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Social Health Insurance in Economic Review: A Comparative Study between Western and Islamic Principles

Abdul Malik Badeges
Department of Shariah and Economics, Universiti Malaya, Malaysia
ambadeges@siswa.um.edu.my

Asmak Ab Rahman[1]
Department of Shariah and Economics, Universiti Malaya, Malaysia
asmak@um.edu.my

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Abstract

Ideally, social health insurance systems are designed to ensure universal access to healthcare services, uphold justice, and protect the most vulnerable groups. However, in reality, many systems face challenges related to sustainability, inclusivity, and ethical alignment, which hinder the full achievement of their original objectives. This study aims to analyze the concept of social health insurance through a comparison between Western and Islamic perspectives, focusing on the principles of justice, equality, and social welfare. This article is classified as a literature-based study using a qualitative approach. The methodology employed is a comparative study with descriptive-analytical explanations. The findings reveal that social health insurance plays a crucial role in ensuring equitable access to healthcare, reducing the financial burden, and maintaining social stability. The comparative analysis indicates that Islamic principles excel in ethics, solidarity, and community engagement, while Western principles stand out for funding stability and structured legal frameworks. Integrating both approaches could produce a system that is financially sustainable while remaining aligned with the moral and cultural values of society.

Keywords*: Insurance, Economic Review, Principles Comparison*

[1] Corresponding Author

Abstrak

Idealnya, sistem asuransi kesehatan sosial dirancang untuk menjamin akses universal terhadap layanan kesehatan, menjaga keadilan, dan melindungi kelompok yang paling rentan. Namun, realitas di lapangan menunjukkan bahwa banyak sistem menghadapi tantangan terkait keberlanjutan, inklusivitas, dan keselarasan etis, sehingga tujuan awalnya belum sepenuhnya tercapai. Penelitian ini bertujuan untuk menganalisis konsep asuransi kesehatan sosial melalui perbandingan antara perspektif Barat dan Islam, dengan fokus pada prinsip keadilan, kesetaraan, dan kesejahteraan masyarakat. Artikel ini tergolong dalam penelitian pustaka dengan pendekatan kualitatif. Metodologi yang digunakan Adalah studi komparasi dengan penjelasan yang dilakukan secara deskriptif analisis. Hasil penelitian menemukan bahwa; Asuransi Kesehatan Sosial berperan penting dalam menjamin pemerataan akses layanan kesehatan, mengurangi beban finansial, dan menjaga stabilitas sosial. Analisis komparatif menunjukkan bahwa prinsip Islam menonjol dalam dimensi etika, solidaritas, dan keterlibatan komunitas, sementara prinsip Barat unggul dalam stabilitas pendanaan dan kerangka hukum yang terstruktur. Integrasi keduanya dapat membentuk sistem yang berkelanjutan secara finansial sekaligus selaras dengan nilai moral dan budaya masyarakat.

Kata Kunci: Ansurasi, Tinjauan Ekonomi, Perbandingan Prinsip

Introduction

Islam is a religion deeply committed to the principles of truth, peace, and the welfare of humanity. These values are not only moral teachings but are institutionalized within Islamic legal and social frameworks (Sahin, 2018). From its early history, Islam has emphasized the significance of justice and the protection of human dignity, particularly through the provision of basic needs such as education, food, and healthcare. As the modern world grapples with healthcare inequalities, the relevance of Islamic social ethics becomes increasingly important. Islamic teachings view health as a divine trust and emphasize both individual responsibility and communal obligation in safeguarding it (Sadr, 2011). This is seen in classical models such as Bimaristans, early Islamic hospitals that provided healthcare services to all, regardless of religion or status. In parallel, the modern concept of social health insurance emerged in Western societies as a response to industrialization and the growing need to protect citizens from health-related financial risks (Rein & Rainwater, 2019). These systems typically involve risk pooling, regular contributions, and state-backed coverage, all with the aim of achieving equitable access to healthcare (Craik, 2022). Social health insurance has become a cornerstone of public welfare in many developed countries, promoted as a way to protect the vulnerable and reduce economic disparity in access to health services (Lavinas, 2018).

