FEATURES OF DEVELOPMENT OF HEALTH INSURANCE IN UZBEKISTAN

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ABSTRACT

This paper examines trends in the health care financing system development. In the article the experience of the best practices of countries will be explored. In particular, it analyzes the importance of the state budget for the health system. At the same time, to reduce the social costs of the state, recommendations for financing of additional insurance have been developed. In this regard, the experience of the respondent countries was widely used.

Keywords: financing health care, health insurance, insurance, Uzbekistan

INTRODUCTION

As a result of reforms in the system of health care and the measures taken to support the financial sector, the Decree of the President of the Republic of Uzbekistan "About measures to further deepening the reform of the healthcare system of Uzbekistan" № PD-1652 dated November 28, 2011 has its own value. This program has identified a reduction (or end) of the share of budgetary financing of the budget of medical institutions. We believe that in the twentieth century, the actual expansion of the range of medical services is important, as well as income from the various financing mechanisms to improve the quality of services. Thus, the market conditions created by the need to improve the quality of medical services, the market on the basis of the formation of the financial interests of the two (or three) sides.

Compensation of the social costs by the state leads to increased financial burden on the economy, which leads to a decrease in efficiency. Public social expenditures should be allocated to ensure a minimum level of social services only to people with low incomes(Nikitenko D., 2009).

Foreign experience, during the transition state, shows that in the development of public health, the state takes the role of regulator of the economy. For example, the total amount of health care costs in developed countries of the gross domestic product is 6.2 percent, 2.3 percent in developing countries, and other countries 1.3% (Sultonova A., 2001).

Despite the fact that it is possible to increase the profit of the health care system by raising taxes, this process could lead to economic problems.

Researcher believe that in the development of socially-oriented financial system the social obligations of the state will gradually move to the citizens themselves.

This article consists of the following parts. Firstly, theoretical bases are described, then some foreign countries trends are studied. Third part investigates the possibilities of improving financing healthcare system in Uzbekistan. Last part of the article is dedicated for conclusion.

THEORETICAL BASES OF HEALTH INSURANCE

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In response to "failure of the market" of the commercial health care, there comes compulsory health insurance. This, in turn, will occur for the following reasons(Ivanov V., Pimkina O., 2012):

i. the limitations of resources, the formation of the insurance funds, income and wages of insurers;

ii. partial reimbursement of medical expenses under the insurance situation;

iii. limited insurance services included in the list of insurance programs;

iv. dependence on the market conditions of medical services;

v. not forming the "common health care" but the "sickness insurance" (that is to say, not a preventive focus, but a minimum medical care).

Compulsory insurance in the country is an instrument of social protection against unexpected financial difficulties and accidents (Kolomin I., 2013).

Public funding of mandatory health insurance provides funding for the following medical services(Juravleva N., 2013):

a. a medical emergency, that can cause serious threat to human life;

b. to identify the disease at home and outpatient conditions, and treatment;

c. emergency dental care to the population under 18 years, pensioners, and women with children up to 3 years.

According to G.Katsyavichyus (2014) in the financing of the European Union's public health system, happens the coordination of "budget" and "insurance". In particular, the budget model in the distribution of funds to states that apply the principles of insurance. This insurance model is used in countries with budget and savings principles.

