Mechanism of Implementation of Mandatory Health Insurance in Uzbekistan under Conditions of Increasing Integration Processes

***Niyozova I. N.*[1], *Alimova Sh. A.*[2]**
[1]*teacher of department of economy, Bukhara State University*
[2]*assistant; Department of Management, Bukhara Engineering and Technology Institute, Bukhara, Uzbekistan*

Abstract: The article examines the tendencies of the formation and development of the insurance market in Uzbekistan, the peculiarities of its functioning, including in the context of integration processes, defining the role of the insurance market of Uzbekistan in the country's integration into the world economy and identifying the main directions of its further development, formulating a holistic view of quantitative parameters of the Uzbek insurance market and its structure. Formation of the insurance market of the Republic of Uzbekistan and the processes associated with ensuring insurance protection of medical interests of legal entities and individuals in the conditions of the formation of the main institutions of the country's market economy.

Key words: compulsory health insurance, health care financing, medical institution, transformation.

To organize a fair and efficient system of health care, it is proposed to introduce such a mechanism of compulsory health insurance, which would provide for the use of three main insurance packages. Moreover, each insurance package must include a list of medical services that a patient can receive on a free and paid basis.

In recent years, Uzbekistan has been implementing measures aimed at the phased introduction of a compulsory health insurance mechanism. No wonder. The availability of high-quality medical services to the population is an urgent problem not only for Uzbekistan, but also for other CIS countries, including the EAEU. This mechanism is already successfully operating in the Russian Federation, Kyrgyzstan and some other countries. The introduction of an effective mechanism of compulsory health insurance will create conditions for increasing the competitiveness of domestic human capital, create favorable opportunities for its reproduction, and therefore for sustainable development of the national economy in the long term.

The government of the republic plans to introduce a compulsory health insurance mechanism in 2021. In order to radically reform the health financing system, it is planned to adopt a law on compulsory health insurance in 2020 and develop organizational measures for the implementation of the new system. As an experiment, this year it will start operating in the Syrdarya region. Currently, it is necessary to develop effective approaches to this mechanism.

In our opinion, any medical institution operating in Uzbekistan is obliged to provide first emergency aid to the patient who applies, conduct an initial examination and give an appointment for further treatment, regardless of whether it is private or public. At the same time, in a state institution, all services should be provided to him free of charge. In commercial institutions, they are paid only for an amount that exceeds the cost of guaranteed free medical services, including emergency ones.

In order to organize a fair and efficient system of medical care, it is proposed to introduce such a mechanism of compulsory medical insurance, which would provide for the use of three main insurance packages: No. 1, No. 2 and No. 3. Each insurance package must include a list of

medical services that a patient can receive on a free (according to package No. 1) and paid basis (according to package No. 2 and No. 3 with compensation at the expense of the MHI insurance fund or at the expense of the patient).

It should be noted that it is advisable for the state to continue the implementation of the program related to the free provision of medical services to persons with serious infectious and socially dangerous diseases (tuberculosis, diabetes, cancer, etc.), which should be provided, if necessary, to every citizen (emergency package No. 4) , as well as for "participants in the Second World War", "Chernobyl victims", sick from childhood and other categories of beneficiaries, within the funds available to the state.

The first package should be used free of charge by all citizens of the country from the moment of their birth and residence in Uzbekistan (regardless of the length of service, assessed contributions and other factors). The state assigns a first level insurance policy to each person.

Medical services under the first package are provided to a citizen upon presentation of a birth certificate, passport or insurance policy in a public or private medical institution. The state guarantees each person a minimum "package of medical services" depending on the age of the recipient of the package. This can be - emergency medical care, consultations, laboratory tests in clinics, hospitals, district polyclinics, obstetrics, other services for men and women. At the same time, in public clinics, primary care is provided to the patient free of charge, and in private clinics, the fee should be taken only for the cost of the service, which exceeds the established cost of the standard first insurance package. For example, if the state provided a citizen with the first package for the amount of medical services in the amount of 300 thousand soums for 2021, then he has the right to receive services for this amount in a private clinic. At the same time, there is the cost of consultation and primary care amounted to 350 thousand soums, then 50 thousand is paid in addition to patients at the expense of personal funds to the cashier of a medical institution. If a patient spends in a private clinic the entire annual cost of his insurance package, then the next service in a private clinic should be carried out at the expense of the patient himself. At the same time, a patient can always apply for free medical care to a state clinic, even if he has spent the entire amount of the first insurance package.

