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Does it matter how we finance healthcare systems?

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In many countries in the world, governments are considering reforming their health financing systems – the way in which they collect and spend funds for healthcare. This is especially the case in low- and middle-income countries (LMICs) as they try to make progress towards universal health coverage (UHC) which aims to ensure populations receive the healthcare they need, without suffering financial hardship.

Funds that pay for healthcare services can come from government taxes, contributions from individuals and employers through both social and private health insurance, or from people paying directly with their own money. Health financing schemes then spend these funds. Each source of funding differs in terms of the contribution made by citizens. Government funding is a non-contributory health financing scheme (i.e., individuals can use healthcare services based on their residence or citizenship, regardless of contributions). Compulsory or social health insurance (SHI) is a contributory health financing scheme (i.e., only individuals who paid a contribution to the insurance scheme can use healthcare services). Finally, out-of-pocket (OOP) funding does not involve prepaid contributions at all, as individuals just pay for the healthcare services they need.

We used data from 124 countries between 2000 and 2017 to investigate how changes in the type of health care financing system funding affected health system outcomes. The outcomes included the extent of healthcare service coverage, life expectancy and the risk of having to make catastrophic health expenses. We first classified each country and year by the "predominant" health financing system operating at the time: non-contributory government financing, contributory SHI, or OOP. We then explored the effect on the health system outcomes of transitioning from OOP-predominant to SHI- or government financing-predominant health financing systems.

While we cannot account for all the potential biases in our analysis, we found it likely that transitions from OOP-dominant to government-financed systems improved most outcomes as compared to transitions to SHI systems. Transitions to government financing increased life expectancy by 1.3 years and reduced mortality in children under 5 years old by 8.7%. It also reduced the chance of incurring catastrophic health expenditure by 3.3 percentage points. These results were significantly better than when countries moved towards SHI funding. This may be because SHI is more expensive to implement and does not always cover all citizens, especially in LMICs where many people work in the informal sector rather than having formal employment Policymakers should therefore be cautious about relying too much on contributory SHI financing to reach universal health coverage goals.

Read the article in the journal Health Economics.

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