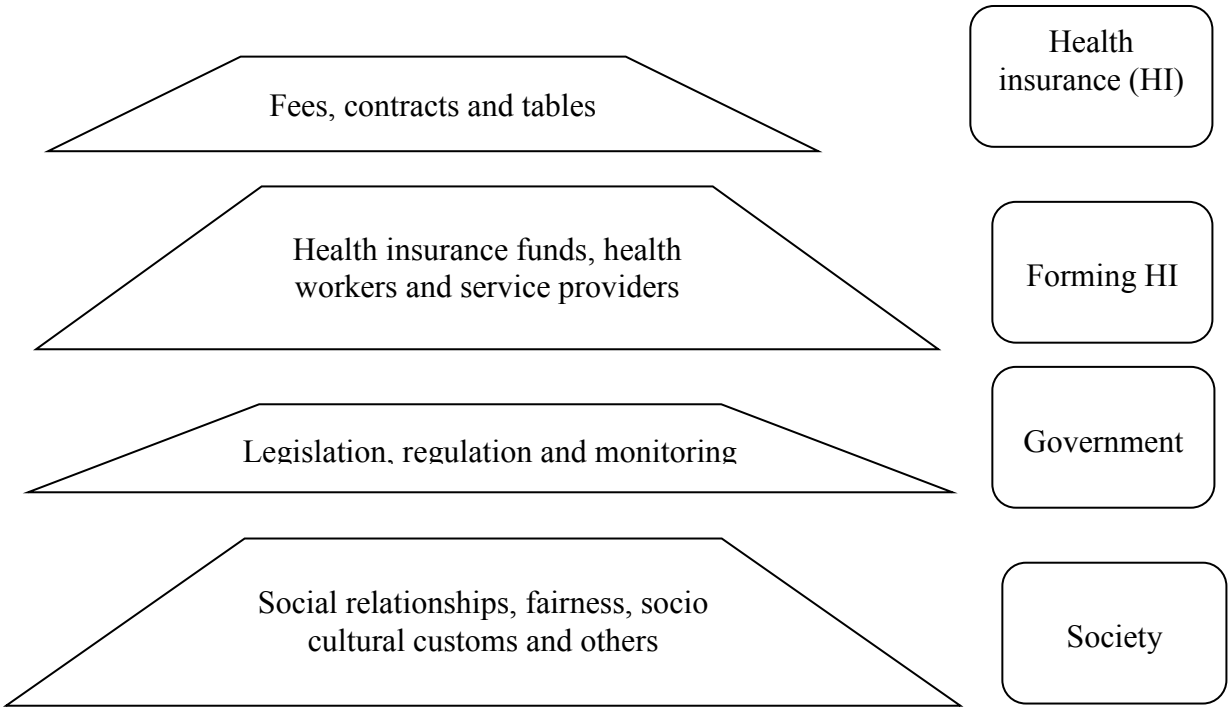

Figure 1. The Pyramid of forming health insurance.

Implementation of the process of public health insurance in the EU countries was carried out in several stages. In particular, the efficiency of funding health insurance depends on many factors. You can watch the evolutionary formation of health insurance, and in order to obtain the financial benefits from it for the community, the process should start with the company itself. This, in turn, can further improve the social security (see Figure 1).

As a result of research revealed specific features of compulsory medical insurance, which can be presented more clearly by examining Table 1.

Table 1. Comparative characteristics of models of organization of compulsory health insurance

Index	*The number of insurers (those that pay for medical services)*	*Single payer for health services. (Uniform Health Insurance Fund)*
Number of funds	Several	Single
population reached	Only insurers and persons under their guardianship.	Individually: population category is insured by the government.
The volume of health insurance	In various different funds.	Equally for the whole population
management	High autonomy	uniform rules
Competition	High	Low
Quality management of health services and its price.	Formed in a competitive environment	centrally determined
Benefits	High adaptability to the requirements of insurers	Long promising stability

The study of international experience plays an important role in developing and implementing effective health financing system in the country. In this part of the research work it is essential to study the experience of some foreign countries in the health care financing, in particular the United States, some of the CIS countries, Europe and Asia.

Table 2. Evaluating the effectiveness of the country's health care system

Country	***Index***	***Rating***	***Financing model***	***control model***
Japan	27,21	1	Insurance	Market
Norway	27,11	2	Insurance	Market
Швеция	26,11	3	Insurance	Market
Iceland	25,59	4	Tax	Government
Germany	23,39	8	Insurance	Market
Malta	21,27	11	Tax	Government
Luxemburg	20,41	14	Insurance	Government
USA	19,83	17	Private	Market

Source: Banin 2011.

At the same time, it would be appropriate to introduce an international ranking of countries on health system performance.

