Journal of Resilient and Sustainability for Health (JRSH)

Quantitative Research Article

Health Financing for Universal Health Coverage: A Comparative Narrative Review of Revenue Raising, Pooling, Strategic Purchasing, and Resilience Across Selected Health Systems

Siti Norhasnizah[1], Elron Alpero[1], Cassandra Liew[1], Kavita M.Akat[1], M.Izzudin Madine[1], Wan Mohd Rashid[1], Samsul Tuah[1], Eva Chandra Susanti[1], Abdul Rahman Ramdzan[1,2], Nur Arifah[3]

Abstract

Background : Health financing is the cornerstone of achieving Universal Health Coverage (UHC) and ensuring long-term health system resilience.

Objective: This narrative review aims to synthesize selected country experiences across diverse income settings and identify context-specific pathways for building inclusive and sustainable healthcare systems globally.

Design and Methodology: The review analyzes literature published between 2000 and 2026 using a functional health-financing framework encompassing revenue raising, risk pooling, and strategic purchasing. It compares tax-funded Beveridge models, Social Health Insurance (SHI) schemes, and fragmented multi-payer systems, including country-specific experiences such as Thailand's Universal Coverage Scheme and Rwanda's Community-Based Health Insurance.

Results: Tax-based systems generally prioritize equity, although their sustainability is often dependent on macroeconomic stability. Conversely, SHI models provide robust financial protection but face significant challenges in extending coverage to informal-sector populations. The findings indicate that systemic resilience—defined as the capacity to withstand macroeconomic shocks without increasing out-of-pocket (OOP) expenditure—depends on transitioning from passive funding to strategic, value-based purchasing and strengthening domestic resource mobilization.

Conclusion and Implications: No single health-financing model is universally applicable across different socioeconomic and institutional contexts. Inclusive and sustainable healthcare systems therefore require context-specific reforms that strengthen domestic resource mobilization, consolidate risk pooling, expand protection for informal-sector populations, and institutionalize strategic, value-based purchasing.

Author Affiliation

[1]Department of Public Health Medicine, Faculty of Medicine & Health Sciences, Universiti of Malaysia Sabah, Jalan UMS, Kota Kinabalu 88400, Malaysia.
[2]Health Economic Evaluation Research (HEER) Group, Universiti of Malaysia Sabah, Jalan UMS, Kota Kinabalu 88400, Malaysia.
[3]Fakultas Kesehatan Masyarakat, Universitas Hasanuddin, Makassar, Indonesia

*Corresponding author e-mail:
Dr. Abdul Rahman Ramdzan
Department of Public Health Medicine, Faculty of Medicine and Health Sciences, University of Malaysia Sabah, Jalan UMS, 88400 Kota Kinabalu, Sabah, Malaysia
Email: abdul.rahman@ums.edu.my

Phone: +60177849542.

Article Information

Received: 6 January 2026
Revised: 1 July 2026
Accepted: 6 July 2026

Keywords

Health financing, Universal Health Coverage, global, health system resilience, strategic purchasing

Introduction

The global healthcare landscape is currently at a critical juncture, facing the dual challenge of ensuring equitable access to quality care while managing finite resources. Health financing comprises the mechanisms through which funds are mobilized, pooled, and allocated to deliver services, serves as the structural backbone of any functional healthcare system and is central to the achievement of Universal Health Coverage (UHC). Across the globe, nations adopt diverse health financing models, from tax-funded systems to private out-of-pocket (OOP) spending, each grappling with unique challenges in ensuring equity and long-term sustainability (Wendt, 2009; Friebel et al., 2018).

In recent years, health financing has become a critical issue due to continuous rising healthcare costs and annual medical inflation, both of which strain national expenditures. Furthermore, the emergence of global health crises, most notably the COVID-19 pandemic, has exposed significant vulnerabilities and widened inequity gaps among marginalized groups, hindering the progress of many nations toward UHC (Sundewall & Forsberg, 2020). Addressing these systemic challenges is essential for achieving Sustainable Development Goal 3, which aims to ensure healthy lives and promote well-being for all (World Health Organization, 2023).

