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Issues and challenges of *waqf* in providing healthcare resources

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Abstract

Purpose – This paper attempts to rejuvenate *waqf* in the health sector by identifying and elaborating on its issues and challenges. The government budget for this sector is significant; thus, the present paper aims to provide a nongovernment budget to lessen the government's burden
Design/methodology/approach – This qualitative study uses structured in-depth interviews with 12 respondents to generate valuable insights and thoughts in order to frame recommendations.
Findings – The findings highlight the key themes: human resources, finance, collaboration and coordination, legal issues, basic healthcare insufficiency, data and digitalization, accountability and sustainability and infrastructure. The following are the proposed solutions: capacity building program (CBP), hybrid *waqf* scheme, big data connectivity, specific legal framework, refocusing and reallocating of resources for the health sector during and after the pandemic
Research limitations/implications – This study focuses on Indonesia and Malaysia as the authors believe that these two countries have a lot of practice in the field. Further studies may focus on other countries, such as Pakistan.
Practical implications – This paper proposes potential ways to embrace government policy consideration, optimize the elaboration among productive *waqf* with other kinds, improve governance of and coordination among *waqf* institutions and increase the awareness to improve significant development.
Social implications – By considering this paper's recommendations, *waqf* stakeholders in the healthcare system can improve the social benefits for poor and needy patients.
Originality/value – This study presents the latest strategic analysis of *waqf*, which is important for the government policy in developing *waqf*.

Keywords Healthcare, *Waqf*, Issues, Resources, Challenges
Paper type Research paper

1. Introduction

Currently, the world is reeling under the effects of the COVID-19 pandemic. As of 14th September 2021, 225,024,781 confirmed cases and 4,636,153 deaths had been reported in 223 countries (Worldometers, 2021). As of 18th September 2021, the top-five most affected countries were the USA (42,799,907 cases), India (33,417,390 cases), Brazil (21,102,536 cases), the United Kingdom (7,371,301 cases) and Russia (7,234,425 cases); cumulatively, these countries reported 4,693,029 deaths. This impacted various sectors, such as the economic sector; for example, curbing measures called for ensuring limited mobility, which certainly impacted the economy.

JEL Classification — B55, D64, I18. **KAUJIE Classification** — E22, E23, E31

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Developed countries are in a relatively advantageous position since they have funds to counter COVID-19. They have sufficient medicines, medical tools and equipment, doctors, nurses, other medical staff, rooms and hospitals. Meanwhile, developing countries are struggling to survive and restore the health sector. Furthermore, developing countries do not have sufficient funds to cover health expenses incurred because of the pandemic. In such times, *waqf* as an Islamic social fund can be considered an important source to overcome this problem (Ascarya, 2021).

Waqf is Islam's unique instrument (Cizakca, 2015), apart from *zakat*, *infaq* and *ṣadaqah* (alms). *Waqf* has also proven to be a strong instrument to reduce various burdens of life, both economically and socially. Moreover, many sick and poor people in various countries have benefited from *waqf*. It has a voluntary charity included in *ṣadaqah jariyah* (Abdullah, 2020), which is one of the precious practices in Islam and offers a great reward. *Waqf* has been a panacea for the needy since the time of Prophet Muhammad (peace be upon him [PBUH]) (Yaacob and Nahar, 2017). Historically, *waqf* provided a source of recovery and health services for the victims of the Battle of *Khandaq* and continued its glory by means of many Islamic *bimaristans* (Islamic hospitals), which acted as a modern *waqf*-based hospitals from the 10th century to the 14th century; under *waqf*, during this time, hospitals provided not only free services to patients but also family incentives (Ascarya and Tanjung, 2021).

Currently, the practice of using *waqf* in the health sector is rife in the Organization of Islamic Cooperation (OIC) member countries, such as Indonesia, which has a *waqf*-based hospital, namely "Dompet Dhuafa". Moreover, "Sulthan Agung" *waqf* hospital, the National *Zakat* Board (BAZNAS) hospital and many others are trying to develop the *waqf*-based health sector. In Malaysia, health *waqf* is managed by a *waqf* company called *Waqf* An-Nur Corporation Berhad (WANCorp), which comprises social and business units (Fahruroji, 2020); it owns 24 clinics, 26 hospitals throughout Malaysia and 4 hospitals abroad and only charges 5 Malaysian ringgit including medicine.

Waqf have been proven to help ease the burden of society and is a unique form of virtue within Islamic teaching since it is a way of worship that incorporates spiritual aspects and material. Socioeconomically, this instrument plays a major role in providing services, including healthcare services (Kahf, 2008). Hence, *waqf* can be the main source of healthcare services, especially for the poor and needy. Many *waqf* institutions exist to solve health problems that lead to a better life for the poor.

Nevertheless, the role of *waqf* in the health sector needs further elaboration. This includes identifying, analyzing, evaluating and elaborating its issues and challenges. By capturing the issues and challenges of specific characteristics of *waqf*-based healthcare institutions and continuing with the proper strategy, the glory of health *waqf*, similar to *bimaristans*, can be achieved. To date, limited empirical studies have been carried out in the area of health *waqf*. Most recent *waqf* studies have focused on the theoretical and conceptual framework (Thaker and Thaker, 2015).

Further, studies that have discussed *waqf* for hospitals have not systematically and comprehensively focused on identifying problems and challenges related to the efforts required to develop *waqf* in the health sector in a way that could be utilized by other *waqf*-based health institutions. This study discusses this gap. Thus, this paper attempts to rejuvenate *waqf* in the health sector by identifying and elaborating its issues and challenges. The motivation for this study lies in the fact that the government budget for this sector is significant; thus, the present paper aims to provide a nongovernment budget to lessen the government's burden.

2. Literature review

2.1 The concept of waqf

Generally, a *waqf* is a voluntary act of charity that comes under the general terms of *ṣadaqah* and *infaq* (Hasan *et al.*, 2015). *Waqf* is one of the Islamic laws related to people's lives. It is also

known as *ijtima'iyyah – the act of* worship for public interest as a devotion to Allah (Rusydiana and Devi, 2018). In *Ja'farī jurisprudence*, *waqf* is defined as a contract that aims to confine the capital while releasing its benefits (Al Ansari, 2013). As a philanthropic act in Islam (Mahat *et al.*, 2015), good *waqf* management can be a solution to poverty alleviation (Oladapo and Rahman, 2016). Most of the management of immovable *waqf* assets is supported by cash *waqf* schemes. These management outcomes deal with education finance, housing, health, social care and commercial activities, basic infrastructure and disaster mitigation (Sulistyowati, 2018).