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World Health Organization (WHO) conducted health system 193stran rating based on analysis of financial and economic, medical and demographic indicators. Some of them can be seen in the data in Table 2.

The trend of development of the health financing system in the European Union

Health expenditure of the European Union is on average between 6-12 per cent of GDP. This, in turn, shows a significant proportion of social economic costs. This figure corresponds to countries such as Germany, France, the Netherlands, Belgium and Portugal. In these countries, health insurance is compulsory for all segments of the population, the provision of health services is the responsibility of the state. (Table №3)

United Kingdom, Czech Republic, Sweden and France have achieved a high level of public health insurance. In order to ensure that compulsory insurance in the United Kingdom and France, a significant influence is exerted on the private insurance companies. It should be noted that public health insurance is paid from the state budget (the United Kingdom and Sweden), or can be paid from the state security.

The United Kingdom national health insurance is free of charge. The National Health Service (- NHS, National Health Service) acts as a government body to provide medical services.

Table 3. Expenditures on health care in EU and their allocation, %

Countries	*Expenditure according to GDP*	*Total*	*Including*				
			Country	*Social care*	*Private funds*	*Private insurance*	*Others*
Dania	10,9	100	84,7	0,0	13,3	1,9	0,1
Sweden	9,5	100	81,6	0,0	17,2	0,3	1,0
Italy	9,2	100	77,6	0,3	18,0	1,0	3,2
Spain	9,3	100	68,2	4,7	21,1	5,7	0,3
Ireland	8,9	100	66,8	0,2	18,1	11,9	3,0
Portugal	10,2	100	64,2	1,3	28,9	4,9	0,6
Finland	9,0	100	60,2	15,1	19,5	2,2	3,0
Austria	10,8	100	32,3	44,9	17,0	4,5	1,2
Greece	9,1	100	23,7	42,2	30,9	2,8	0,3
Estonia	5,9	100	10,7	69,4	17,8	0,3	1,8
Belgium	10,5	100	10,5	65,4	19,7	4,2	0,2
Luxemburg	6,6	100	8,9	74,1	12,3	3,8	0,9
Netherlands	11,9	100	8,1	77,5	6,0	5,6	2,9
Slovakia	7,9	100	7,2	66,5	23,6	0,0	2,6
Germany	11,3	100	6,9	70,1	12,4	9,7	0,9
Czech Republic	7,5	100	4,7	79,2	15,0	0,1	1,0
France	11,6	100	3,7	73,5	7,7	14,4	0,7
Slovenia	8,9	100	1,7	71,3	12,2	13,6	1,1

Source: OECD, 2013.

It may be noted that health services in the UK are fully covered by the state budget, but patients spend months of waiting, as well as low access to health care professional(Finance and credit journal, 2013).

The development of the health insurance system in France is directly and closely linked to the law adopted in 2004. In particular, the law covers two aspects of the introduction of health insurance, administrative and financial. If the first, government and health insurance agencies is in the charge of, the latter, health insurance companies gradually increase the premium (in 2003 to 3.1 percent in 2004 and 4 percent in 2005 and 4.9 per cent) (Ostrovskaya, 2007).

As in France, a public-health insurance is mandatory, it is used by 80-90% of the population. Medical service of national health insurance system, which was introduced in 1945, aims to increase the level of comfort and reach the masses. It organizes the French authorities on the basis of the tripartite management of social security. These include: boards of directors, trade unions and employers. The trust funds of financial resources for employers, employees and business income tax is constantly formed. In the period of before income taxes, employees of the insurance premium are calculated at a rate of 20%.

It also provides the functioning of certain social protection programs for students. In particular, 98 percent of French insurance companies of the compulsory health insurance 55.6% is from additional medical insurance (Mikhailova, 2013).

In the Netherlands in 1986 passed laws on the "insurance" and "co-financing of compulsory health insurance for the elderly".

The Netherlands, the only country in the EU, with the compulsory health insurance by private companies. They adopted a law on the reduction of health financing in 2006. This, in turn, ensures that each health insurance policy will not deny concluding the insurance contract. Public health insurance is valid in accordance with the law «Algemene Wet Bijzondere Ziektekosten» (AWBZ, 1968)

The peculiarity of health insurance in the Netherlands is that, all insurance fees are covered by the employee (see Figure 3).

