Al-Ihkam: Jurnal Hukum dan Pranata Sosial, 20 (2), 2025: 423-457
ISSN: 1907-591X, E-ISSN: 2442-3084
DOI:-https://doi.org/10.19105/al-lhkam.v20i2.21377

Redesigning Healthcare *Waqf*: Key Characteristics and Strategic Models for Indonesia Using the Delphi–Likert Approach

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Article history: Received: July 27, 2025, Accepted: December 09, 2025,
Published: December 31, 2025

Abstract:

This study explores the essential characteristics of healthcare *waqf* and proposes context-appropriate models for implementation in Indonesia. Employing the Delphi method alongside a Likert scale, expert consensus validated 23 out of 31 proposed characteristics, with significant agreement indicated by Kendall's W. The identified healthcare waqf types include clinics, general hospitals, children's hospitals, and specialist hospitals. These institutions can be financed through a blend of Islamic social and commercial finance and managed

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by a subsidiary, third party, or *nāẓir* (*waqf* manager). Based on these characteristics, four models are proposed: social, simple productive, innovative productive, and integrated social-productive healthcare *waqf* models. These models aim to provide accessible healthcare services for both underserved populations and the general public. While designed for Indonesia, the study's methodological approach and conceptual framework can be adapted for application in other contexts. This research offers a novel foundation for developing effective, sustainable healthcare waqf initiatives.

Keywords:
Waqf; Healthcare waqf; *Waqf* model; Delphi

Introduction

Health is a vital foundation for human well-being, productivity, and economic growth. A healthy population lives longer, works more efficiently, and contributes more to national development. Achieving a healthy society requires not only adequate medical facilities but also equitable access to healthcare for all.[1] However, the COVID-19 pandemic exposed major global inequalities in healthcare systems. As of 14 September 2021, over 225 million cases and more than 4.6 million deaths were recorded worldwide.[2] While developed countries had the resources to manage the crisis—such as sufficient medicines, equipment, and medical personnel—developing countries faced severe challenges due to limited funding and weak infrastructure. This crisis highlighted an urgent need for innovative, resilient, and inclusive healthcare financing models that can sustain health systems in the post-pandemic recovery phase.

In such contexts, Islamic social finance can play a critical role. Cizakca states that *waqf* (Islamic endowment) is a unique Islamic instrument alongside *zakāt, infāq*, and *ṣadaqah*, that has historically

[1] Baqutayan, Shadiya Mohamad Saleh, and Akbariah Mohd Mahdzir, "The Importance of Waqf in Supporting Healthcare Services," *Journal of Science, Technology and Innovation Policy* 4, no. 1 (2018): 13–19, https://doi.org/10.1108/IMEFM-01-2017-0001.

[2] Keyfitz, Nathan, and Wilhelm Flieger, *World Population* (Chicago: University of Chicago Press, 1968).

supported essential services, including healthcare.[3] During the time of Prophet Muhammad (peace be upon him), *waqf* was used to provide care for the sick and poor. Its legacy continued with the establishment of *bīmāristāns* (Islamic hospitals) from the 10th to 14th centuries, which offered free healthcare and family support under a sustainable waqf-based system.[4] Today, health *waqf* refers to donations made by individuals, organizations, or institutions to support healthcare, including building clinics, providing equipment, funding treatment, or offering professional medical services.[5] Thus, revitalizing healthcare *waqf* in Indonesia could significantly advance the Sustainable Development Goals (SDGs), particularly those related to health and social equity.

Despite these promising insights, the state of the art in healthcare waqf research remains largely conceptual. Most existing research focuses on theoretical or conceptual frameworks.[6] Proposed models often rely on author opinion or literature synthesis without

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[3] Murat Çizakça, "Islamıc Wealth Management in History and at Present," *JKAU: Islamic Econ* 28, no. 1 (2015): 3–19, https://doi.org/10.4197 / Islec. 28-1.1; Yevhen Leheza et al., "The Human Right to an Environment Safe for Life and Health: Legal Regulation, Contemporary Challenges and Comparative Perspectives," *Syariah: Jurnal Hukum dan Pemikiran* 23, no. 2 (2023): 138–50, https://doi.org/10.18592/sjhp.v23i2.12257.

[4] Ascarya, Jardine A Husman, and Hendri Tanjung, "Determining the Characteristics of Waqf-Based Islamic Financial Institution and Proposing Appropriate Models for Indonesia," *International Journal of Ethics and Systems* 39, no. 1 (2022): 143–64, https://doi.org/10.1108/IJOES-01-2022-0001; Erike Anggareni, Gustika Nurmalia, and A. Kumedi Ja'far, "Utilizing the Banking System For Digital Waqf Behavioral Approach of Millennial Muslims," *El-Usrah: Jurnal Hukum Keluarga* 7, no. 1 (2024): 390–405, https://doi.org/10.22373/ujhk.v7i1.22562.

[5] Fahruroji, "Health Endowments in Pakistan and Malaysia," *BWI*, April 22, 2020, https://www.bwi.go.id/4679/2020/04/22/wakaf-kesehatan-di-pakistan-dan-malaysia/.

[6] Mohamed Asmy Mohd Thas Thaker and Hassanudin Mohd Thas Thaker, "Exploring the Contemporary Issues of Corporate Share Waqf Model in Malaysia with the Reference to the Waqaf An-Nur Corporation Berhad," *Jurnal Pengurusan* 45, no. 1 (2015): 165–72, https://www.ukm.my/jurnalpengurusan/wp-content/uploads/2022/10/jp_45-15.pdf; Norshahira Kamarzaman, Azlin Alisa Ahmad, and Mohd Zamro Muda, "Utilizing Waqf in Enhancing Islamic Finance Contributions for Overcoming Research and Innovation Funding Challenges in TVET Education Sector," *Samarah: Jurnal Hukum Keluarga dan Hukum Islam* 9, no. 1 (2025): 178–203, https://doi.org/10.22373/sjhk.v9i1.26381.

structured validation or scientific testing.[7] Therefore, a critical research gap remains: to identify and validate the essential characteristics of healthcare waqf through expert consensus, ensuring models are both socially impactful and financially sustainable.

Analytically, the post-pandemic context magnifies this gap. COVID-19 not only exposed inequities in healthcare provision but also redefined expectations of how societies fund and manage health risks. Healthcare *waqf* can be funded through cash, physical assets, or untapped *waqf* resources, serving both social and commercial purposes.[8] As health is essential for fulfilling religious obligations, *waqf* offers a viable mechanism to complement government spending and reduce public budget burdens.[9] Various operational models have been proposed, including collaborations between waqf institutions and hospitals, the Corporate *Waqf* for Healthcare (CWFH) model to promote equitable wealth distribution, and cross-subsidization schemes where commercial healthcare providers charge wealthier patients to subsidize free treatment for the poor.[10] Indonesian

[7] Khairul Fikry Jamaluddin and Rusni Hassan, "Corporate Waqf for Healthcare in Malaysia for B40 and M40," in *Islamic Wealth and the SDGs: Global Strategies for Socio-Economic Impact*, ed. Mohd Ma'Sum Billah (Cham: Springer International Publishing, 2021), 521–37, https://doi.org/10.1007/978-3-030-65313-2_27; Mohamad Bazli Md Radzi, Salmy Edawati Yaacob, and Azlin Alisa Ahmad, "The Impact of Mosque-Based Economic Activities on Local Communities: A Case Study in Sarawak," *El-Usrah: Jurnal Hukum Keluarga* 7, no. 2 (2024): 581–601, https://doi.org/10.22373/ujhk.v7i2.26674.

