Foreign experience of financing the health care sector: budget model

Dinara Alisherovna Mamatmurodova
Ruxshona O'tkir qizi O'ktamova
Sherzod Farxodovich Majidov
ijtimoiy.km@umail.uz
Samarkand State Medical University

Abstract: In this work, some aspects of the foreign experience of the field of health care financing and the role of insurance mechanisms in it are researched.

Keywords: health care, medical financing, insurance, public finance, budjet model

Health insurance and public health protection, briefly called healthcare, are an essential component of the social policy of European countries. From the point of view of organizational and financial features, two main models of healthcare can be distinguished: insurance and budgetary. However, due to the fact that over time, each state was forced to improve the existing system, in no country these models are presented in their pure form.

The main source of healthcare financing in most countries is contributions to compulsory health insurance (hereinafter referred to as compulsory medical insurance), paid on a parity basis by employers and employees. The deficit of compulsory and private health insurance funds is covered by government loans (for example, in Belgium).

Funds received from voluntary health insurance (hereinafter referred to as VHI) at the expense of employers or from citizens' own funds are also allocated to finance healthcare. VHI is most widespread in European countries such as Germany and the Netherlands.

In many states, payment for medical services and medications can also be made from the patients' personal funds. This is due to the fact that health insurance does not always cover all costs of medical care. The structure of patients' out-of-pocket expenses for co-financing healthcare is not uniform. Thus, their fairly high share in countries such as Italy and Greece is explained by the prevalence of individual co-payments by citizens for the purchase of medicines and payment for medical services, and in Germany, France and Belgium the bulk of expenses are accumulated in the funds of medical insurance companies providing services within the framework of VHI . This is due to the developed VHI market, the large number of private insurance

companies competing with each other, as well as the stability of the financial market, which allows medical insurance companies to carry out successful investment activities.

A model (system) of budgetary financing of health care exists in European countries such as Great Britain, Sweden, Denmark, Ireland and Italy. Its conceptual foundations were laid in the report of the English economist W.Beveridge, presented to the British government in 1942. The main characteristics of this model are:

• universal coverage of the population with health services;

• financing from the state budget;

• control by parliament and management of government bodies.

In the process of implementing this model, this concept was called the "National Health Services Program", since the main provider of services and the only "insurer" in such systems is the state. In this model, two forms of healthcare financing are possible:

• through government funds, the resources of which are used to finance medical institutions;

• direct financing of medical institutions, bypassing state funds.

In most countries with a fiscal health financing model, the responsibility for setting public health policies and ensuring access to health care rests with ministries of health. An example is the organization of the health system in England, where the financing and delivery of health services is entrusted to the National Health Service and its local branches.

In budgetary models of health care, the functions of the central government and local health authorities are usually clearly delineated. The division of responsibility for the provision of medical care lies in the fact that general issues of health care development are resolved by central government bodies, and the organization and planning of the activities of local medical institutions are under the jurisdiction of local authorities. The fundamental feature of the budgetary model of financing healthcare is equal access to medical care for all citizens of the country. This circumstance prevents the formation of social inequality in the sphere of population's access to health services.

The budget model of healthcare, in contrast to insurance systems, is characterized by greater efficiency, which is manifested in a lower level of administrative costs. This is due to the fact that the state can restrain the growth of health care costs using macroeconomic levers. In addition, with budgetary health care financing, the incentives to contain costs and the ability to do so are combined in one governing body, which allows for savings and avoids duplication of functions. Therefore, budgetary healthcare models tend to cost society less than insurance ones. The flip side of state control over the state of health care is the political costs for the

authorities in the form of increased public discontent and criticism from health care providers. Therefore, the expenditure allocated to the public health system often depends on political priorities.

The English health care system is a typical budget model. It is a system of public health financing with highly centralized funds and a limited role for local financing. Its key principle is to ensure accessibility of medical services for the entire population of the country. Health care in England is financed from the state budget and partly from part of the social tax paid by employees and employers. It is believed that the English health care system was formed under the influence of ideas first embodied in the USSR state health care system, created in the 1920–1930s. with the participation of academician N.A. Semashko. The principles of organizing and financing healthcare in the USSR had a significant impact on the development of healthcare not only in England, but also in other countries. However, in contrast to foreign budgetary healthcare systems (most of which were formed several decades later than the Soviet one), the USSR healthcare system was characterized by the dominant role of the state in the organization of healthcare and excessive centralization of management. In addition, doctors and administrative staff of medical institutions in the Soviet healthcare model often had less rights in organizing their activities, and the system itself was not accountable to the population. However, it should be noted that in England, taxpayers do not always have information about the expenditure of funds allocated for healthcare, and the system itself does not have clear criteria for determining the quality of medical services provided. In most countries, public health care consists of both a system of voluntary health insurance and an extensive sector of medical services paid for out of the personal funds of citizens. In the USSR and other socialist countries, along with the state health care system, there was a small sector of private services (for example, dentures).

