very relevant, since many of them have begun the transition to the system of insurance medicine. It is likely that it is

impossible to build an ideal health financing scheme that would be equally suitable for all states, since a model that is suitable for one country may not be acceptable for another. To this end, we will consider the experience of more developed countries in this direction, taking into account the methods they use to finance the health insurance system.

Let's start with the Federal Republic of Germany, where health insurance is compulsory for all employees, except for employees with an annual income of more than 53,200 €.

The main amount of payment to the insurance fund is 5.5% of the citizen's salary, while 0.9% of the citizen's salary is a special contribution for dentist services and sick leave. The balance, which is 4.6% of the total salary, is paid by the employee and the company in which he works in equal shares. These insurance contributions are only deducted from the employee if he earns more than € 500 per month. The maximum insurance premium is approximately 38 € per month for the employee and employer. An employee is exempt from insurance premiums only if he is sick and is on sick leave, this period will not be deducted from the insurance premium [2].

In addition, the non-working members of his family must be included in the insurance policy, and they also receive medical assistance in full. The employee's insurance premium depends only on his salary, regardless of how many family members are included in the insurance policy [3].

In order to somehow limit the consumption of medical services, there is a system of co-payments when receiving medical care. For example, a consultation with a specialist doctor is 0 €, without insurance the cost of this service is much higher, a small co-payment is charged in order to discourage people from seeking help without the need for it, in addition, a co-payment for prescribing medicines, etc. is also applied.

All types of financing in Germany go through the health insurance funds, by attaching an employee to one specific fund. The scope of health insurance services in Germany is quite extensive, which allows citizens to completely recover from their illnesses.

A relatively small percentage of residents (8%) who are allowed not to have compulsory health insurance are insured in private health insurance companies, while choosing only those medical services that they consider necessary, or are not insured at all. They can also insure partial coverage of outpatient care for 75% or 65%, i.e. there are a lot of options [4].

The basic principles underlying the German health insurance system were created by Chancellor Bismarck in 1884. It was based on the principle of national solidarity: the number of medical services does not depend on the amount of contributions of each person, wealthy people bear costs for the poor, and healthy people - for the sick.

Next, consider Israel, where medical care is guaranteed to all citizens of the country and is based on compulsory state health insurance, with all costs being borne by the country's government.

As in the Federal Republic of Germany, all types of financing go through the health insurance funds by attaching the employee to one specific health insurance fund, but if the employee expresses a desire to change the health insurance fund, then 4 shekels is charged from him.

The Israeli National Insurance Institute levies a tax on medical care, and the amount of this tax depends primarily on the income of a citizen of the country.

From incomes up to 60% of the average wage in the country, the contribution is 3%, from incomes exceeding 60% of the average wage, the contribution is 5%. Contributions are

deducted from employees' wages by employers; delay in payments does not infringe upon the employee's rights. Citizens of retirement age pay 86 shekels a month, while the old-age benefit, together with social benefits, is 27 shekels. Minors are exempted from paying insurance premiums, and the unemployed pay about 30 per month from unemployment benefits [5]. Of the GNP, healthcare costs account for about 7.8%. The number of beds (in hospitals) per 000 inhabitants is 2.2. A working Israeli misses an average of 9 work days a year due to illness. Average life expectancy: men - 8 years; women - 82 years old. Infant mortality: 3 per 000 births. So, the principles underlying the Israeli health insurance system are that medical care is guaranteed to all Israeli citizens regardless of social status. The current Israeli healthcare system is considered one of the best in the world, medical services are provided at 4 levels determined by the state: a family doctor in district polyclinics; referral specialists in district polyclinics; hospitalization; rehabilitation [7]. A slightly different health insurance system has developed in the United States. In terms of spending on medicine, the United States has occupied a place in the world for many years. 7.5% of GDP (or 2.6 trillion per year), in contrast to the EU countries, where these costs average 8.3% of GDP. The average salary for a doctor in the United States is 50,000 per year. Depending on the percentage of coverage of medical expenses, there are 5 basic insurance plans: platinum - about 90% are paid by the insurance company; gold - the insurance company pays about 80%; silver - the insurance company pays about 70%; bronze - the insurance company pays about 60%; minimum insurance - designed only for emergencies [8]. Almost every American company provides its employees with health insurance, but in most cases, the employer finances only part of the cost of the insurance, and the employee pays the rest. The concept of American "minimum" insurance is of interest. The minimum insurance covers only very expensive treatment: surgery, or treatment after an accident. Visits to the doctor, tests, discounts on the purchase of medicines are not included in it. The cost of the minimum insurance (depending on the patient's health level) starts at \$ 90 per month.

