# THE ESSENCE AND ORIGIN OF MEDICAL INSURANCE

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The health insurance system is implemented in 25 countries of the world, where about 1 billion people live, which is 18% of the world's population. Health insurance is a broader concept than insurance medicine.

Insurance medicine is a type of organization and financing of medical care, a set of medical institutions and personnel that provide medical care under health insurance programs.

Medical insurance is a type of personal insurance in case of loss of health due to illness or as a result of an accident. Medical insurance is used for the purpose of mobilizing and effectively using funds to cover the costs of medical care for policyholders [1].

Health insurance is related to the compensation of citizens' expenses for receiving medical care, as well as other expenses aimed at maintaining health.

The object of medical insurance is the life and health of citizens.

The purpose of medical insurance is to ensure citizens, in the event of an insured event, receive medical assistance at the expense of accumulated funds and financing of preventive measures.

Medical insurance should provide funding for medical care in case of:

- treatment in outpatient polyclinic conditions;
- treatment in hospital conditions;
- purchase of medicines according to doctors' prescriptions;
- provision of dental care and dentures;
- carrying out preventive and health measures;
- provision of other medical services specified in the program or insurance agreement.

The functions of health insurance include: accumulation function, which provides for the formation of a specialized insurance fund; compensatory function involves indemnification of losses in the event of an insurance event. Compensation for damages is possible in the form of providing medical assistance or reimbursement of expenses for payment of medical assistance. The preventive function involves financing and organizing a set of preventive measures to prevent the occurrence of an insured event.

In countries where a system of compulsory health insurance has been introduced, the insured are: for unemployed population - local administration; employers -

enterprises, institutions, organizations; directly persons engaged in individual labor activity; working persons of liberal professions (artists, sculptors, writers, others).

In the system of voluntary health insurance, the insured are: individual citizens who have civil legal capacity; enterprises representing the interests of citizens. [2].

The health insurance system should be divided into three parts:

1) the first part is the planning of minimum funds in the budget, through which provision of free medical supplement is ensured for all categories of the population;

2) the second part is related to the introduction of mandatory medical insurance at the expense of business entities, as well as individuals;

3) the third part - voluntary health insurance - provides for the purchase of an insurance policy by individuals or legal entities at the expense of their own funds.

In order to form a mutually agreed system of medical insurance in international practice, medical insurance is provided in two forms: voluntary medical insurance; mandatory social health insurance.

The choice of the form of health insurance in each country depends on specific economic and cultural-historical conditions, on the characteristics of demographic and social indicators, the level of morbidity and other factors that characterize the general state of health and the level of medical care [3].

Compulsory health insurance is a component of the social insurance system, which is carried out under the conditions and procedure provided by the legislation of the country, in accordance with the rules and the basic program.

Voluntary health insurance is a type of financial and commercial activity that is regulated by the relevant legislation and operates on the basis of contractual relations between the insured and the insurer. The general conditions and procedure for voluntary health insurance are determined by the insurance rules established independently by the insurer, in accordance with the requirements of the Laws of Ukraine "On Insurance" and "Basics of the Legislation of Ukraine on Health Protection".

In most countries of the world, mandatory social health insurance provides medical care, and voluntary health insurance contracts include insurance programs that include both certain types of medical care and medical services [2].

When mandatory and voluntary health insurance operates in the country, every citizen has the right to: mandatory and voluntary medical insurance; free choice of an insurance company, a medical and preventive institution and a treating doctor in accordance with the Contract of compulsory or voluntary medical insurance; receiving medical care throughout the country, including outside permanent registration or residence; receiving medical care in accordance with the principles of evidence-based medicine and clinical protocol; obtaining medical services in accordance with the Medical Insurance Contract; observance of the principles of informed consent, medical secrecy and other principles of bioethics by the insurance company and the medical and preventive care institution; filing a lawsuit against the insured, the insurance company, and the medical and preventive care institution for financial compensation.

At the same time, the insured person is obliged to: deliberately not to create a risk of loss of health; reliably inform the insurer and the medical and preventive care

institution about your state of health, anamnesis data and the results of diagnostic studies in other health care institutions; comply with the doctor's prescriptions and the rules of the internal procedure of the treatment and prevention institution [4].