[8] Ascarya, Husman, and Tanjung, "Determining the Characteristics of Waqf-Based Islamic Financial Institution and Proposing Appropriate Models for Indonesia"; Sulistyowati, "Designing Integrated Zakat-Waqf Models for Disaster Managemen," *Journal of Islamic Monetary Economics and Finance* 4, no. 2 (2018): 347–68, https://doi.org/10.21098/jimf.v4i2.1011; Tamrin Muchsin and Sri Sudono Saliro, "Open Defecation Free in Kartiasa Village in the Era of Regional Autonomy: Implementation and Barriers," *Syariah: Jurnal Hukum dan Pemikiran* 20, no. 2 (2020): 121–34, https://doi.org/10.18592/sjhp.v20i2.4061.

[9] Baqutayan, Saleh, and Mahdzir, "The Importance of Waqf in Supporting Healthcare Services"; Raditya Sukmana, "Critical Assessment of Islamic Endowment Funds (Waqf) Literature: Lesson for Government and Future Directions," *Heliyon* 6, no. 10 (2020): 1–13, https://doi.org/10.1016/j.heliyon.2020.e05074.

[10] Jamaluddin and Hassan, "Corporate Waqf for Healthcare in Malaysia for B40 and M40"; Baqutayan, Saleh, and Mahdzir, "The Importance of Waqf in Supporting Healthcare Services"; Raja Aishah binti Raja Adnan, Mahazan Abdul Mutalib, and Muhammad Ridhwan Ab Aziz, "Factors Necessary for Effective Corporate Waqf Management for Malaysian Public Healthcare," *ISRA International Journal of Islamic Finance* 14, no. 1 (2022): 73–88, https://doi.org/10.1108/IJIF-11-2019-0178.

healthcare providers are encouraged to adopt diverse waqf models—social, productive, or integrated types.[11] Successful examples include the USIM Specialist Clinic, which partners with multiple agencies to serve disadvantaged communities and innovative approaches such as integrating micro health takaful with *waqf* to lower healthcare costs.[12]

Based on this background, the objectives of this study are twofold: first, to identify and validate the essential characteristics of Islamic socio-commercial finance-based healthcare *waqf* using the Delphi–Likert method; and second, to design and propose healthcare waqf models suitable for implementation in Indonesia. By doing so, the study seeks to bridge the gap between conceptual and empirical work in healthcare *waqf*, contributing to the development of sustainable, inclusive, and resilient healthcare systems in the post-pandemic era.

Methods

To develop robust and contextually relevant healthcare *waqf* models, this study employs the Delphi–Likert method, which is particularly suited to areas with limited empirical grounding but rich expert knowledge. The Delphi technique facilitates iterative, anonymous consultation among experts, allowing for convergence of opinion and reduction of bias. When combined with Likert-scale measurement, it enhances methodological rigor by quantifying the degree of consensus. Compared with alternatives such as focus groups or nominal group techniques, Delphi–Likert offers a structured approach that ensures both depth (qualitative reasoning) and precision (quantitative validation)—an approach previously endorsed in Islamic finance model development.

The Delphi method typically uses data from a focus group discussion (FGD) or in-depth interviews, involving 3–21 respondents

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[11] Ascarya and Hendri Tanjung, "Structures of Healthcare Waqf in Indonesia to Support SDGs BT," in *Islamic Wealth and the SDGs: Global Strategies for Socio-Economic Impact*, ed. Mohd Ma'Sum Billah (Cham: Springer International Publishing, 2021), 305–24, https://doi.org/10.1007/978-3-030-65313-2_15.

[12] Fathima Begum Syed Mohideen1 et al., "Waqf Concept Health Clinic – 'Uniqueness in Disguise' USIM Experience," *Malaysian Journal of Science Health & Technology* 7, no. 2 (2021): 54–57, https://doi.org/10.33102/mjosht.v7i2.211; Muhammad Yafiz et al., "Localizing Islamic Economics: Integrating Sharia Principles Into the Salingka Nagari Tradition in Minangkabau," *Jurnal Ilmiah Peuradeun* 13, no. 3 (2025): 1643–68, https://doi.org/10.26811/peuradeun.v13i3.2022.

or 6–12.[13] This study involved two groups of knowledgeable respondents: 16 experts—including regulators and senior *waqf* academicians—and 17 experienced healthcare *waqf* practitioners for the in-depth interview stage. The Delphi-Likert survey then included seven experts and seven practitioners (see Table 1).

Table 1. The Respondents of The Delphi-Likert Method

Stage of Research	Experts	Practitioner	Total
In-depth Interview	16	17	33
Delphi-Likert	7	7	12

The experts represented *waqf* scholars from various universities, the Indonesian Waqf Board (BWI), the Ministry of Religious Affairs, and the Ministry of Finance. The practitioners came from leading healthcare waqf institutions: Dompet Dhuafa, Sinergi Foundation, Wakaf Salman ITB, Rumah Wakaf Indonesia, Wakaf Sultan Agung, Wakaf Muhammadiyah, and Wakaf Nahdlatul Ulama. Furthermore, the steps of the Delphi-Likert method are shown in Figure 1.

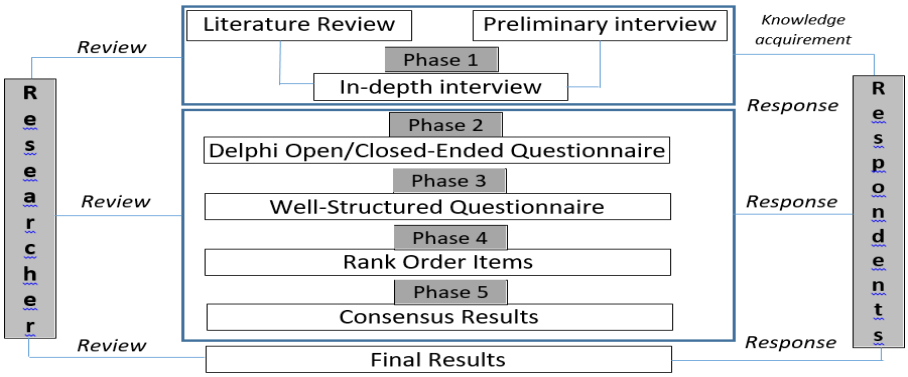


Figure 1. Steps of The Delphi-Likert Method

[13] Rana Muhammad Dilshad and Muhammad Ijaz Latif, "Focus Group Interview as a Tool for Qualitative Research: An Analysis," *Pakistan Journal of Social Sciences (PJSS)* 33, no. 1 (2013): 191–98, https://api.semanticscholar.org/CorpusID:46644223; Tobias O.Nyumba et al., "The Use of Focus Group Discussion Methodology: Insights from Two Decades of Application in Conservation," *Methods in Ecology and Evolution* 9, no. 1 (2018): 20–32, https://doi.org/10.1111/2041-210X.12860.