The Islamic worldview positions human beings as Khalifah (stewards) on Earth, with duties to preserve their own health and support the welfare of others. Social health insurance, when examined from this lens, can be seen as a collective responsibility to uphold justice (*'adl*), mutual care (*takaful*), and human dignity. The historical legacy of Islamic governance, such as the welfare-oriented practices of Caliph 'Umar bin al-Khattab, who ensured even non-Muslim residents received financial and health support, demonstrates a strong foundation for what is now understood as social security (Akram Laldin & Furqani, 2013; Aziz & Mohamad, 2016). In addition, Islamic jurisprudence (*fiqh*) has long integrated considerations of public interest (*maslahah*) and necessity (*darurah*) when addressing health-related matters. These principles support the development of socially responsive health systems that prioritize communal benefit over individual profit. As healthcare challenges evolve, particularly in Muslim-majority contexts, there is a growing need to explore how Islamic principles can complement or offer alternatives to secular models of social health insurance (Iskandar et al., 2023). This comparative reflection becomes especially pertinent as global interest in ethical, inclusive, and sustainable healthcare systems increases (Junaidi et al., 2023).

Ideally, social health insurance systems in Western or Islamic should offer universal access to healthcare, ensure equity among citizens, and be designed in ways that reflect ethical integrity and social justice. In theory, both traditions promote the idea that health is a human right and that the state or society has a moral obligation to protect individuals from the financial burden of illness. The values of risk-sharing, protection of the vulnerable, and social solidarity are embedded in both Western welfare economics and Islamic social finance principles. However, the actual implementation of social health insurance often diverges from these ideals. In many countries, Western health insurance models have faced criticism for being overly bureaucratic, cost-intensive, and exclusionary, particularly toward marginalized populations (Farooq, 2022). Likewise, while Islamic principles offer a comprehensive ethical framework, their application in modern health systems remains fragmented or underdeveloped. Muslim-majority countries vary widely in their adoption of Islamic principles in public policy, and the integration of Islamic ethics into contemporary social insurance remains limited or symbolic (Ahyani & Figueiredo, 2024; Zaki et al., 2024). This disjunction between ideal theory and real-world practice presents a gap that warrants deeper examination.

This study aims to explore and compare the conceptual and structural foundations of social health insurance from both Western and Islamic economic perspectives. The objective is to analyze how each tradition defines justice, equity, and public welfare in the context of health insurance systems. Through this comparison, the research seeks to identify points of convergence and divergence, and to assess the practical relevance of Islamic ethical and economic principles in addressing contemporary health challenges. This research contributes to the growing discourse on Islamic social economics by offering a comparative lens on the ethics and structure of health insurance systems. By highlighting the historical precedents and normative values within Islamic thought, the study provides a foundation for rethinking health policy in Muslim-majority societies. It also offers

insight for policymakers, scholars, and health practitioners interested in developing inclusive and morally grounded health systems. Ultimately, the research underscores the potential of Islamic economic principles to enrich global debates on equitable and sustainable healthcare.

Literature Review

The study of Social Health Insurance (SHI) from an economic perspective, both from Western and Islamic viewpoints, is not new. Several scholars have examined and published works on this topic using various methods and approaches. Beveridge, in his work *Beveridge's Social Insurance and Allied Services*, discussed the concept of social insurance as part of the development of the modern welfare state. He emphasized the importance of universal participation and social solidarity through collective contributions to ensure broad and equitable access to healthcare services. The main finding of this work is that an inclusive social insurance system can serve as the foundation of social justice in a modern state (Beveridge, 1942). The similarity between Beveridge's work and the present study lies in the focus on the principles of universality and collective welfare. The difference, however, is that Beveridge's work is entirely rooted in a secular paradigm and does not accommodate the moral-religious dimensions such as *takaful* (mutual assistance) and *maslahah* (public interest), which are central to the Islamic approach.

