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FEATURES OF ORGANIZATION AND FINANCING OF HEALTHCARE SYSTEMS IN THE WORLD

PhD ***Umarov Hasan***
Westminster International University in Tashkent
ORCID: 0000-0001-5852-9669
ha.umarov@wiut.uz
PhD ***Karaleu Yury***
Westminster International University in Tashkent
ORCID: 0000-0002-7178-7563
ykaraleu@wiut.uz

Abstract. *This article provides a comparative analysis of various healthcare financing models currently used in countries around the world. These models aim to provide the population with access to a wide range of medical services and improve social well-being, which directly impacts labor productivity and economic growth. The article examines in detail the operational features, advantages, and disadvantages of each healthcare financing model.*

Keywords: *financing models, healthcare system, health insurance.*

DUNYODA SOG‘LIQNI SAQLASH TIZIMLARINI TASHKIL ETISH VA MOLIYALASHTIRISHNING XUSUSIYATLARI

i.f.n. ***Umarov Xasan***
Toshkent shahridagi Xalqaro Vestminster universiteti
i.f.n. ***Korolev Yuriy***
Toshkent shahridagi Xalqaro Vestminster universiteti

Annotatsiya. *Ushbu maqolada dunyo mamlakatlarida hozirda qo‘llaniladigan turli xil sog‘liqni saqlashni moliyalashtirish modellarining qiyosiy tahlili keltirilgan. Ushbu modellar aholiga keng ko‘lamli tibbiy xizmatlardan foydalanish imkoniyatini berish va ijtimoiy farovonlikni yaxshilashga qaratilgan bo‘lib, bu mehnat unumdorligi va iqtisodiy o‘sishga bevosita ta’sir qiladi. Maqolada har bir sog‘liqni saqlashni moliyalashtirish modelining operatsion xususiyatlari, afzalliklari va kamchiliklari batafsil ko‘rib chiqiladi.*

Kalit so‘zlar: *moliyalashtirish modellari, sog‘liqni saqlash tizimi, tibbiy sug‘urta.*

ОСОБЕННОСТИ ОРГАНИЗАЦИИ И ФИНАНСИРОВАНИЯ СИСТЕМ ЗДРАВООХРАНЕНИЯ В МИРЕ

к.э.н. ***Умаров Хасан***
Международный Вестминстерский университет в городе Ташкенте
к.э.н. ***Королев Юрий***
Международный Вестминстерский университет в городе Ташкенте

Аннотация. *Данная статья посвящена сравнительному анализу различных моделей финансирования здравоохранения, применяемых сегодня в разных странах мира, в целях обеспечения населения доступа к широкому перечню медицинских услуг, повышения благосостояния общества, что непосредственно влияет на производительности труда и экономический рост. В статье подробно рассматриваются особенности функционирования, а также преимущества и недостатки каждой из моделей финансирования здравоохранения.*

Ключевые слова: *модели финансирования, система здравоохранения, медицинское страхование.*

Introduction.

Protecting and promoting of the public health is one of the fundamental roles of the government to ensure social stability and the well-being of an entire population as well as to increase life expectancy and decrease of infant mortality rates in the country. This role of the government is fixed in the Constitution of many countries of the world.

At the same time, creation of well-functioning healthcare system with timely access to health services for population requires sufficient financial resources from governments. They are engaged not only on consistently expanding coverage of free medical care, rationalizing funding sources and resource allocation methods, but also on improving healthcare system in general in order to improve its efficiency and proper management of costs.

Literature review.

The study's objects were data from the authors' scientific publications, obtained from online sources, as well as WHO and UNDP reports, characterizing the organization of healthcare systems and drug supply in various countries. The historical aspects of the development of insurance-based medicine are examined in detail in the works of Kachaeva and Dey (2015). The authors trace the evolution of health insurance from elements of mutual assistance in ancient civilizations to modern compulsory medical insurance systems, emphasizing the key role of the state in shaping the regulatory framework and institutional structure of healthcare.

Scientific literature from Western countries analyzes the specifics of national healthcare systems. For example, Ridic, Gleason, and Ridic (2012) compare the healthcare models of the United States, Canada and Germany in terms of efficiency and social equity. The authors demonstrate that the Canadian system, based on a single public insurer and tax financing, ensures universal coverage and minimal direct patient costs, but faces problems with waiting lists and limited access to high-tech medical care. In contrast, the US system, which relies primarily on private insurance, is characterized by high costs and a significant proportion of the population without comprehensive insurance coverage.

The paper of the Hajo Zeeb, Julika Loss and other (2025) co-authors provides a comprehensive overview of the German public health system, including its structure, history, strengths, and weaknesses and suggests areas for improvement. Although the German healthcare system is a benchmark for many countries worldwide, it faces systemic challenges in public health and preventive care. The authors emphasize that without systematically strengthening preventive care, Germany will continue to spend increasingly more on healthcare without improving public health.