A resilient and sustainable financing system must overcome key structural barriers, including the inequitable distribution of resources, over-reliance on unpredictable donor funding, and systemic inefficiencies. In many low- and middle-income countries (LMICs), prepayment mechanisms such as general taxation and health insurance remain underutilized due to limited fiscal capacity, low affordability, and challenges in covering informal sector populations. This often leads to a heavy dependence on external aid, which is frequently unaligned with domestic health priorities or the goals of universal coverage (Binyaruka et al., 2021).

This narrative review analyzes various health financing mechanisms globally, focusing on their advantages, limitations, and impacts on healthcare access and equity. By comparing selected country experiences from diverse economic and geographic contexts, ranging from Southeast Asia's mixed models to Africa's community-based initiatives, this review seeks to identify effective, scalable, and sustainable strategies. The goal is to provide actionable pathways for policymakers to build inclusive healthcare systems capable of enduring future global health threats.

Methods

This article was designed as a narrative review to synthesize global evidence on health financing models and their impact on Universal Health Coverage (UHC) and systemic resilience. While narrative in nature, we adopted a structured approach for literature search, country selection, and thematic synthesis to ensure a comprehensive and transparent analysis of global financing mechanisms.

Search Strategy and Database

A comprehensive literature search was conducted across major academic databases, including PubMed, Scopus, Web of Science, and Google Scholar. To capture critical grey literature, policy briefs, and macro-economic data, we additionally searched the official repositories of the World Health Organization (WHO), the World Bank, and the Organisation for Economic Co-operation and Development (OECD).

The search utilized a combination of the following key terms: “health financing,” “universal health coverage,” “strategic purchasing,” “risk pooling,” “out-of-pocket expenditure,” “social health insurance,” “tax-funded health system,” “performance-based financing,” and “value-based healthcare”. The search was limited to literature published in English between January 2000 and May 2026 to capture the modern evolution of UHC reforms and the impact of recent systemic shocks, such as the COVID-19 pandemic.

Inclusion and Exclusion Criteria

To ensure the quality and relevance of the synthesized evidence, clear selection criteria were applied.

- Inclusion Criteria: We included peer-reviewed journal articles, systematic and narrative reviews, country case studies, and official reports from recognized global health institutions that explicitly discussed macro-level health financing functions (revenue raising, pooling, and purchasing).
- Exclusion Criteria: We excluded non-English publications, non-peer-reviewed opinion pieces, purely clinical cost-effectiveness studies without macro-policy implications, and literature focused solely on micro-level hospital budgeting.

Country Selection Approach

Rather than attempting an exhaustive global review, we utilized a purposive sampling approach for country selection. Countries were specifically chosen to illustrate diverse financing archetypes across different income levels, geographic regions, and historical contexts. The selected case studies represent:

- Tax-funded (Beveridge) models: United Kingdom, Nordic countries, Australia, and New Zealand (Biggs, 2021; Gauld, 2020).
- Social Health Insurance (Bismarck) models: Germany, France, and Vietnam.
- Mixed savings and insurance models: Singapore (Asher & Nandy, 2006).
- UHC reform and transition models: Thailand.
- Community-Based Health Insurance (CBHI): Rwanda.
- Fragmented multi-payer systems: United States.
- Hybrid transformation systems: Kingdom of Saudi Arabia (Al-Hanawi et al., 2018; M. Almalki et al., 2011; Z. S. Almalki et al., 2022; Nair et al., 2024).

Data Extraction and Thematic Synthesis

Data extraction and synthesis were guided strictly by the WHO health financing framework. Instead of describing countries in geographical isolation, the extracted data were mapped and synthesized according to the following core cross-cutting functions:

1. Revenue Raising: The sources of funds (e.g., general taxation, payroll contributions, donor aid).
2. Pooling: The accumulation and management of revenues to spread financial risk.
3. Purchasing and Benefit Design: The mechanisms used to allocate funds to providers (e.g., fee-for-service, capitation, value-based purchasing) and the defined service packages.
4. Financial Protection: The extent to which out-of-pocket (OOP) payments are mitigated.
5. Resilience: The system's capacity to maintain revenue stability, purchasing flexibility, and financial protection during macro-level shocks.