The history of Social Security has its roots in various church programs to help the poor, charitable organizations, and local governments. In 1349, the Decree on Menial Workers was adopted in England, which introduced the principle of responsibility of local authorities for helping the poor. In the 13th century in the city of Dubrovnik, a contributory health insurance program was announced.

The first organized forms of health insurance were introduced in the Middle Ages in the Netherlands. Guilds provided their members with financial support in case of illness. At the end of the 18th century this function passes to benevolent organizations of the church, employers and doctors. Recently, in order to ensure a certain level of financial security, they began to carry out treatment with further compensation of their costs based on the creation of so-called medical funds, which were financed by contributions from clients: patients, their relatives and employers.

In the following centuries, along with the successive development of the role of the state in social policy, the separation of the functions of the church and the state was observed. In most Western European countries, private and state health insurance systems arose as a result of the realization of society's need to ease the financial burden for an individual in case of illness and to place this burden on society as a whole. A similar task was initially solved by trade unions and mutual aid funds until the beginning of the 20th century. remained almost exclusively managed by the private sector. Then the state began to play an increasingly prominent role in the organization and financing of health care.

Chancellor of Germany Otto von Bismarck and Lord William Beveridge of Great Britain had the greatest influence on the development of the social insurance system.

Chancellor O. Bismarck created a complete social insurance system in less than ten years: law on insurance in case of illness - 1883; the law on insurance against industrial accidents - 1884; the law on old age and disability insurance – 1889.

The system of Laws adopted under the leadership of Bismarck served as the beginning of the wide distribution of the so-called cash medicine in various countries of the world. It is based on an insurance methodology that establishes a parity relationship between the contributions of employees and employers, as well as between payments and contributions.

Bismarck's system is defined by four fundamental principles: provision is based exclusively on labor and is therefore limited only to those persons who managed to win for themselves this right to provision through their labor; compulsory insurance only for those employees whose wages are below the specified minimum amount, i.e. for those who cannot use individual insurance; provision based on the insurance methodology, which establishes a parity relationship between the contributions of employees and employers, as well as between payments and contributions; provision managed by employers and employees themselves.

Workers in certain branches of the economy had to insure themselves in case of illness in a mandatory manner established by law. Insurance funds were formed at the

expense of mandatory insurance contributions of both the employees themselves and their employers. Another series of laws adopted by Bismarck's government formed the social insurance system, the most important and organic part of which was health insurance. The health care system that arose on its basis was called the "Bismarck Health Care System" or insurance medicine [5].

The system of insurance medicine is managed by state authorities, but it is financed, as a rule, from three sources:

1. State subsidies
2. Target contributions of employers
3. Contributions of the employees themselves.

Contributions and social insurance funds are a type of taxes and are under the control of the state. Insurance funds are formed on a targeted basis and are designed for a certain circle of people who participate in the relevant insurance program.

The state legally obliges employers to participate in the payment of medical assistance to employees through hospital funds. Employers pay only part of the cost of medical care provided to employees. The second part of the cost of medical care is paid by the employees themselves. Target contributions are mandatory for all income earners and are paid as a certain percentage of wages (France -16%, Italy -13%, Netherlands -9%, Japan -7%).

The volume of medical services does not depend on material wealth and the amount of contributions to insurance funds. As a result, the rich pay for the poor, the young for the old, the healthy for the sick, that is, the principle of social solidarity applies.

According to the Bismarck system, insurance companies and structures that are subjects of the medical services market are obliged to use all collected funds only for the payment of medical care. The activities of independent insurance funds are managed through state or private insurance companies and are strictly regulated by the state. Doctors are free subjects who offer their services on the market of medical services.

Bismarck's system is the basis of the modern organization of the health care system in Austria, Belgium, Luxembourg, Germany, the Netherlands, France and Switzerland.

The second historical origin of the development of health insurance was the Beveridge model. William Beveridge served as chairman of the Social Security Committee in the British government from 1941. On December 1, 1942, the report "Social Insurance and Allied Services", better known as the "Beveridge Report", was presented to Parliament. The report, in particular, proposed the introduction of social insurance to create a general system of social security and a universal, comprehensive, free national health care service.

