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Healthcare in selected Islamic countries: a study on the composition of health care expenditure

Summary

The purpose of this article is to analyse the healthcare regimes in selected Islamic countries, underlining the aspects that differentiate them from the healthcare system in the European countries and identifying the features that might constitute the basis for the identification of an Islamic model of healthcare.

The present study identifies five different groups of countries, with five different national health account (NHA) composition schemes. The conclusion of this article will demonstrate how the healthcare system in the selected Islamic countries, although it does not constitute one original model, shows specific aspects that diverge from the canonical regimes and may be considered peculiar for the countries under investigation.

Key words: Islam, healthcare model, welfare system, national health account (NHA)

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Introduction

The study of the national healthcare systems may provide helpful insights of the approach that each country has on social policies, helping to determine how both the government and the population perceive the accessibility to the welfare and how the "social contract" is established between the ruling elite and the rest of the country.

The study of the financing schemes that regulate the access to the healthcare offers a helpful point of view on the ways the population *actually* access to the healthcare, especially in non-Western society, where the existence of pervasive informal structure strongly influences the access to the social services.

The study of the healthcare regimes in the selected Islamic countries aims to underline the social structures that underlie the welfare provision, see if and in which way they differ from the Western models, and identify the common patterns that might constitute the basis for a broader regime.

Literature review

In the sections below, I will shortly describe the academic literature concerning the healthcare modelling and financing, providing coverage of the following issues:

- a short introduction to the *Welfare Regimes Theory*, with reference of the works by Gøsta Esping-Andersen and Maurizio Ferrera;
- the contributions of Geof Wood and Ian Gough to the definition of the welfare systems beyond the Western models;
- a description of the different financing schemes that constitute the *national health account* (NHA);
- a review of the study conducted by Federico Toth and his attempt to prove the validity of the *Southern European model of healthcare* (SEMH), as identified by Ferrera—through the measurement of the composition of the NHA.

The Welfare Regimes Theory: Esping-Andersen and Ferrera

The Three Worlds of Welfare Capitalism (1990) by Gøsta Esping-Andersen is generally considered to be a milestone in the analysis of the welfare state, introducing the concept that the social policies may be investigated not only from a quantitative point of view—*how much does a government spend?*, but also from a qualitative point of view—*how does the Government spend and what are the social implication of the welfare policies?* Esping-Andersen (1990) categorised the welfare system of the western capitalist countries focusing on two social dimensions: the degree of de-commodification (the possibility for the individual to receive social assistance without relying on the market) and the level of stratification, the connection between the access to the social service and the current class structure of the society (Arts, Gelissen, 2010). Esping-Andersen identified three welfare regimes: (1) the social democratic or Scandinavian, common in the Nordic

countries, characterised by a low degree of de-commodification and an universal welfare system, (2) the conservative or Bismarckian, typical of continental Europe, which has a medium degree of de-commodification and a moderate level of social solidarity, (3) and the liberal or Anglo-Saxon, spread in the English-speaking countries, which is marked by a low degree of de-commodification and a an higher level of social differentiation.

Esping-Andersen's analysis has been commented, criticised and amended by several authors, but even some of the harshest critics recognised the validity of Esping-Andersen's approach as a starting point in the study of the discipline.[2] An important contribution to the welfare regimes approach was produced by Maurizio Ferrera, who introduced another regime that included the Southern European countries—Greece, Italy, Portugal, and Spain. Although Ferrera had been not the first author claiming the existence of a so-called "Latin Rim" (Leibfried, 1992; Bonoli, 1997), he specifically defined the Southern European model for being characterised by the following aspects:

- a strong degree of inequality in the levels of social protection;
- an important role of the family as a "social clearing house";
- an universalistic approach to healthcare *in theory*, but a much lower level of accessibility *in practice*;
- a significant role of the informal sector and the strong political clientelism incidence (Ferrera, 1996).[3]

Welfare beyond the West: Wood and Gough

Meanwhile the welfare regimes theory as designed by Esping-Andersen and Ferrera mostly focuses on Western countries,[4] it should be considered how the same methods may be effective when applied to non-Western scenarios. Geof Wood and Ian Gough analyse the problems appearing in shifting the focus of the research from the welfare system in the Western countries to the welfare systems in non-Western countries.

What should be stressed is that in the West, social provision relies on generally stable social institutions that are capable and willing to ensure the accessibility to the welfare for the entire population. The citizens may count on a legitimate State, reasonably efficient bureaucratic structures, and a pervasive labour market. On the basis of such assumptions,

[2] Bambra (2007) stated: "Although the three worlds of welfare capitalism is clearly an acceptable starting point in terms of examining within and between welfare state differences in health, it is vital for the ongoing utility of public health research in this area that in the future it is able to more adequately reflect, and therefore benefit from, the evolution of welfare state regime theory."