According to research by Russian author Arkhipov (2023), compulsory health insurance plays a crucial role as the primary source of funding for healthcare, ensuring widespread population coverage, sustainable financial flows and the principle of solidarity. However, this system also may lead to reduced incentives for resource conservation and increased inefficient spending.

Research methodology.

The methods of logical and structural analysis, grouping, economic and statistical analysis, mutual and comparative comparison were effectively used in the implementation of the set research objectives.

To achieve this goal, empirical and comparative methods of scientific research will be used.

Analysis and discussions.

To ensure that a broad segment of the population receives a minimum guaranteed level of free medical care, countries rely on a variety of sources – incomes taxes, broader-based value-added taxes or insurance premiums from natural and juristic persons. Based on the

dominant method of financing healthcare systems, nowadays three basic models of healthcare delivery are distinguished in the world:

1) **"Bismarck model"**: this model was named after the first Reich Chancellor of Germany – Otto von Bismarck – who is considered as the founder of health insurance in the world. During his ruling, he introduced 3 laws, aimed at protection of the working class: the "Workers' Sickness Insurance Law" (15.06.1883), the "Accident Insurance Law" (06.07.1884), and the "Disability and Old-Age Insurance Law" (22.06.1889).

The essence of the budget-insurance model is to fund healthcare system from the state budget and insurance contributions of both employers and employees. Medical services are provided by private and public health care institutions, which are financed through special insurance funds (so-called "Krankenkasse" or "sickness funds") of insurance companies. These funds are primarily funded by employers and employees. The state's role is limited to regulating the activities of these funds and make contributions to these funds only on behalf of unemployed citizens.

Under this model, health insurance is mandatory for all citizens and is based on the principle of social solidarity. It means that insurance premiums are paid by all citizens in varying amounts depending on their income level, while an access to medical services through sickness funds for them is provided only when illness occurs.

This method of financing the healthcare system is now successfully operating in many countries, including Germany, Belgium, the Netherlands, Luxembourg, Austria, France and other countries. The main advantage of this module is the creation of a special medical fund that is targeted and therefore independent of political circumstances. Besides, participation of insurance companies, which often operate in highly competitive conditions, encourages them to improve the quality of services provided to clients. At the same time, high administrative costs of insurance companies and eventually rising cost of providing medical care place additional pressure on the sickness funds. It is becoming a significant burden in certain countries, which experience shrinking of funding due do decrease of working-age population in combination with increase of costs due to rise of elderly population.

2) **"Beveridge model"**: this model got its name in honor of the English economist William Beveridge, who in 1942 published a government report entitled "Social Insurance and Allied Services". His proposal was to provide free medical care to the population exclusively at the expense of the state budget without putting any additional pressure on natural and juristic persons. It is noteworthy that William Beveridge drew his inspiration from the experience of the USSR, where, under the leadership of N.A. Semashko in the 1930s, a centralized healthcare system with unified organizational principles was established, guaranteeing universal and free access to medical services for all citizens.

According to this model, most hospitals and clinics are publicly owned. Private healthcare facilities are permitted to operate, and their services may be paid for by the state after preliminary approval on the side of the state authorities. The state acts as both a purchaser and provider of healthcare services through public healthcare facilities, exerting strict control over most aspects of the medical goods and services market, determining pricing, etc.

Today, in addition to the UK, this healthcare financing model is used by Spain, Portugal, Denmark, Norway, Finland and some other countries, where healthcare is financed and controlled by the state, which helps to control the growth of costs for medical services and medicines, ensure the principle of equality for all citizens.

3) **a private healthcare model**, in which medical services are provided to citizens on a fee-for-service basis, financed by the individuals themselves or their employers via insurance policies. In this model insurance companies play a key role in financing the healthcare system and the government's role is limited to the regulation of the activities of insurance companies, including their solvency ratios, customer satisfaction, etc. In some cases, the government assumes responsibility for medical coverage for vulnerable groups of citizens (the poor, the

unemployed, etc.).

Under this model, public and private medical institutions provide medical care to patients under various insurance programs. These programs are governed by the terms of the insurance contract, concluded with each patient (policyholder). High competition among insurers in the medical services market positively impacts the quality of medical services and customer service. However, this primarily affects wealthier citizens, who pay high insurance premiums in exchange for a broader range of medical services. This represents the major drawback of this model, which may leave people with low-income level or with high morbidity risks without adequate health insurance coverage.