In recent years, health care spending has increased in America, although there has been little improvement in this area, which is heavily criticized by society. It is also worth noting that over the past 0 years the cost of insurance for the employee has doubled.

It should be noted that this insurance sector is monopolized and in practice there have been and are many examples of discrimination against patients both before and after the conclusion of a health insurance contract, including in the form of refusal to pay [11].

In the EU countries, the health care system turned out to be more efficient than in the USA, so the US government began health care reform in 204.

Under this reform, all citizens and residents of the state were required to have health insurance, and those citizens who did not want to have this kind of insurance had to pay a fine of 95 for adult individuals, or% of the amount of a person's income, but since January 206 the fine has increased up to 695, or 2.5% of the person's income.

Medical insurance is purchased by each person individually only when its price is not higher than 8% of his annual earnings. Otherwise, if the price of the health insurance policy is higher than 8% of the annual income, and the annual earnings are less than 4400 per person, or less than 29,330 per year for a family of 4, then the country will bear the costs of Medicaid health insurance [12].

Tax subsidies have also been introduced for citizens whose annual earnings range from 4400 to 43320 per person or from 29330 to 88200 for a family of 4 people.

The establishment of inflated insurance rates and denials of health insurance for the population with high risks of illness to insurance companies are prohibited.

The country controls and regulates the income of insurance firms - firms are required to use at least 80-85% of the sums received as insurance premiums to pay for medical services (administrative costs), the profit from insurance firms is no more than 5-20% of income.

The main expenses for this reform are planned to be taken from the federal budget - 90%, the remaining 0% will be covered by the state budgets. It is planned to spend \$ 940 billion on the reform within ten years [13].

Thus, different countries have different approaches to insurance. Somewhere, as in Germany, health insurance is compulsory and subject to verification, somewhere - voluntary, but they still prefer to use it,

A feature of the compulsory health insurance system of the Federal Republic of Germany is that the quality of medical services is not depends on the amount of contributions from each person. Wealthy people bear the costs for the poor, and healthy people for the sick - this makes it possible to create social security, on the one hand, without shifting responsibility onto the shoulders of the state, and on the other, forcing the patients themselves to bear the entire burden of expenses from their own pockets. Thus, at the heart of CHI (Compulsory health insurance) is based on the distributive principle of financing. Despite the fact that the amount of premiums is not strictly linked to the degree of risk, as is typical for private insurance companies, and the amount of premiums is the same for all insured, the volume of medical services provided to each of them differs significantly. This is due to the well-known fact growing needs for health care with age. Funds are redistributed from young and healthy to elderly and sick members of insurance funds. It is necessary to note another important social component of the German CHI system, consisting in the fact that with compulsory insurance, all family members of the insured are jointly insured without making additional contributions if the income of each does not exceed a certain minimum (327 euros in the old and 322 euros in the new lands). Thus, the compulsory health insurance system represents is the preferred (and often the only possible) option for receiving health care for people with low incomes, for families with children with a single source of income, and for the elderly [14].

The German health insurance system assumes the existence of an extensive system of insurance institutions. About 1,500 health insurance funds are involved in the implementation of compulsory medical insurance in Germany, representing self-governing financial and credit institutions that perform the functions of compulsory health insurance funds. The health insurance funds collect insurance premiums, keep records of the insured, organize and pay for the necessary medical care. There are health funds for enterprises, agricultural workers, artisans' unions, health funds for seafarers and miners, as well as the so-called ersatzkassy, who are engaged in insurance of people with high incomes, for whom, due to the existence of an income ceiling participation in the general system of compulsory insurance is not provided. Unlike health insurance funds, ersatzkassa do not receive government subsidies. If earlier insurance was carried out by a particular health insurance fund by territorial or production characteristics (that is, attachment was possible only locally residence or place of work), now every worker can freely choose any of them [15]

In addition to the main tasks associated with the health insurance process, the health insurance funds inform policyholders on all issues related to threats to their health and the prevention of diseases.

In order to protect joint interests, the health insurance funds are united in alliances at the federal level or the level of individual lands. There are two main types of physician organization: physician associations and physician wards.

The health insurance associations conclude contracts with medical associations, on the basis of which the latter provide service. In turn, the health insurance funds pay reimbursements to the medical associations.

The health insurance funds pay for the work of doctors and hospital services in accordance with the established tariffs for a specific disease.