Chetty, in his work *Optimal Unemployment Insurance: Theory and Evidence*, examined the design of social insurance through an economic model that considers individual risk aversion, consumption needs, and labor market behavior. Chetty's findings indicate that optimally designed insurance schemes can reduce hardship without diminishing work incentives (Chetty, 2006). The similarity between Chetty's research and this study is the shared focus on balancing financial protection and the economic behavior of society. The difference lies in the object of study, where Chetty focuses on unemployment insurance within the framework of Western liberal economics, while this research addresses health insurance in an Islamic context, considering financial instruments such as *zakat* and *waqf*.

Mustafa et al., in their work *Systematic Review of Demand for Health Takaful in Malaysia*, explored socio-demographic and religious factors that influence individual participation in Sharia-compliant health insurance. Their findings emphasize that religiosity, income, and education are important determinants in the decision to participate in health *takaful*. The similarity with this study is the shared interest in examining the influence of values and worldview on SHI participation. The difference is that Mustafa et al. focus on demand-side behavior, whereas this study examines SHI from an integrated ethical, legal, and economic perspective. Hussin et al., in their work *A Thematic and Bibliometric Review*, reviewed the *takaful* literature from 1989 to mid-2023, focusing on trends such as Sharia compliance, risk management, micro-*takaful*, and community awareness. Their findings show a shift from operational issues toward ethical governance and inclusivity (Hussin et al., 2024). The similarity with this study is the effort to extend Islamic normative foundations into SHI design. The difference is that Hussin's research focuses on bibliometric analysis, while the present study

combines a comparative analysis of Islamic jurisprudence with Western welfare economics.

Although many studies have discussed SHI, the majority of previous research has only examined SHI from a technical-economic perspective within a secular framework or has discussed Islamic health financing through single instruments such as *zakat* or *takaful* without integrating them into a comprehensive, ethics-based model. Furthermore, comparative studies that equally evaluate Western legal-economic principles and Islamic normative frameworks are still rare. This research addresses that gap by presenting an in-depth comparative analysis that integrates Islamic jurisprudence with Western welfare economics, examining how each system conceptualizes justice, equity, moral obligation, and social responsibility in the design and implementation of SHI.

Research Methodology

This article falls under qualitative-based library research. The methodology employed is a comparative study explained through descriptive analysis. The primary data sources in this research include various academic materials such as indexed journal articles, books, theses, dissertations, institutional reports, and other scholarly works. These materials are selected based on their relevance to the topic and their contribution to understanding the philosophical, legal, and economic foundations of social health insurance systems. The qualitative approach facilitates an in-depth exploration of both theoretical and practical dimensions of this topic, enabling a richer analysis of the principles, implementation mechanisms, and socio-economic impacts of social health insurance from both Islamic and Western perspectives.

The comparative analysis method is used to identify similarities and differences between the two perspectives. This process involves systematically categorizing the literature into themes such as fundamental principles, funding mechanisms, beneficiary eligibility, and the role of the state and community. The Islamic perspective is examined through the lens of *Maqasid al-Shariah* (objectives of Islamic law), highlighting how principles such as solidarity (*takaful*), justice (*'adl*), and public welfare (*maslahah*) form the foundation of Islamic social health insurance models. Simultaneously, the Western perspective is analyzed to understand how concepts such as equity, universality, and individual responsibility shape modern health insurance systems. This comparative framework allows for the identification of gaps, potential overlaps, and points of convergence or divergence between the two paradigms, while also providing insights into how Islamic principles can contribute to contemporary discourse and practice in social health insurance.

The Concept of Social Insurance in the Western World

The concept of social insurance in Western countries, especially in Commonwealth and European nations, has largely been shaped by a belief that healthcare is a basic human right. In these regions, the government plays a central role in ensuring universal and portable coverage. In contrast, the U.S. healthcare

system is fragmented, offering varied options like veterans' care, Medicare for senior citizens, Medicaid for low-income individuals, and employer-sponsored health insurance plans, while many others forgo coverage (Shi & Singh, 2022). Social insurance differs from private insurance in key ways: contributions are mandatory and may come from employers, employees, and the government, but benefits are not directly proportional to individual contributions. Unlike welfare programs that rely solely on government funding, social insurance is self-funded through dedicated contributions.