Medical insurance based on financing of health care institutions has the following main characteristics:

i. decentralized financing;
ii. freedom of selection an insurance company;
iii. the presence of competition between insurance companies;
iv. insurance companies control the cost and quality of medical services;
v. expansion of funding sources;
vi. choice for patient to choose the medical care.

At the same time, the following problems may arise:

i. may be artificially increased the medical costs;
ii. may have difficulty in forming a long-term financial plan;
iii. decrease in the implementation of national health care.

Spain, in the framework of the restructuring carried out by the health system covered 83 per cent of public funds expenditure. If the patients in the first year of illness pays 40%, and

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patients with chronic diseases pay 10%, pensioners have been fully exempted from payment(Ponedelko,2004).

In 2007 In Germany, the government passed a law on the introduction of forms of obligatory medical insurance. In Germany, health insurance, as a part of social security, divide the expenses equally between employer and employee.

According to the German Social Code, compulsory medical insurance provides funding for (Alekseev, 2010):

i. prophylaxis the diseases, health care;
ii. medical screening of the disease;
iii. outpatient, inpatient, dental treatment and medicines, home health care and nursing;
iv. emergency medical care and medical institutions;
v. other services (provision of information to patients).

If at the state medical insurance, the payment for insurant for treatment is paid by transfer at once, in the private the medical insurance is paid the initial fee at the beginning, and after the treatment the entire amount is paid.

Germany the costs of medical insurance: from the state budget 76%, up to 10 percent of compulsory insurance, direct payments between 13% and others 1% (Thompson, et. al., 2010).

In Germany, first aid is provided by general practitioners, and payment is made to them using a points system based on medical insurance. Inpatient care is provided by different hospitals; their costs also covers medical insurance. The public health insurance system in the country is financed as follows: 1) Hospitals; 2) medical fees; 3) pharmaceutical preparations; 4) Medications; 5) Dentistry; 6) Administrative expenses; 7) dentures; 8) other expenses.

In developed European countries, the share of health insurance funds accounts for 6-9 per cent of GDP. In Germany, the percentage of GDP per year for a stake in the health care system assets reached 11.1, which is the next record after Switzerland. But the figure was 15 percent in the United States (Saskovets, 2006). General practitioners and physician's assistants working in the state insurance companies providing services to the insured persons, referred to as "health insurance fund doctors." They take care of the patients, independently of each other, and receive payment, depending on the disease. The private insurance system, doctors who provide medical care to the insured people receive payment through the social insurance office.

Laws: "German Civil Code" and "professional indemnity insurance" provide quality health care, as well as serve as a reliable protection of patients' rights. In addition, the cost of the doctor responsible for damage caused by mistake paid not by the health and voluntary insurance, but by the personal insurer of a doctor.

In Germany, the government determines the amount of insurance payments of insurers, but also the state determines the minimum amount of insurance premiums. At the moment, 90 percent of the population is involved in this system (8 per cent in the private insurance system, 2% - to ensure the poor) (Nurmukhamedova, 2011).

The insured person can change the mandatory health insurance to an additional insurance, if he wants to get more medical care.

Experience shows that voluntary health insurance in Germany without causing any health insurance fund deficit, causes an increase in medical expenses for the maintenance of the elderly.

Studying the experience of developed countries as a continuation of the above, we offer the following:

- To determine the amount of medical services financed from the accumulated fund health care, at a certain period of time;
- To determine the duration and volume of the same period funded by the accumulated funds of health services and medical care;
- The right to require medical care, and other health care quality indicators available to the insured people;
- In order to increase the responsibility of health workers in private medical sector to use compulsory professional liability insurance;
- Establish work on solving problems to increase the share of budget funds in the country's GDP;
- Install and control pecuniary damage inflicted by a medical officer or a medical institution to the patient;

Researcher believes that the professional liability insurance is not only for patients, but also serves as a mechanism for the protection of doctors and medical personnel. This, along with the strengthening of the responsibility of medical staff improve the quality of medical care.