The experience of functioning of budgetary healthcare systems has shown that over the course of more than 60 years of their existence, they have proven to be quite effective in a number of indicators, providing the population with relatively inexpensive and high-quality medical services. Thus, in England, only 12% of the country’s residents use the services of VHI, which finances certain specific surgical operations, dental and ophthalmological services. The main factor that determines the demand for VHI services in the UK is the need for a long wait in public health care institutions. However, as some authors note, “evidence on the relationship between the length of the waiting list for treatment and voluntary health insurance is not entirely convincing, since the waiting lists are becoming longer and the level of coverage of the population with voluntary health insurance has decreased. One of the possible reasons for this decline is the extreme high cost of insurance premiums, the growth of which constantly outpaces the rate of inflation”.

Most health care services are provided within the public health system. The exception is dental care, most of the cost of which (about 80%) is paid by the patient himself. Despite this, patient cost-sharing in the UK is lower than in European countries such as France or Italy, where this form of cost-sharing is more common. In England, pregnant women, children, recipients of state social assistance and unemployment benefits, patients with chronic diseases, pensioners and war veterans are exempt from additional payments for medical care. Despite the smaller share of funds spent on healthcare in the structure of GDP in the UK compared to other OECD countries (9.7% in 2016), the country's healthcare performance is far from the worst, and in a number of indicators it is superior to a number of European ones countries

Despite the positive qualities characteristic of the budget model, it should be noted that it has disadvantages that lead to a decrease in the quality of medical care provided and a complication of control over the activities of medical institutions by patients. A monopoly in healthcare contributes to the emergence of a costly mechanism for spending taxpayers' funds without significantly improving the quality characteristics of the population's health. Monopolization in the industry is causing a growing shortage of medical services, in particular long waits for certain types of medical care (for example, outpatient care). The latter factor may also be an indicator of underfunding of the industry.

Since health care management is carried out by government agencies and professional health workers who have the status of civil servants, the budget model is characterized by excessive bureaucratization and authoritarian management. The predominance of state ownership in the healthcare sector also leads to restrictions on the free market for medical services.

Despite the wide coverage of the population with medical services, the budget model is characterized by inequality in the distribution of medical care; only certain types of services are paid for, for example, prescriptions and preventive examinations.

In general, all budget systems are subject to constant pressure from health care providers to increase private funding and increase the share of service user charges, regardless of the availability of private insurance. Budget models are especially sensitive to such pressure in times of financial crises. It is typical for budgetary systems that doctors practicing in the public and private sectors can manipulate waiting periods for services in order to encourage patients to make private payments.

Increased private payments may lead to worse access to public health services. The large incomes that doctors working in private clinics receive encourage them to limit the time they see patients and underwork in the public sector. Of course, private payments help redistribute access to treatment when supply is insufficient, but in a

health care model financed primarily by tax dollars, any form of private out-of-pocket payment is a way of acquiring privileged access to a service, much of which is paid for primarily by someone else's taxes. Finally, the disadvantages of the budget model include its great dependence on changing political priorities.

References

1. Khakberdiyeva, V.J., Abdukhabibova, S.D., Majidov, S.F. (2021). Social philosophy and its importance in society. Science and Education, 2(11), 1010-1015.

2. Naimjanova, P.U., Sobirjonova, M.J., Majidov, S.F. (2021). On the history of the formation of the world and national school of pedagogical cardiology. Science and Education, 2(11), 970-976.

3. Djuraev, D.R., Majidov, Sh.F. (2021). Nekotorыe voprosы ucheniya Aristotelya ob ekonomike i xrematistike. Science and Education, 2(5), 1022-1026.

4. Majidov, Sh. F. (2014). Konfliktnost etnokulturnых protsessov epoxi globalizatsii v kontekste ucheniya P. Sorokina. Sorokina/Pitirim Sorokin i paradigmы globalnogo razvitiya XXI veka (k 125-letiyu so dnya rojdeniya). Sыktыvkar, 601-606.

5. Majidov Sh. (2015). Razvitie etnokulturnых protsessov v sentralnoy Azii i sentralnoy Yevrope: sravnitelnыy analiz //Obщestvo i etnopolitika. – 2015. – S. 352-356.

6. Majidov Sh.F. (2014). K voprosu ob etnokulturnых protsessax v sentralnoy Azii i Yevropeyskom Soyuze //Yevraziystvo: teoreticheskiy potensial i prakticheskie prilojeniya. – 2014. – №. 7. – S. 238-243.