However, the distribution of benefits generally considers contributions rather than individual needs. Countries like Australia, Sweden, and Denmark depend heavily on state contributions, while social insurance operates on risk-pooling principles with solidarity. This means that a group contributes a fixed amount to a common fund, with benefits distributed according to pre-defined rules, ensuring social fairness over individual risk assessments. The theory behind social insurance emphasizes the collective responsibility of individuals within society, with a focus on meeting societal needs and reducing inequality (Lehtonen & Liukko, 2011).

In terms of historical background, early social insurance theories did not propose a system based on contributions from employers, workers, and the state. These schemes have evolved into systems that can be entirely voluntary, partly compulsory, or entirely compulsory. Alfred Plummer's classification of social insurance schemes provides a clear understanding of their funding mechanisms, with contributory, non-contributory, and mixed systems designed to ensure equitable access and financial sustainability (Plummer, 1927). Social health insurance fits into this framework, often structured as a contributory system to support broad coverage and risk pooling. As both social insurance and social health insurance share core principles like solidarity and risk pooling, they aim to reduce social risks and promote justice. Over the 20th century, the emergence of the social insurance state transformed public sectors globally, with Germany and Austria leading the way.

The theories behind social insurance, such as the justice motive, highlight a collective willingness to ensure fairness and equity, even at personal cost. This is crucial in the context of social health insurance, where individuals may contribute despite financial burden, driven by a belief in the moral imperative to provide equitable healthcare (Almgren, 2017). Broadie's theory on justice emphasizes that systems that uphold legality and fairness are seen as just, while those that perpetuate inequality or violate laws are unjust (Broadie & Rowe, 2002). Social insurance schemes, particularly in developed countries, have proven to be effective in providing a safety net for citizens, ensuring solidarity and protecting individuals from economic hardships during illness or disability. As evidenced by historical developments, social insurance systems have gradually expanded and evolved to meet the complex needs of diverse populations, demonstrating the importance of adapting these programs to specific social and economic contexts.

Social Health Insurance and Welfare in the Islamic World

The Islamic world has a long and multifaceted history of healthcare and social welfare rooted in religious principles and institutional practices. Islam, as a transformative civilization, has shaped healthcare through its unique worldview that integrates religious, ethical, and communal responsibilities. From its earliest periods, Islamic governance demonstrated a commitment to social welfare, notably through the establishment of charitable endowments (waqf), which supported hospitals, schools, and public services, reducing dependence on state funding (Iskandar, 2022). The healthcare practices of the Islamic world have been shaped by diverse influences from Egyptian, Persian, Greek, and Indian medical traditions (Alotaibi, 2021), particularly during the medieval and early modern periods, when Islam's contributions to medicine were globally recognized (Kunhibava et al., 2024).

Central to Islamic thought is the holistic understanding of health as encompassing physical, mental, and spiritual dimensions. The Qur'an and Hadith emphasize cleanliness, personal responsibility, and care for the ill as religious obligations. The concept of Tawheed (oneness of God) underpins this view, suggesting that all aspects of life, including illness and healing, are governed by divine will. Health, therefore, is seen not merely as the absence of disease but as a balanced state aligned with both spiritual and worldly well-being. Islamic medical tradition classifies illness into spiritual, functional, structural, and superficial types—highlighting the interconnectedness of the body and soul (Zarkasyi & Ihsan, 2024; Shaheen, 2018). The institutionalization of healthcare began early in Islamic history, with the establishment of Bimaristans hospitals that provided free and inclusive care regardless of religion or ethnicity. The first notable example was in Damascus in 707 CE, followed by more elaborate hospitals in Cairo and Baghdad. These facilities were often funded by waqf and reflected the Islamic emphasis on equity and public welfare. Such practices illustrate a deep-rooted tradition of community-based healthcare, motivated not only by practicality but also by religious imperatives of compassion and justice.