A patient can go to a state clinic for help an unlimited number of times as needed and receive primary care free of charge (at the expense of the state). He simply signs on the statement of receipt of specific assistance (consultation, standard general tests, simple procedures) for the appropriate amount and makes a note in the journal about the quality of the service in order to monitor the use of public funds.

It is imperative that a medical institution (private or public) draw up an estimate of the costs and determine the cost of medical care for a patient who seeks help. All expenses within this level are covered by the state funds (both public and private).

Thus, the insurance policy of compulsory health insurance of the first, in fact, is needed by the patient only when contacting a private, commercial clinic.

According to the package, all citizens, including those employed in the public or commercial sector, the unemployed, pensioners, disabled people, minor children, other dependents and persons receiving benefits from the budget, are entitled to receive primary health care services directly from clinics (including emergency care).), without contacting an insurance company. At the same time, in district city family clinics (rural medical stations) they receive it free of charge, and in private ones they pay only the amount that exceeds the cost of the established insurance package of services within the framework of compulsory health insurance.

The second package is used only by citizens who work in the commercial sector of the economy. The employee is required to open a separate personal account and issue an insurance plastic card, which receives monthly messages about the accrued funds (from wages or from other sources).

The funds themselves go to the insurance company, which is responsible for administering the compulsory health insurance mechanism in the event of an employee's illness. The package is implemented through the patient's appeal to the insurance company, which sends him to a medical institution for examination and treatment (on an alternative basis at the patient's choice). If the employee did not fall ill within a year and did not seek help from the insurance company, then 50% of the accrued amount remains at its disposal, and the other half is transferred to the employee for use. By agreement of the parties, the employee can undergo a medical examination or preventive treatment free of charge (during work leave or at any other time convenient for him).

If an employee is sick, but his accrued funds are insufficient for his full treatment, then all the missing funds come from the funds of the insurance company. In this case, the risks and possible loss of funds are distributed evenly and fairly: the employee (in the absence of cases of illness), and the insurance company (in the case of illness of the insured).

In the event that this minimum amount on the insurance card or account is insufficient to use the second insurance package, he can always use the first insurance package and contact the public medical institution at the place of residence, where he will receive free primary care.

The insurance organization that administers the second package is obliged to reimburse all the costs of treatment and accommodation of the patient in the amount that includes the cost of the second package, and take all necessary measures for his speedy recovery.

The third package of compulsory health insurance. This insurance package is intended for persons who carry out their activities in the public sector of the economy (civil servants, military, police, judges, etc.). Persons of this category can also use free services included in the first insurance package.

The third package entitles the employee to apply to a departmental or private clinic for treatment. In the departmental clinic, all services rendered are provided to the patient free of charge (at the expense of the state). If there is no departmental clinic, then a civil servant can apply for treatment at a private clinic. In this case, the state will reimburse the employee a certain part of the costs, which will be set by the limit for the corresponding year. If the employee has not applied for compensation for sickness expenses during the year, then the budgetary organization in which he works has the right to send him at the beginning of the next year for a free preventive examination or a short-term rest in a sanatorium (during labor leave or at any time convenient for him).

In conclusion, it should be noted that the introduction of the compulsory health insurance mechanism at the first stage should be carried out at the expense of funds received from the currently valid taxes, deductions and fees (excise tax on domestic products, social tax, and others). In this case, it will not affect the growth of the tax burden on the activities of legal entities and individuals and will contribute to the legalization of the activities of legal entities and individuals.

The general principle of financing the costs of compulsory health insurance at the first stage is as follows. Part of the budget funds (30%), which was previously distributed directly to medical institutions, should be transferred to an insurance organization, which, if necessary, will pay for the treatment and accommodation of the employee in the event of his temporary disability.

At the second stage of the introduction of compulsory health insurance, when taxpayers see the advantages of this mechanism, it will be possible either to introduce a surcharge to the value of the Social Tax. Funds from this premium or insurance premium should be directed at the disposal of a specialized insurance company. This stage can be introduced only after a significant reduction in the shadow activities of legal entities and individuals, increasing the confidence of taxpayers in the government's initiatives in terms of insurance of citizens.

The insurance company should divide these funds into two specially created sources: the fund for living with temporary disability of the employee and the fund for medical care, as well as the implementation of preventive measures to support the health of citizens of Uzbekistan. The division of funds into these two funds is due to the fact that it is impossible to achieve a quick recovery of the patient without good nutrition.

In order to increase the efficiency in the use of insurance funds, to enhance their stimulating role in the legalization of the activities of individuals, it is necessary to clearly define how they will be formed, for what purposes they will be directed and strictly adhere to the chosen principles.

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