In Round 1, experts receive open-ended (original Delphi) or closed-ended (modified Delphi) questionnaires to gather input on key topics. In Round 2, structured questionnaires based on Round 1 results are shared, and experts rank the listed elements to identify initial priorities and levels of agreement. In Round 3, respondents may revise their answers or justify keeping their original views. Round 4 provides a final opportunity for adjustments, and responses are considered final. The number of rounds typically ranges from three to five, depending on the desired level of consensus. For details, see Figure 1.

Multiple survey rounds are needed to reach expert consensus on each topic in the questionnaire based on Table 2. This study involves in-depth interviews with 14 experts and practitioners, starting with an open or closed-ended questionnaire, followed by a structured one based on initial responses. Experts can revise their answers to align with others. If responses do not converge, another round is conducted. Convergence is measured using Kendall's coefficient of concordance (Kendall W) and its p-value.[14] In this study, the geometric mean and Kendall's W are jointly applied to ensure a more reliable and objective quantification of expert consensus within the Delphi process. Moreover, the Likert scale employed in this study ranged from 1 to 6.

Result and Discussion

Health Waqf Model (HWM) Characteristics

The results of rater agreement (Kendall W) and its P-value indicating the agreement level of each respondent group (expert, practitioner and both) on the various characteristics of HWM can be seen in Table 3.

Table 3. The Sub-Characteristics of HWM

No	Sub-Characteristics	Rater Agreement/Kendall's Coefficient of Concordance (*W*)					
		Expert	P-value	Practitioner	P-value	All	P-value
1	**The waqf form of HWM**	0.714	0.000***	0.669	0.001***	0.664	0.000***

[14] Chia-Chien Hsu and Brian A. Sandford, "The Delphi Technique: Making Sense of Consensus," *Project Appraisal* 3, no. 1 (1988): 55–56, https://doi.org/10.1080/02688867.1988.9726654.

No	Sub-Characteristics	Rater Agreement/Kendall's Coefficient of Concordance (*W*)					
		Expert	P-value	Practitioner	P-value	All	P-value
2	**The timing to be developed**	1.000	0.000***	0.678	0.000***	0.805	0.000***
2a	Social HWM	1.000	0.000***	0.788	0.000***	0.873	0.000***
2b	Productive HWM	0.944	0.000***	0.531	0.040**	0.587	0.000***
2c	Integrated HWM	0.907	0.000***	0.502	0.002***	0.679	0.000***
3	**Healthcare type of HWM**	0.278	0.100*	0.502	0.007***	0.332	0.001***
3a	Clinics	0.420	0.019**	0.539	0.005***	0.453	0.000***
3b	General hospital	0.506	0.007***	0.644	0.004***	0.544	0.000***
3c	Children hospital	0.469	0.011**	0.539	0.012**	0.494	0.000***
3d	Specialist hospitals	0.469	0.011**	0.644	0.004***	0.524	0.000***
3e	Other type of hospital	0.396	0.026**	0.576	0.021**	0.451	0.000***
4	**The type of financing**	0.455	0.001***	0.672	0.000***	0.466	0.000***
4a	Social HWM	0.342	0.035**	0.524	0.003***	0.390	0.000***
4b	Productive HWM	0.392	0.011**	0.302	0.048**	0.320	0.000***
4c	Integrated HWM	0.413	0.008***	0.472	0.003***	0.336	0.000***
5	**Healthcare type of waqf**	0.470	0.003***	0.602	0.000***	0.612	0.000***
5a	Social HWM	0.294	0.054*	0.602	0.000***	0.495	0.000***

No	Sub-Characteristics	Rater Agreement/Kendall's Coefficient of Concordance (*W*)					
		Expert	P-value	Practitioner	P-value	All	P-value
5b	Productive HWM	0.512	0.001***	0.512	0.001***	0.587	0.000***
5c	Integrated HWM	0.427	0.006***	0.518	0.001***	0.515	0.000***
6	**Management type of waqf**	0.197	0.219	0.379	0.014**	0.122	0.116
6a	Social HWM	0.171	0.054*	0.329	0.032**	0.111	0.000***
6b	Productive HWM	0.198	0.215	0.512	0.189	0.172	0.025**
6c	Integrated HWM	0.195	0.224	0.122	0.530	0.090	0.275
7	**Management type of HWM**	0.204	0.199	0.091	0.689	0.099	0.215
7a	Clinics	0.200	0.211	0.329	0.552	0.108	0.172
7b	General hospital	0.120	0.541	0.206	0.615	0.113	0.149
7c	Children hospital	0.111	0.589	0.113	0.578	0.094	0.246
7d	Specialist hospitals	0.109	0.567	0.087	0.721	0.083	0.326
8	**The benefit for the *ummah***	0.812	0.000***	0.349	0.045**	0.549	0.000***
9	**Sustainability aspect**	0.755	0.000***	0.353	0.042**	0.525	0.000***
10	**Based on the HW ecosystem**	0.653	0.001***	0.408	0.022**	0.505	0.000***

***significant at the 0.01 level; **significant at the 0.05 level; *significant at the 0.10 level

Source: Author's Calculations (2025)

Table 3 shows that there are 23 out of 31 criteria (74.2%) which have achieved significant rater agreement of W by all respondents, which complies to the Delphi requirement, where at least a certain

range, such as 70% consensus, is met.[15] The most disagreement occurred only in the type of management of various types of healthcare, which could not be generalized, but it depends on the situation and condition. The results of the Delphi-Likert method in determining the various characteristics needed by the Islamic social and commercial finance-based healthcare waqf comprise three generic models, namely 1) Social HWM; 2) Productive HWM; and 3) Integrated Social-Productive HWM, which can be seen in Table 4.

Table 4. The *Waqf* Type of HWM

No	The waqf form of HWM	Expert		Practitioner		All	
		Ag	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
1	**The form of HWM that need to be developed:**						
1.1	Social HWM	7	0	7	0	**14**	**0**
1.2	Productive HWM	7	0	6	1	**13**	**1**
1.3	Integrated Social-Productive HWM	7	0	6	1	**13**	**1**
1.4	All are needed	6	1	3	4	9	5
1.5	All are not needed	0	7	0	7	0	14

Source: Author's Calculations (2025)

Table 4 shows that the most agreed type of HWM to be developed is Social HWM (14), where all experts and practitioners agree, followed by Productive HWM and Integrated Social-Productive HWM (13), where only one practitioner disagree. Moreover, all respondents disagree on whether "all are not needed" to be developed.