From a social insurance perspective, Islam emphasizes collective responsibility for the welfare of all members of society. This is exemplified by institutions such as zakah, a compulsory almsgiving that mandates the redistribution of wealth to support the poor, including through healthcare access. The Qur'an clearly identifies care for the needy as a central aspect of righteousness (Al-Qur'an 2:177). Early Islamic governance, particularly under Caliph Umar Ibn al-Khattab, institutionalized these values through structured welfare policies. His administration provided public healthcare, food distribution, and pensions to the elderly and the poor, financed by religious taxes like zakah, ushr, khums, and sadaqah (Hardana & Kholiq, 2023; Nadvi & Khalid, 2023).

In modern times, many Muslim-majority countries have attempted to integrate these principles within state-run healthcare systems. Contemporary examples include Islamic movements in Jordan establishing low-cost clinics to serve underprivileged populations, as well as scholarly efforts to explore alternative financing mechanisms such as using zakah to support national health insurance. These initiatives reflect a continued effort to align healthcare policies with Islamic ethical and economic principles, especially in ensuring equitable

access for the most vulnerable. Ultimately, the Islamic perspective on social health insurance blends theological commitments, historical precedents, and practical mechanisms. It promotes a vision of healthcare as a communal duty supported by both individual piety and institutional frameworks. This stands in contrast to many Western models that are more secular and state-centric but offers complementary insights into designing inclusive and just health systems.

Islamic Economics Perspective on Social Health Insurance

Islamic jurisprudence, particularly the concept of Maqasid al-Shariah (the objectives of Islamic law), asserts that the state has a fundamental duty to protect the life, health, and well-being of its citizens. This is seen as part of the state's responsibility to fulfill the broader goals of justice, equity, and welfare. The state's duty to ensure access to healthcare, particularly in cases where individuals are unable to meet their own needs, is embedded in Islamic law (Rasool et al., 2020; Sulistiani et al., 2023). Scholars such as Imam Al-Nawawi emphasized the *fard kifayah* (communal obligation) to care for the vulnerable, including ensuring access to healthcare services. In his works, Al-Nawawi argued that the state's role is to intervene when individuals fail to meet these needs, underscoring the public health responsibility inherent in Islamic governance (Nura Abubakar Gwadabe & Asmak Ab Rahman, 2020).

The findings of this study highlight the strong alignment between the principles of Islamic economics and the foundational values underpinning social health insurance. At its core, Islam emphasizes a deep commitment to social welfare, particularly the obligation to care for the poor and needy. This is exemplified in the doctrine of *fard kifayah*, a communal obligation, as explained by Imam al-Nawawi in Al-Majmu' Sharh al-Muhadhdhab, mandates that if individuals fail to assist the vulnerable, the state must intervene. In the realm of healthcare, this principle situates health services not solely as a personal responsibility, but as a collective one, with the state bearing the duty to ensure access for all. Social health insurance fits within this framework by operationalizing the Islamic value of takaful (mutual assistance), in which resources are pooled to secure the well-being of every member of society, especially those facing financial hardship (Badeges et al., 2024).

Another relevant concept in Islamic jurisprudence is *wakalah* (agency), which provides a model for understanding the delegated responsibilities involved in healthcare systems. In this framework, individuals (principals) entrust institutions such as the state or health insurance providers (agents) to act on their behalf in delivering equitable healthcare services. This relationship is built on trust, accountability, and the ethical imperative of mutual responsibility. In cases where individuals are unable to afford or access care, the state, as an appointed wakil, is religiously and morally obligated to fulfill that need. This reflects the Islamic legal principle that governance must serve the public good and safeguard essential human needs.