This method of financing the healthcare system is operating in the USA, Israel, South Korea and other countries. The USA is the biggest market in terms of per-capita health spending, which uses the private healthcare system. Around 85% of population is covered by either public (Medicare and Medicaid programs) or private health insurance. Private health coverage is employment related, largely due to the cost savings associated with group plans. It leaves around 15% of the population (45 million people) without any coverage. It is noteworthy that the murder of Brian Thompson, CEO of the largest health insurance company, UnitedHealthcare, on December 4, 2024, in New York City, sparked a storm of speculation about the killer's motives, expressed in dissatisfaction with the work of health insurers and the healthcare system in the USA.

Table 1.

Advantages and disadvantages of different models

	Advantages	Disadvantages
Bismarck model	Formation of funds on a targeted basis	No budgetary restrictions on the cost of treatment
	The relationship between the insurer and the policyholder is on a contractual basis	A deficit in insurance funds as the number of pensioners grows and the share of the working-age population declines
	Funding is less dependent on political circumstances	Increase in insurance premium rates
	The patient's choice of doctor	Higher administrative costs
	Transparency of funding	Providing more expensive and not always necessary medical services to patients (clients)
	Control over the use of resources allocated for payment of medical care	Increased insurer spending on marketing, advertising, etc.
	Competition between insurers providing compulsory medical insurance	Low level of preventive and anti-epidemic measures
Beveridge model	Free of charge	Dependence of the system on political priorities
	Public accessibility	Increasing complexity of control over the activities of medical institutions
	Planned development	Growing shortage of medical services
	Preventive focus	Long queues and excessive bureaucratization
	Economy	Restriction of the medical services market
Private healthcare model	Financial and legal independence	High cost of medical services
	Competition between medical organizations to improve medical services	Lack of access to assistance for low-income groups
	Effective resource management	Prescribing unnecessary procedures in order to collect more money
	Greater sensitivity to user needs	Lack of a system of preventive and anti-epidemic measures, home care
	Flexible access, shorter waiting	Insufficient quality control of medical care

Source: *prepared by the authors.*

It's impossible to definitively state which model is the most optimal for implementation in any given country. Each model has its own advantages and disadvantages (see Table 1). It is up to any state to choose which model to implement in the country based on its historical context, political and cultural needs, social preferences, level of economic development, available resources and many other factors. Some countries use mixed financing model, whereby the state provides the population with basic medical services free of charge through compulsory medical insurance. All other medical services, not covered by the CMI program, are purchased out of pocket by citizens through various voluntary health insurance schemes. Thus, these two forms of health insurance exist in parallel and complement each other, ensuring coverage for almost all types of illnesses.

What can be said for sure is that the state plays the central role in each model in terms of organization and operation of the healthcare system due to the social significance of this sector. Its involvement can be fundamental, as in the "Beveridge" model, where the state exercises almost complete control over all aspects of the healthcare sector, or indirective as in the private healthcare model.

It is noteworthy that COVID-19 exposed fragility of all three models, revealing the shortages of health workers and funding sources, challenges with accessibility, quality and resilience of health services. It also highlighted the critical importance to focus not only on who pays and finances the healthcare system, but also on prevention measures, importance of improving workforce productivity and digitalization factors to improve operational processes and as part of cost-saving strategies. On the one hand, life expectancy is increasing in the world, which reflects improvements in medical technologies. On the other hand, birth rates are declining. This demographical shift places a growing demand on health and long-term care services as well as increase of health expenditure and financing. In this context, healthcare financing models should increasingly be assessed through their ability to support resilient health systems, capable of absorbing shocks while maintaining continuity of care. This requires a reorientation from predominantly curative care approach toward preventive and primary healthcare, better integration of health and social care services, and the more efficient use of limited human and financial resources.

Furthermore, digital transformation offers significant potential for further development of the healthcare system and can play a critical role in reducing administrative burdens, enhancing clinical decision-making and enabling more patient-centered care. For those people, who live in isolated or remote areas, can get online access to medical services via telemedicine. Implementation of electronic health records, data analytics and artificial intelligence may also allow to improve both efficiency and accessibility of healthcare services without proportional increases in expenditure.

Conclusion & Suggestions.

This study demonstrates that no universal healthcare financing model exists, as each system reflects a country's historical background, economic capacity and social priorities. The comparative analysis of the Bismarck, Beveridge and private healthcare models shows that while they differ in funding mechanisms and institutional arrangements, all face growing challenges related to population ageing, rising healthcare costs and workforce shortages.

The COVID-19 pandemic further revealed structural vulnerabilities across all models, underscoring the importance of prevention, workforce productivity and digital transformation in improving system resilience and cost efficiency. In practice, most countries increasingly rely on mixed financing models that combine compulsory health insurance with voluntary schemes to ensure broader coverage and financial sustainability.

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