7. Davranov, E.A., Majidov, Sh.F. (2021). Filosofiya meditsinы i meditsinskiy vzglyad na filosofiyu. Science and Education, 2(5), 826-832.

8. Majidov Sh.F. (2016). Razvitie grajdanskoy kulturы skvoz prizmu modernizatsii obrazovaniya (na primere Respubliki Uzbekistan) //Aktualnыe problemы sotsiologii kulturы, obrazovaniya, molodeji i upravleniya. – 2016. – S. 585-589.

9. Majidov Sh.F. (2020). On the issue of ethnopolitical aspects of national security //Mejdunarodnыy jurnal Konsensus. – 2020. – T. 1. – №. 2.

10. Majidov, Sh.F. (2020). Milliy havfsizlikni etnosiyosiy jihatlari: YeI tajribasi (2000-yillar boshi). Vzglyad v proshloe, (SI-1№ 2).

11. Majidov, Sh.F. (2017). K voprosu ob etnokulturnoy bezopasnosti (na primere sentralnoy Azii). In Vlast v logike i ritorike mejnatsionalnых i mejkonfessionalnых otnosheniy (pp. 78-81).

12. Majidov, Sh.F., Saidova, X. (2007). Reformы v sfere obrazovaniya i lichnost prepodavatelya. Obrazovanie cherez vsyu jizn: neprerыvnoe obrazovanie v interesax ustoychivogo razvitiya, 5, 225-225.

13. Xalimbetov, Yu. M., Ibragimova, E. F., Arslonova, R. R., Rustamova, X. X., & Naimova, Z. S. (2020). Formirovanie molodeji v Uzbekistane kak nauchno upravlyaemыy protsess. Nauka i obrazovanie segodnya, (2 (49)), 57-59.

14. Majidov S.F., Karimova R. (2022). The formation of dentistry as a science: international and national experience. Thematics Journal of History, 8(1).

15. Umurov, S.R. (2022). Turkistonda XIX asrning ikkinchi yarmida vaqf mulklarining ahvoli. Science and Education, 3(4), 1460-1466.

16. G'offorov, S.S., Umurov, S.R. (2021). Rossiya imperiyasining Turkistonda ta'lim sohasi va vaqf mulkchilik siyosatiga munosabati tarixshunosligi masalalari. Science and Education, 2(11), 1120-1126.

17. Radjabovich, U.S. (2022). On the issue of the policy of the Russian Empire to waqf property in Colonial Turkestan. Thematics Journal of Social Sciences, 8(3).

18. Umurov, S.R. (2022). In the second half of the XIX century in Turkestan waqf condition of property. Thematics Journal of Social Sciences, 8(2).

19. Umurov, S.R. (2021). Issues of historiography of the Russian Empire's attitude to education and foundation property policy in Turkestan. International Journal of Advanced Research in Management and Social Sciences. Vol. 10. No.12. Dec 2021//https://garph.co.uk/IJARMSS/Dec2021/G-3.pdf

20. Maxmudova A.N. IX-XII asrlarda Movarounnahrda ilm-fan, madaniyat rivoji tarixidan //Yangi O'zbekistonda milliy taraqqiyot va innovasiyalar. – 2022. – C. 272-275.

21. Nugmanovna M.A. The place and significance of social and legal control in the legal socialization of the individual in civil society //Asian Journal of Research in Social Sciences and Humanities. – 2022. – Т. 12. – №. 2. – С. 21-33.

22. Ibragimov, B.D., Majidov, Sh.F. (2022). Stanovlenie stomatologii kak professii i nauchnoy dissiplinы. Science and Education, 3(11), 237-247.

23. Rustamovna, M. S. F. A. P., & Tulkinovna, I. S. (2023). THE FORMATION OF DENTISTRY AS SCIENCE DISCIPLINE. Journal of Modern Educational Achievements, 7(7), 182-192.

24. Xaydarova, D. S., Umarova, M. M., Oripova, D. A., & Majidov, S. F. (2023). Euthanasia as a humanistic problem in modern medicine. Science and Education, 4(11), 57-64.

25. Beveridge W. Full employment in a free society. London; 1944.

26. Cylus J., Richardson E., Findley L., Longley M., O'Neill C., Steel D. United Kingdom: health system review. In: European observatory on health systems and policies. Copenhagen; 2015.

27. Mossialos E., Tomson S. Dobrovolnoe meditsinskoe straxovanie v stranax Yevropeyskogo soyuza. M.: Ves mir; 2006. 224 s.

28. Berthet F., Calteux A., Wolter M., Michèle W., Weber L. Luxembourg: HiT in brief. In: European observatory on health systems and policies. Copenhagen; 2015.

29. Busse R., Blümel M. Germany: health system review. In: European observatory on health systems and policies. Copenhagen; 2014.