[15] L E Miller, "Determining What Could/Should Be: The Delphi Technique and Its Application," in *Meeting of the 2006 Annual Meeting of the Mid-Western Educational Research Association, Columbus, Ohio*, 2006; Barbara Green et al., "Applying the Delphi Technique in a Study of GPs' Information Requirements," *Health and Social Care in the Community* 7, no. 3 (1999): 198–205, https://doi.org/10.1046/j.1365-2524.1999.00176.x.

Table 5. The HWM Development Timing

No	HWM development timing	Expert		Practitioner		All	
		Ag	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
2	**Timing to develop the HWM:**						
2.1	Now	7	0	7	0	**14**	**0**
2.2	Within very short-term	7	0	7	0	**14**	**0**
2.3	Within short-term	7	0	7	0	**14**	**0**
2.4	Within medium-term	5	2	4	3	9	5
2.5	Within long-term	3	4	3	4	6	8
2.6	No need to develop	0	7	0	7	0	14
2a	**Timing to develop Social HWM:**	**Ag**	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
2a.1	Now	7	0	7	0	**14**	**0**
2a.2	Within very short-term	7	0	7	0	**14**	**0**
2a.3	Within short-term	7	0	7	0	**14**	**0**
2a.4	Within medium-term	4	3	4	3	8	6
2a.5	Within long-term	3	4	2	5	5	9
2a.6	No need to develop	0	7	0	7	0	14
2b	**Timing to develop Productive HWM:**	**Ag**	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
2b.1	Now	7	0	6	1	**13**	**1**
2b.2	Within very short-term	6	1	6	1	**12**	**2**
2b.3	Within short-term	6	1	6	1	**12**	**2**
2b.4	Within medium-term	4	3	3	4	7	7
2b.5	Within long-term	2	5	2	5	4	10
2b.6	No need to develop	0	7	1	6	1	13

2c	**Timing to develop Integrated HWM:**	**Ag**	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
2c.1	Now	7	0	6	1	**13**	**1**
2c.2	Within very short-term	7	0	5	2	**12**	**2**
2c.3	Within short-term	7	0	6	1	**13**	**1**
2c.4	Within medium-term	6	1	5	2	11	3
2c.5	Within long-term	3	4	4	3	7	7
2c.6	No need to develop	0	7	0	7	0	14

Source: Author's Calculations (2025)

Next, Table 5 shows the characteristics of the HWM based on the 'development timing', where all or most respondents agree that the development timing of any type of HWM (in general, Social HWM, Productive HWM and Integrated Social-Productive HWM) has to be now, within a very short-term or within short-term. All or most respondents also disagree that there is "no need to develop" HWM.

Table 6. The Healthcare Type of HWM

No	**Healthcare type of HWM**	**Expert**		**Practitioner**		**All**	
		Ag	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
3	**Healthcare form of HWM that need to be developed:**						
3.1	Social HWM	7	0	7	0	**14**	**0**
3.2	Productive HWM	6	1	6	1	**12**	**2**
3.3	Integrated Social-Productive HWM	7	0	6	1	**13**	**1**
3.4	All are needed	3	4	5	2	8	6
3.5	As needed	3	4	2	5	5	9
3a	**Clinic HWM that need to be developed:**						
3a.1	Social HWM	7	0	7	0	**14**	**0**
3a.2	Productive HWM	6	1	6	1	**12**	**2**

No	Healthcare type of HWM	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
3a.3	Integrated Social-Productive HWM	7	0	7	0	**14**	**0**
3a.4	All are needed	4	3	5	2	9	5
3a.5	As needed	3	4	2	5	5	9
3b	**General hospital HWM that need to be developed:**						
3b.1	Social HWM	7	0	7	0	**14**	**0**
3b.2	Productive HWM	6	1	6	1	**12**	**2**
3b.3	Integrated Social-Productive HWM	7	0	6	1	**13**	**1**
3b.4	All are needed	4	3	4	3	8	6
3b.5	As needed	4	3	3	4	7	7
3c	**Children hospital HWM that need to be developed:**						
3c.1	Social HWM	7	0	7	0	**14**	**0**
3c.2	Productive HWM	6	1	6	1	**12**	**2**
3c.3	Integrated Social-Productive HWM	7	0	6	1	**13**	**1**
3c.4	All are needed	3	4	4	3	7	7
3c.5	As needed	3	4	3	4	6	8
3d	**Specialist Hospital HWM that need to be developed:**						
3d.1	Social HWM	7	0	7	0	**14**	**0**
3d.2	Productive HWM	6	1	6	1	**12**	**2**
3d.3	Integrated Social-Productive HWM	7	0	5	2	**12**	**2**
3d.4	All are needed	3	4	3	4	6	8
3d.5	As needed	3	4	2	5	5	9

No	Healthcare type of HWM	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
3e	**Other types of Hospital that need to be developed:**						
3e.1	Social HWM	7	0	7	0	**14**	**0**
3e.2	Productive HWM	6	1	5	2	**11**	**3**
3e.3	Integrated Social-Productive HWM	7	0	5	2	**12**	**2**
3e.4	All are needed	3	4	3	2	6	6

Source: Author's Calculations (2025)

Table 6 above shows the characteristics of HWM based on the type of healthcare to be developed. Almost all or the majority of respondents agreed that all healthcare types (in general, clinic, general hospital, children's hospital, specialist hospital and other kind of hospital) need to be developed in the form of Social HWM, Productive HWM and Integrated Social-Productive HWM.

Table 7. Types of HWM Financing that Need to be Developed

No	Characteristics of financing	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
4	**Type of HWM's financing that need to be developed**:						
4.1	Raising waqf	6	1	7	0	**13**	**1**
4.2	Raising Waqf, ZIS (*zakāt, infāq, ṣadaqah*)	7	0	5	2	**12**	**2**
4.3	Raising *Waqf*, ZIS, Hibah	7	0	7	0	**14**	**0**
4.4	Raising *Waqf*, *Qardh*	5	2	7	0	**12**	**2**
4.5	Raising *Waqf*, Co-Investor	5	2	6	1	11	3

No	Characteristics of financing	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
4.6	Raising *Waqf*, Sharia bank financing	5	2	4	3	9	5
4.7	Raising *Waqf*, Foreign financing	3	4	5	2	8	6
4.8	Raising *Waqf*, sukuk issuance	4	3	6	1	10	4
4.9	Raising *Waqf*, BOT (*Built-Operate-Transfer*)	4	3	5	2	9	5
4.10	Raising *Waqf*, other financing	4	3	3	4	7	7
4a	**Type of Social HWM's financing:**						
4a.1	Raising *Waqf*	6	1	7	0	13	1
4a.2	Raising *Waqf*, ZIS	7	0	7	0	**14**	**0**
4a.3	Raising *Waqf*, *Hibah*	7	0	6	1	**13**	**0**
4a.4	Raising *Waqf*, ZIS, *Hibah*	7	0	7	0	**14**	**0**
4a.5	Raising *Waqf*, *Qardh*	5	2	7	0	12	2
4a.6	Raising *Waqf* and other combination	4	3	5	2	9	5
4b	**Type of Productive HWM's financing:**						
4b.1	Raising Fully waqf	5	2	7	0	**12**	**2**
4b.2	Raising *Waqf*, Co-Investor	6	1	6	1	**12**	**2**
4b.3	Raising *Waqf*, Sharia bank financing	6	1	5	2	**11**	**3**
4b.4	Raising *Waqf*, Foreign financing	3	4	5	2	8	6
4b.5	Raising *Waqf*, sukuk issuance	6	1	5	2	**11**	**3**