Waqf is studied as an Islamic legal concept in both Arabic and English literature (Al Ansari, 2013). As mentioned in the hadiths, the evidence can be gleaned from the saying of the Prophet (PBUH): "When a human being dies, his work for God comes to an end except for three: a lasting charity, the knowledge that benefits others, and a good child who calls on God for His favour" (Sahih Muslim, Book of Wills, Hadıth No. 4005) (Ramli *et al.*, 2019). In addition, complying with the verse, Abu Talha endowed his exquisite garden for *waqf*, which was favored by the Prophet (PBUH). In this context, *waqf* institutions within the realm of the Islamic social finance (ISF) framework can be seen as a social intermediary platform to achieve effective utilization of perpetual social savings (Shaikh *et al.*, 2017).

Waqf means "detention", "to prevent" and "to restrain". Terminologically, *waqf* is a dedication of property either in express terms or by implication for any charitable and religious purposes to secure benefit for a human being (Mahamood and Rahman, 2015). Thus, many studies stated that *waqf* sources are used not only for social purposes but also for funding commercial projects that are supplied from the Islamic philanthropic (Ascarya *et al.*, 2017; Khan, 2015; Tanjung, 2018).

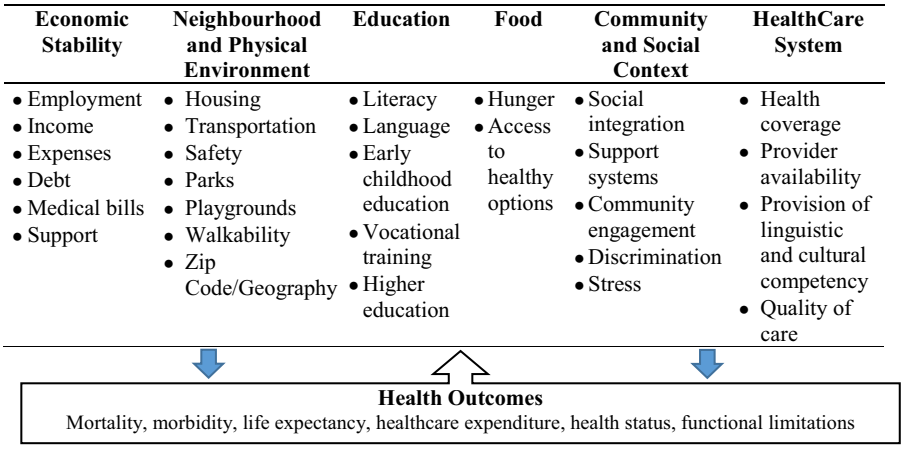
2.2 Health waqf

Health acts as a crucial aspect for the performance measurement of a country's development and is strongly related to well-being (Bohari, 2015). Good healthcare services lead to a healthy society, so these services must be ensured (Atan *et al.*, 2017). Oladapo and Rahman (2016) defined health as the physical, mental, social and spiritual alertness of an individual to perform actively in society. Basically, society affects health in varying ways. Productivity is determined by the level of health; citizens in good health conditions ensure high productivity, which, in turn, results in a country's development (Bohari, 2015).

The COVID-19 pandemic has led to extreme and drastic changes. Before the pandemic, health factor was majorly determined by social determinants described below (see Figure 1) (Artiga and Hinton, 2018; Pacquiao, 2017).

The above-mentioned determinants form a reciprocal relationship with health sector outcomes. All these determinants have been changing drastically since the beginning of COVID-19 in January 2019 and will continue to do so for an unknown period. *Waqf* as one of the important institutions in Islamic finance clearly has the potential role to foster the Sustainable Development Goals (SDGs) (Alshaleel, 2020) and to play a role along with the authorities in tackling the impacts of the pandemic. Although *waqf* institutions seem similar to trusts formed as part of general legal systems (Islamiyati *et al.*, 2020), there are differences in terms of perpetuity: ownership of *waqf* is deemed to be under Allah *Subhanahu Wata'aala*, while a trustee acts as the owner of a trust established under conventional English laws (Alshaleel, 2020).

Numerous studies generally discuss ISF in relation to *waqf*, *zakat* and *ṣadaqah*, either separately or as a whole (Alhorani, 2013; Noordin *et al.*, 2018; Ramli *et al.*, 2018; Thaker, 2018). There are even more studies about *waqf* as Islamic social and commercial finance (Ambrose *et al.*, 2018; Hassan *et al.*, 2018; Thaker and Pitchay, 2018). However, unfortunately, not much research specifically focuses on the health sector, which has become the main concern of *waqf* (Adnan *et al.*, 2021) in many countries.



Source(s): Artiga and Hinton, 2018; Pacquiao, 2017

Figure 1.
Social determinants of health

The authors found a study that discussed *waqf* as a source of financing *takaful* for healthcare. Another study emphasized the past, current and future development of *Waqf*-based healthcare institutions, specifically in Malaysia. In this regard, Baqutayan and Mahdzir (2018) claimed that *waqf* provides an efficient alternative source of funding for the development of healthcare institutions; it follows a transparent system that directs the administration of funds.

Ahmed *et al.* (2015) proposed a model related to financing construction and management of *waqf* hospitals and towers in Uganda. This model, called Uganda Islamic Endowment Corporation (UIEC), proposed the idea of issuing *waqf* certificates to donors and investors that support better quality and affordable healthcare for the poor and the needy. Uganda as one of the OIC countries considers *waqf* as the main concern that requires more focus. Beyond the public healthcare services, the majority of poor Ugandans cannot afford high-cost private healthcare services. Moreover, Al Ansari (2013) specifically carried out the study of *bimaristan* as a case of *waqf*. *Waqf* is the model used to establish hospitals in the Muslim world and was successful in achieving large numbers of medical care facilities and ensuring the sustainability, quality of service and accessibility to the public during the 10th century in Baghdad, 12th century in Damascus and 13th century in Cairo.

Htay *et al.* (2015) investigated a microhealthcare *takaful* supported by *waqf* fund. This fund helps people cover their healthcare expenses. In agriculture, *waqf* faces the challenge of solving the financial problems of farmers. Moh'd *et al.* (2017) proposed a *Waqf-Muzara'ah* supply chain model, which mitigates the issues related to high interest rates and collaterals in a partnership arrangement. As per experts, various *waqf* systems, such as Cash *Waqf*-Financial Cooperative-*Mushārakah Mutanāqisah* (CWFCMM) model, provide financially affordable options in Malaysia. This model has to apply the sophisticated model business due to the profit in *waqf*. For instance, the nongovernmental organization such as the Malaysian Medical Relief Society (MERCY) has this benefit (Zabri and Mohammed, 2018). To help refugees, Kachkar (2015) proposed a Cash *Waqf* Refugee Microfinance Fund (CWRMF), which expands the refugee's microbusiness. Talib *et al.* (2020) found that the *waqf* report must be standardized due to the regulator from the State of Islamic Religious Councils (SIRCs) that make sure the operational concern on Islamic principles.

