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LEGAL ISSUES OF IMPROVING HEALTH INSURANCE IN THE REPUBLIC OF UZBEKISTAN

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ABSTRACT

In the field of human health, it is important to make medical services affordable in all respects, high quality and financially affordable for the population. In the provision of medical services, the organization of the relationship between the medical institution, the doctor and the patient, the creation of the necessary conditions for the treatment of patients in the medical institution is organized in different ways. One of the most effective of these methods in modern medicine today is health insurance. Through health insurance, the insurance company takes all organizational (financially hospitalized, highly qualified doctors) financial measures related to the treatment of the insured person (patient) in the event of an insured event, and as a result the insured person has access to qualified and quality medical care. Today, there are no clear approaches to the role of health insurance in legal regulation and jurisprudence, which area of insurance it is: life insurance and general insurance. This at the same time creates a number of problems and gaps in the legal regulation of the interpretation of the essence of the health insurance contract and its application. Therefore, it is important to determine the essence of health insurance, its content and specifics as a legal relationship, and thus create a legal basis for health insurance.

KEYWORDS

Insurer, insured person, health insurance institution, citizen, insurance company, health insurance.

Introduction

In the maintenance and maintenance of human health, all branches of law, in addition to the provision of a certain level of protection and protection measures, determine the implementation of such provision through various means. For example, the spheres of rights by defining the rights and obligations of health care system organizations, introducing the organizational and legal norms for providing qualified medical services to patients, establishing responsibility for health injuries and providing for the powers of state bodies in this regard provide for the legal procedure for maintaining and ensuring the health of citizens. At the same time, the provision of the health of each citizen through the setting of purposeful and infidel -oriented measures for the maintenance of human health is of particular importance today.

The Institute of medical insurance, as such a measure, creates a system of specific relationships for the maintenance of human health and provides the patient with the right to use Guaranteed medical services in medical institutions. The citizen will have the right to demand that the costs of treatment be covered by the insurance organization in case of further deterioration of his health, if he remains unwell, through the provision of health insurance. In addition, as an object of medical insurance, a citizen may be provided for a certain period of time and with a ticket to the healer of a medical institution to undergo a medical examination, to cover the costs of diagnostics and medical advice[1]. In this situation, the provision of category medical services is an object of medical insurance, through which the costs of rendering medical services in accordance with the established procedure to a citizen who has health insurance are covered by the insurance organization.

Law of the Republic of Uzbekistan "On insurance activity" In Article 4, insurance is divided into life insurance and General Insurance[2]. Medical insurance is considered to be dependent on the sphere of life insurance. Life insurance in the civil code (in subsequent places – FC)is defined as personal insurance. As an object of a personal insurance contract, damage to life or health is provided for. In addition, in the life of the insured person, the occurrence of another event (insurance event) entered into the contract by agreement of the parties is also considered an object of personal insurance, provided for in the first part of Article 921 of the FC.

As can be seen from the above – mentioned ratio and analysis of norms, there is no clarity in the legislation on which two types of medical insurance – insurance contracts-belong to some kind of property or personal insurance, what constitutes its object. 2002 year of the Cabinet of Ministers of the Republic of Uzbekistan

To the regulation "on the licensing of insurance activities of insurers and Insurance Brokers", which is considered an appendix to the decision № 413 of November 27

The 1-appendix insurance activity classifier also does not specify medical insurance[3]. And this shows the need to determine the place and essence of medical insurance in terms of legislative point of view and scientific interpretation.

Legal literature does not have a unanimous view and understanding of the role and scope of medical insurance. A group of scientists note that medical insurance in most cases is misinterpreted as liability insurance and Damage Risk Insurance[4]. The other group of specialists interpret health insurance as a type of personal insurance contract[5]. Some researchers conclude that medical insurance directly refers to the obligations of a medical institution and that the object of the bond is the property interests of the insurer, that is, the costs associated with its compensation in case of damage to health[6]. At the same time, in some developing countries, health insurance is also seen as a method of financial support of the population, and in conditions where the prices of medical services are high, this method is assessed as a measure of support for the low-income stratum of the population[7].