Since a large number of private practitioners are contractually affiliated with health insurance funds, they are not entitled to service the patients insured in them. Since the insurers generally set aside a small set amount per patient for the fee fund, many doctors compensate for the loss of income by serving more voluntary health insurance patients. Doctors' associations guarantee proper performance for their members, which includes, inter alia, the financial records of each doctor before merging based on a catalog of services, each of which corresponds to a certain price reference [16].

In total, medical insurance services cover about 90% of the population of Germany. They are workers and employees whose monthly income does not exceed 75% of the pension insurance contribution limit, disabled workers, agricultural workers and relatives who help them, some groups of independent workers (for example, artists), retirees, if during their working life they participated in pension insurance, workers who underwent rehabilitation after suffering occupational diseases, students, as well as the unemployed. In the circle not covered by compulsory medical insurance includes self-employed persons (sole proprietors), government employees and private practitioners regardless of their annual income, since it is believed that due to corporate they can get free medical care from their colleagues. The main factor limiting the circle of persons subject to compulsory health insurance, is the desire of the state to protect segments of the population with low incomes from burdensome expenses for paying, as a rule, higher contributions to voluntary health insurance system. An important point is also the possibility of subsidies on the part of government agencies in the event of a decrease in income or loss of work in general [17].

In general, the scope of medical services of compulsory health insurance is quite wide and includes:

□ Outpatient and inpatient treatment, in which the patient has the right to freely choose a doctor. In a circle services provided within the framework of medical care include medical advice, examination, surgical treatment, provision of medicines, as well as the provision of other medical assistance necessary and appropriate in a particular situation. Within the framework of medical care provided by funds of the compulsory insurance fund, the services of a dental specialist are also provided free of charge (with the exception of dental prosthetics, the amount of its payment by the health insurance fund ranges from 30 to 65%). When stationary treatment, the patient has the right to freely choose the medical institution, the referral to which is made on based on the instructions of the attending physician with the consent of the patient. Inpatient treatment under the CHI provides for certain conditions for keeping the patient: general conditions of service, wards with only a few beds, etc.

In case of impossibility of hospitalization for any reason, medical assistance can be provided to the patient at home. After completing the course of treatment, he can be provided with the necessary assistance for rehabilitation with compensation for all costs, including travel expenses.

Also subject to compensation:

Payment of cash benefits due to loss of earnings due to illness, the maximum benefit does not exceed 90% of the last net earnings of the insured.

Medical care for mothers, which extends not only to the insured, but also to uninsured married women, is provided to them within the framework of family support programs. Medical services include medical services and counseling for pregnant and lactating mothers, assistance with childbirth and postpartum period. Women eligible for health insurance in an employment relationship on the basis of an employment contract concluded at least six months before delivery, they have the right to receive cash benefits for a period of six to eight weeks after the birth of a child in an amount not less than the salary at the previous place of work. In 1979, working women were given the right to require additional four months of parental leave in excess of the mandatory two months previously established by law [18].

During this vacation, the woman receives a sick leave benefit cash desk in the amount of half of the salary determined by her at the workplace.

Medical care for those abroad. In this case, a rather limited amount of necessary medical services is provided only in the countries of the European Union, with which this hospital there is an agreement on the provision of medical care. As a rule, in order to receive the full scope of medical care, the insured is recommended to conclude an additional health insurance contract.

Provision of other assistance in matters of birth control, difficult cases of pregnancy, as well as free provision of contraceptives [19].

The principle of financial independence, which underlies the organization of health insurance institutions in the Federal Republic of Germany, gives the health insurance funds the full right to make decisions on all issues related to obtaining distribution of income, which makes them independent of the provision of public resources. The CHI is financed by:

- 1) At the expense of contributions paid equally by employers and employees.
- 2) At the expense of the pension fund, insurance premiums of students of higher educational institutions.
- 3) At the expense of the federal labor department, which it pays for the unemployed.
- 4) In an insignificant amount, funding is also provided through state subsidies paid to health insurance funds to support motherhood [20].
- 5) An important source of financing for the compulsory health insurance system in the Federal Republic of Germany is compulsory additional payments from insured persons. Such additional payments include, for example, partial payment for medicines, dental services, etc. It should be noted that the mechanism of participation of the population in medical expenses exists in most countries of the European Union, and is intended primarily to limit excessive consumption of health services; and containment of growth in public health spending. Moreover, this contributes to the limitation of the supply of services by the medical staff, because, knowing that the patient does not pay for the care provided to him, the doctor will be inclined to recommend more expensive treatment.

The compulsory health insurance system has developed so much in Germany that most health care services are covered by compulsory insurance. In this regard, not without reason, there are problems associated with a significant increase in costs.