2.3 Health waqf throughout the history

In Islamic history, health gained attention from several great *waqf* hospitals, such as those in Baghdad, Cairo and Cordova, which had libraries, pharmacies, outpatient centers, separate wards for men and women and efficient medical staff (Manaf and Mahmood, 2013). Most poor citizens of OIC countries suffer from severe health problems, and recently, *waqf* sources have become one of the solutions. A health *waqf* facilitates healthcare services that are established based on *waqf* sources, concepts and principles. *Waqf* is a crucial part of healthcare operations. Many types of programs under various sectors can be funded by *waqf*; one of these sectors is the healthcare sector (Wahab and Rahman, 2011).

The success of health *waqf* in the past began with Rasulullah Muhammad (PBUH) (Baqutayan, 2018). During the Battle of *Khandaq* in the year 627, health *waqf* was practised after Sa'id bin Mu'az was injured and treated in a separate tent (Atan and Johari, 2017). A mobile dispensary existed then, and Ummi Rufaidah Binti Sa'ad, the first Muslim female nurse, was assigned to take care of the patients during the war (Razali, 2015). Years later, under *waqf*, three types of advanced medical facilities were introduced: dispensaries, hospital buildings and emergency treatment centers (Ahmed *et al.*, 2015).

Figure 2 describes the greatness of *waqf* throughout the history:

Furthermore, historical records evidence health *waqf*'s enormous success by means of four Islamic healthcare institutions: *Bimaristan al-ʿAḍudī* (in 10th-century Baghdad), *Bimaristan al-Nūrī* (in 12th-century Damascus), *Bimaristan al-Manṣūrī* (in 13th-century Cairo) (Al Ansari, 2013) and *Dimnah* (in 14th-century Tunisia). *Bimaristans* and *dimnah* provide exceptional care in that they consider compensation for patients and their families during treatments (Al Ansari, 2013). Bimaristan al-ʿAḍudī was the first *waqf* hospital, built by Caliph Adhud al-Dawlah during the time of Harun al Rasyid (786–809 AD). It had best medical equipment, doctors, nurses and health consultants, and the staff got salary from the Caliph. Bimaristan al-Nūrī in Damascus by Caliph Nur Al-Din Zanji claims to be the first hospital that gave relevant education to the doctors and recorded patients' details. The renowned doctor Ibn Al-Nafis was an alumnus of Bimaristan al Nuri.

Moreover, Bimaristan *al Manṣūrī* in Cairo had thousands of beds, which were categorized based on diseases. Further, there was a separation between men and women (Al Ansari, 2013), and the hospital offered a huge hall for courses, a library, a mosque, offices and a music therapy psychiatry program; all of these were free of charge. Plus, incentives were provided as compensation to replace the lost daily income during treatment. In 1913, *waqf* institutions

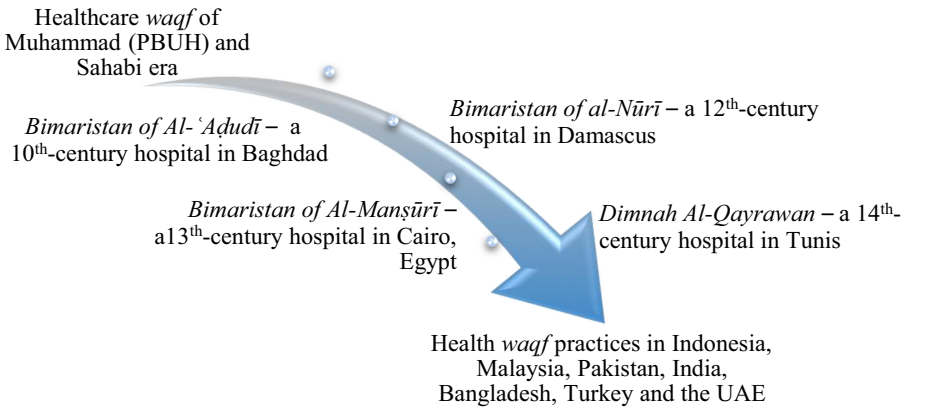


Figure 2.
Timeline of health *waqf*

Source(s): Al Ansari, 2013; Authors' compilation from official websites; Interview results

had more than 11 hospitals, which treated over a million patients (Ahmed *et al.*, 2015). Dimnah *Al-Qayrawan* in Tunis was established by *Sultan Ziyadatallah* in 1,426; it had large wards, lounges and clinics categorized based on diseases. *Waqf* and alms acted as main sources to operate this institution (Respondent R1, A1).

Currently, health *waqf* practices in many countries are dominated by private institutions. Several developing countries, such as Indonesia, Malaysia (see Table 3), Pakistan, India and Bangladesh, have large *waqf*-based health institutions, such as *Hamdard* Cancer hospitals and medical universities (Hayat and Naeem, 2014), which offer free health services and consultancy and medicines at a minimal charge (see Table 1).

	Pakistan	India	Bangladesh
Established	1948	1948	1953
First *Mutawalli*	Hakeem M. Said	Hakeem A. Hameed	Hakeem M. Yousaf
Current *Mutawalli*	Mrs. Saida Rasid	Abdul Mueed	*Hakim N. Marjhan*
Healthcare unit	500	750	200
Health *university*	1	1	1

Source(s): Hayat and Naeem (2014), interview results; official websites

Table 1.
Hamdard health *waqf*

In Turkey, *Sultan Al Fatih* established a free *waqf* hospital for all citizens. In addition, *Sultana Bezmialeem* succeeded in developing a health *waqf* named *Bezmialeem*, under which a hospital that offered free services and had over 2.000 beds was established (Sulistyowati, 2020). In the United Arab Emirates (UAE), an Islamic philanthropy had *Jamiyyatul Iman Liri'ayati Mardha Sarathan al-Khairiyyah* (Institute for the Benevolence of *al-Iman* for the Treatment of Cancer Patients) in Jeddah built the *Waqf* Hospital for Cancer Treatment on a *waqf* land area of 4,700 meters. This hospital provided healthcare services as well as offered psychological rehabilitation for cancer free of charge (Respondent P1, A4).

2.4 Previous studies

None of the studies till date have reviewed the health *waqf* literature. However, a few studies covered *waqf* in general. One of them was by Atan *et al.* (2017), who focused on the role of *waqf* as a poverty alleviator from 2006 to 2016; only three of the 289 *waqf* articles discussed healthcare issues. Dahlan and Mohamad (2019) studied *waqf* literature specifically from Malaysia for the last 60 years and found that only one of the 809 *waqf* articles covered healthcare issues. Meanwhile, Sowtali (2021) identified that the understanding of the *waqf* concept in the healthcare delivery system (HDS) is still new in Malaysia. Therefore, there arises a need to further explore this matter to understand its purpose, the types of *waqf* that can be implemented in HDS, the management procedure and the mechanism in sustaining the *waqf* for future investment.