In our opinion, medical insurance is different from the usual manifestations of personal and property insurance with social orientation. From the point of view of its object, it is appropriate to interpret medical insurance as a kind of personal insurance. Because, in medical insurance, as an insurance accident, the food related to the maintenance of a person's health includes: medical services (diagnosis, counseling, treatment, medical procedures and surgery) and treatment-prophylactic treatments related to health recovery. In this case, unlike personal insurance, the insured person will not receive insurance money in the event of damage to his health or the accident provided for in the insurance contract, but will have the right to receive a course of free treatment and recovery in the appropriate medical

institution. The advantage of medical insurance is associated not only with the reimbursement of the cost of treatment, but also with the fact that the medical institution, the rooms in it and the treatment courses, the types of treatment are prescribed in advance in the contract. In this case, in addition to conducting appropriate treatment procedures when an insurance accident occurs with the insured person, the medical institution will have to perform such actions as hospitalization, appropriate medication and diagnostic efforts, conducting a full medical examination, attracting qualified specialists.

As far as the content of the medical insurance contract is concerned, Z. Ivanishin expresses the following: in medical insurance, the insurer undertakes to organize and finance the provision of medical and other medical services by the executor of medical services, which after payment of the insurance premium to the insured person has contractual relations with him[8]. V.Lazareva points out that the purpose of medical insurance is to ensure that citizens receive medical care and guarantee the financing of preventive measures on the account of the accumulated funds in the event of an insurance accident[9]. The point is that the purpose of medical insurance is not limited to the fact that a Citizen can serve as a guarantee in the field of health care. Medical insurance also serves as a "preliminary contract for the future medical service" between the medical institution and the insured person, constantly monitoring the health of the citizen. For this reason, medical insurance is considered as an insurance policy that provides for the use within the framework of the insurance money paid by the insurer from the medical service in the restoration and maintenance of the health of the insured person. This situation most often presents the insured the use of a guaranteed medical service, accompanied by the Prevention of the occurrence of unforeseen necessary expenses in the event of an insurance accident, for example, when his health deteriorates. In order to conclude a medical insurance contract, the insurer will not only enter into a contractual relationship with the insurer, but will also have to enter into contractual relations with the relevant medical institution. Such relations are connected with the need to provide qualified medical services to the insured person in the event of an insurance accident.

In world practice, medical insurance is defined as insurance based on risks. Full health insurance covers the following risks:

- the cost of medical services in the following cases:

a) treatment; B) prophylactics; C) rehabilitation; d) medical and household care;

- loss of personal income as a result of incapacity for work:

a) temporary; B) permanent.

In the first case, the insurance covers the expenses that the insured person must be made to receive medical care, and in turn this guarantee is considered to be more conducive to the insurance of property losses and protects the client from payment of expenses that arise. In the second case, the insurer pays the property insurance to the insured person for the time of failure to work, and this guarantee is considered to be money insurance, since it protects the personal income of the insured person[10].

From an economic point of view, medical insurance is a form of social protection in the field of health care of the population, representing a guaranteed payment for medical care from the account of insurance funds collected by the insurer in the event of an insurance accident. The development of medical insurance is associated with the need to provide comprehensive qualified and acceptable medical services to the population in the conditions of exchange of the concept of "free medicine" with the concept of "medical insurance" [11]. In fact, medical insurance is an effective tool that is aimed at ensuring the need of the population for medicine in the provision of paid medical services and is used

in the relationship of the Real market economy of maintaining the health of citizens, and not in the conditions in which there is" free medicine". Of course, medical insurance in this place, the insurance Institute in general, the level of acceptance by the population is also considered significant. In most cases, the level of validity of medical insurance also does not have a significant increase, as a result of the fact that citizens perceive insurance as a negative fact, "to think of evil instead of good intentions and to hold out insurance in advance so as not to be superfluous", as well as to consider the excess output for insurance unnecessary. However, the advantages of medical insurance it will be necessary to apply it gradually, to lessen the amount of insurance premiums and contributions, as well as to carry out explanatory work on the population.