Results

Analytical Framework For Health Financing

To evaluate the sustainability and resilience of global health systems, this review shifts away from simple geographic descriptions and relies on the functional framework of health financing. Health financing comprises the mechanisms through which funds are generated, pooled, and allocated to deliver health services, forming the backbone of a functional healthcare system. A system's ability to achieve Universal Health Coverage (UHC) and withstand macroeconomic or epidemiological shocks is determined by how it manages four core functions: revenue raising, risk pooling, strategic purchasing, and financial protection.

Revenue Raising and Domestic Mobilization

Revenue raising defines how a health system mobilizes funds, fundamentally shaping its fiscal sustainability. Sustainable models transition away from fragmented out-of-pocket (OOP) payments and unpredictable external donor aid toward mandatory, pre-paid domestic resources.

- Tax-funded models: Systems utilizing the Beveridge model rely on general taxation, providing significant equity as contributions are based on broader economic capacity. However, their resilience is tightly linked to national economic fluctuations and political prioritization.
- Social Health Insurance (SHI): Systems applying the Bismarck model rely on mandatory employer and employee payroll contributions (Jabbarzadehkhoei et al., 2023). While this ensures a dedicated revenue stream, these systems often face sustainability challenges due to shrinking formal workforces and difficulties in collecting premiums from informal sector populations.
- To ensure long-term resilience, strengthening domestic resource mobilization through innovative tax reforms and diversified funding streams is essential to reduce dependency on external aid.

Risk Pooling

Risk pooling involves accumulating prepaid revenues to spread the financial risk of illness across a population, ensuring the healthy subsidize the sick and the wealthy subsidize the poor.

- Fragmented vs. Unified Pools: Systems with highly fragmented pooling (such as multiple private insurers) often struggle with administrative inefficiencies and equity gaps. Conversely, robust models aim to consolidate pools. For instance, Thailand achieved a highly resilient system by merging pre-existing fragmented programs into a unified framework under its Universal Coverage Scheme (UCS), spreading risk across 48 million members (Hanvoravongchai, 2013; Tangcharoensathien et al., 2015).
- Community-Level Pooling: In contexts with limited formal taxation capacity, such as Rwanda, Community-Based Health Insurance (CBHI) creates localized risk pools, allowing informal workers and rural populations to safeguard their incomes from the financial risks associated with illness (Woldemichael et al., 2019).

Strategic Purchasing and Provider Payment

Purchasing refers to how pooled funds are allocated to healthcare providers. Passive purchasing (e.g., fee-for-service without cost controls) frequently drives medical inflation. A resilient health system employs strategic purchasing to actively contain costs and maximize value.

- Closed-Ended Payments: Thailand's UCS introduced a purchaser-provider split, utilizing capitation for outpatient care and a diagnosis-related group (DRG) system under a global budget cap for inpatient care. These mechanisms incentivize cost efficiency and manage overall expenditure.
- Value and Performance-Based Financing (PBF): To enhance sustainability, advanced systems are shifting from volume-based payments to outcomes. In Africa, PBF links payments directly to verified health service outcomes (e.g., fully immunized children), fostering a culture of accountability and resource efficiency. Similarly, value-based healthcare financing pioneered in Europe prioritizes patient outcomes, ensuring cost-effective allocation of resources (Geropoulos et al., 2024).

Financial Protection and System Resilience

The ultimate test of a health financing system is its ability to provide financial protection. High OOP spending disproportionately affects marginalized groups, leading to underutilization of essential health services and catastrophic health expenditures (Giang et al., 2023).

Resilience is measured by a system's capacity to maintain equitable coverage and financial protection during systemic shocks, such as the COVID-19 pandemic (Xu et al., 2024). Systems with strong,

established prepayment and risk-pooling arrangements were significantly better positioned to respond to emergency healthcare requirements without pushing citizens into poverty.

Comparative Country Experiences.