A significant problem that stands in the way of such a system of financing medical activities, is the direct impact that doctors can have on the level of their own income, carried out through the choice of treatments and medicines that are not the same in cost. Thus, the decision on the choice and method of treatment and the means used for this, which are in the competence of the doctor, gives him, so to speak,

“The key to the fireproof closet of the cash register, which contains money” [21]. The total income of the doctor is determined as the difference between costs and turnover, which includes such components as the number of patients in the fund, the average number of visits to the doctor, the number of services provided to each patient per visit, and the personal fee. Since about 90% of the population are members of the CHI, that is, members of health insurance funds, their contributions are a livelihood for most doctors. Since the quality of service is largely dependent on time, spent by the doctor for each patient, then the high costs associated with treatment, thereby should infringe on his income. A serious problem of compulsory health insurance that has emerged in recent years,

is the outstripping increase in wages and insurance premiums in the growth of treatment costs. This leads to a reduction in funding for health care, which inevitably affects the deterioration of the quality of the medical services. This is manifested, in particular, in the fact that doctors, in order to reduce costs, are forced to abandon expensive examinations and treatment, prescribe cheaper, but less effective drugs, and in hospitals - to deny patients an operation.

The ways to overcome the negative phenomena that exist in the compulsory medical insurance of Germany have been outlined in the course of the health care reform currently under way in the country. The following provisions can be distinguished as its basic elements:

- 1) A decrease in the number of medical services provided under the CHI. This is planned to be done at the expense increasing the share of participation of the population in paying for medical services.
- 2) It is planned to change the procedure for collecting contributions, which will take into account not only the level of wages fees, but also other income, such as income from securities or side business activities.
- 3) An important point for improving the quality of medical services is the expansion of the rights of doctors, which will allow them to individually negotiate with insurance funds about medical services without mediation associations of doctors.
- 4) It is also envisaged to expand the rights of the insured, which will allow the latter to have more information about doctors and methods of treatment.
- 5) An important element of health care reform is the requirement that everyone should be insured.

This will increase the amount of funds received by attracting certain individuals who were not previously required to be insured population groups.

- 6) Since the costs of health insurance funds for medicines are constantly increasing, it is planned to streamline functioning of the pharmaceuticals market, significantly reducing the range of pharmaceuticals that are paid for health insurance funds. In addition, it is envisaged to strengthen control over the rise in prices for medicines, as well as establishment of material liability of doctors for the prescription of drugs, the cost of which exceeds the legislatively

established budgetary limits. An alternative (and addition) to the CHI in Germany is voluntary health insurance, which applies to citizens who, due to their high income or professional activity, are not subject to CHI, but also for those people who have the means and desire to receive additional help. Existence in the country two different forms of sickness insurance stimulates competition in the health care market. The main the factor determining the difference between compulsory and private health insurance is income, which is 40,034 euros per year. If the income is higher, then the citizen has the right to services private insurance.

Unlike compulsory health insurance, voluntary health insurance offers a greater amount of medical services. For example, within the framework of the VHI there is a free choice of a hospital, as well as improved conditions of stay in it, the services of a personal doctor, reimbursement of up to 100% of the costs associated with inpatient treatment (in compulsory medical insurance, as a rule, part of the costs is reimbursed by the patient) Compared to compulsory medical insurance, in which the amount of premiums does not depend on the degree of probability of an insured event, premiums in the VMI system are formed taking into account individual risk.

Private insurance companies use a wide variety of regional and professional rates for this. Since age characteristics have a significant impact on the size of insurance premiums, the most favorable rates in VHI are for young people. It should be noted that in recent Over the years, the volume of expenditures of the population of Germany in VHI is constantly increasing, on average by 5% [1]. A significant difference from the CHI system is that for each age group of insured persons in VHI there is its own financing your expenses. In the context of a general complication of the demographic situation in all European countries (an increase in the number of pensioners in relation to the working part of the population) such a system for the formation of insurance contributions does not depend on this trend and in the future, VHI can be one of the ways to avoid accumulating financial difficulties in the CHI system.