No	Characteristics of financing	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
4b.6	Raising *Waqf*, BOT (build-operate-transfer)	5	2	6	1	**11**	**3**
4b.7	Raising *Waqf* and other combination	5	2	5	2	10	4
4c	**Type of Integrated HWM's financing**:						
4c.1	Raising Fully *waqf*	5	2	7	0	**12**	**2**
4c.2	Raising *Waqf*, ZIS	7	0	7	0	**14**	**0**
4c.3	Raising *Waqf*, Co-Investor	6	1	6	1	**12**	**2**
4c.4	Raising *Waqf*, Islamic bank financing	6	1	6	1	**12**	**2**
4c.5	Raising *Waqf*, Foreign financing	4	3	4	3	8	6
4c.6	Raising *Waqf*, sukuk issuance	6	1	5	2	11	3
4c.7	Raising *Waqf*, BOT	4	3	5	2	9	5

Note: Ag = Agree); and Dis = Disagree

Source: Author's Calculations (2025)

Table 7, meanwhile, shows the HWM characteristics based on financing types, including general, social, productive, and integrated social-productive HWMs. For social HWM, most respondents agreed on using Islamic social funds such as *waqf, infāq, zakāt*, and *hibah*. For productive HWM, respondents supported combining Islamic social funds with commercial sources like co-investors, Islamic bank financing, sukuk, and BOT (Build-Operate-Transfer). For integrated social-productive HWM, most agreed on using both Islamic social (*waqf, zakāt, infāq, ṣadaqah*) and commercial financing (co-investors and Islamic banking).

Table 8. Characteristics based on the Healthcare Type of HWM

No	Healthcare type	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
5	**Healthcare type needs to be developed:**						
5.1	Clinics	7	0	7	0	**14**	**0**
5.2	General hospitals	7	0	7	0	**14**	**0**
5.3	Children hospital	6	1	7	0	**13**	**1**
5.4	Specialist hospitals	6	1	7	0	**13**	**1**
5.5	Other types of hospitals	6	1	7	0	**13**	**1**
5.6	All are needed	6	1	4	3	10	4
5.7	As needed	4	3	3	4	7	7
5a	**Social HWM healthcare need to be developed:**						
5a.1	Clinics	7	0	7	0	**14**	**0**
5a.2	General hospitals	6	1	7	0	**13**	**1**
5a.3	Children hospital	6	1	7	0	**13**	**1**
5a.4	Specialist hospitals	5	2	7	0	12	2
5a.5	Other types of hospitals	6	1	6	1	12	2
5a.6	All are needed	7	0	3	4	10	4
5a.7	As needed	4	3	3	4	7	7
5b	**Productive HWM healthcare need to be developed:**						
5b.1	Clinics	6	1	7	0	**13**	**1**
5b.2	General hospitals	5	2	7	0	**12**	**2**
5b.3	Children hospital	6	1	7	0	**13**	**1**
5b.4	Specialist hospitals	6	1	7	0	**13**	**1**
5b.5	Other types of hospitals	6	1	7	0	**13**	**1**
5b.6	All are needed	5	2	2	5	7	7
5b.7	As needed	4	3	2	5	6	8

5c	**Integrated S-P HWM need to be developed:**						
5c.1	Clinics	7	0	7	0	**14**	**0**
5c.2	General hospitals	7	0	7	0	**14**	**0**
5c.3	Children hospital	7	0	7	0	**14**	**0**
5c.4	Specialist hospitals	6	1	7	0	**13**	**1**
5c.5	Other types of hospitals	5	2	6	1	11	3
5c.6	All are needed	7	0	2	5	9	5
5c.7	As needed	4	3	3	4	7	7

Note: Ag = Agree); and Dis = Disagree

Source: Author's Calculations (2025)

Table 8 shows healthcare types which need to be developed. In this characteristic, respondents have almost the same answers where clinics, general hospital, children's hospital, and specialist hospitals need to be developed in general HWM, social HWM, productive HWM and integrated social-productive HWM.

Table 9. The type of HWM Management

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	**Dis**	**Ag**	**Dis**	**Ag**	**Dis**
6	**The type of HWM management in general:**						
6.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
6.2	Managed by Subsidiary	5	2	7	0	**12**	**2**
6.3	Managed by the external third parties	4	3	4	3	8	6
6.4	Managed by Subsidiary and the external third parties	5	1	5	0	10	1
6.5	Managed by *Nāẓir* and the external third parties	7	0	5	2	**12**	**2**
6.6	Managed by the external third	5	2	4	3	9	5

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
	parties, then by *Nāẓir*						
6.7	Managed by the external third parties, then by Subsidiary	4	3	7	0	**11**	**3**
6a	**The type of Social HWM management:**						
6a.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
6a.2	Managed by Subsidiary	5	2	7	0	**12**	**2**
6a.3	Managed by the external third parties	3	4	3	4	6	8
6a.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
6a.5	Managed by *Nāẓir* and the external third parties	7	0	4	3	**11**	**3**
6a.6	Managed by the external third parties, then by *Nāẓir*	5	2	4	3	9	5
6a.7	Managed by the external third parties, then by Subsidiary	4	3	7	0	**11**	**3**
6b	**The type of Productive HWM management:**						
6b.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
6b.2	Managed by Subsidiary	6	1	7	0	**13**	**1**
6b.3	Managed by the external third parties	4	3	5	2	9	5

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
6b.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
6b.5	Managed by *Nāẓir* and the external third parties	7	0	6	1	**13**	**1**
6b.6	Managed by the external third parties, then by *Nāẓir*	4	3	5	2	9	5
6b.7	Managed by the external third parties, then by Subsidiary	4	3	6	1	10	4
6c	**The type of Integrated HWM management:**						
6c.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
6c.2	Managed by Subsidiary	6	1	7	0	**13**	**1**
6c.3	Managed by the external third parties	4	3	5	2	9	5
6c.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
6c.5	Managed by *Nāẓir* and the external third parties	7	0	4	3	**11**	**3**
6c.6	Managed by the external third parties, then by *Nāẓir*	4	3	3	4	7	7
6c.7	Managed by the external third parties, then by subsidiary	4	3	6	1	10	4

