Some aspects of the insured medical system and lessons from foreign experience

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Abstract: In this work, based on the relevance for the medical system of Uzbekistan, which is currently being reformed, we present the results of studying the operation of the medical insurance system in a number of foreign countries.

Keywords: medical financing, health care, system, insurance, citizens, European Union

The insurance model of healthcare exists in many countries around the world. Due to its relevance for the currently reformed medical system of Uzbekistan, we studied the functioning of the health insurance system in a number of foreign countries. We would like to present the results of our research here.

In Europe, the insurance model of healthcare has become widespread in Germany, Belgium, the Netherlands, Austria and France. Unlike the US, in EU countries health insurance is compulsory for the majority of the population. This healthcare model began to take shape at the turn of the 19th and 20th centuries, when many European countries adopted laws on compulsory medical insurance. The implementation of the ideas of social solidarity in the healthcare sector and the lack of funds to pay for medical services among the population prompted the authorities to intervene in the process of organizing and monitoring health insurance. As a result, a health insurance financing system emerged, the main features of which were:

• universal coverage of the population;

• participation in the financing of insurance funds for employees, employers and the state;

• control over the activities of medical insurance organizations (hereinafter referred to as HMOs) by policyholders;

• coordination of tariffs for medical services and quality control of medical care on the part of insurers and the state.

The main reason for the introduction of insurance medicine in European countries was the emergence of a large private sector in healthcare with high prices for medical services, which became inaccessible to many citizens.

The health insurance model is based on the principle of solidarity, which presupposes the existence of insurance funds managed on a parity basis by employees and employers. These funds accumulate social contributions from wages to make insurance payments. Health insurance systems are generally not financed from the state budget, with certain exceptions. Thus, for low-income members of society who cannot receive medical services for a number of reasons (for example, due to lack of necessary insurance coverage), medical care is financed by the state. In this case, we are talking about auxiliary mechanisms that represent deviations from the basic logic of the insurance model, but without them, ensuring full coverage of the population with medical services would be impossible. In health insurance models, the principle of compulsory health insurance is not fully observed, which is due to the existence of "ceiling" salary levels for persons with high incomes. Exceeding this level leads either to the impossibility of participation in the compulsory medical insurance program (only voluntary insurance is possible), or to the limitation of insurance contributions (in this case, within the compulsory medical insurance, insurance contributions are made only within the "ceiling" level of wages, and social benefits are calculated in relation to this level).

In the insurance model, health insurance is mandatory for all employees. In most European countries, compulsory health insurance covers almost the entire population. Thus, in Luxembourg, only 1-3% of the population remains uninsured, which includes mainly wealthy residents. In Germany, a significant part of the workforce is covered by compulsory medical insurance, and only a small part of them is legally excluded from it (persons with high incomes). There are groups of the population that can choose between public and private health insurance. In the Netherlands, the insured population is divided based on income: persons with low incomes are included in the compulsory health insurance system, and persons with high incomes are included in the private health insurance system.

In the health insurance model, the amount of insurance premiums paid to insurance funds is calculated based on wages and income. In this case, there is a redistribution of resources from highly paid categories of the population to lower paid workers, from the young and single to the elderly and large families. In this way, social solidarity is ensured within groups of insured persons. The amount of insurance premiums usually depends on the amount of wages. In most EU countries, insurance premiums are distributed on a parity basis: one part is paid by the employer and the other by the employee. Insurance premiums can be paid in different proportions. So, if for Germany, Belgium, Luxembourg this ratio is equal for workers and employers, then in France most of the costs of financing insurance funds are borne by employers.

A pressing issue, addressed differently in European countries, is the participation in the compulsory medical insurance system of a large group of its participants - pensioners. Most often, as a contribution to compulsory medical insurance, they pay the same share of their pension as working citizens do of their salary. However, there are exceptions. For example, if in Germany and Luxembourg this amount is divided between the pensioner and the state pension fund, which in this case acts as the employer, then in the Netherlands the pensioner pays the insurance premium for himself in full. In some cases, healthcare financing is supplemented from the state budget, however, unlike the budget model, in the insurance healthcare model this practice is applied only in cases of shortage of insurance funds. Thus, in contrast to the budget model, financing of health insurance is carried out on a tripartite basis - from the funds of employees, entrepreneurs and, if necessary, the state. The ratio of the size of financial participation in the formation of health insurance funds often depends on the economic situation and tax policy of the state. Despite the fact that in most EU countries insurance funds are self-governing, the government or parliament has a significant influence on setting the insurance premium rate. For example, in France, the government, representatives of employees, entrepreneurs and social security organizations (pension funds) agree on contribution rates, but the government has the final say. In the Netherlands, the function of setting contribution rates is assigned to the health insurance board, which recommends the contribution rates for the following year to the Ministry of Health, Social Affairs and Sports. Only in two EU countries - Germany and Luxembourg - the authority to set premium rates belongs to health insurance funds (insurance funds), although in these states they are subject to government approval.