Medical insurance as a form of social protection of the population in the field of health guarantees the provision of medical care for any reason, including in case of loss of health related to illness or unfortunate event. It provides for measures to formulate separate insurance funds intended for the financing of medical care within the framework of insurance programs. Being an object of medical insurance is an insurance risk associated with financing the provision of medical care in the event of an insurance accident. Medical insurance is based on the social principals in the distribution of risks, namely: the rich pays for the poor, the healthy-for the sick, the young – for the elderly. Following insurance printing: if you get sick, if you stay healthy, you lose[12]. In the event that the insured person is not ill and the reason for applying for medical care does not arise, the insurer will win. After all, the failure of the insured event, established in the contract of insurance, during the period of validity of the contract, frees the insurer from paying the insurance premium and leads to the termination of the contract.

The experience of foreign countries plays an important role in the expression of the essence of medical insurance. Because, by strengthening medical insurance at the legislative level and studying the experience of legal systems with positive experience in the practice of application, it becomes possible to develop positive and effective rules of legal regulation of this type of insurance. It should pay attention to the ownership of certain difference aspects of insurance carried out for the fee evasion of the health regulation system. In European countries, the print of social inclusion in health care, while in the US, the philosophy of strong competition and Individuality continues to rule. The regulatory tone of health insurance is associated with the adoption of legislation on compulsory insurance of the population of European countries in the XIX – XX centuries. In these countries, only a rich stratum of the population does not participate in compulsory health insurance, it is not necessary. Health insurance in the US is everyone's personal business (with the exception of the content provided by Mediker and Medikeyd government programs) and a large part of the low-income population is deprived of the opportunity to insure their health[13]. Trade unions and socio-democratic movements, socialism based on religious organizations have led to the rapid development of health insurance in European countries as well as the growth of health insurance indicators in the United States. In particular, low-income, chronic and severe musculature for health, regulated by insurance, will be exempted from additional payment. The system assumes the payment of a large part of the costs for medicines (in Frantism – 95 %), injections and prostheses (80-95%), laboratory analysis (80-90%). In Germany, Sweden, Belgium, the expenses for the treatment of patients (within the specified amount), as well as the costs of their treatment in sanatoriums, are covered. Base insurance services in the US have not had steady growth rates since long ago.

The high level of insurance coverage of European countries, the breadth of the scope of medical care for insured persons is based on a significant level of subsidies allocated by governments, as well as on the redistribution of funds among insurance companies. Currently, the working part of the US population (under 65 years of age) is considered to be completely deprived of government subsidies ("Medikeyd"), as well as there is a fierce competition between insurance companies.

Usually the health insurance regulatory system ensures that each any physician insured person has the opportunity to apply for a relatively simple payment evasion for the medical service rendered to the hospital. In the 80-90-ies of the last century, the system of doctors of Health societies in the US was widely used, in which the patient could refer only to these healers. As for today's Ken, it is noted that the patient's choice of a healer, a method of treatment, a hospital significantly increased free level.

In European countries developed a system of price cuts for medical services. The practice of negotiation between law and insurance companies and doctors ' associations (sometimes directly, in some cases with the participation of government officials) will help to keep the prices at a lower level than, and in some cases, taking into account the level of inflation. It is noted that in the US it is impossible to curb price growth and the inability of the government to do so.

It can be seen that in the application of the medical insurance service it is desirable to apply the EU model, to carry out the appropriate polishing in the case of medical insurance contributions and the high absence of the prices of medical services provided for in the event of an insurance accident provided for in the contract, not to allow monopolies in this.

When interpreting the essence of medical insurance, it will be necessary to take into account its relevance to the scope of application and the obligation to follow directly. So, an additional obligation for the insurer when concluding a medical insurance contract, that is, it has entered into a contractual relationship with a medical institution that is able to provide the appropriate medical services, and the corresponding obligations are imposed on that medical institution. Therefore, medical insurance is considered to be the type of medical institution in which the insurer, in contrast to the usual insurance relations and entered into contractual relations with him, and the availability of the opportunity to indicate the relevant medical procedures provided for by this institution in the insurance contract.