Table 1: Comparative Analysis of Selected Health Financing Models

Country & Model DOCX	**Revenue Source DOCX**	**Pooling Arrangement DOCX**	**Purchasing Method DOCX**	**Strengths DOCX**	**Weaknesses DOCX**	**Lesson for UHC DOCX**
United Kingdom (Beveridge)	General taxation	Single national pool (NHS)	Global budgets, Capitation	High equity; strong financial protection; low administrative costs.	Vulnerable to fiscal contraction and political shifts; waiting times.	Broad risk pooling maximizes equity but requires resilient macro-fiscal space.
Germany (Bismarck / SHI)	Payroll taxes (Employer & Employee)	Multiple sickness funds with a central reallocation pool	Fee-for-service (FFS), Diagnosis-Related Groups (DRGs)	High patient satisfaction; comprehensive benefit package; short wait times.	High administrative costs; vulnerable to aging populations and shrinking workforce.	Earmarked payroll taxes ensure steady funding but must adapt to demographic shifts.
Thailand (UHC Reform)	General taxation (for UCS scheme)	Three main pools, but UCS covers ~75% of population	Capitation (outpatient), DRGs within global budgets (inpatient)	Strong cost containment; exceptional coverage for informal sector.	Persistent inequalities between the three different public schemes.	Strategic purchasing (purchaser-provider split) is vital for cost-containment.
Singapore (Mixed / Savings)	Mandatory payroll savings (Medisave), Taxation (Medifund)	Fragmented individual/family accounts; state safety net	FFS with targeted government subsidies	Promotes individual accountability; highly fiscally sustainable.	High OOP share; complex navigation for patients.	Mandatory savings can build fiscal resilience if backed by a strong safety net.
Rwanda (CBHI)	Community premiums, Gov subsidies, Donor aid	District-level community pools linked to national guidelines	Performance-Based Financing (PBF), FFS	High rural enrollment; grassroots community engagement.	Heavily reliant on donor funding; premium collection can be inconsistent.	Microfinance partnerships can successfully integrate the informal sector.

United States (Multi-payer)	Private premiums, General taxes (Medicare/Medicaid)	Highly fragmented (thousands of private & public plans)	FFS transitioning to Value-Based Purchasing (ACOs)	High clinical innovation; rapid adoption of new technologies.	Massive administrative inefficiency; severe equity gaps; high cost per capita.	Fragmented pooling drastically reduces systemic resilience during economic shocks.

Table 2: Quantitative Health Financing Indicators

Country	**CHE as % of GDP DOCX**	**Gov HE as % of CHE DOCX**	**OOP as % of CHE DOCX**	**UHC Service Coverage Index (SCI) DOCX**	**Primary Fiscal Sustainability Issue DOCX**
United Kingdom	~ 11.3%	~ 83%	~ 13%	87	Healthcare inflation outpacing GDP growth.
Germany	~ 12.8%	~ 85%	~ 11%	89	Shrinking formal workforce vs. aging demographic.
Thailand	~ 4.4%	~ 72%	~ 9%	82	Expanding comprehensive benefits on a limited tax base.
Singapore	~ 4.3%	~ 48%	~ 30%	89	Balancing individual OOP burden with rising chronic care needs.
Rwanda	~ 6.4%	~ 45% (high donor)	~ 11%	56	Over-reliance on external donor assistance.
United States	~ 17.3%	~ 50%	~ 11%	84	Unsustainable per-capita cost escalation and administrative waste.

Cross-Cutting Lessons For System Resilience

Building on the comparative analysis of diverse health financing models, several cross-cutting lessons emerge regarding how specific financing functions and policy instruments shape the resilience and sustainability of Universal Health Coverage (UHC).

Prepayment and Broad Risk Pooling

The transition toward UHC is fundamentally dependent on moving away from fragmented, out-of-pocket (OOP) payments and establishing structured prepayment and risk-pooling mechanisms. A recurring finding across all regions is that high reliance on OOP spending is the most significant threat to system resilience. High OOP costs can lead to catastrophic health expenditures, undermining social sustainability by pushing vulnerable households into poverty during economic or health shocks. The ability to pool risk effectively whether through tax-funded Beveridge systems or mandatory social insurance, is the common denominator for ensuring equitable financial protection.