In conclusion, it can be concluded that the data contained in the social sector has become a priority for all countries.

Improving the Financing of Health System in Uzbekistan

The introduction in our country the given countries' health systems financing practices cannot justify itself. Since the economic and social situation of the countries are different. The implementation of these proposals and recommendations for the development of the republic's economy and to improve the health care financing system will give their results.

In our opinion, in the process of health system financing and the development of modern methods plays an important role in improving the performance of funds.

In this regard, the Decree of the President of the Republic of Uzbekistan from April 10, 2007 "On measures to further reform and develop the insurance market» № PP-618. The decree states the introduction of the reform program and development of the insurance market. It is planned to develop and put into practice the project " Law on health insurance "in Uzbekistan.

In our opinion, in the creation of regulatory and legal document regulating health insurance in the country following points should be taken into account.

In other words, funding will be as follows: the state budget - health care facility - a citizen (the current system), the state budget (social fund) - the citizen - health care institutions (proposed system) (see Figure 2). In this regard, for the financing of social health insurance can provide a fund of the state budget on health care costs and contributions to workers and employers .

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In particular, the study of the experience of foreign countries, aimed at improving the health of financial institutions as a result of the introduction of compulsory health insurance, it is vital to create the following funds:

i. Approved a special account of health worker services in order to ensure the mandatory health insurance of the financial system. The fund is used only to cover the health care costs of interest, or to use other destinations on all agencies to provide medical care when using of assets:

ii. In order to enhance the professional liability of medical workers in the private practice of insurance;

iii. Implement the methodology to use by health insurance.

iv. To enhance the importance of health insurance to implement "security experience";

v. To provide tax relief to employees of small businesses in order to promote health insurance.