As subjects participating in the medical insurance relationship, a citizen is an insured person, an insured person, an insured medical organization is an insurer, a medical institution. According to the rule formed in the practice of insurance, a citizen is an insured person who is considered a beneficiary. In other words, the main purpose of the entire medical insurance system is to ensure that the citizen receives medical care from the account of the funds accumulated when the insurance accident occurred and to finance the preventive measures. When we say prophylactics in modern insurance systems, measures to reduce the scope of an insurance accident are understood, and prophylactics measures of a broad meaning in which the health systems of the state are responsible are not taken into account. It should be remembered that large-scale measures to preserve the health of the population, the Prevention of various diseases, epidemics and pandemics, as well as the elimination of the causes of their occurrence are primarily an obligation on the health care system of the state. In contrast, medical insurance provides for the restoration of the health of citizens and the creation of specific organizational, legal and financial institutions for treatment. Because, through the structure of the medical insurance contract, a specific three-party relationship is formed, and when an insurance accident occurs in the insured person and the insured person, the insurance company is required to resolve organizational and legal issues of the relevant medical services and finance the treatment process.

As an insurer in the medical insurance contract, different individuals can participate, depending on the nature of the current legislation and the existing social relations. For example, employers as an insured in compulsory medical insurance, various social funds participate as a party to the contract. At the same time, citizens themselves are allowed to become insured in voluntary medical insurance and conclude a medical insurance contract.

The insurance organization is an insurance company that has a license to carry out relevant activities in the network of life insurance, as well as offers medical insurance services. In medical insurance, the most important aspect in the purpose of the insurer's activities is the implementation of the basic principal "money is spent on the health of patients". Medical insurance means that the insurance company for the patient is interested in choosing for him the best doctor and treatment institution, and doctors will stop receiving money "for a visit", and now doctors will have to get the money for the service. And in the absence of medical insurance, doctors work on the basis of a system of obtaining a certain amount of money for each visit from citizens. It is considered a practice that is formed almost all over the world, and how much a citizen sees or does not see from such a visit, does not interest either a doctor or a medical institution, and does not even take responsibility for this with a certain justification and consequences. It is necessary to recognize that such a negative and effective method of medical care and one of the acceptable methods of eliminating the negative method of "remuneration for a visit", in turn, is considered to be medical insurance. After all, health insurance guarantees a high-quality medical service and creates the opportunity to receive it, as well as additional financial resources to the health sector to help solve the problem.

The treatment-prophylactics institutions, in which medical services are produced and provided, are an independent subject in the market of the sale of insurance services and are an organization that can assume "entrepreneurial risk" in the competitive struggle for the right to conclude contracts with insurance companies that have full-fledged funds of the insured population. One of the main objectives of the introduction of medical insurance is the creation of a market environment for business activities of health institutions, which, in turn, will allow organizations and the population to raise additional funds through insurance. At the same time, as a result of this, the market of medical services is formed, and the heads of the treatment and prophylactic institution become sellers of medical services.

World experience has shown that the efficiency of using funds is higher in insurance systems than in the distribution of them in the budgetary system. In market conditions, the income of healthcare professionals depends on how satisfied the client is with his or her medical services and whether he or she will re-apply to that address where he or she needs medical care again. In the provision of medical services, it will be important not only how the patient is treated, but also how he is treated. The patient receives a guarantee of the quality of medical care – a medical insurance organization, which monitors not only the cost, but also the quality of medical care.

From the above analysis, it can be concluded that in order to establish the legal regulations for the introduction of medical insurance and its application, it is necessary, first of all, to establish the legislative framework for medical insurance. In this it is necessary to refer to the current civil code special articles on medical insurance and specify in it the most basic rules that are specific to medical insurance. In addition, for the wide application of medical insurance, the adoption of the law "on compulsory medical insurance" and the introduction of the organizational, legal and contractual procedure for its implementation are required. The implementation of these measures, in turn, will lead

to the development of medical insurance in our country, as well as to the improvement of the system of ensuring the health of the population and the increase in the quality of stable medical services.

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