The commitment to justice (‘*adl*) in Islamic economics further strengthens the case for inclusive and equitable healthcare systems. Scholars such as Al-Ghazali have long argued for the fair distribution of wealth and resources as a reflection of

social justice, with healthcare being a central part of this vision. In this context, ‘adl means not only treating people equally but also ensuring equitable access by addressing structural disadvantages (Khalidin, 2024). Social health insurance systems that provide universal coverage and reduce barriers to care closely mirror this ethical mandate. They ensure that vulnerable populations are not excluded and that healthcare remains a right rather than a privilege, thereby reinforcing a moral economy rooted in Islamic teachings.

The broader framework of social justice in Islam, as articulated in classical works such as *Al-Ahkam al-Sultaniyyah and Al-Muwafaqat*, insists that states must uphold the dignity and welfare of all individuals. These texts underline that governance must be responsive to the needs of the population, particularly in providing for those unable to meet their basic needs. Access to healthcare is a critical dimension of that responsibility. When Social Health Insurance systems function to reduce health disparities, protect the poor, and extend essential services to all, they fulfill a key objective of Islamic economic justice (Badeges et al., 2024). This model ensures that healthcare is not commodified but distributed as a vital public good in line with Islamic moral obligations.

Furthermore, the concept of takaful, which emphasizes mutual cooperation and solidarity, provides a compelling ethical foundation for cooperative insurance models. Rooted in Quranic injunctions such as those found in Surah Al-Maidah (5:2), and Hadiths that portray the Muslim community as one body, takaful reflects the collective nature of Islamic responsibility. Applied to healthcare, takaful underpins a model where individuals contribute to a common fund used to support members during health crises. This fosters social solidarity and ensures that the financial burden of illness is not carried by individuals alone but shared by the community.

Closely related to takaful is the principle of ta‘*āwun* (mutual assistance), which reflects the communal spirit of Islamic societies. The Qur’an repeatedly urges believers to cooperate in righteousness and to support one another, especially in relieving hardship. This is institutionally embodied in practices such as zakat (obligatory almsgiving) and sadaqah (voluntary charity), which function to redistribute wealth and provide social security. Social health insurance, understood in this context, is an institutional mechanism that reflects ta‘āwun by organizing collective resources to safeguard the health of society’s most vulnerable members.

Lastly, the principle of maslahah (public interest) provides a legal and ethical rationale for the development and implementation of social health insurance within an Islamic framework. As articulated by Al-Ghazali in Al-Mustasfa min ‘Ilm al-Usul, public policy must aim to protect essential objectives of Islamic law (*maqasid al-shari‘ah*), among which the preservation of life (*hifz al-nafs*) is paramount. Health insurance systems that protect public welfare, reduce preventable suffering, and increase access to essential services are not only permissible in Islamic law but actively encouraged. The promotion of maslahah requires states to establish systems that benefit society as a whole, and healthcare is among the most critical areas where this principle should be realized (Rasool et al., 2020).

Comparative Analysis: Islamic and Western Perspectives

The comparative overview between Islamic and Western models of social health insurance reveals fundamentally different philosophical and institutional foundations. The Islamic model is rooted in religious and communal ethics, drawing on practices such as *waqf* (endowments), *zakah* (almsgiving), and the historical establishment of public hospitals known as bimaristans (Iskandar et al., 2023). These institutions reflect a system in which healthcare is viewed as a collective moral obligation rather than a service bound by market logic or legal entitlement. In contrast, the Western model evolved through the rise of the welfare state in response to industrialization and urban poverty. Its foundation is more secular, emphasizing social rights, state responsibility, and legal frameworks as mechanisms for delivering health services.

One of the key differences lies in the funding mechanisms. In Islamic systems, financial support is drawn from religious obligations and voluntary giving, guided by spiritual incentives and community solidarity. Waqf and zakah offer redistributive tools that are not dependent on a centralized tax system, but instead, reflect grassroots philanthropy. Western systems, on the other hand, rely heavily on tax revenue and compulsory insurance contributions, which provide stable but often bureaucratic funding structures. While efficient in many ways, these systems sometimes lack the local ownership and moral commitment that waqf-based models can inspire, especially in communities with strong religious identity.

