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THE ROLE OF MEDICAL INSURANCE IN THE FIELD OF HEALTH CARE AND LEGAL ISSUES OF ITS IMPLEMENTATION

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Abstract
It is important to make medical services acceptable in all respects, high-quality and financially feasible for the population in the preservation of human health. In the provision of medical services, the organization of mutual relations between the medical institution, the doctor and the patient, and the creation of necessary conditions for the treatment of patients in the medical institution are organized in different ways. Medical insurance is considered the most effective of such methods in today's modern medicine. Through medical insurance, the insurance organization takes all organizational (placement of the patient in a medical institution, 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 will have the opportunity to receive qualified and quality medical services. Today, there are no clear approaches to the role of medical insurance in legal regulations and areas of jurisprudence, which branch of insurance it belongs to: life insurance and general insurance. At the same time, this creates a number of problems and gaps in the legal regulation in the interpretation of the essence of the medical insurance contract and its application. Therefore, it is important to determine the nature of medical insurance, its content and peculiarities as a legal relationship, and thereby create the legal basis of medical insurance.

KEYWORDS: Insurance, health care, insurer, insured, insured person, medical insurance institution, citizen, insurance company, medical insurance.

INTRODUCTION

All areas of law in the maintenance and provision of human health provide for a certain level of protection and protection measures, and determine the implementation of such provision through various mechanisms. For example, by defining the rights and obligations of health care system organizations, introducing organizational and legal mechanisms for providing qualified medical services to patients, establishing responsibility for health injuries, and providing for the powers of state bodies in this regard. the spheres of law envisage the legal procedure of maintaining and ensuring the health of citizens. At the same time, ensuring the health of every citizen by determining the targeted and individually oriented measures of ensuring human health is of particular importance today. As such a measure, the Institute of Medical Insurance creates a unique system of relations related to the provision of human health and ensures the patient's right to use

guaranteed medical services in treatment facilities. By taking out his health insurance, a citizen has the right to demand that the insurance organization reimburses him for the costs of treatment in the future when his health deteriorates or he becomes ill. In addition, as an object of medical insurance, it may be provided that a citizen undergo a medical examination within a certain period and with a referral from a doctor of a medical institution, as well as cover the costs of diagnostics and medical consultation[1]. In this situation, the provision of medical services is considered an object of medical insurance, and the costs of providing medical services to a citizen who has health insurance are reimbursed by the insurance organization.

Law of the Republic of Uzbekistan "On Insurance Activities" in Article 4, insurance is divided into life insurance and general insurance[2]. Medical insurance belongs to the field of life insurance. In the Civil Code (hereinafter - CC), life insurance is defined as personal insurance. Damage to life or health is provided as the object of the personal insurance contract. In addition, it is stipulated in the first part of Article 921 of the CC that the occurrence of another event (insurance event) included in the contract with the agreement of the parties in the life of the insured person is also considered an object of personal insurance.

Above, it can be seen from the correlation and analysis of the norms that there is no clarity in the legislation regarding whether medical insurance belongs to one of the two types of insurance contracts - property or personal insurance, and what constitutes its object.

Legal literature does not have unanimous opinions and understandings about the role of medical insurance. A group of scholars note that health insurance is often misconstrued as liability insurance and indemnity insurance [4]. Another group of experts interpret health insurance as a type of personal insurance contract[5]. Some researchers come to the conclusion that medical insurance directly implies the obligations of the medical institution, and that the object is the insured's property interests, that is, the expenses related to his compensation in the event of damage to his health [6]. At the same time, in some developing countries, health insurance is seen as a way of financial support for the population, and in the conditions of high cost of medical services, this method is used as a measure to support the low-income segment of the population. is evaluated [7].

In our opinion, health insurance is socially oriented and differs from the usual forms of personal and property insurance. From the point of view of its object, it is appropriate to interpret medical insurance as a type of personal insurance. Because, in medical insurance, as an insurance event, food related to the maintenance of human health: a complex of medical services (diagnosis, consultation, treatment, medical procedures and surgery) and related to health restoration includes direct treatment-prophylactic procedures. In this case, unlike personal insurance, the insured person does not receive the insurance money in the event of damage to his health or an event provided for in the insurance contract, but has the right to receive free treatment and a recovery course at an appropriate medical institution. . The advantage of medical insurance is not only the reimbursement of treatment costs, but also the fact that the medical institution, the rooms and treatment courses, and the types of treatment are determined in advance in the contract. In this case, the medical institution, in addition to carrying out appropriate treatment procedures with the insured person in the event of an insured event, includes placing him in a hospital, taking appropriate medication and diagnostics, conducting a full medical examination, qualified it will be necessary to carry out complex actions such as attracting specialists.

Commenting on the content of the medical insurance contract, P.Z.Ivanishin states the following: in medical insurance, the insurer has contractual relations with the insured after payment of the insurance premium by the insured. undertakes the organization and financing of the provision of medical and other health-related services by the provider of medical services [8]. Y.V. Lazareva emphasizes that the purpose of medical insurance is to ensure that citizens receive medical care and finance preventive measures at the expense of the accumulated funds in the event of an insured event [9].