The formation of an insurance fund in the VHI system is based on a mixed distribution-accumulative principle of financing. Every month, a certain amount is allocated from the insurance premium of each insured, which is placed at interest in the accumulative capital reserve. This part of the funds is intended to provide increased needs of the insured in old age. With age, the portion of the contribution allocated to the "savings portion" gradually decreases. Thus, if the CHI has a problem of increasing the amount of required medical services are solved by solidarity redistribution from young to old, then, as you can see, in the VHI the inevitable increase in medical costs is taken into account by including their cost in the insurance premium from the very start. It should be noted that there are certain drawbacks to this funding mechanism. The first this is due to the difficulty of transferring the accumulative part of the insurance fund when the client changes the insurance companies. In principle, of course, such a possibility exists, however, as a rule, it is not applied in practice: a savings part intended to cover increased medical costs in old age, usually not transferred to another insurance company, and the funds of this part are not paid to the insured. For this reason, the facts of changing the insurance company in Germany are quite rare. It creates, with one On the other hand, a certain stability of the private insurance market, on the other hand, limits the competition between VHI companies for clients.

The distinguishing features of VHI include higher amounts of sickness benefits (they are insured separately), reimbursement of expenses for spa treatment, the possibility of obtaining full medical assistance abroad (since it is not required to conclude an insurance contract

additional to the main one), and also exemption from payment of contributions in case of not seeking medical care for 1 to 6 months (CHI does not provide such a service).

Unlike mandatory in the private health insurance system, the conclusion of an insurance contract occurs exclusively on a voluntary basis, the content of which (volume and quality of medical services) negotiated by the parties. Also, unlike compulsory medical insurance, in the private insurance system, the insured, receiving medical care, is obliged to pay for it himself, after which, by presenting the paid invoice to the insurance company, he can receive appropriate compensation for treatment costs in accordance with the insurance contract. An exception exists for paying for inpatient care, the costs of which can be burdensome for the patient.

If there is an agreement between the insurance company and the insured, they can be paid without participation the latter. VHI insurance for such categories of the population as the unemployed (if they were previously insured in VHI) and students differs from the general procedure. The fact is that partial financing of their participation takes the relevant government agency is responsible. In the first case, it is the Federal Office for Labor, and in the second is the education committee. Insurance companies operating in the private health insurance market, do not directly limit the scope of medical care provided. The insured must take care of himself to ensure that the medical services he needs are covered by the scope of insurance under the contract, which means that he can independently decide which form of treatment or examination is more suitable for him. So, unlike compulsory medical insurance, voluntary health insurance offers a higher degree of patient independence and at the same time great responsibility.

The German experience of organizing the health care system undoubtedly deserves close attention: it is not only interesting, but also useful for use in Republic of Uzbekistan. However, referring to this experience, it is necessary to remember the reasons that led to the introduction of health insurance in Germany. First of all is existence a vast private healthcare sector with high prices for healthcare services. That is why the idea of the general availability of these services to the population became key in the implementation of the German insurance model, which was facilitated by established market relations in the economy. Insurance medicine has been selected as a mechanism to reduce financial burden on the population as a result of the constant rise in prices for medical services.

The development of health insurance in Republic of Uzbekistan took place in fundamentally different conditions. First, unlike Germany, Republic of Uzbekistan initially had virtually no private sector in healthcare.

So, in the Republic of Uzbekistan, from July 17, 2020, a law on compulsory health insurance was issued.

The draft Law of the Republic of Uzbekistan "On Compulsory Health Insurance" (hereinafter referred to as the draft Law) was developed in pursuance of paragraph 4 of the Program of Measures for the Implementation of the Concept for the Development of the Healthcare System of the Republic of Uzbekistan in 2019-2021, approved by the Decree of the President of the Republic of Uzbekistan dated December 7, 2018 No. UP- 5590 "On measures to radically improve the health care system of the Republic of Uzbekistan."

Secondly, a necessary prerequisite for the effective operation of insurance systems is a sufficiently high level of income of the population: only then the insurance system will be effective. In addition, this condition is directly related to the problem of ensuring equal access and payment for medical care provided to people from high-risk groups (the elderly, the poor,

the disabled). To prove that the majority of the population of our country due to the low level of their income falls into a similar risk group, probably not necessary. In Republic of Uzbekistan, as in other post-socialist countries, the choice of the insurance system was determined by the desire to expand sources of funding health care and get new channels of stable receipt of additional funds. It was assumed that the introduction of an insurance financing system will create institutional conditions for increasing efficiency use of resources in health care. However, unlike in Republic of Uzbekistan, in Germany the issue of population participation in payment for treatment did not have such a public response. This was largely due to the fact that the system was formed in Germany not by a one-time decree, but gradually, by a series of legislative acts that expanded the sphere of social guarantees. Moreover, each new step was commensurate with real possibilities and was accompanied by thorough analysis of the resource base. The current state of healthcare and health insurance in Republic of Uzbekistan requires an equally balanced comprehensive reform of the entire health insurance system.

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