Both models aspire to ensure equity and access, but they approach these goals differently. The Islamic view ties health provision to religious accountability, where helping the sick is an expression of faith and fulfilling communal duties. Access is not just a policy issue but a spiritual obligation. Western systems tend to frame equity in terms of citizenship rights and distributive justice, seeking to guarantee coverage through legal mandates. However, practical disparities still exist in both systems, especially in terms of geographic reach, service quality, and funding sustainability. Interestingly, hybrid models that integrate Islamic social finance with formal insurance systems are emerging as potential solutions in many Muslim-majority countries.

To understand how different societies conceptualize and organize social health insurance, it is important to compare the underlying principles and structures that shape these systems. Islamic and Western economic perspectives offer distinct approaches, each informed by their respective ethical, historical, and institutional foundations. While both aim to ensure access to healthcare and protect individuals from financial hardship, they differ in how they define responsibility, mobilize resources, and deliver services. The following table outlines key differences between the Islamic and Western models of social health insurance across several core aspects.

Aspect	Islamic Model	Western Model
Historical Foundations	Rooted in Waqf, Zakah, and early Islamic governance	Developed through welfare state evolution post-industrialization
Funding Mechanism	Endowments (Waqf) and almsgiving (Zakah)	Taxes and insurance premiums
Access and Equity	Strong emphasis on universal access and communal obligation	Equity framed in terms of rights and social justice

Table 1; Comparison Table

The table offers a structured overview of the key distinctions and shared goals between Islamic and Western models of social health insurance. By outlining differences in historical roots, funding sources, institutional forms, and ethical foundations, it highlights how each system is shaped by its broader cultural and philosophical context. The Islamic model emphasizes communal responsibility and moral obligation grounded in faith, while the Western approach is driven by secular principles and state mechanisms. Recognizing these contrasts not only clarifies how healthcare is delivered within each framework but also provides valuable insight for developing more inclusive and culturally responsive health policies.

In sum, the Islamic economic tradition provides a comprehensive moral and legal basis for supporting Social Health Insurance as a mechanism for promoting justice, equity, and collective welfare. By aligning contemporary health systems with principles such as takaful, wakalah, ʻadl, and maslahah, policymakers in Muslim-majority countries can strengthen both the ethical and practical dimensions of healthcare delivery. These findings suggest that integrating Islamic values into health policy design offers not only cultural relevance but also a robust foundation for achieving universal, equitable, and sustainable healthcare systems.

Conclusion

Based on an economic review, Social Health Insurance (SHI) functions as a strategic instrument to ensure equitable access to healthcare services, reduce the financial burden on society, and maintain social stability. From an Islamic perspective, SHI aligns with the principles of *maqasid al-shariah*, which prioritize the protection of life (*ḥifẓ al-nafs*), justice (*ʿadl*), and public welfare (*maṣlaḥah*). Concepts such as *takaful* (solidarity), *wakalah* (agency), and *fard kifayah* (communal obligation) emphasize that the provision of healthcare is not merely an

individual responsibility but a collective duty that must be fulfilled by the state, particularly for vulnerable groups. Meanwhile, in the Western perspective, SHI is founded on the principles of equality, distributive justice, and citizens' rights, with a focus on funding efficiency through taxation and mandatory insurance premiums. Although the two models are grounded in different value systems, both share the goal of promoting inclusion and equity in healthcare provision.

The comparative analysis shows that the Islamic model excels in ethical dimensions and community-based moral commitment, while the Western model stands out for its funding stability and clear legal frameworks. The Islamic model relies on philanthropic mechanisms such as *waqf* and *zakat*, which foster local ownership and spiritual motivation, whereas the Western model depends on centralized fiscal systems and formal regulations to ensure service sustainability. Integrating these two approaches could create an SHI system that is not only financially robust but also rooted in the moral and cultural values of society. By combining the moral strengths of Islam with the efficiency of the Western system, health policies can become more responsive, sustainable, and capable of addressing the challenges of equitable healthcare delivery across diverse social contexts.

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