[3] Some authors identified a similarity among the Southern European model as describe by Ferrera (1996) and the welfare system of certain MENA (Middle Eastern and North Africa) countries: Grütjen (2008) analysed the similarity between Ferrera's model and the Turkish welfare state, Jawad (2009) acknowledged certain analogies between the Southern European welfare and the social policies in the MENA region and, and Mohamed (2014) stated that the Egyptian welfare state has certain parallelism with the Southern European one.

[4] The fact that from the beginning, Japan was included among the countries under investigation should indeed be considered.

it was possible to construct the Western model of welfare state. The situation in the global South do not enjoy the same favourable conditions due to the fact the social institution mentioned above are much more precarious, if not totally lacking (Wood, Gough, 2006). What should be taken into account is that the social relations in non-Western countries rely on a set of informal structures that grant access to the welfare in cooperation with the public and private sector (Wood, Gough, 2006).

The existence of such informal mechanisms makes the analysis of the non-Western welfare systems more difficult, as it became necessary to assess how much the citizen can effectively rely on formal protection. Indeed the formal protection that theoretically covers all the citizens may be in reality not accessible for all the citizens. To have a clearer picture of the state of healthcare protection, it might be helpful to refer to the composition of the NHA in order to have visibility on how *actually* the users access to healthcare.

The financing schemes

The national health account include all the health expenditure by financing schemes. The financing schemes are the financial arrangements that people use in order to receive medical care. The main financing schemes that will be considered in this study will be shortly described here below, divided between public schemes (with the direct involvement of the state) and private schemes (mainly a transaction between users and private health services providers).

Public schemes:

- Government schemes: government schemes are financed through the public budget and cover generally all the citizens or certain groups of citizens defined by the law (e.g. low income). The benefits are generally non-contributory and distributed universally or to some particular group of citizens defined by the law. The government schemes do not necessarily cover all the costs, but rather participate in cost-sharing (OECD, Eurostat, WHO, 2017).
- Social health insurance schemes: it is a financing scheme that provides access to medical care to those who pay a non-risk related contribution. The Social Insurance is often defined and regulated by a specific law and is generally mandatory for all the citizens or for specific groups defined by the law (e.g. specific types of workers). The medical coverage may extend to the family of the insured workers and the state may contribute to certain categories of the insured. Contributions are derived from payroll taxes and are shared between employers and employees (OECD, Eurostat, WHO, 2017).

Private schemes:

- Voluntary health care payment schemes: it is a voluntary agreement between the user and private insurer. The insurance premiums of the are not income-related, but often risk-related and may be co-financed by the state (OECD, Eurostat, WHO, 2017). Following the WHO Global Health Expenditure classification, they may be divided in voluntary health insurance schemes, non-profit institution serving household (NPISH)

financing schemes, enterprise financing schemes, and unspecified voluntary health care payment schemes.

- Out-of-pocket (OOP) payments: are direct payments used to finance the purchase of medical services. OOP payments are strongly correlated with the inability of the state to guarantee effective financial protection and with the impoverishment of the household that relies on them access to healthcare.

National health expenditure and the models of the healthcare

Federico Toth (2010) uses the analysis of the NHA in order to prove the validity of the Southern European welfare model, identifying the main differences between the Bismarckian healthcare, the Beveridgean healthcare and the SEMH through the analysis of the NHA.

Bismarckian model healthcare—in the Bismarckian countries, the prominent scheme that composes the NHA is the social health insurance, which is mainly financed through payroll taxes, and managed by para-public or private companies. Its goals are the following: a Bismarckian healthcare system is in place, on one hand, to ensure income maintenance to the working population against the risk of impoverishment connected to the OOP, on the other to share the burden of health financing between the state, the employers and the employee. In a Bismarckian healthcare system, the healthcare expenditure is mainly financed through social health insurance schemes.

The Beveridgean healthcare model—in Beveridgean countries, the healthcare system aims to provide access to healthcare for the whole population, regardless of their income status, occupation, and contributions. The medical services are therefore mainly financed through the public budget—often from taxation. In a Beveridgean healthcare system, healthcare expenditure is mainly covered by government schemes.