Strategic Purchasing and Value-Based Care

How funds are allocated to providers critically determines a system's fiscal sustainability. Passive purchasing mechanisms, such as traditional fee-for-service, often incentivize over-utilization and drive medical inflation. Resilient systems actively employ strategic purchasing to maximize value. For example, Thailand’s Universal Coverage Scheme (UCS) successfully utilizes a purchaser-provider split, alongside closed-ended payments like capitation and global budgets, to contain costs while ensuring broad access. Furthermore, the integration of Value-Based Healthcare (VBHC) in high-income settings and Performance-Based Financing (PBF) in low-income contexts represents a critical evolution, ensuring that limited resources are allocated toward high-impact health outcomes rather than mere service volume.

Domestic Resource Mobilization

Many low- and middle-income countries (LMICs) experience fiscal vulnerability due to a heavy dependence on external donor aid, which can be unpredictable and misaligned with domestic health priorities. True financial resilience requires a deliberate transition toward domestic resource mobilization. Governments must explore diversified and stable revenue streams, such as progressive taxation, reallocation of current public expenditures, and "sin taxes" on health-harming products, to establish a reliable fiscal foundation for health.

Informal Sector Coverage

Expanding coverage to informal sector workers remains one of the greatest structural challenges for traditional Social Health Insurance (SHI) models. Systems that successfully bridge this gap often rely on innovative, context-specific interventions. Rwanda’s Community-Based Health Insurance (CBHI) model demonstrates that leveraging grassroots community engagement and partnerships with microfinance organizations can significantly increase enrollment among rural and informal populations (Woldemichael

et al., 2019). Alternatively, covering the informal sector may require substantial government subsidies funded through general taxation, rather than relying solely on individual premium contributions.

Governance and Digital Data Systems

The contrast between highly regulated European models and fragmented, multi-payer systems underscores the vital role of governance in systemic resilience. While fragmented systems may drive clinical innovation, they frequently suffer from massive administrative inefficiencies and critical gaps in coverage during crises. Conversely, systems with centralized regulation and equitable pooling provide a more robust social safety net. To sustain these systems, transparent governance must be coupled with robust digital data infrastructure; digital health tracking and integrated claims systems are crucial for monitoring expenditure efficiency and ensuring funds effectively reach marginalized populations.

Policy Implications By Country Context

Universal Health Coverage (UHC) cannot be achieved through a single, uniform policy framework. Because financing instruments possess unique strengths and vulnerabilities, reforms must be carefully tailored to a country's specific economic, demographic, and systemic context. Based on the functional analysis of global health systems, the following targeted policy implications are recommended:

Low- and Middle-Income Countries (LMICs) with High OOP

In LMICs where out-of-pocket (OOP) payments dominate health financing, populations face weak financial protection and high risks of impoverishment. To build resilience, policymakers in these settings should prioritize the introduction of tax-funded premium subsidies specifically targeted at the poorest households. Furthermore, developing explicit, cost-effective benefit packages is essential to ensure that limited pooled funds are directed toward the most critical primary care needs.

Countries with a Large Informal Sector

In economies characterized by a vast informal labor force, attempting to expand traditional Social Health Insurance (SHI) is often administratively unfeasible, as collecting regular payroll contributions is difficult. To achieve UHC, governments in these contexts must shift their financing strategies. Instead of relying on individual premium contributions from informal workers, policymakers should leverage general taxation revenues to fully subsidize and integrate these populations into national health pools.

Donor-Dependent Countries

Health systems that are heavily reliant on external donor assistance suffer from extreme fiscal vulnerability, as international funding can be unpredictable, fragmented, or abruptly withdrawn due to shifting global priorities. For these nations, the primary policy imperative is to design and execute a clear transition plan from external donor reliance toward sustainable Domestic Resource Mobilization (DRM).

This includes strengthening tax collection infrastructure and establishing dedicated, earmarked domestic health funds.

High-Income Aging Countries

For established, high-income health systems (such as those utilizing the Beveridge or Bismarck models), the primary threat to fiscal sustainability is rapid cost escalation. This is driven by demographic aging, a shrinking formal workforce, and the rising burden of chronic diseases. Policy reforms must focus on aggressive cost-containment and value optimization. Recommended instruments include enforcing strict global budgets, rigorously utilizing Health Technology Assessment (HTA) for coverage decisions, developing sustainable financing mechanisms specifically for long-term care, and accelerating the transition toward value-based purchasing.