Beveridge's model functions in Great Britain to this day. Its main difference from Bismarck's model is that medicine is not financed by insurance contributions, but by taxation. It is based on the transfer system of ordinary insurance principles. Medical care is guaranteed by the state and is provided to all citizens regardless of social and property status. The state extends transfer payments only to people who cannot provide themselves with medical care. Subsidies are provided to persons with low wages, the

unemployed and pensioners. In this model, there is less opportunity to choose service providers and institutions that provide medical care. This often leads to the appearance of long (several weeks of waiting) queues for receiving certain types of medical services.

The Beveridge system is based on the several principles. The principle of universal provision - a complete system of provision for any case, be it a threat to health, individual or family income for all people who find themselves in a difficult situation. So, based on national solidarity and a guaranteed minimum income for all, this policy of social security for the whole society initiated the assertion of the right to work, the right to medical services, the right to a minimum guaranteed income.

The principle of unity in provision includes several concepts, such as: adequate nature of contributions and payments, the same nature of system organization. The principle of unity also meant the unified character of the organization of the system, based on a single contribution to the unified system of national insurance, with the exception of social insurance against accidents at work, as well as family assistance, which was financed from public funds (the state budget) [6].

The principle of integration envisaged the coordination of three main policy areas: social policy based on guaranteed income, health policy and full employment policy, which were implemented by the National Health Service and the State Employment Service. These three pillars of the welfare policy, united together, were supposed to overcome the main factors of social insecurity.

At the same time, in this model there are both insurance principles and co-payments of the population. Thus, in Great Britain, 80% of medical care costs are financed by taxes, 12% by state insurance and another 8% by patient co-payments. The Beveridge system is implemented in Great Britain, Greece, Denmark, Ireland, Italy, Spain, Canada, Norway, Portugal and Finland.

The French model of health insurance is characterized by effective integration with the general social insurance system. The first insurance rules were developed in the time of King Louis XIV. And the first organizations that protected their members from the financial consequences of the disease were mutual aid associations. At the beginning of the XIX century. many attempts were made to establish collective health insurance programs, but health insurance in its modern form began to develop after the adoption and implementation of state insurance programs in 1930.

At first, private insurers provided health insurance only to freelancers who were not covered by state health insurance programs. Naturally, such programs in the first stages provided only limited coverage of treatment costs: the cost of treating an illness or surgery was reimbursed. Private health insurance programs in France have since been expanded, and many now include disability or other insurance. In 1945, the Order of the French government was issued on the introduction of a system of social health insurance for workers in industry and trade, but this initially did not significantly change the situation. Further, the extension of public health insurance programs to the self-employed in 1961 (AMEXA) and in 1969 (TNS) limited the role of private health insurance as a supplemental insurance to reimburse the cost of medical care. Today, the French social insurance system consists of more than 20 different types of

insurance, including medical; by illness; temporary disability; accidents; pregnancy and childbirth [7].

The health insurance system in Switzerland is one of the best in the world. It began to take shape in the 70s of the 19th century, when large factories in the German-speaking part of the country began to create social funds, where workers saved part of their wages to help the sick. In 1911, a decision was made to support the most prosperous cash registers from the national budget.

For Switzerland, health insurance is a relatively new type of personal insurance. It practically did not exist until the beginning of the 30s of the 20th century, and until the end of the Second World War it developed very slowly. By providing daily benefits for loss of earnings, group contracts, which were introduced in the late 1940s, played a significant role in the development of health insurance. In the following decade, personal health insurance became one of the main types of business as a result of the general economic development and the development of the collective bargaining system, which created favorable conditions for companies entering into contracts for insurance of daily benefits [8].

Despite the different historical ways of forming health insurance systems in different countries of the world, they all have common features, namely: patient's free choice of doctor and medical institution; provision of medical care of the same scope and quality to all insured persons according to the principles of evidence-based medicine; state regulation of formation of insurance funds, activities of insurance companies and medical and preventive institutions.

The health insurance systems of different countries of the world are multifaceted and differ in management principles, the nature of financing, ways of attracting patients, and the list of types of medical care and medical services.

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