The Southern European Model of Healthcare (SEMH) is characterized by an high level of financial involvement of the state in the health sector, demonstrated by the important role of the government schemes in the NHA, and by the relevant size of the private expenditure, especially OOP, that reveals how the users are often unable or unwilling to rely on public health providers and therefore decide to purchase health services privately.

Figure 1 presents the composition of the NHA for five countries generally considered Bismarckian (Austria, Belgium, France, Germany, and the Netherlands), five considered as Beveridgean (Denmark, Finland, Norway, Sweden, and United Kingdom) and the four Southern European countries (Greece, Italy, Portugal, and Spain). As it is possible to observe from Figure 1, in the Bismarckian countries, healthcare expenditure is mainly accessed through social health insurance schemes.[5] In Beveridgean countries, on the other hand, healthcare expenditure is mostly provided through government schemes. Finally,

[5] The Nederland are a partial exception because the health expenditure is mainly financed through a private mandatory insurance.

in the Southern European countries, the main source of financing are the government[6] schemes, but the private sector has a relevant role in providing medical services.

What should be addressed is the fact the prominence of different financing schemes refers to both the internal evolution of the relations between the state and the society, and the driving force of external actors—such as the international financial institution (IFIs)—and ideas that influenced the welfare policies. Meanwhile, ad example the predominance of government schemes might suggest a less structured and less divided society, the prevalence of the social health insurance schemes might be the result of a more divided and a more complex national background.

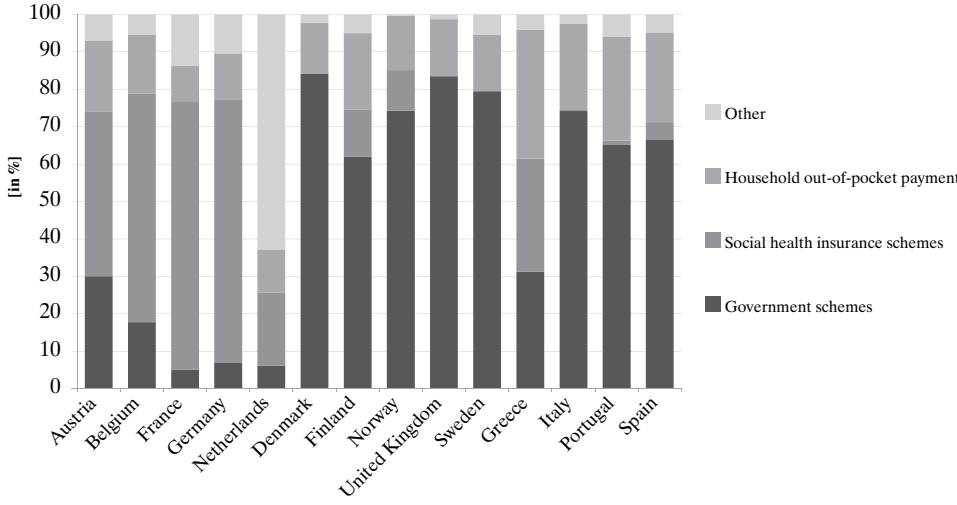

Figure 1. NHA Composition (2016)
Source: WHO-Global Health Expenditure Database.

In the case of the Southern European countries, the analysis of the NHA reveals an aspect that contributes to identifying the SEMH, which is the relevant reliance on the OOP payments as a method of financing the healthcare, although the government schemes theoretically provide coverage to the population. The existence of this apparent paradox may provide visibility on the "informal sector" identified by Ferrera, which characterizes the Southern European welfare model in general. The identification of the informal features of the SEMH through the analysis of the NHA induces the present study to apply the same analysis to the selected Islamic countries in order to obtain a clearer view on the ways the population have access to the health provision.

[6] As it has been stated also by Toth (2010), Greece is a mixed model where healthcare is jointly financed by government schemes and social health insurance schemes.

Through the analysis of the NHA is, therefore, possible not only to identify the ways the population use to access to the healthcare, but it also to provide visibility of the social constructs that are underlying it.

Healthcare in selected Islamic countries

One main issue occurs in defining the selected Islamic countries; indeed, the Islamic world is ample and heterogeneous and it is not the purpose of this article to provide a comprehensive analysis of all the Muslim countries. This study will, therefore, exclude the Sub-Saharan African and the post-Soviet Central Asian countries, which constitutes a set of complex realities that should be analysed separately and will instead focus on the Middle Eastern and North Africa (MENA) region and on the main South Asian Islamic countries. The Islamic countries under analysis in this study are Algeria, Bahrain, Bangladesh, Egypt, Indonesia, Iran, Iraq, Kuwait, Jordan, Lebanon, Libya, Malaysia, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Syria, Tunisia, Turkey, United Arab Emirates (UAE), and Yemen.