Fragmented Multi-Payer Systems

Countries operating with highly fragmented, multi-payer models struggle with profound administrative inefficiency, high per-capita costs, and severe equity gaps (Rice et al., 2020). To enhance both resilience and economic sustainability, reforms in these systems must target pooling consolidation. Policymakers should focus on integrating national claims data to reduce administrative waste and reforming strategic purchasing mechanisms to leverage collective bargaining power across the fragmented system (McWilliams et al., 2018).

While this narrative review provides a comprehensive overview of global health financing strategies, several limitations must be acknowledged. First, because this study did not employ statistical meta-analysis techniques, the synthesis of evidence is inherently qualitative and designed to identify broad thematic trends rather than to measure precise effect sizes. Additionally, the selection of countries was purposive, aimed at illustrating distinct financing archetypes (e.g., Beveridge, Bismarck, CBHI) rather than providing an exhaustive global inventory; as a result, the findings may not capture the full nuance of financing challenges in unrepresented regions or micro-states. Furthermore, the review draws on a heterogeneous mix of peer-reviewed empirical studies, macro-level institutional reports, and policy briefs that inherently vary in their methodological rigor and scope. Comparability is also constrained by the fact that health financing models are deeply embedded in unique political, demographic, and macroeconomic contexts, meaning cross-country models and their outcomes are not always directly comparable on a 1:1 basis. Finally, the quantitative indicators utilized to support the analysis such as Out-of-Pocket expenditure shares and UHC Service Coverage Indices, occasionally rely on differing national data definitions and reporting years, creating a temporal and definitional variance that limits the precision of direct cross-country statistical comparisons.

Conclusion

The quest for Universal Health Coverage (UHC) is fundamentally a challenge of designing health financing systems that are both fiscally sustainable and systemically resilient. This narrative review demonstrates that while there is no "one-size-fits-all" model, the most successful global practices prioritize the transition from fragmented out-of-pocket payments to robust, integrated prepayment mechanisms (World Health Organization, 2023). Whether through the tax-funded Beveridge systems of Oceania and Europe or the Social Health Insurance models seen in Thailand and Germany, the common denominator for resilience is the ability to pool risk effectively (Tangcharoensathien et al., 2015; Wendt, 2009). Furthermore, the integration of Value-Based Healthcare and Performance-Based Financing represents a critical evolution in sustainability, ensuring that limited resources are allocated toward high-impact health outcomes rather than mere service volume (Binyaruka et al., 2021; Friebel et al., 2018). Ultimately, a resilient system is one that protects its citizens from financial catastrophe during economic or health shocks while maintaining a stable, predictable funding stream for providers. To achieve this, policymakers must reject monolithic approaches, instead adopting context-specific reforms such as targeted premium subsidies in low-income settings or pooling consolidation in highly fragmented markets, to secure long-term equity and sustainability.

Acknowledgements : The author extends deep gratitude to the Health Economic Evaluation Research Group (HEER) at Universiti Malaysia Sabah for their invaluable guidance and support in conducting the review.

Declarations

Funding: This review received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflicts of Interest: The authors have no conflicts of interest to declare.

References

Al-Hanawi, M. K., Khan, S. A., & Al-Borie, H. M. (2018). Healthcare human resource development in Saudi Arabia: Emerging challenges and opportunities—a critical review. Public Health Reviews, 39(1), 1-16. https://doi.org/10.1186/s40985-018-0082-x

Almalki, M., Fitzgerald, G., & Clark, M. (2011). Health care system in Saudi Arabia: An overview. Eastern Mediterranean Health Journal, 17(10), 784-793. https://doi.org/10.26719/2011.17.10.784

Almalki, Z. S., Alahmari, A. K., Alqahtani, N., Alzarea, A. I., Alshehri, A. M., Alruwaybiah, A. M., Alanazi, B. A., Alqahtani, A. M., & Ahmed, N. J. (2022). Households' direct economic burden associated with chronic non-communicable diseases in Saudi Arabia. International Journal of Environmental Research and Public Health, 19(15), 9736. https://doi.org/10.3390/ijerph19159736

Asher, M. G., & Nandy, A. (2006). Health financing in Singapore: A case for systematic reforms. International Social Security Review, 59(1), 75-92.