The healthcare sector comprises institutions that provide medical services, medicines, medical staff, insurance and everything related to patient health facilities (Nazer and Tuffaha, 2017). *Waqf* can be categorized into khayri and *waqf* ahli; the aim of both is to ensure well-being. *Waqf* has multiple benefits; one of the main benefits is that it helps establish institutions such as hospitals (Jabeen and Faisal, 2018), clinics, insurance companies, schools and other medical care institutions. Ascarya and Tanjung (2021) proposed a solution for medical assistance using *zakat* and *infaq* and health-care *waqf* using *waqf* from ISF instruments, especially *zakat*, *infaq* and *waqf* that could help the government during the pandemic.

Waqf-based healthcare services are funded by *waqf* sources in the form of cash *waqf*, *waqf* assets (land and building) and *waqf* potentials. In Islam, health is an important part of life that needs *waqf* for aid, since *waqf* is an Islamic social and commercial instrument

(Ascarya *et al.*, 2017; Sulistyowati, 2018). Moreover, obligations of three of the five pillars of Islam require that Muslims be of sound health (Baqutayan, 2018). Ambrose *et al.* (2018) proposed the *waqf* model for financing public goods and mixed public goods in Malaysia; as per them, cash *waqf* investment can be allocated for government expenditures. *Waqf* donated to the health sector certainly lessens the burden on government budgets (Sukmana, 2020). Therefore, governments may consider creating policies to attract more awqaf (plural of *waqf*) by providing incentives, such as tax rebates.

Adnan *et al.* (2021) performed research to discover the aspects that must be considered while developing a collaboration arrangement between *waqf* organizations and hospitals. The research relied on secondary data, which was processed with NVivo 12. The findings showed that there are four main factors to consider when developing a good *waqf* governance model for hospitals: (1) decentralized architectural design and management, which were highlighted as important factors in previous literature on *waqf* hospital management; (2) good governance, which is an important factor in managing *waqf* hospitals; (3) partnership through the *Mudharabah* contract and (4) *Sharīʿah* compliance. Hassan and Jamaluddin (2022) developed the Model for Corporate *Waqf* for Healthcare (CWFH) using the *waqf* instrument. The model is important for the distribution of wealth and resources to improve health and well-being of the masses. It provides solutions and suggestions for maintaining the essential ethics of wealth through the *waqf* system.

According to Dukhan *et al.* (2021), *waqf* investment entities utilize several approaches to assure healthcare support for the poor. A commercial healthcare entity can act as an investment for a health *waqf* entity that is targeting the poor. Another option in this field is to limit *waqf* to the healthcare service, with the needy people benefiting from *waqf* and the wealthier patients paying for their treatment at the commercial market price, which will, in turn, serve as *waqf* investment. According to Ascarya and Tanjung (2021), healthcare services in Indonesia are typically provided by not-for-profit or for-profit healthcare providers, and these providers can benefit from awqaf such as not-for-profit health *waqf*, for-profit health *waqf* or integrated social-productive *waqf*.

Furthermore, the challenge in developing *waqf* lies with government support in maximizing the benefits of *waqf*. Government support leads to improved infrastructure, especially in healthcare services (Fauzia, 2017). Both traditional and modern healthcare methods are embedded in *waqf* healthcare systems (Krah *et al.*, 2018). Jamaluddin and Hassan (2021) suggested that *waqf* can mitigate the problems with healthcare sector in Malaysia. At least, the proposed structure can prevent the problem from getting multiplied in the future. With the advent of e-wallet *waqf*, *waqf* may act as the beacon of light for the economic progress in Malaysia. Meanwhile, Hayat and Naeem (2014) highlighted the best practice of *Hamdard* health *waqf* in Pakistan, India and Bangladesh, in which 85% of the profits are set aside for the welfare of the poor, health improvement and other humanitarian causes.

Mohideen *et al.* (2021) discussed the establishment of Universiti Sains Islam Malaysia (USIM) Specialist Clinic, which was found based on the idea of using *waqf* for providing healthcare for the less fortunate. By collaboration of many agencies, the clinic has served the needy to access better healthcare. Moreover, Htay *et al.* (2015) suggested that microhealth *takaful* supports the *waqf* that becomes the subsidies of funding. It helps people cover their healthcare expenses. In agriculture, *waqf* faces the challenge of solving the financial problems of farmers. Moh'd *et al.* (2017) proposed a *Waqf-Muzārʿah* supply chain model, which mitigates the issues related to high interest rates and collaterals in a partnership arrangement. Furthermore, Billah (2020) briefed that today money is one of the most expensive components of expenditure, which is not affordable to everyone. Thus, medical *takaful* may be a solution.

Various *waqf* systems, such as CWFCMM model, provide financially affordable options in Malaysia. This model has to apply the sophisticated model business due to the profit comes in *waqf*. For instance, nongovernmental organizations, the Malaysian Medical Relief Society (MERCY) that has this benefit (Zabri and Mohammed, 2018). To help refugees, Kachkar (2015) proposed a CWRMF, which expands the refugee micro business. Talib *et al.* (2020) found that the *waqf* report must be standardized due to the regulator from the SIRCs that make sure the operational concern on Islamic principles. Sukmana *et al.* (2018) investigated productive *waqf* in Islamic Hospital, Malang Islamic University, Indonesia. In the hospital, the VIP patient room building was built from *waqf* funds provided by the government. The researcher emphasized that the key success of these lies in efficiency and the ability to seek a profitable project.

3. Methodology

3.1 Data

The paper aims to rejuvenate *waqf* in the health sector by identifying and elaborating its issues and challenges. The primary and secondary data were used to identify and elaborate on the issues and challenges. The data were collected from respondents after careful consideration regarding relevance and expertise.

3.1.1 Respondents. Respondents were categorized into three groups that represented three related elements. The health *waqf* practitioners formed Group 1; the group comprised four respondents from the following selected institutions: WANCorp, Dompet Dhuafa' health *waqf* Indonesia, Muhammdiyah health *waqf* Indonesia and Kasih *waqf* Hospital Malaysia. Those four health *waqf* institutions were chosen based on their size and age of operation. These are considered representatives of the *waqf*-based health sector. Group 2 comprised government officials serving as regulators. *Indonesia Waqf Board* (BWI), *Ministry of Religious Affairs Waqf* Department, *Ministry of Finance* and *National Zakat Board* (BAZNAS) were chosen after careful consideration. Group 3 comprised academicians and researchers. *International Islamic University Malaysia* (IIUM), *Airlangga University* (Indonesia), *Fathoni (Yale) University* (Thailand) and *Universitas Indonesia* were chosen to obtain fruitful knowledge and rich perspectives regarding the role of *waqf* in providing resources in the healthcare sector.