Although the study of the social policies in the Islamic world has not been deeply investigated yet, it should be noted that relevant studies provided a general overview of the current situation, especially concerning the state of the healthcare. One of the most recent studies has been published by Markus Loewe (2013) and it provides a general overview of the healthcare system in the Arab countries[7] by highlighting the following issues:

- The welfare state in the Islamic has been characterised by an implicit agreement between the ruling classes and the population: the first would grant generous social benefits in exchange for recognition of their authority. The financing for such social provision was coming from the income generated by the hydrocarbons. During the Eighties and the Nineties, the fall of the oil prices and the financial instability forced some countries to restrain and reduce the welfare programs.
- The generous welfare system established in the Sixties and the Seventies in the Arab regimes is generally still standing, but deprived of the funds necessary to ensure its correct functioning.
- Funds are generally distributed inefficiently and foster social inequalities in the population.
- Medical expenses represent an important risk of further impoverishing the low-income households due to the extensive use of OOP as a method of financing healthcare (35% of the average health expenditure in the region is financed through OOP (Loewe, 2013)).
- The rural areas are disadvantaged in the fruition of medical services, due to ill-equipped, poorly-funded and distant health facilities.

A more recent important contribution to the analysis came from Randa Alami (2017), who focused on the analysis of the health financing systems and their ability to achieve

[7] The countries analysed by Loewe (2013) and Alani (2016) partially match the set of countries that are under analysis in the present article, but the two authors mentioned above focus mainly on Arab countries.

the Universal Health Coverage (UHC). In this work, Alami stresses the need for major governmental involvement in order to guarantee more comprehensive access to healthcare for the whole population. Alami also focuses on the inadequacy of the social insurance approach in order to provide the UHC the Arab countries, due to their tendency to neglect the informal sector and, in the case of private insurers, the tendency to favour profit over the UHC reach. Alani states also that the Arab countries had initially a general tendency toward the Beveridgean model, but the recent reforms bent the system toward the Bismarckian, creating *de facto* various mixed regimes. Alani also provided an overall description of the healthcare system present in the region, underlining both the estimated level of medical coverage and the impact of the OOP on the accessibility to the medical services in the Arab countries.

The purpose of the present study is to provide through the analysis of the NHA a deeper understanding of healthcare system in the selected Islamic countries, making it possible to identify the following issues:

- whether healthcare regimes in the selected Islamic countries represent a construct that is analogous to the Western models; or rather the Islamic healthcare regimes distance from them, heading towards more original structures. The solution to this issue would provide a better understanding of a more general problem, that is the "nature" of the welfare system in the non-Western (in this case Islamic) countries, taking into account that the welfare state[8] itself is a product of the Western world. In case the differences with the Western models would be particularly relevant, it would be possible to investigate the existence of a local "evolution" of the welfare systems;
- whether healthcare regimes in the selected Islamic countries present characteristics that might be considered peculiar and shared among a considerable number of them, in a way that could led to identifying an Islamic model of healthcare, common to the Islamic countries under analysis.

The analysis of the NHA resulted with the identification of five different groups of countries, that share a common composition of the financing schemes. The five groups will be described here below, it will be analysed if exist a correlation with the European models, and will be briefly investigated which social construct could determine the composition of the NHA.

Group 1: governmental

The first group, named "governmental", include the countries in which healthcare expenditure is mainly financed through government schemes and where private expenditure, mainly OOP payments, is considerably high (above 25% on the NHA). The group includes four countries: Algeria, Jordan, Libya, and Malaysia.

[8] As understood in this study, "welfare state" is the creation of a state-controlled system of social provisions that was the result of the process of industrialisation and bureaucratic centralisation that occurred in the West, and excludes the traditional forms of poor relief that are generally common to many Western and non-Western cultures.

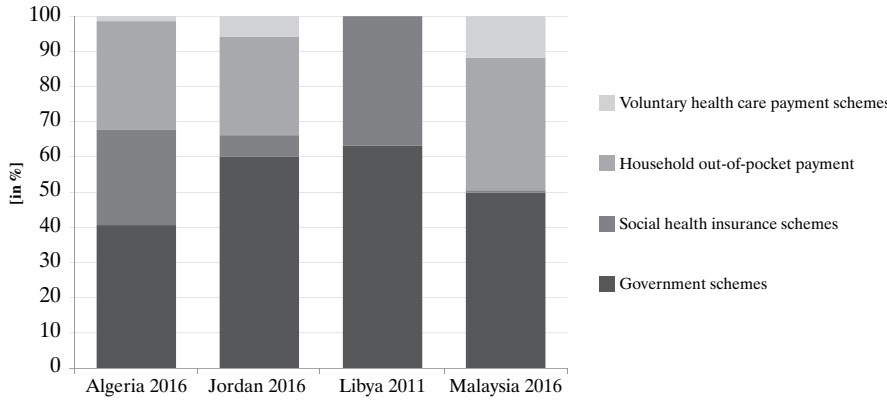

Figure 2. NHA Composition—group 1 (last data available)
Source: WHO-Global Health Expenditure Database.