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
7	**The type of HWM management in general:**						
7.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
7.2	Managed by Subsidiary	6	1	7	0	**13**	**1**
7.3	Managed by the external third parties	4	3	5	2	9	5
7.4	Managed by Subsidiary and the external third parties	6	1	5	2	**11**	**3**
7.5	Managed by *Nāẓir* and the external third parties	6	1	5	2	**11**	**3**
7.6	Managed by the external third parties, then by *Nāẓir*	5	2	4	3	9	5
7.7	Managed by the external third parties, then by Subsidiary	3	4	6	1	9	5
7a	**Type of Clinic HWM's management:**						
7a.1	Managed by *Nāẓir*	6	1	4	3	10	4
7a.2	Managed by Subsidiary	6	1	7	0	**13**	**1**
7a.3	Managed by the external third parties	5	2	6	1	**11**	**3**
7a.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
7a.5	Managed by *Nāẓir* and the external third parties	6	1	5	2	**11**	**3**

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
7a.6	Managed by the external third parties, then by *Nāẓir*	5	2	3	4	8	6
7a.7	Managed by the external third parties, then by Subsidiary	3	4	6	1	9	5
7b	**Type of General hospital HWM's management:**						
7b.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
7b.2	Managed by Subsidiary	6	1	6	1	**12**	**2**
7b.3	Managed by the external third parties	5	2	5	2	10	4
7b.4	Managed by Subsidiary and the external third parties	5	2	4	3	9	5
7b.5	Managed by *Nāẓir* and the external third parties	5	2	6	1	**11**	**3**
7b.6	Managed by the external third parties, then by *Nāẓir*	5	2	5	2	10	4
7b.7	Managed by the external third parties, then by Subsidiary	4	3	6	1	10	4
7c	**Type of Children hospital HWM's management:**						
7c.1	Managed by *Nāẓir*	6	1	5	2	**11**	**3**
7c.2	Managed by Subsidiary	6	1	7	0	**13**	**1**

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
7c.3	Managed by the external third parties	5	2	5	2	10	4
7c.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
7c.5	Managed by *Nāẓir* and the external third parties	6	1	6	1	**12**	**2**
7c.6	Managed by the external third parties, then by *Nāẓir*	4	3	4	3	8	6
7c.7	Managed by the external third parties, then by Subsidiary	4	3	6	1	10	4
7d	**Type of Specialist hospital HWM's management:**						
7d.1	Managed by *Nāẓir*	6	1	4	3	10	4
7d.2	Managed by Subsidiary	6	1	7	0	**13**	**1**
7d.3	Managed by the external third parties	5	2	5	2	10	4
7d.4	Managed by Subsidiary and the external third parties	5	2	5	2	10	4
7d.5	Managed by *Nāẓir* and the external third parties	7	0	6	1	**13**	**1**
7d.6	Managed by the external third parties, then by parties	3	4	3	4	6	8
7d.7	Managed by the external third	4	3	6	1	10	4

No	The type of HWM Management	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
	parties, then by Subsidiary						

Note: Ag = Agree); and Dis = Disagree

Source: Author's Calculations (2025)

Table 9 shows the respondents' agreement on HWM management types. Most preferred HWMs—whether social, productive, or integrated—to be managed by a subsidiary or by a *nāẓir* with an external third party. The second preference was management by a *Nāẓir* or third party, followed by a subsidiary. For healthcare types (clinics, general, children, and specialist hospitals), all respondents agreed they should be managed by a subsidiary, with the next preference being *Nāẓir* and third-party management. Other options showed varied opinions and no clear consensus.

Table 10. Other Aspects of HWM's Characteristics

No	Characteristics of *Waqf*-based Healthcare	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
8	**Types of HWM, based on the benefit to the *ummah*:**						
8.1	Social HWM	7	0	7	0	**14**	**0**
8.2	Productive HWM	7	0	6	1	**13**	**1**
8.3	Integrated Social-Productive HWM	7	0	7	0	**14**	**0**
8.4	All are needed	6	1	6	1	12	2
8.5	None	1	6	0	7	1	13

No	Characteristics of *Waqf*-based Healthcare	Expert		Practitioner		All	
		Ag	Dis	Ag	Dis	Ag	Dis
9	**Types of HWM based on sustainability consideration:**						
9.1	Social HWM	6	1	5	2	**11**	**2**
9.2	Productive HWM	7	0	6	1	**13**	**1**
9.3	Integrated Social-Productive HWM	7	0	6	1	**13**	**1**
9.4	All are needed	5	2	4	3	9	5
9.5	None	2	5	0	7	2	12
10	**HW ecosystem need to be developed:**						
10.1	Social HWM	7	0	7	0	**14**	**0**
10.2	Productive HWM	7	0	7	0	**14**	**0**
10.3	Integrated Social-Productive HWM	7	0	7	0	**14**	**0**
10.4	All are needed	6	1	5	2	11	3
10.5	None	2	5	3	4	5	9

Note: Ag = Agree); and Dis = Disagree

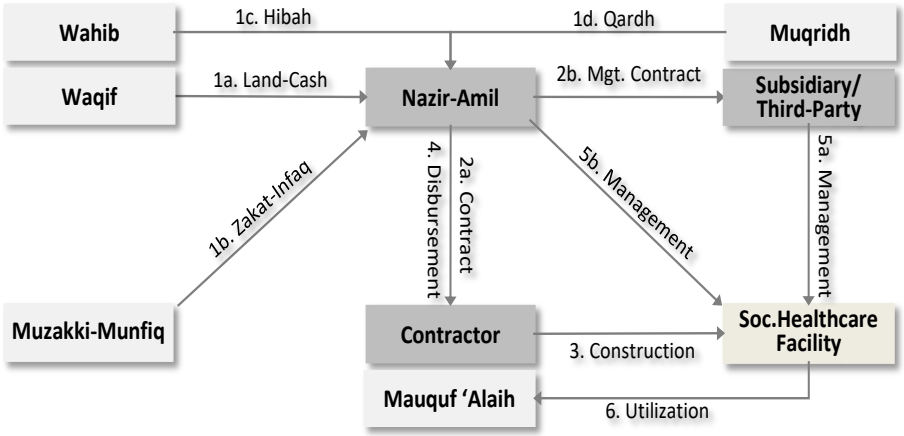
Source: Author's Calculations (2025)

In addition, Table 10 shows other HWM characteristics. All or almost all respondents agreed that social HWM, productive HWM and integrated social-productive HWM are beneficial to the *ummah*, sustainable and need to be developed as an ecosystem. Furthermore, the Healthcare *Waqf* Models (HWMs) could be implemented at various levels, including the national and local levels. Healthcare *Waqf* Models in practice can take its form as a clinic, general hospital, children's hospital, specialist hospital, and other kind of hospitals through social HWM, productive HWM and integrated social-productive HWM. The source of financing to develop HWM could vary from Islamic social and commercial finance, while the management of HWM could vary

and depend on the complexity of the HWM. Based on all of these determined characteristics, we propose three HWM, namely, social HWM, simple productive HWM, innovative productive HWM and integrated social-productive HWM. Those models are related to previous studies on relevant issues.[16]

Proposed Healthcare *Waqf* Models (HWMs)

Healthcare *Waqf* Models (HWMs) could be implemented at various levels, including the national and local levels. Practically, it can take its form as a clinic, general hospital, children's hospital, specialist hospital, and other kinds of hospitals. Healthcare *waqf* could take the form of social HWM, productive HWM and integrated social-productive HWM. The source of financing to develop HWM could vary from Islamic social and commercial finance, while the management of HWM could vary and depend on the complexity of the HWM. Based on all of these determined characteristics, we propose three HWM, namely, social HWM, simple productive HWM, innovative productive HWM and integrated social-productive HWM, based in Figure 2.