No	Code	Initial	Group	Designation	Education
1	P1	AS	Health *waqf* practitioner	Head of the health council	MSc
2	P2	BM	Health *waqf* practitioner	General manager	MBA
3	P3	MB	Health *waqf* practitioner	General manager	BBA
4	P4	MF	Health *waqf* practitioner	Founder	MSc
5	R1	ITS	Regulator	Commissioner's council	PhD
6	R2	FN	Regulator	Head of Ziswaf Department	MSc
7	R3	DIH	Regulator	Head of Sharīʿah Fund Group	MSc
8	R4	HZ	Regulator	Head of Ziswaf center	PhD
9	A1	FH	Academic	Faculty member	PhD
10	A2	Fa	Academic	Faculty member	PhD
11	A3	SK	Academic	Dean	PhD
12	A4	SL	Academic	Vice rector	PhD

Note(s): *Ziswaf: *zakat*, *infaq*, *ṣadaqah* and *waqf*

Table 2.
Respondent profile

As Table 2 describes, respondents were positioned in roles relevant to the field researched. Most of the interviewees were highly educated. A total of 50% of the interviewees had doctorate degrees, 41.67% had master's degrees and 8.33% had bachelor's degrees. Among the interviewees, two (16.67%) were females.

Furthermore, secondary data were obtained from reviewing relevant literature, such as scientific paper journals, books, official websites and other relevant websites.

3.1.2 Questionnaires. Two sets of questionnaires were prepared to collect the primary data. Set 1 consisted of five main questions for three respondents as representatives of each group in the Round I session (preliminary interview). The representatives were chosen after careful consideration regarding expertise and time availability in order to obtain deep and comprehensive insights and help with formulation of the framework of the questions. Set 2 consisted of eight questions for all respondents. The questions had a different importance for each group of respondents.

Set 1 (Round I).

(1) Kindly give us your perspective on the role of *waqf* in providing healthcare services.

(2) According to you, what were the health *waqf* institutions that existed in the past?

(3) Based on your outlook, what are the health *waqf* institutions that exist?

(4) What are the existing issues with health *waqf*? Why?

- As practitioner?
- As regulator?
- As academic?

(5) What are the existing challenges with health *waqf*? Why?

- As practitioner?
- As regulator?
- As Academic?

Set 2 (Round II).

(1) Kindly give us your perspective on the role of *waqf* in providing healthcare services. (The three respondents in Round I are excepted).

(2) According to your outlook, what were the health *waqf* institutions that existed in the past? (The three respondents in Round I are excepted).

(3) Based on your outlook, what are the health *waqf* institutions that exist? (The three respondents in Round I are excepted).

(4) Please arrange the key issues and challenges identified below in an order starting from the one that needs to be solved most urgently. Please justify the order.

- Data, technology and digitalization
- Human resources
- Legal issues of health *waqf*
- Funding or Finance
- Collaboration and coordination
- Fundamental healthcare insufficiency
- Infrastructure and management
- Accountability and sustainable development

(5) How to overcome the issues identified? How to face the challenges identified?

(6) What is the key success to developing the health *waqf* in the future?

(7) What is your recommendation as a/an practitioner/regulator/academic?

3.2 Methods

The study applied qualitative research method through literature reviews and in-depth interviews. In Phase 1, relevant literature was reviewed to identify and classify the issues and challenges. For interviews, open-ended questionnaires were used with 12 selected respondents. A preliminary interview was conducted, which was important to determine the research gap and set the second questionnaire (Ullah and Khanam, 2018) (See Figure 3).

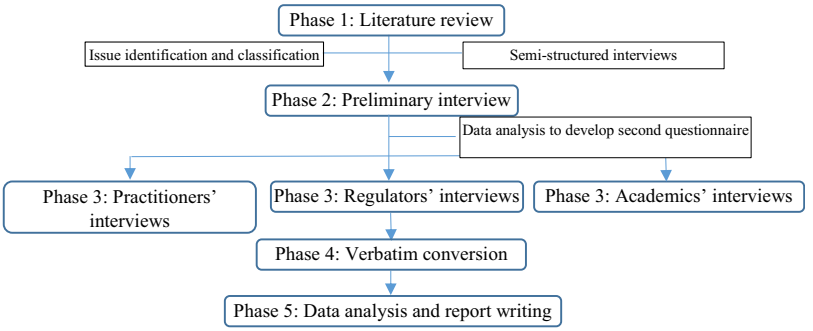


Figure 3.
Steps of research

Phase 2 started with preliminary in-depth interviews with a representative from each group to obtain valuable insights about the issues identified as well as to produce final questionnaires. Data obtained from preliminary interviews are considered a valid reference for the next step. Subsequently, Phase 3 comprised in-depth interviews with all respondents. It commenced with prepared questions. However, respondents displayed considerable latitude to adapt their answers to a specific direction. This allowed for more intuitive and natural conversations as well as helped obtain deep insights. Next, Phase 4 involved data conversion using a verbatim technique, and last, Phase 5 involved data classification, analysis and synthesis into report.

4. Findings and discussion

This section focuses on two points: (1) literature review and preliminary interview results and (2) comprehensive interview results and discussion.

4.1 Current practices of waqf-based healthcare institutions

In this subsection, results from the literature review and partial results from preliminary in-depth interviews with the representatives of each group are covered. The current practices of *waqf*-based healthcare institutions, as identified in one of the questionnaires, can be described as follows:

Table 3 provides empirical data of current *waqf*-based healthcare institutions. The *waqf*-based hospitals and clinics of Indonesia are dominated by private Islamic philanthropy foundations, such as DD, Muhammadiyah, Hasyim As'ari Hospital, Sulthan Agung hospitals, RBC free hospitals and Salman Hospital (Respondents P2, R3 and A1). Malaysia has some

Indonesia Foundation	Institution	Malaysia Foundation	Institution
DD Foundation	DD Hospital and Clinics; mobile dispensaries and health services	JCorp and MAIJ	WanCorp Hospitals and Clinics
BWI-DD	Achmad Wardi Eye hospital	USIM and MAIN	USIM Specialist Clinic
Muhammadiyah Foundation	2.119 units of hospitals, clinics and health services	MAIN; Tabung *Waqaf Kasih*	*Kasih Waqf* Hospital
NU-DD	Hasyim As'ari Hospital	Muamalat Bank	Health *waqf* services
BAZNAS	BAZNAS free hospital	JAWHAR	Free dispensaries
YBWSA	Sulthan Agung hospitals	ABIM	Al-Islam Hospital
Sinergy Foundation	RBC free hospitals	MAIWP	*PUSRAWI* Hospital
Waqf Surakarta	Surakarta Islamic Hospital	The Congregation of the Brothers of Mercy	Al-Islam Hospital
PAII	Medikidz *waqf*	*Waqf* hospital *Madinatussalam* (Thailand)	
Salman ITB	Salman Hospital	*Myint Myat Phu Zin waqf* Clinic (Myanmar)	