In the four countries, we have a clear involvement of the state in the healthcare financing, that manages contain the rise of the OOP payments as the main source of financing (this does not apply anymore to Libya in the current moment).

Do the following healthcare systems fall into a known model? The prominent role of the governmental schemes might suggest a connection with the Beveridgean model, and therefore a resemblance to the Nordic countries or, more likely—considering the relevant role of the OOP payments—to the SEMH. Such hypothesis fails anyway to consider relevant aspects that distance Group 1 from the Beveridgean countries. The first aspect that should be considered is that in two countries (Algeria and Jordan), healthcare is delivered officially through social health insurance to targeted groups and then extended to a larger amount of population via government schemes, fostering unequal access to the health services. Libya's healthcare systems witnessed instead the transition to a quasi-Semashko model, were the private practice was restrained, to a progressively more open system, where anyway the state preserves a large degree of control. Finally, the Malaysian healthcare includes strong public involvement in healthcare financing but the government manifests a great interest towards the devolution of healthcare provision to private and para-public actors (Meerman, 2008). The second point to be addressed is the fact that health policies in Group 1 do not seem to be strongly committed to universalism and equal access to healthcare, but rather to the extensions of basic coverage to those who are excluded, often for political purposes or to preserve internal social structures.

Is it possible to identify a common pattern in healthcare systems? Healthcare is used as an important political tool to ensure conservation of power and integrity of the society. In countries such as Algeria, Jordan, and Libya, access to healthcare may still be considered a part of the old social agreement that regulated the relationship between elites and the people and financed generous social services in exchange for political abidance. In Jordan and Malaysia, healthcare—and, more generally, welfare provision—is a tool that regulates relations between different national communities (Transjordanians and Palestinians in

Jordan, Malay and Chinese in Malaysia), therefore a generous social policy should be interpreted as a way to avoid the emergence of inter-communal conflicts and secure the stability of the country.

Group 2: private expenditure

Group 2 consider the countries where the healthcare expenditure is largely financed by private expenditure (>50%). The group includes Bangladesh, Egypt, Iraq, Morocco, Pakistan, Syria, and Yemen.

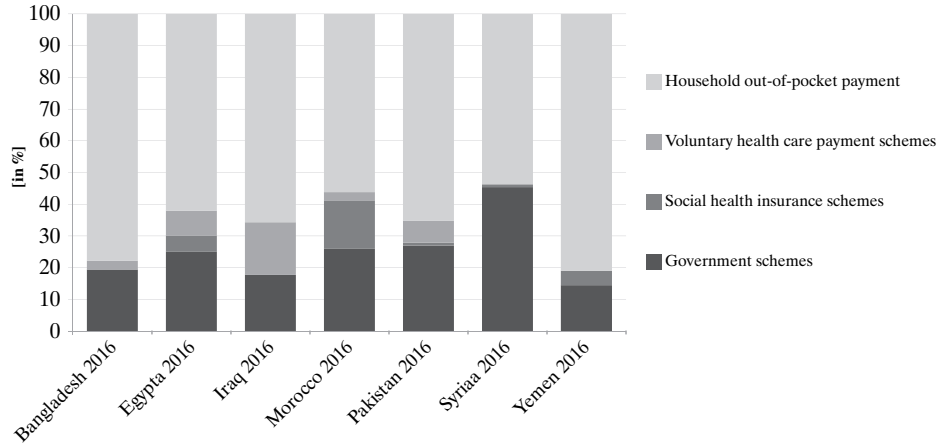

Figure 3. NHA Composition—group 2 (last data available)
Source: WHO-Global Health Expenditure Database.