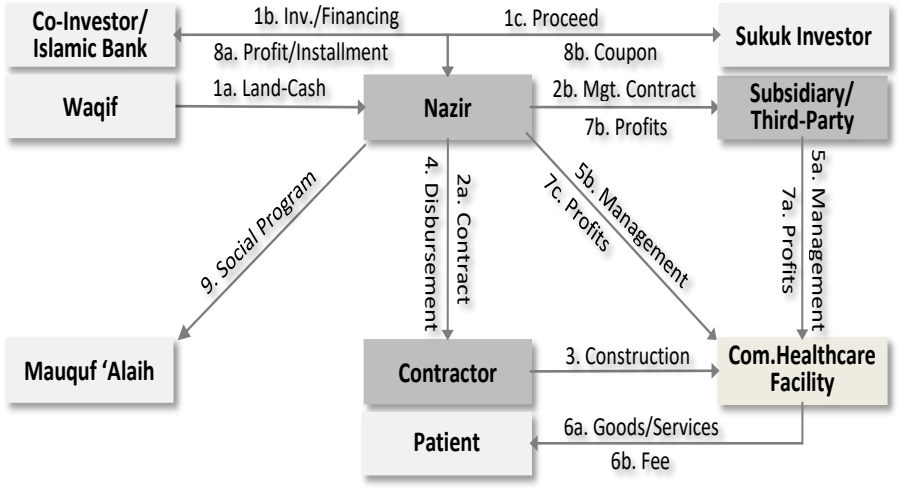


Source: Authors' illustration based on the results

Figure 2. Social HWM structure

[16] Ascarya and Tanjung, "Structures of Healthcare Waqf in Indonesia to Support SDGs BT."

Based on Figure 2, the social HWM can be initiated by a *nāẓir* who is also a certified *amil*, collecting Islamic social funds such as land and cash *waqf, hibah*, and *qardh* to build the facility. Operational costs are supported by *zakāt* and *infāq*. It provides free healthcare for the poor and may also serve the general public (see Figure 2). Small social HWMs can be managed by a *nāẓir*, medium by a subsidiary, and large by a subsidiary or third party. This is consistent with existing research, which notes that Jamaluddin and Hassan introduced the Corporate Waqf for Healthcare (CWFH) model to enhance wealth distribution through healthcare services.[17] Dukhan et al. also proposed models in which commercial healthcare entities support *waqf* by offering paid services to the wealthy while providing free care to the poor, thereby ensuring sustainability.[18] Figure 3 shows a simple productive HWM structure without BOT.



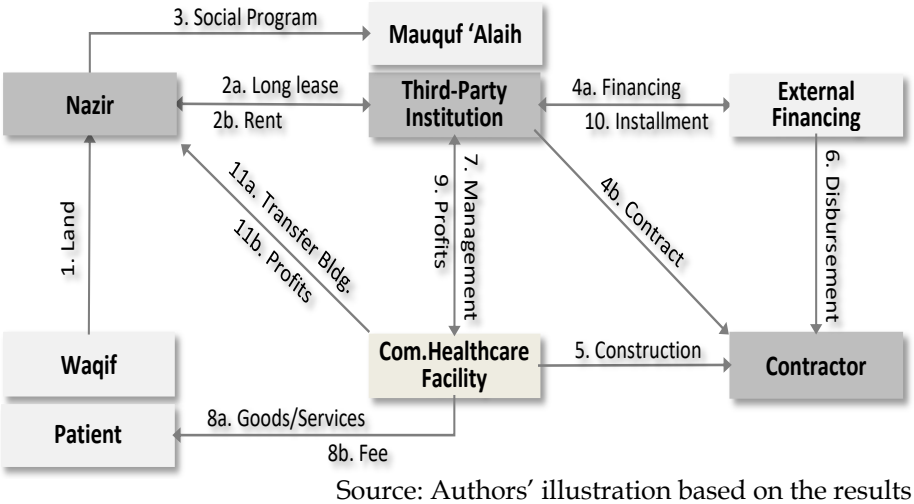
Source: Authors' illustration based on the results

Figure 3. Simple productive HWM structure

[17] Jamaluddin and Hassan, "Corporate Waqf for Healthcare in Malaysia for B40 and M40."

[18] Barae Dukhan, Mustafa Omar Mohammed, and Mohamed Cherif El Amri, "Contributions of Waqf Investments in Achieving SDGs," in *Islamic Wealth and the SDGs: Global Strategies for Socio-Economic Impact* (Springer, 2021), 501–20, https://doi.org/10.1007/978-3-030-65313-2_26.

Based on Figure 3, a Simple productive HWM is built on *waqf* land using cash *waqf* and additional Islamic commercial financing (e.g., co-investors, Islamic banks, *sukuk*), requiring a reputable *nāẓir*. After completion, it offers commercial health services to the public. Profits cover financing obligations first, and any surplus can fund social programs. Small productive HWMs can be managed by a *nāẓir* or subsidiary, while medium and large ones are best managed by a subsidiary or third party. This finding aligns with previous research demonstrating that waqf serves as a key instrument for supporting health as both a social and commercial endeavor.[19] Figure 4 shows the structure of an innovative productive HWM involving a BOT scheme.