Table 3.
Current practices of *waqf*-based healthcare institutions in Indonesia, Malaysia, Thailand and Myanmar

Note(s): DD = Dhompet Dhuafa; BWI = Indonesia *Waqf* Board; NU = Nahdlatul Ulama; BAZNAS = National *Zakat* Board; RBC = Rumah Bersalin Cuma-Cuma; PAII = Pengelola Aset Islami Indonesia; MHDC = Medical Health Center; ITB = Institut Teknologi Bandung; JCorp = Johor Corporation; WanCorp = *Waqaf* An Nur Corporation; MAIJ = Majlis Agama Islam Johor; USIM = Universiti Sains Islam Malaysia; MAIN = Majlis Agama Islam Negeri; JAWHAR = Jabatan *Zakat Waqf* and Haji; ABIM = Angkatan Belia Islam Malaysia; MAIWP = Majlis Agama Islam Wilayah Persekutuan
Source(s): Authors' compilation from official websites and various sources; in-depth interview results

waqf-based healthcare institutions that are dominated by WanCorp spreads out of the states. In addition, Thailand and Myanmar, which are Muslim-minority countries, also have *waqf*-based healthcare institutions, namely Madinatussalam hospital and Myint Myat Phu Zin *waqf*-based clinic. In this regard, Respondent A4 stated

> Indeed, not many health *waqf*'s references in these two Muslim-minority countries.

Current health *waqf* practices in South East Asia are dominated by Indonesia and Malaysia as these are Muslim-majority countries. Likewise, references to this field are abundant in these two countries. During the COVID-19 pandemic, Indonesia focused on tackling COVID-related health problems, with *waqf* playing an important. Now, Malaysia's understanding of the *waqf* concept in the HDS is new; beyond COVID-19 concerns, renal care, cancer care and stroke care are other focus areas in this country. In this regard, there is a lot to be explored; however, among the most critical requirements are ensuring patients' quality of life and reducing family burden in caring for those affected.

4.2 Issues and challenges of waqf *in providing healthcare resources*

In this subsection, eight issues and challenges with them are discussed. First, results from the preliminary open-ended in-depth interviews are described.

4.2.1 Preliminary findings. In this subsection, findings from the preliminary interviews are described. The fruitful outlook from the group representatives provided valuable insights for the main interview framework and determined the research concept. All respondents agreed that the health sector is the most important pillar (more important than economic, educational and social sectors) that has to be tackled by *waqf* resource, particularly during and after the pandemic.

According to Respondent P4,

> The COVID-19 era is the right time to prove the essential role of *waqf*; health is the first most urgent sector to solve before others.

Furthermore, the success of current health *waqf* institutions (see Table 3) was influenced by the past practices. Respondents claimed that some *waqf* hospitals (*bimaristans*) that existed during the 10th–14th centuries (see Figure 2) can become the ideal models.

The Commissioner of Indonesia *Waqf* Board (Respondent R1) explained,

> *Waqf* . . . mainly the productive *waqf* . . . is designated to support the public facilities, particularly in the health sector. In the past, one of the examples was Al-Adudi Hospital in Baghdad in the 10th Century. In Baghdad, some of the farmland helped the hospital finances. What was the hospital doing at that time? First, it provided services to patients without a membership system. Second, it treated patients free of charge, treating citizens, non-citizens and even travellers. If the patients were poor, they were given some money so that they could start a business after they recovered.

In addition, the authors recapitulate the issues and challenges regarding health *waqf*: (1) human resources, (2) funding or finance, (3) collaboration and coordination, (4) health *waqf* legal issues, (5) fundamental healthcare insufficiency, (6) data, technology and digitalization, (7) accountability and sustainable development and (8) infrastructure and management.

4.2.2 The key issues and challenges of health waqf during the pandemic. Focused discussions were conducted with the respondents based on the eight key issues and challenges identified to analyze the problems and obtain valuable insights to formulate solution recommendations for relevant stakeholders. The recapitulation of the research process will be led to the proper mapping of issues and challenges (see Figure 4).

The COVID-19 pandemic has had ill effects at the global level (Razak *et al.*, 2021). Among the sectors affected, the most critical one is the health sector. In the context of the healthcare

Source(s): Interview results

Figure 4.
The eight key issues and challenges of health *waqf*

sector, COVID-19 has triggered new habits and behaviors, such as increased awareness regarding health protocols. These changes are permanent. Today, all sectors are struggling and trying to survive. Similarly, health *waqf* is also facing emergency issues and challenges that must be tackled to make things better during and after the pandemic.

(1) Human resources

Crucial issues of human resource in relation to health *waqf* are weak performance of fund manager, the lack of *waqf* jurisprudence/*fiqh* and healthcare management skill and the lack of medical experts with mental toughness and physical endurance. The readiness of human resources for a health *waqf* institution is an absolute condition to be obtained (Respondent P3). The *nazir's* or *mutawalli's* skill and competence in managing health *waqf* sources influence the outcome.

The General Manager of DD health *waqf* (Respondent P2) stated

> There is a lack of human resources expertise means the mastery of relevant literacy and the ability to operate healthcare system appropriately.

Countries with good healthcare report better health outcomes and fewer hospital admissions (Bresick *et al.*, 2019) because of fewer ill people. This also leads to professionality and ensures high-quality human resources. Low quality of human resources at social service institutions such as those funded by health *waqf* is a problem that must be tackled immediately. Another human resource issue identified in relation to contemporary health *waqf* practices is poor human development. Colleges and universities as human capital providers do not socialize with and encourage students to pursue their careers at social health institutions rather than at commercial health institutions.

Human capital is a key component that controls the organizational system and is a determinant of an organization's success. The numbers of idle *waqf* assets and lands is a reflection of Nazhir's inability. Respondent P1 emphasized,

> If you want to succeed in a business, it must be managed by people who have relevant expertise and the potential, and they should also be competent to do it. I see from your question whether we will submit this to the private professionals. So that we can do as you mentioned. could running well or assistance. Assistance means that Nazir and Nazir's partners are in the same boat, the term is assisted by a professional.

The Capacity Building Program (CBP) for *Nazir* must develop *waqf* human capital (WHC) by providing intensive training to impart human agility in the "new normal" era. Also, maintaining loyalty-based talent is important. Since the pandemic, medical profession is being considered a risky profession, and human capital has become more relevant. The agility to face uncertainty and the capability of built up by each unit of competency in health *waqf* institutions are the need of the hour.