Biggs, A. (2021). Health in Australia: A quick guide. Parliament of Australia: Research Papers Series.

Binyaruka, P., Kuwawenaruwa, A., Ally, M., Piatti, M., & Mtei, G. (2021). Assessment of equity in healthcare financing and benefits distribution in Tanzania: A cross-sectional study protocol. BMJ Open, 11(9). https://doi.org/10.1136/bmjopen-2020-045807

Friebel, R., Molloy, A., Leatherman, S., Dixon, J., Bauhoff, S., & Chalkidou, K. (2018). Achieving high-quality universal health coverage: A perspective from the National Health Service in England. BMJ Global Health, 3(6). https://doi.org/10.1136/bmjgh-2018-000944

Gauld, R. (2020). The New Zealand Health System. Health Systems in Transition, 22(4).

Geropoulos, N., Voultsos, P., Geropoulos, M., Tsolaki, F., & Tagarakis, G. (2024). Hybrid model: A promising type of public procurement in the healthcare sector of the European Union. Frontiers in Public Health, 12. https://doi.org/10.3389/fpubh.2024.1359155

Giang, L. T., Pham, T. H. T., Phi, P. M., & Nguyen, N. T. (2023). Healthcare services utilisation and financial burden among Vietnamese older people and their households. International Journal of Environmental Research and Public Health, 20(12), 6097. https://doi.org/10.3390/ijerph20126097

Hanvoravongchai, P. (2013). Health financing reform in Thailand: Toward universal coverage under fiscal constraints (UNICO Study Series No. 20). The World Bank.

Jabbarzadehkhoei, F., Hernandez, J., & Sabeghi, P. (2023). Implementing the Bismarck model for dental care in San Diego County. Open Access Research Journal of Life Sciences, 6(1), 098–102. https://doi.org/10.53022/oarjls.2023.6.1.0058

McWilliams, J. M., Hatfield, L. A., Landon, B. E., Hamed, P., & Chernew, M. E. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. New England Journal of Medicine, 379(12), 1139-1149.

Nair, K. S., Mughal, Y. H., Albejaidi, F., & Alharbi, A. H. (2024). Healthcare financing in Saudi Arabia: A comprehensive review. Healthcare, 12(24), 2544. https://doi.org/10.3390/healthcare12242544

Rice, T., Rosenau, P., Unruh, L. Y., Barnes, A. J., & van Ginneken, E. (2020). United States: Health system review. Health Systems in Transition, 22(4), 1-441.

Sundewall, J., & Forsberg, B. C. (2020). Understanding health spending for SDG 3. The Lancet, 396(10252), 650-651. https://doi.org/10.1016/S0140-6736(20)30963-6

Tangcharoensathien, V., Limwattananon, S., Patcharanarumol, W., Thammatacharee, J., Jongudomsuk, P., & Sirilak, S. (2015). Achieving universal health coverage goals in Thailand: The vital role of strategic purchasing. Health Policy and Planning, 30(9), 1152-1161. https://doi.org/10.1093/heapol/czu120

Wendt, C. (2009). Mapping European healthcare systems: A comparative analysis of financing, service provision and access to healthcare. Journal of European Social Policy, 19(5), 432-445. https://doi.org/10.1177/0958928709344247

Woldemichael, A., Gurara, D., & Shimeles, A. (2019). The impact of community based health insurance schemes on out-of-pocket healthcare spending: Evidence from Rwanda (Working Paper No. 19/38). International Monetary Fund.

World Health Organization. (2023). Health financing in Africa: Progress and challenges towards Universal Health Coverage. Retrieved from https://www.who.int

World Health Organization. (2024). The Global Health Observatory. Retrieved August 7, 2024, from https://www.who.int/data/gho

Xu, K., Aranguren Garcia, M., Barroy, H., Chalkidou, K., Dupuy, J., Eigo, N., Li, D., Mathauer, I., Touré, H., McDonald, L., Mieses, J., Rivas, L., Šarec, E., Daven, J., Morgan, D., Mueller, M., Kurowski, C., Blecher, M., & Yazbeck, A. (2024). Global spending on health: Emerging from the pandemic. World Health Organization.