In our opinion, the purpose of medical insurance is not limited to the guarantor of a citizen's health care. Medical insurance serves as a kind of "preliminary contract for future medical services" between the medical institution and the insured person, and it is a constant monitoring of the citizen's health. Therefore, medical insurance is considered a mechanism that ensures the use of medical services for the restoration and maintenance of health of the insured person within the insurance money paid by the insurer. First of all, this situation provides the policyholder with the use of guaranteed medical services, while preventing unexpected necessary expenses in the event of an insured event, for example, when his health deteriorates. In order to conclude a medical insurance contract, the insurer must not only enter into contractual relations with the insured, but also enter into contractual relations with the relevant medical institution. Such contacts are related to the need to provide qualified medical services to the insured person in the event of an insured event.

In world practice, medical insurance is defined based on insurance risks. In this case, full medical insurance covers the following risks:

- medical expenses for the following cases:

a) treatment; b) prevention; c) rehabilitation; g) medical and household care;

- loss of personal income due to incapacity for work:

a) temporary; b) constant.

In the first case, the insurance covers the insured person's necessary expenses for medical care, and in turn, this guarantee applies to property loss insurance and protects the client against sudden expenses. . In the second case, the insurer pays property insurance to the insured person for the period of incapacity for work, and this guarantee is considered money insurance, as 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 public health care and represents a guaranteed payment for medical care at the expense of insurance funds collected by the insurer in the event of an insured event. . The development of medical insurance is related to the need to provide comprehensively qualified and acceptable medical services to the population in the context of the exchange of the concept of "free medicine" with the concept of "medical insurance" [11]. In fact, medical insurance is aimed at ensuring the population's need for medicine in the provision of paid medical services, and not in the conditions of "free medicine", and is used in the real market economy relations of public health care. is a tool. Of course, the level of acceptance of medical insurance and the insurance institute in general by the population is also important. In many cases, citizens perceive insurance as a negative reality, consider it inappropriate to "think bad things instead of good intentions, and insure that this will happen in advance", as well as insurance As a result of considering the excess expenditure as unnecessary, the coverage rate of health insurance does not have a significant increase. However, it will be necessary to gradually apply the advantages of medical insurance, to set the amount of insurance premiums and contributions to a lower level, and to carry out relevant explanatory work for the population.

Health insurance, as a form of social protection of the population in the field of health care, guarantees the provision of medical care in case of loss of health for any reason, including illness or accident. It provides measures for the formation of separate insurance funds intended to finance medical care within the framework of insurance programs. The object of medical insurance is the insurance risk associated with the financing of medical care in the event of an insured event. Health insurance is based on the principle of social solidarity in the distribution of risks, that is: the rich pay for the poor, the healthy pay for the sick, the young pay for the old. The following insurance principle applies: if you are sick, you win, if you stay healthy, you lose [12]. The insurer wins if the insured person does not get sick and does not have a reason to seek medical help. After all, the non-occurrence of the insured event specified in the insurance contract during the period of validity of the contract frees the insurer from paying the insurance premium and leads to the cancellation of

the contract.

The experience of foreign countries is also important in expressing the essence of medical insurance. Because, by strengthening medical insurance at the legislative level and studying the experience of legal systems that have positive experience in the practice of application, it becomes possible to develop positive and effective mechanisms of legal regulation of this type of insurance. In this case, it is necessary to pay attention to the fact that the regulatory system of health care has certain differences from paid insurance. In European countries, the principle of social solidarity in health care continues, and in the USA, the philosophy of strong competition and individuality continues to rule. The type of regulation of health insurance is related to the adoption of legislation on compulsory insurance of the population of European countries in the 19th - 20th centuries. In these countries, not only the rich strata of the population participate in compulsory health insurance. Health insurance in the US is a private affair (except for the contingent served by the government programs Medicare and Medicaid), and a large portion of the low-income population does not have access to health insurance. will be deprived [13]. Social solidarity based on trade unions and social-democratic movements, religious organizations led to the rapid development of health insurance in European countries and the growth of health insurance indicators in the United States. In particular, low-income, chronically and seriously ill patients are exempted from additional payment for health insurance. In this case, the system provides for the payment of a large part of the costs for drugs (in France - 95%), glasses and prostheses (80-95%), laboratory analysis (80-90%). In Germany, Sweden, Belgium, the costs of transporting patients (within the specified amount), as well as their treatment in sanatoriums, are covered. Basic insurance services in the US have not had a picture of steady growth for many years.

The high level of insurance in European countries, the wide range of medical care for insured persons is based on the significant level of subsidies allocated by governments, as well as the redistribution of funds among insurance companies. Currently, the working part of the US population (under 65 years of age) is completely deprived of government subsidies ("Medicaid"), and fierce competition between insurance companies is observed.

Usually, the regulatory system of health insurance provides each insured person with the opportunity to apply to any doctor or hospital for medical services for a relatively simple fee. In the 80s and 90s of the last century, the system of hiring doctors from Health Societies was widespread in the USA, where the patient could only refer to these doctors. Today, it is noted that the patient's level of freedom to choose a doctor, treatment method, and hospital has greatly increased.

