EFFECTIVE MODELS OF HEALTHCARE FINANCING

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Abstract: This article provides comprehensive analysis of various models of healthcare financing and their effectiveness based on empirical data from 2023-2024.

Keywords: healthcare financing, health insurance, Beveridge model, Bismarck model, universal coverage, health service pricing, government budget, private financing, health economics, healthcare reforms

Healthcare financing represents a critical challenge for modern states balancing universal access to quality medical services against limited public resources. According to World Health Organization data, global healthcare expenditure reached 9.8 trillion USD in 2023, representing 10.8% of world GDP, yet significant variations exist across countries in both spending levels and health outcomes achieved. This paradox underscores the importance of financing model selection and implementation quality. For Uzbekistan, this topic holds particular relevance as the country undergoes fundamental healthcare transformation. Since 2017, Uzbekistan has pursued ambitious reforms transitioning from Soviet-legacy state budget financing characterized by chronic underfunding and inefficiency to a modern mandatory health insurance system. Presidential Decree PQ-4890 (December 2020) established the legal framework for MHI implementation, which began as a pilot in Tashkent in 2021 and extended nationally by 2023. However, critical questions remain regarding whether the chosen Bismarck-type social insurance model is optimal for Uzbekistan's context, how implementation challenges can be addressed, and what international experiences offer relevant lessons. The research addresses the absence of comprehensive academic studies comparing healthcare financing models in the Uzbekistan context and the need for evidence-based policy guidance as the MHI system matures.

The thesis employs mixed-methods design combining quantitative comparative analysis, qualitative case studies, and policy analysis. Quantituve methods include descriptive statistical analysis of healthcare financing indicators across 38 OECD countries examining distributions and variations, correlation and regression analysis investigating relationships between financing model characteristics and performance outcomes, data envelopment analysis assessing technical efficiency by identifying best-performing countries achieving

maximum health outcomes for given expenditure levels, and equity analysis examining financing progressivity and financial protection measured through catastrophic health expenditure rates. Qualitative methods include comparative case study analysis of six representative countries examining historical development, institutional arrangements, financing mechanisms, coverage breadth, benefit packages, provider payment systems, performance indicators, strengths and weaknesses, and recent reforms through document review of government reports, statistical publications, and academic studies.

The Beveridge model achieves highest equity with universal coverage from general taxation but faces budget constraints and longer waiting times, averaging 18 weeks for elective surgery. The Bismarck model demonstrates best overall balance with universal mandatory social insurance achieving excellent health outcomes including Japan's 84.5 years life expectancy while spending 10.5-12.5% of GDP and maintaining strong technical efficiency. The US market model leads in innovation but suffers severe equity problems with 8% uninsured population, 66% of personal bankruptcies due to medical expenses, and highest per capita spending of 12,555 USD yet below-average life expectancy of 78.9 years.

Hybrid models like Singapore achieve remarkable efficiency spending only 4.7% of GDP while achieving 85.1 years life expectancy through combination of mandatory savings accounts, catastrophic insurance, and means-tested government assistance. Second, universal coverage is achievable under different financing models as both tax-funded and insurance-based systems successfully achieve near-universal coverage when politically supported and properly designed through mandatory participation eliminating adverse selection, broad risk pooling ensuring affordability, and adequate funding enabling comprehensive benefits. Third, higher spending does not automatically yield better health outcomes as efficiency analysis reveals the United States spends 2.5 times OECD average yet achieves below-average outcomes while countries spending 4,000-5,000 USD per capita achieve superior results, reflecting factors including fragmented system structure, fee-for-service payment incentives, high administrative costs of 12-18% versus 3-6% in single-payer systems, and neglect of social determinants.

Uzbekistan's MHI implementation shows mixed results with positive developments including coverage expansion from 18% in 2021 to 67% in 2024, reduced out-of-pocket spending from 24.3% to 13.9%, expanded medicine compensation for 235 essential medicines, and increased preventive examination coverage from 48% to 71%, yet significant challenges persist including 33% population remaining uninsured concentrated among informal workers representing 32% of labor force, only 78.4% of planned contributions actually collected due to enforcement weaknesses, limited benefit package excluding expensive treatments,

inadequate provider network with infrastructure deficits particularly in rural areas, and weak information systems with only 42% of facilities having electronic health records.

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