The countries in this group could not manage—or were unwilling—to establish a well-working public sector, leaving a significant part of healthcare to public providers. In countries such as Egypt, Morocco, Syria, and Yemen, the initial public commitment towards welfare provision as a part of the implicit agreement between elites and population was progressively eroded by the worsening of the economic situation, the adoption of market-oriented policies and the influence of cronyism and clientelism, which drained large part of the resources. In the case of Pakistan and Bangladesh, the state was from the very beginning unable to enforce proper control of the healthcare sector leaving space to the private sector. In the Iraqi case, instead, a once generous state-financed healthcare system was devastated by the imposition of sanctions during the Nineties and the recent eruption of sectarian violence and militia warfare.

Do the following healthcare systems fall into a known model? The countries in Group 2 fail to be included in any known healthcare model, mainly because they fail to reproduce a model, *but rather the absence of a model*. The formal schemes, governmental, social, and private insurances, are not capable to ensure coverage to the large part of the population; and this happened for internal reasons (government's inability) and/or

external (poor economic conditions or conflict eruptions). A high level of reliance on the OOP payments is not a result of a precise policy, but the effect of inability to carry on a proper policy.

Is it possible to identify a common pattern in the healthcare systems? As it has been previously underlined, the governments fail to establish proper healthcare system for different reasons. Anyway, the common pattern may be identified in the effects of the lacking of a proper healthcare regime: the governments are generally detached from their population and no social agreement effectively regulates the provision of welfare. On the other side, external actors, such as international financial institutions, have a higher degree of influence on the political process and on the economic measures that are adopted.

Group 3: mixed

Group 3 include those countries that may be considered as mixed: indeed meanwhile the private expenditure is still the main source of financing, there is not a clear predominance between the governmental schemes and the social health insurances. The countries in Group 3 are Indonesia, Iran, Lebanon, and Tunisia.

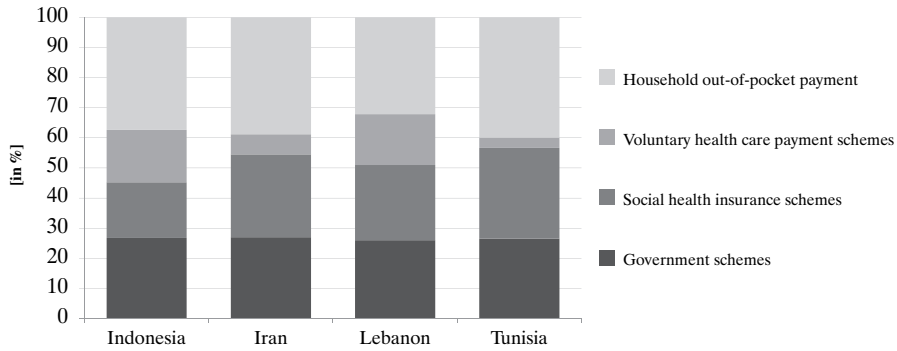

Figure 4. NHA Composition—group 3 (2016)
Source: WHO-Global Health Expenditure Database.

The four countries in Group 3, although still plagued by a high level of OOP, managed to implement a reform of the healthcare toward a social insurance systems that, more or less effectively, are able to provide coverage to a large number of citizens. Anyway, the financial support of the state is not totally faded, but it may be considered as complementary to social health insurance, providing assistance to the most economically fragile part of the population.

Do the following healthcare systems fall into a known model? The countries of Group 3 do not fall precisely into any known model, but instead occupy a middle ground between a Beveridgean and a Bismarckian health system. Unlike in the countries in the other groups analysed until now, social health insurance manages to provide an effective coverage to a considerable part of the population, and is considered by the governments and part of

population as an essential way to provide and access to medical services. Nevertheless, the economic situation of the selected Islamic countries differs from the European context and large strata of the population are unable to access social health insurance, forcing the governments to draft specific programs, funded with public resources, to target the uncovered.

Is it possible to identify a common pattern in the healthcare systems? The governments are generally committed to the provision of social services, although in the case of Lebanon, the presence of an highly fragmented and sectarian central authority makes the government ineffective in the provision of social services. However, the actions of the governments must deal with the entrenched positions of certain classes or groups that are willing to preserve their exclusive access to the healthcare provision. Therefore, a moderately involved government must maintain an open dialogue with a generally active society in the definition of the healthcare accessibility.

Group 4: the Bismarckian model

The fourth group, which only consists of Turkey, would include the countries that replicate the Bismarckian model in the closest way. The Turkish healthcare expenditure is mostly financed by social health insurance (above 50%) and the private expenditure is below 20%.