Source: Authors' illustration based on the results

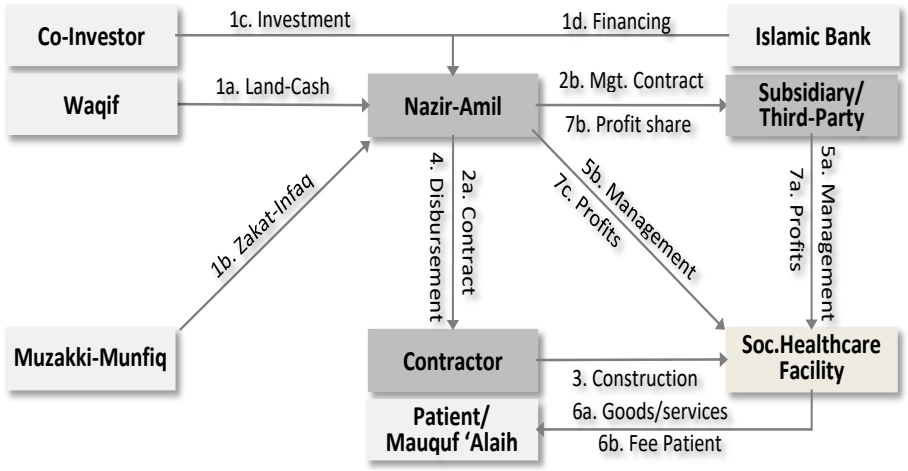
Figure 4. Productive HWM with BOT structure

Based on the model Figure 4, a *nāẓir* and a reputable third party agree on a long-term lease of *waqf* land (donated by a *waqif*). The third party builds a large commercial healthcare facility—such as a mall or business complex—using its own or external financing (e.g., Islamic

[19] Ascarya and Tanjung, "Structures of Healthcare Waqf in Indonesia to Support SDGs BT"; Sulistyowati, "Designing Integrated Zakat-Waqf Models for Disaster Managemen"; Huzaimah Al-Anshori et al., "Clarifying Heirs' Rights in Indonesian Waqf Law: Toward Stronger Governance and Conflict Prevention Huzaimah," *Nurani: Jurnal Kajian Syari'ah dan Masyarakat* 25, no. 2 (2025): 529–53, https://doi.org/10.19109/nurani.v25i2.30 356.

banks, sukuk, or international sources). The third party manages the facility, pays annual rent to the *nāẓir*, and keeps the remaining profits. The *nāẓir* uses the rent to support social programs. Once the lease ends, ownership of the facility transfers to the *nāẓir*, along with full profit rights.

Finally, Figure 5 shows the structure of an integrated social-productive HWM, which combines social and productive models. It offers free healthcare for the poor and regular services for the public, supporting both outreach and sustainability.



Source: Authors' illustration based on the results

Figure 5. Integrated social-productive HWM structure

Based on Figure 5, the construction can be funded by Islamic social financing (cash *waqf, zakāt, infāq*) and commercial financing (co-investors, Islamic banks). Operational costs are covered by fees from regular patients. Small models can be managed by a *nāẓir*, medium by a subsidiary, and large by a subsidiary or third party.

The social HWM excels in reaching the poor and needy by offering free health services, but lacks financial sustainability, as it depends on external support. In contrast, the productive HWM is financially sustainable because it generates income through commercial services, but has limited reach to the poor. The integrated social-productive HWM combines the strengths of both: it provides

free healthcare to the poor while generating income from paid services to ensure sustainability. Social HWMs are best suited for poorer areas, while productive HWMs can operate in wealthier regions. Profits from productive HWMs can help fund the operations of social HWMs, creating a balanced and sustainable healthcare *waqf* system.

Based on the validated characteristics, four models emerged: social, simple productive, innovative productive, and integrated social–productive. These models are built on both domestic and international best practices, such as Indonesia's Cash *Waqf* Linked Sukuk (CWLS) initiative, which funds eye health services and medical equipment for underserved communities,[20] and Malaysia's USIM Specialist Clinic and Kelantan Health Waqf Scheme, which offers low-cost specialist treatment supported by cash *waqf* contributions.[21] Each model accommodates varying levels of commercial integration: from purely social healthcare *waqf* offering free or subsidized care, to hybrid models where revenue-generating services to sustain broader social missions. The design also accounts for flexible management structures—subsidiary-owned, third-party managed, or *nāẓir*-led—to ensure operational efficiency and accountability. These models aim to provide equitable healthcare access for marginalized populations while fostering financial resilience, thereby reviving healthcare *waqf* as a sustainable instrument for public health and socio-economic development in Indonesia.

[20] Yuli Yasin, "Dawr Al-Ṣukūk Al-Murtabiṭah Bi Al-Waqf Al-Naqdī Fī Taṭwīr Mu'assasat Al-Ri'āyah Al-Ṣiḥḥīyah Bi Banten," *Studia Islamika* 30, no. 1 (2023): 151–84, https://doi.org/10.36712/sdi.v30i1.31590; Norashikin Ahmad, Mohd Shukri Hanapi, and Yusma Fariza Yasin, "Maqasid Shariah and Islamic Fintech Research: Trends, Topics and Collaborations," *Jurnal Ilmiah Peuradeun* 13, no. 3 (2025): 2271–2310, https://doi.org/10.26811/peuradeun.v13i3.1829; Ali Sati and Syafrianto Tambunan, "Management of Waqf Assets for the Welfare of the Community in the Perspectives of Maqāṣid Al-Sharī'ah: A Case Study on Muhammadiyah Institution," *Samarah: Jurnal Hukum Keluarga dan Hukum Islam* 9, no. 1 (2025): 254–72, https://doi.org/10.22373/sjhk.v9i1.11839.

[21] Wan Abdul Fattah Wan Ismail et al., "Implementation of Healthcare Waqf: A Case Study of Universiti Sains Islam Malaysia's Health Specialist Clinic," *Al-Shajarah: Journal of Islamic Thought and Civilization* 24, no. 1 (2019): 125–48, https://doi.org/10.31436/shajarah.v0i0.926.

Conclusion

The findings of this study demonstrate that healthcare *waqf* can take various forms—social, productive, or integrated social-productive—each with distinct implications for equity and sustainability. The social healthcare *waqf* model (HWM) effectively reaches the poor and needy by providing free health services; however, its dependence on external donations makes it financially vulnerable. Conversely, the productive HWM achieves financial sustainability by generating income through commercial healthcare services but has limited outreach to underprivileged groups. To address these limitations, the integrated social-productive HWM merges the strengths of both models, offering free healthcare for the poor while maintaining financial viability through paid services. Social HWMs are best suited for low-income areas, while productive HWMs can thrive in wealthier regions, with profits from the latter supporting the operation of social HWMs—thus creating a balanced and sustainable waqf-based healthcare ecosystem. Based on the 31 identified characteristics, healthcare waqf facilities may take the form of clinics, general hospitals, children's hospitals, or specialist hospitals, financed through both Islamic social finance instruments (*waqf, zakāt, infāq, hibah,* and *qardh*) and Islamic commercial finance mechanisms (co-investors, Islamic bank financing, international funding, or BOT schemes). Management can be conducted directly by *Nāẓir*, through subsidiaries, or in partnership with third parties. Policymakers and waqf institutions must therefore assess which HWM type and healthcare facility best fit each region's socioeconomic context. Regulators and governments should also introduce supportive policies and incentives to facilitate the implementation and scalability of these models. Although this study's findings are based on Indonesian experts and practitioners, making the proposed HWMs most applicable to Indonesia, the conceptual framework and Delphi–Likert methodology can be adapted for other countries with similar contexts. Future research should expand the scope of respondents and explore alternative methods to further refine and validate healthcare waqf models across diverse settings.

Acknowledgment
The authors would like to acknowledge the support provided by the Ministry of Higher Education, Science, and Technology (Kemendiktisaintek) of the Republic of Indonesia, which made this research possible.

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