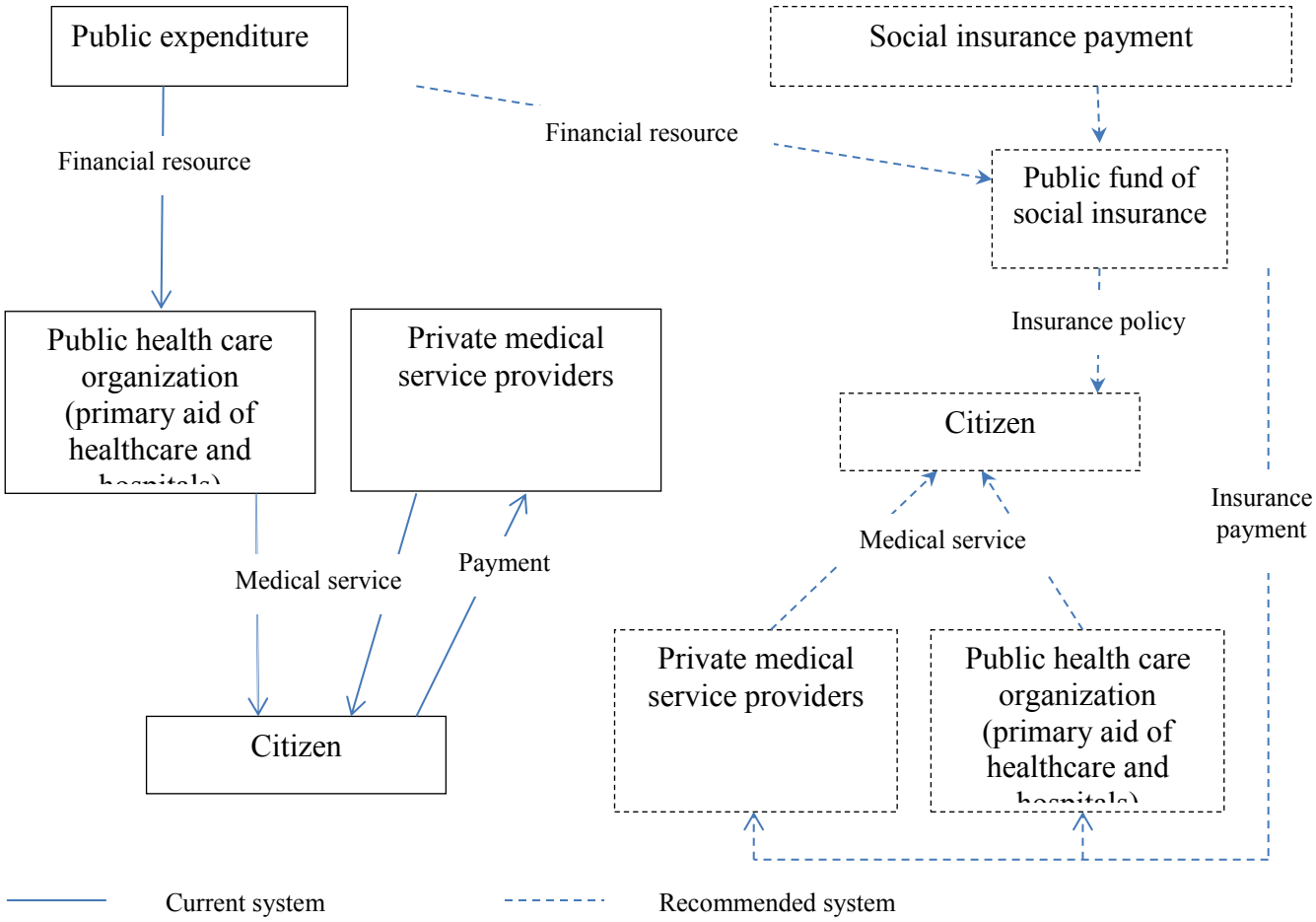

Figure 2. Structure of implying the public health insurance

First, the financing of the state budget allocated to free primary health care exerted full citizen cannot fit. The reason for this can be explained as follows:

i. Lack of transparency of information about free health care;

ii. Due to the lack of competition in the market of medical services the citizen may end up using their personal savings for medical services;

iii. Absence of the criteria for the quality of medical services;

iv. Long waiting lists for medical services;

v. responsibility to provide medical services to the patient;

It should be noted that the state budget and state health insurance funds for the financing of the system, use the following options(Finance and credit, 2013):

i. Create the necessary conditions for equal health care services;

ii. The protection of the financial risks of the citizens;

iii. systematization of payment of medical services.

Secondly, due to the introduction of national health insurance, efficiency of use of funds allocated to the state budget is achieved. It is intended to draw attention to the following:

i. Improving the selection of medical services for citizens through the development of a competitive environment;

ii. the provision of primary health care is not only the community, but also throughout the country;

iii. measures aimed at improving the quality of development and support of innovative activity;

iv. improving financial stability through the expansion of health insurance information;

v. allocate the roles in mandatory health insurance between the state, employers and employees.

Several sources of funding for the planning of the health system costs (budget, compulsory medical insurance) their management capabilities, along with the formulation complicates the management of the quality of medical services (Rybin, 2012). This in turn means the introduction of new quality control mechanisms is essential.

Third, another important aspect of enhancing the effectiveness of health care financing is to determine the responsibility of a health care provider. This, in turn, increases the financial responsibility of health professionals and health institutions. Through this practice, we can improve the quality of health care, and will increase confidence in the public service

Thus, it is necessary to introduce compulsory insurance system.

In our opinion, the responsibility of insurance regulation is necessary in the following cases:

i. put in the list of documents for the health care worker who takes a job in a medical institution;

ii. assign responsibility of the employer to control the process of compulsory insurance otherwise responsible for damage to the responsibility of the employer.

CONCLUSION

In conclusion, we note that the implementation of market-oriented reforms required the development of a competitive environment in the market of medical services. That is to say, it providing direct funding of public health facilities at the expense of the state budget

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indirectly (that is, with the participation of citizens) on the method of implementation. As a result, selected proposals, introducing insurance funding model can achieve the task.

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