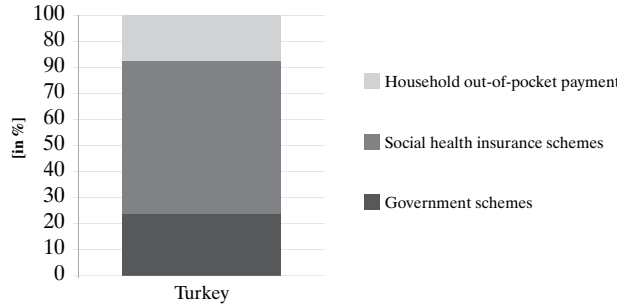

Figure 5. Composition of the NHA—group 4 (year 2016)
Source: WHO-Global Health Expenditure Database.

Before 2004, when the reform of the healthcare was introduced, the Turkish healthcare system was formed by several insurance schemes that provided coverage to specific types of workers and a targeted program, the *Green Card Programs*, that ensured limited access to free healthcare for the poor people. The political and economic instability, especially during the Nineties, made it impossible for the governments to carry our an effective reform of the system and only the Justice and Development Party (Turkish: Adalet ve Kalkınma Party, AKP), that had monopolized the Turkish politics since 2002, managed to promote a decisive political action and unify all the different systems in one general insurance.

Do the following healthcare system falls into a known model? Turkey was able to create a system that can be considered as Bismarckian, thanks to the strong control that

the government established on society. The AKP-led governments carried on a series of reforms that included both aspects of financial discipline—avoiding extensive publicly financed schemes—and welfare generosity—in order to ensure public opinion support. The Turkish case, due to its peculiar characteristics (strong and committed government and generally compliant society) represent an isolated case among the selected Islamic countries.

Group 5: the Gulf Cooperation Council (GCC) countries

The fifth and last group include the six GCC countries: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates (UAE). The healthcare expenditure in the GCC countries is largely financed through governmental schemes and the OOP payment are below the 25% of the NHA.

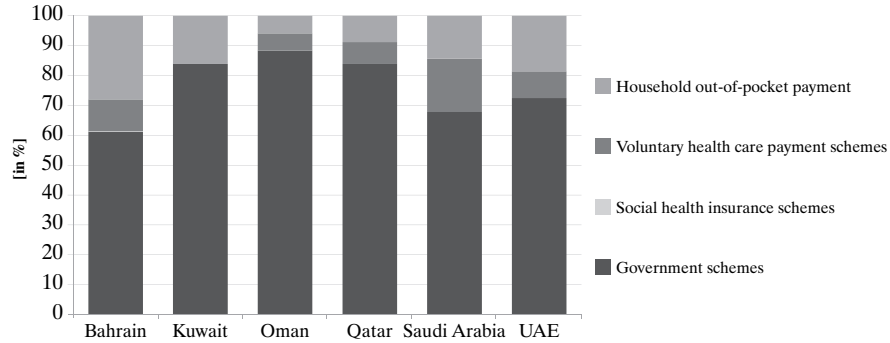

Figure 6. NHA Composition—group 5 (year 2016)

Source: WHO-Global Health Expenditure Database.

The common feature of the six countries that form the Gulf Cooperation Council (GCC) is the establishment of a modern and high level healthcare system, financed from the revenues of the oil rent. The provision of high quality healthcare for all the citizen was part of the informal authoritarian bargain that granted the stability of the ruling elites in the GCC countries (Mamtani, Lowenfels, 2007).

In the recent years, in order to establish a more cost-efficient Healthcare in face of the growing population, many GCC countries started a process of privatizing healthcare through a public-private partnership model (French, 2012) and increasing viability and accessibility of health insurance plans (Alkhamis, Hassan, Cosgrove, 2014).

An important aspect that distinguishes the social composition of the GCC countries is the relevant presence of foreign workforce, that generally access to healthcare services in different ways from the indigenous population, and often their condition of permeates by "legal ambiguity" (Shlala, Jayaweera, 2016) that jeopardize their possibility to access to medical care.

Do the following healthcare systems fall into a known model? How is it possible to observe from the chart the GCC countries rely mostly on government schemes to

finance their healthcare expenditure despite the arguable similarity with the Beveridgean model, the social structure of the GCC countries is radically different from the one in the Northern European countries, meanwhile the pillar of the Nordic model is the general absence of social inequalities that allow a more equitable distribution of the welfare. In the GCC countries the current stratification of the society finances a generous social policy in order to preserve itself.

Is it possible to identify a common pattern in the healthcare systems? The GCC countries constitutes an unique model in the Islamic countries, that is possible thanks to their reduced population (with the exception of Saudi Arabia) and considerable wealth. Either way, it would not be possible to apply this model to any other state lacking the features mentioned above.

