

How to Sustainably Finance Universal Healthcare

To achieve [universal health coverage](#), a country needs a healthcare system that provides equitable access to high-quality healthcare, which requires sustainable financing over the long term. Publicly provided healthcare should be on the basis of need, a citizen's entitlement for all, regardless of means.

Health Inequalities Growing

But recent decades have seen healthcare trending towards a two-tier system—a perceived higher-quality private sector and lower-quality public services. One typical consequence is that medical doctors, especially specialists, are leaving public service for much more lucrative private practice.

This 'brain drain' has led to longer waiting times and complaints of deteriorating public service quality, as more people with means turn to private facilities. As costs in private hospitals are high and increasing, this causes those who can afford private health insurance to turn to it to hedge their bets.

If these trends are not checked, gaps between private and public health sectors, in terms of charges and quality, will grow. This increases polarisation in access to quality healthcare between haves and have-nots.

Healthcare Financing

Financing arrangements are key to developing an equitable healthcare system that is financially sustainable in the long run.

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For universal coverage and equitable access, health financing should be based on social solidarity through cross-subsidisation, with the healthy financing the ill and the rich subsidising the poor.

Experience the world over shows health markets commonly exhibit deficiencies, both in financing and providing healthcare. Furthermore, heavy reliance on market solutions has contributed to spiralling costs and constrained healthcare access.

Private Health Insurance

A voluntary private health insurance (PHI) scheme cannot be financially viable in the long term as individuals with lower health risks are less likely to buy insurance from a scheme which they see as primarily benefiting those who are less healthy.

Since voluntary schemes are usually based on PHI, government support for such schemes would strengthen these companies. There

are good reasons to be wary of the growing influence of PHI interests in healthcare financing discussions.

Premiums for PHI are risk-rated, meaning that individuals with pre-existing conditions and higher risks—such as the elderly, or those with family histories of illness—will face un-affordably high premiums or be denied coverage.

'Moral hazard' and 'supplier-induced demand' in a 'fee-for-service' reimbursement system encourages unnecessary investigations and overtreatment or costly monitoring to limit such abuse. Hence, PHI companies use 'managed healthcare' services to contain costs by limiting investigations and treatments.

Voluntary PHI schemes charge high premiums while fee-for-service payments escalate costs, which inevitably raises premiums. As a matter of example, the US spends the most on health in the world but with surprisingly modest health outcomes to show for it.

Much public expenditure is needed to insure the poor, especially those with prior health conditions. Achieving Universal Healthcare (UHC) would require costly public subsidisation of such profitable arrangements. This would not be cost-effective, let alone equitable.

Government support for PHI companies would strengthen their growing presence and influence, typically involving transnational insurance conglomerates. PHI companies are likely to try to undermine others who threaten their interests.

Social Health Insurance

Unlike voluntary PHI, social health insurance (SHI) is usually mandatory to cover the entire population. Although often proposed and promoted with the best of intentions, the limitations and [problems of SHI](#) are also important to consider.

SHI would effectively require collecting an additional ‘payroll tax’ from the public. This could be designed with various distributional consequences. A progressive policy in this sense could very well end up being regressive. As an additional tax would reduce levels of take-home incomes, SHI schemes have been difficult to introduce.

Like PHI, SHI also has inherent tendencies for overtreatment and cost escalation due to ‘moral hazard’ and ‘supply-induced demand’. These require costly, strong and typically bureaucratic administrative controls.

Surviving SHI schemes owe their ‘success’ to specific reasons. As an example, Germany’s SHI evolved from its long history of union-provided health insurance. But [most working people in developing countries](#) are not in formal employment, let alone unionised. Hence, SHI would have difficulty gaining broad acceptance there.

In any case, countries like Germany with previously effective SHI systems are shifting towards increased revenue-based healthcare funding. This shift is in response to the decline in formal employment and unionisation, which is occurring due to changing labor dynamics.

Under SHI, government funds would still be required to provide coverage for the impoverished and the indigent. It is difficult to collect premiums from the self-employed or casual and informal workers who are not on regular payrolls. But

universal coverage would not be achieved without including them.

Revenue-Financed Healthcare

Inherited revenue-based healthcare financing is basically sound and should not be replaced due to other healthcare system problems. In most societies, revenue-sourced healthcare financing can be retained, reinforced and improved by:

- increasing government healthcare allocations
- reducing ‘leakages’ by eliminating waste, corruption, ‘cronyism’, etc.
- promoting ‘developmental governance’, competitive bidding, etc.
- raising government revenue, especially from more progressive taxation, e.g., wealth, ‘windfall’ and ‘sin’ taxes, especially on activities that worsen health risks, such as tobacco and sugar consumption.

Revenue-Financing Is Better

Revenue-financing avoids many of the administrative costs incurred by PHI and SHI. It has no need for an elaborate parallel system, costly mechanisms or numerous staff to register, track and pay SHI contributors and beneficiaries, or prevent self-serving, opportunistic behaviour.

Compared to PHI, SHI seems like a step forward for countries with weak or non-existent public healthcare systems. But moving from revenue-financing to SHI would be a step backwards in terms of both equity and cost-effectiveness.

SHI requires additional layers of healthcare system administration—to enrol, collect, ascertain coverage, determine benefits and make payments—which incur unnecessary costs compared to revenue-financing.

Hence, such insurance systems involve much more per capita health spending, raising it by 3–4 per cent. Despite being much more costly than revenue-financed systems, they do not have better health outcomes.

As SHI effectively imposes a payroll tax, it discourages employers from hiring employees with ‘proper’ labour contracts. Hence, SHI was estimated to reduce formal contracts by 8–10 per cent and total employment by 5–6 per cent in rich countries.

International evidence clearly shows that progressive tax-funded public health systems are [more equitable, cost-effective and beneficial than SHI](#). Public health programmes that need popular participation, such as breast or cervical cancer screening, have worse outcomes with SHI compared to revenue-financing.

A better system can be achieved by improving or developing a revenue-funded healthcare system, with additional resources deployed to expand and enhance primary healthcare and better service conditions for medical personnel.

Strengthening public healthcare services can do much, not only to improve staff working conditions but also morale and pride in their work.

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