(2) Funding/finance

The interviews resulted in a consensus that health *waqf* suffers from the lack of funding. In other words, *waqf* funds collected were far from the expected amount. This limits the utilization of *waqf*-based health resources. Now, health is closely linked with other crucial sectors, such as economic, social, educational, cultural and environmental; thus, the issue ultimately affects all these sectors. In the case of health, the problem occurs in one society and affects many dimensions of life. Respondent A2 posited

> Generally, high public health government expenditures were dominated by developed countries with the best healthcare systems such as Norway, Netherlands, Luxembourg and Australia. Meanwhile, most developing countries, particularly Asia and Africa, are having trouble obtaining sufficient healthcare funds.

A general manager (Respondent P3) said,

> In the past, the entire welfare budget including health budget in Istanbul during the Osman Caliphate came from charitable foundations and was almost without financial shortage. Indeed, since the beginning of Islam, health care has been financed by *waqf*, *zakat*, *infaq* and other sodaqo. Nowadays, the government should be more advanced than private social funding organizations.

Currently, in many countries, most of the *waqf*-based healthcare foundations, such as hospitals, clinics and nonpermanent healthcare institutions, from developing countries are facing financial crisis, which hinders institutions' sustainability (Respondent R2). *Waqf*-based healthcare institutions are facing financial obstacles because of the mismatch between supply and demand of *waqf* funds. These institutions, even those under large corporations such as *Waqf* An-Nur clinics and hospitals supported by WANCorp (Malaysia) and Dompet Dhuafa hospital and clinics powered by Tabung *Waqf* (Indonesia), are facing insecurity and financial crisis (Respondents P2 and P3).

The Head of ZISWAF Department (Respondent R1) insinuated,

> One of the biggest obstacles in developing *waqf*-based health care is the limited investment for operation and healthcare facilities' sufficiency . . .. *Waqf* is one solution to these problems. Of course, blended finance with other resources is needed, both from the private and government resources.

The "income variation" by joined program with health equipment, health infrastructure providers and other facilities supporters is brilliant to the financial independence. Moreover, subsidiaries of *waqf*-based healthcare institutions can also cooperate with pharmacy companies, coffee and laundry firms, parking service providers, minimarkets, etc. (Respondent P2). Further, hybrid *waqf* develops and strengthens healthcare institutions. This means, all kinds of *waqf* and other Islamic social funds should synergize with the other sources of social funds. Health *waqf* may also take advantage of cross-subsidies among OIC member countries (Respondent A1). Additionally, hospitals supporting businesses related to the operational needs can be organized as a "new income generators," which significantly support health *waqf*. Furthermore, to tackle the insufficiency and ineffectiveness of funding in the healthcare system, *waqf* provides flexibility with funds and utilization. It is compatible with a kind of allocation that guarantees the poor and vulnerable population health in the form of medical *waqf takaful*.

Additionally, a strong political will is needed in the form of legislation or regulations as the legal basis of the initiatives set up by the health *waqf*. *Waqf* regulation in Indonesia is implemented under Act No. 41 of 2004 and Government Regulation Number 42 of 2006; these are not specific legislations, yet they regulate health *waqf* management. Meanwhile, each Malaysian state issues the legal basis for *waqf*, such as Administration of Islamic Law (Federal Territories) (Act 505 of 1993), Selangor Wakaf Enactment (No. 7 of 1999), Trustee Act 1949 (Act 208), Malacca Wakaf Enactment (2005) and Negeri Sembilan Wakaf Enactment (2005). Many efforts are being made to improve Malaysia's *waqf* system in terms of administration management. *Waqf* can be managed by addressing the application of the company *waqf*, which appears to have succeeded in reforming the Malaysian *waqf* system.

Respondent A2 stated:

> The effectiveness and validity of health *waqf* implementation at least must deeply consider four aspects: clear legal administration, the founder professionalism, the proper beneficiaries, sustainable funding.

Indeed, the characteristics of the implementation of *waqf* law between Indonesia and Malaysia are adjusted to the strength of *waqf* resources themselves. Therefore, the government should prove its support by easing the process of *waqf* operation in the form of a constitution. Developing a particular legal framework in the health *waqf* that eases and simplifies the

implementation is an appropriate step. For instance, "istibdal" regulation is relaxed to enable development of productive *waqf* in the health sector. The government should also regulate the specific harmony of the legal structure between *waqf* law and health legislation so that private and public health institutions can achieve a healthy society together.

(3) Fundamental healthcare insufficiency

Poverty and health problems are closely related issues. Poverty, caused by financial factors, is a major cause of ill health and a barrier to basic healthcare access – poor people do not have sufficient funds to pay for the increasingly expensive health costs (Respondent A2). The third of the 17 SDGs is "good health and well-being", which ensures healthy lives, reduced child mortality that raises life expectancy and promotion of well-being for all ages. Currently, this is not achieved comprehensively (Respondent R4) (see Figure 5).

The multi-dimensional impact of COVID-19 first considers the health sector itself to be the core of the problem and the poor and vulnerable the most impacted parties. The highest risks affect these cohorts, causing the system to be overwhelmed and leading to a prolonged multi-dimensional crisis.

Respondent P4 explained:

> Primary healthcare is a difficult thing to achieve for poor and vulnerable groups. Even during normal conditions before the Covid-19 pandemic, these people have difficulty preventing the disease and categorizes as a high death potential cohort.

The health condition in the OIC member countries has become a massive challenge and needs innovative problem-solving. The low-income population needs basic health guarantees from public and private health institutions, even though public health is under the governmental domain as part of the government's obligations to provide and manage the benefit for society well. Healthy living is a natural concern for everyone and proper healthcare is a basic requirement, even for the poorest people. Proper healthcare needs to be implemented immediately by the source of *waqf*. Meanwhile, funding and financial settlements are essential matters of this social health institution. A reliable fundraising program is needed to

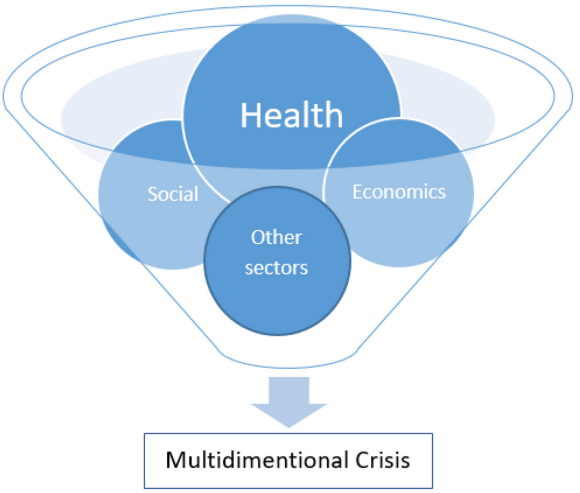


Figure 5.
The sectors most impacted by the COVID-19 pandemic

Source(s): Interview result synthesis

settle the *waqf* health institutions that provide permanent financial assistance through *waqf*, *zakat* (almsgiving), sodaqo and other kinds of donations.