Final conclusion

The table below resumes the five groups division that has been explained in this study. The five groups express five different behaviours of the healthcare systems in the Islamic countries. According to the data collected herein, it is possible to verify if the Islamic countries developed certain healthcare systems that should be considered as unique and different from the ones that are common in Europe. First of all, it should be said that, with the exception of Group 5, the countries in each group hardly share political and historical background, even lacking geographical proximity. Therefore the similarity of the composition of the healthcare expenditure in each group should be considered accidental rather than the result of a shared historical process.

Table 1. Healthcare models in selected Islamic countries, author's conclusions

Name	Countries	Description
1: governmental	4 (Algeria, Jordan, Libya, Malaysia)	the government schemes are prominent over the social insurance and the share of the OOP is below 50% of the NHA
2: private	7 (Bangladesh, Egypt, Iraq, Morocco, Pakistan, Syria, Yemen)	the government schemes are prominent over the social insurances and the share of the OOP is largely above the 50% of the NHA
3: mixed	4 (Indonesia, Iran, Lebanon, Tunisia)	the OOP payment are the main source of financing for the healthcare, but they are still around 50% or below the NHA. The government schemes and social health insurance shares of the are very similar
4: Bismarckian	1 (Turkey)	the healthcare system largely relies on the social insurance system (above 50% of the NHA)
5: GCC countries	6 (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, UAE)	the government schemes are the main source of financing of the healthcare expenditure, the OOP payments are below the 25% of the NHA

The second issue, whether the analysis of the composition of the NHA may imply a difference from the models common in Europe, offers a slightly different outcome.

- Group 1 may suggest a proximity to the Beveridgean and the Southern European model, but those two models are based on a universal government scheme, meanwhile, Algeria and Jordan rely on a highly subsidized social health insurance. This aspect represents a deviation from the standard Beveridgean model and the ground for an original development of healthcare.
- Group 2 shows a composition of the healthcare expenditure that is mostly a result of the inability of the state to establish a proper healthcare system, therefore it is possible to assume that Group 2 does not refer to a model, but rather to the lack of model.
- Group 3 includes the countries that dissociate the most from the canonical models due to the generally homogeneous operation of government schemes and social health insurance. Further studies in this direction may point out a new tendencies in healthcare financing and provision.
- Group 4 represents instead the closest continuity and identification with the classical models, in this case, the Bismarckian one.
- Group 5 includes instead a specific group of countries that share similar characteristics and therefore have developed an original healthcare model, due to the income deriving from the hydrocarbons and the relatively small population, Saudi Arabia excluded. Thanks to such specific characteristics, the governments manage to finance a generous public healthcare system.

Healthcare systems in the countries under analysis hardly fall under the known Western healthcare regimes, but rather deviate from them into mixed system where the healthcare is generally financed by public money, household private resources, and partially by social health insurance schemes. With the exclusion of Turkey and the GCC countries, financing schemes seems to be predominant. However, what appears to be the main issue is the ability of the government to guarantee a minimum coverage for the neediest citizens, grant the acquired rights of the urban white collars and respect the budgetary constraints, often under international supervision. The governments seems not to be able to establish an unified system and the citizens must juggle different formal and informal schemes in order to access to the medical assistance. In such uncertainty, the traditional forms of Muslim poor relief offer a partial solution.

A second perspective that should be noticed is that even in the cases where the government was enough involved in the healthcare to sensibly reduce the share of the OOP, it did not lead to a proper "healthcare regime", but to bigger support for the most vulnerable part of the population and the *de facto* perpetuation of the social differences; as underlined by Loewe (2013) the social provisions were often granted in exchange of political support and the general population have been prevented from having any say on the social issues.

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Opieka zdrowotna w wybranych krajach islamskich: badanie struktury wydatków na opiekę zdrowotną

Streszczenie

Celem artykułu jest analiza systemów opieki zdrowotnej w wybranych krajach islamskich. Podkreślono w niej cechy odróżniające je od systemów opieki zdrowotnej w krajach europejskich i zidentyfikowano cechy mogące stanowić podstawę do określenia islamskiego modelu opieki zdrowotnej.

W badaniu wyróżniono pięć grup krajów islamskich różniących się pod względem struktury narodowych rachunków zdrowia (NHA). Wnioski z tego artykułu pokazują, w jaki sposób systemy opieki zdrowotnej w wybranych krajach islamskich, choć nie stanowią jednego oryginalnego modelu, różnią się od klasycznych europejskich systemów.

Słowa kluczowe: islam, model opieki zdrowotnej, welfare system, national health account (NHA)