In European countries, a system of price controls for medical services has been developed. The law and the practice of negotiations between insurance companies and medical associations (sometimes directly, in some cases with the participation of government officials) keep prices relatively low, and in some cases inflation-adjusted. helps to maintain. In the US, it is noted that it is impossible to control the price increase and the government is helpless in this regard.

It is clear from this that the application of the European Union model in the application of medical insurance service, the appropriate restraint on the medical insurance premiums and the price of the medical services provided in the event of the insurance event provided for in the contract should not be high. to implement, to prevent monopoly in this field, to receive qualified medical services within the framework of medical insurance and to use full medical services of the insured person and thus to restore his health, subject to the amount of the relevant insurance money it is appropriate to choose a way to create a system.

When interpreting the essence of medical insurance, it is necessary to take into account its scope of application and its connection with the direct obligation. After all, when concluding a medical insurance contract, an additional obligation is assumed for the insurer, that is, entering into a contractual relationship with a

medical institution capable of providing relevant medical services and assigning relevant obligations to this medical institution. For this reason, medical insurance is defined as the type of medical institution with which the insurer entered into a contractual relationship, unlike the usual insurance relations, and the possibility of this institution providing the relevant medical procedures provided for in the insurance contract.

Subjects participating in medical insurance relations are the citizen - the insured person, the insured, the insurance medical organization - the insurer, and the medical institution. According to the rule established in the practice of insurance, the citizen - the insured person is the beneficiary. In other words, the main goal of the entire medical insurance system is to guarantee the citizen's access to medical care and to finance preventive measures at the expense of funds collected in the event of an insured event. In modern insurance systems, prevention refers to measures to reduce the scope of an insured event, and preventive measures in a broad sense, for which the health care systems of the state are responsible, are not taken into account. It should be remembered that large-scale public health measures, prevention of various diseases, epidemics and pandemics, and elimination of their causes are primarily the responsibility of the state health care system. In contrast, health insurance provides for the creation of specific organizational, legal and financial mechanisms for the restoration of citizens' health and treatment. Because a unique tripartite relationship is formed through the conclusion of a medical insurance contract, and in the event of an insured event between the insurer and the insured, the insurance company is required to resolve the organizational and legal issues of the relevant medical services. financing of the treatment process is required.

Depending on the specifics of the current legislation and existing social relations, different persons may participate in the medical insurance contract as the insured. For example, employers and various social funds are parties to the contract as insurers in compulsory medical insurance. At the same time, the citizens themselves are allowed to be insured in voluntary medical insurance and to conclude a medical insurance contract.

An insurance organization is an insurance company that has a license to carry out relevant activities in the life insurance network and offers health insurance services. In medical insurance, the most important aspect of the goal of the insurer's activity is the implementation of the main principle "money is spent on the health of patients". Health insurance means that the insurance company has an interest in choosing the best doctor and treatment facility for the patient, and doctors stop getting paid "per visit" and doctors are now paid for the services they provide. In cases where there is no medical insurance, doctors work based on the system of charging citizens a certain amount of money for each visit. This is a practice that has been formed almost all over the world, and the doctor or the medical institution does not care how much the citizen benefits or not from such a visit, and does not take any reasonable and consequential responsibility for it. It is necessary to recognize that one of the acceptable ways to end such a negative and ineffective medical service method and the negative "pay-per-visit" method is medical insurance. After all, health insurance guarantees high-quality medical care and makes it possible to receive it, and also helps to solve the problem of the allocation of additional financial resources to the health sector.

Treatment-prophylactic institutions, where medical services are produced and provided, are independent entities in the market for the sale of insurance services, and in the competitive struggle for the right to enter into contracts with insurance companies that have paid-up funds of the insured population, "entrepreneurship" is an organization that assumes risk. One of the main goals of the introduction of health insurance is to create a market environment for the work of health care institutions, and this, in turn, is to attract additional funds through insurance by organizations and residents. allows. At the same time, as a result of this, the market of medical services will be formed, and the managers of treatment and prevention institutions will become sellers of medical services.

World experience shows that the efficiency of the

use of funds is higher in insurance systems than in their distribution in the budget system. In market conditions, the income of healthcare workers depends on how satisfied the client is with his medical service and whether he will return to this address when he needs medical help again. In the provision of medical services, not only how the patient is treated, but also how he is treated is important. The guarantee of the quality of medical care for the patient is the health insurance organization, which controls not only the costs, but also the quality of the medical care.

From the above analysis, it can be concluded that in order to establish the legal regulatory mechanisms for the introduction of medical insurance and its application, it is necessary to create the legal basis for medical insurance first of all. In this case, it is necessary to include special articles on medical insurance in the current Civil Code and define the most basic rules specific to medical insurance. In addition, in order to implement medical insurance on a large scale, it is necessary to adopt the Law "On Compulsory Medical Insurance" and introduce the organizational, legal and contractual procedure for its implementation. The implementation of these measures, in turn, along with the development of medical insurance in our country, will lead to the improvement of the population's health care system and increase in the quality of stable medical services.

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