(4) Data, technology and digitalization

For *waqf* to deal thoroughly and firmly with healthcare matters requires valid data and high digitalization. A comprehensive integrated information and data system linking the *waqf* foundation and health institution to the entire world is not yet available. The lack of data validation of asset *waqf* and cash *waqf* is also a weakness that requires technological advancements. The role of digital information appropriates, such as blockchain, must be realized. Hospital technology and medical equipment are not prepared for unpredictable and unexpected pandemics, such as COVID-19.

Respondent P4 opined:

> *Waqf* that involves high digital technology is considered to improve supportable health services.

The innovation of health institutions powered by *waqf* will occur postpandemic. Many aspects of work that shift towards the "new normal" are handled virtually, such as consulting doctors, healing guidance and recipe redemption. Therefore, the millennial-dominated labor force, which is fully engaged in information technology (IT) needs to attract and maintain IT and data involvement in health *waqf*. Furthermore, the integrated data centre will support *waqf* digitalization as it is one of the keys to strengthening health *waqf* growth. Digital awareness and digital readiness are crucial for the resilience of social health institutions. Social health institutions must connect with others to generate the "big data" of *waqf* health.

(5) Accountability and sustainable development

Some respondents acknowledged the lack of accountability and transparency. The revival of *waqf* institutions in recent years has been accompanied by accountability and transparency issues, even as *waqf* performance is increasingly being discussed by academicians and constituents. In the meantime, most practitioners are considering the potential lack of security related to sustainability. The prolonged situation of uncertainty during and postpandemic is the essential cause. Furthermore, the development of health *waqf* is affected by several factors, such as the lack of support, obstacles in the form of cash *waqf* and "*istibdal*", which is concerned with the regulation in each country.

The unsolved problems of accountability, sustainability and development have become a major concern for stakeholders. *Waqf* accountability is supported by three strategic factors: regulatory, stakeholders, and religious image. The study result shows that the management and administration of *waqf*, which has been hindered by mismanagement, misappropriation and lack of talent, can be improved and managed systematically. Digital accounting and competitive operation of health *waqf* institutions guarantee sustainability and development. Compliance with *waqf* governance according to the provisions of Islamic law in terms of health designation must be fulfilled. These laws also deal with digital accounting. The competitive operation of health *waqf* institutions further guarantees sustainable development.

(6) Infrastructure and management

The minimal infrastructure that does not suffice for patient needs does not get enough attention, particularly in small medical care facilities, such as clinics and mobile dispensaries established by small *waqf* organizations. The development of infrastructure, both hard and soft, such as the system itself and delivery of specialized services to patients, needs to be fulfilled adequately. Commercialization of healthcare has become a major trend in countries without the capacity to strictly regulate the healthcare sector. The domination of for-profit health services massively supported by stunning and comprehensive infrastructures extends

to many private independent providers, majorly in African and Asian countries. The infrastructure gap between commercial and social healthcare providers is highlighted by most respondents.

Respondent A3 argued:

> Obviously, lack of infrastructure is one of the constraints in expanding the operation to a larger scale than existed.

"Re-focussing [and] re-allocating" the resources during and postpandemic must prioritize these two vital aspects of the healthcare sector. They must be closely connected to, for example, Ṣukūk and must cooperate with health corporations and infrastructure companies to elevate the health *waqf* to a wider scope and higher level of quality. The important role of the nazir here is to credibly and competently gather, manage and co-brand infrastructure procurement and many kinds of *waqf* sources. The success of the nazir/mutawalli can change the community mindset and foster trust. Furthermore, the investment of *waqf* funds in public infrastructure projects can be a good step. The benefits from the endowed infrastructure project can be altered to supply public health facilities.

The above eight key issues highlighted the massive challenges that must be utilized as an opportunity to achieve better health *waqf* development during and postpandemic. Based on the key issues and challenges identified, most of the respondents voted that the eight issues that urgently needed to be solved from most to least are human resources; funding or finance; collaboration and coordination; legal issues of health *waqf*; the fundamental healthcare insufficiency; data, technology and digitalization; accountability and sustainable development; infrastructure and management. Therefore, researchers have arranged the report according to respondents' votes order. Several respondents' justification emphasized a solution to the essential issues and challenges identified. It must be followed by real action, such as organizing moveable *waqf* assets, to support health funds and infrastructure for urgent COVID-19 handling.

5. Conclusion and policy recommendation

This paper attempts to rejuvenate *waqf* for the health sector by identifying and elaborating its issues and challenges. Accordingly, this paper recapitulates the eight issues and challenges regarding (1) human resources; (2) funding or finance; (3) collaboration and coordination; (4) legal issues of health *waqf*; (5) fundamental healthcare insufficiency; (6) data, technology and digitalization; (7) accountability and sustainable development (8) infrastructure and management. Therefore, the proposed solution for the issues and challenges identified are (1) the importance of the CBP for Nazhir as the WHC must be manifested in the form of intensive training towards human agility in the "new normal" era. Maintaining talent-based loyalty is important. The agility skill facing uncertainty and the capability of building up by each unit of competency in a health *waqf* institution is needed for high-level thinking skills; (2) the hybrid *waqf* needs to be realized to develop and strengthen comparative health institutions. This means all kinds of *waqf* and other Islamic social funds can synergize whether other sources of social funds are non-permanent; (3) social health institutions must connect with other relevant institutions in terms of "big data" of *waqf* health; (4) a particular legal framework must be developed in the health *waqf* that eases and simplifies the implementation. Compliance with *waqf* governance according to the provisions of Islamic law in terms of health designation must be fulfilled. This also deals with digital accounting so that competitive operation of health *waqf* institutions further guarantees sustainable development; (5) re-focusing and re-allocating the resources during and postpandemic must prioritize these two vital aspects of the health sector.

Experts and scholars believe that strong partnership and collaboration among three parties, practitioners, regulators and academics, in tackling the above issues can be the

solution and a potential way that essentially embraces the government as a policy consideration, optimizing the elaboration among productive *waqf* with other kinds, improving government-*waqf* institution's coordination and increasing awareness to improve the significant development of healthcare *waqf* in the new normal. The regulator needs to be concerned about the legal reformation of *waqf*, whereby the government should consider re-evaluating *waqf* acts with the health sector.

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