In the EU health insurance system, special insurance conditions apply to self-employed persons - entrepreneurs, farmers, artisans, lawyers, etc. They are subject to special insurance rules than to persons working under a contract of employment. Payment of insurance premiums depends on the current taxation procedure. If in Russia health insurance premiums are deducted from wages before the employee receives it, then in Germany or France, contributions to health insurance funds are made after employees receive wages. The same form of collection of insurance premiums also applies in the UK national health care system, with the only difference being that the part of the collected single social contribution intended for health care is transferred to the corresponding fund of the country’s National Health Service.

The accumulation of resources in the insurance model is carried out in non-governmental non-profit (insurance) funds, which act as intermediaries between the insured and medical institutions (doctors). In a number of countries, insurance funds are organized on various bases: professional, territorial, religious and even political. The management of these organizations in most countries is the same and is carried

out by representatives of the insured and insurers. Thus, in contrast to the budgetary healthcare model, the insurance model is characterized by decentralized financing.

The insurance system of healthcare financing has a number of advantages compared to the budget system. The reason for one of them is differences in the form of formation of funds. Since insurance funds are formed on a targeted basis and are designed for a certain circle of people, insurance medicine also acquires a targeted and targeted nature. This is due to her greater focus on the patient. Unlike the budget model, in the insurance system the doctor is the primary authority - he takes responsibility for ensuring the provision of all necessary medical services. In addition, unlike the budget model, where the patient's funds going to the state budget are actually depersonalized, in the insurance system complete depersonalization is impossible due to the presence of a chain.

An important feature of insurance models that distinguishes them from budgetary systems is the fact that their financing is less dependent on the political situation. In insurance models, a significant part of insurance premiums remains, as a rule, locally. They are redistributed in accordance with territorial equalization and can be controlled by insurers and insured persons in terms of the use of resources allocated to pay for medical care and the quality of medical services provided. In addition, patients have a wider choice of doctor and treatment facility than in low-cost healthcare models. Another advantage of the insurance insurance system is that employees and entrepreneurs can choose insurance funds, thereby promoting competition between different insurance companies.

The advantage of decentralized financing in insurance systems is the ability to ensure a stable flow of finance to enterprises and workers interested in receiving medical care. This circumstance is due to the transparency of financing of insurance medicine, as well as the direct, and not indirect, as in the budget model, the formation of funds. The insurance nature of healthcare financing may, at the same time, give rise to problems associated with increased treatment costs. This is due to the fact that, since insurance systems do not set strict budget constraints, the effect of the cost mechanism is enhanced in them. In turn, this leads to a shortage of insurance funds and, as a consequence, to an increase in insurance premium rates for entrepreneurs and workers. When the cost of medical care increases, it is easier for an insurance organization to decide to increase insurance premiums than for the government (in the case of a budget model, to increase taxes). Therefore, the macroeconomic cost of the insurance model turns out to be more expensive: its costs as a percentage of GDP are usually higher than in the budget healthcare system2. In addition to rising insurance premiums, the high cost of the insurance model is also due to factors such as higher administrative costs, which are caused by the need for insurance organizations to process financial reports of medical institutions; the specifics of the

activities of doctors interested in providing more expensive services that are not always necessary for the patient; increase by insurance companies of their own expenses on marketing and advertising in conditions of market competition.

The problem of rising treatment costs in healthcare insurance models in EU countries is solved differently. Thus, measures that can reduce the growth of health care costs may include:

• reduction in the number of medical services that are guaranteed under compulsory health insurance. This is possible by increasing the share of patients' out-of-pocket expenses in paying for medical care;

• unification of insurance premium rates and services provided.

However, reforms in recent years in European countries have made insurance medicine systems more flexible, combining both centralized and decentralized management principles, less susceptible to market fluctuations.

The disadvantages of the insurance model of health care often include its limited capabilities in the field of public health and health education, as well as in the implementation of preventive health care measures, due to the insufficient financial capabilities of insurance funds and their obvious disinterest in allocating significant funds for these purposes. The weakness of the insurance model, due to its decentralized nature, is the difficulty of managing and coordinating the activities of medical institutions, especially in countries with limited resources and heterogeneous territorial divisions. For this reason, the success of the formation of a Russian healthcare system, which is guided by the principles of both the budget and insurance models of financing, largely depends on the quality of health insurance management. Finally, a serious disadvantage of the insurance model is that it depends on the demographic situation in the country.

Today, it is demographic changes in the population structure of developed European countries, the aging of the population and the fall in the birth rate that are becoming the main reasons for the crisis of modern medical insurance systems.

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