

Strategic Implementation of Productive Waqf in Healthcare Social Security: AHP-Based Analysis

Ripki Mulia Rahman^A, Indupurnahayu^B, Qurroh Ayuniyyah^C, Didin Hafidhuddin^D

Abstract

The sustainability of healthcare financing remains a major challenge for developing countries pursuing Universal Health Coverage (UHC). In Indonesia, the National Health Insurance system (*Jaminan Kesehatan Nasional*-JKN) administered by BPJS Kesehatan has significantly expanded access to healthcare but continues to face structural constraints, including financial deficits, service coverage gaps, and operational inefficiencies. This study examines the strategic role of productive waqf as a complementary mechanism to strengthen healthcare-based social security in Indonesia. Using a mixed-methods approach, the study integrates qualitative data from in-depth interviews with key stakeholders—waqf regulators, nazir practitioners, healthcare managers, and social health insurance experts—with the Analytical Hierarchy Process (AHP) to prioritize implementation strategies under multi-criteria and multi-stakeholder conditions. The findings indicate that the limited contribution of productive waqf to healthcare social security is primarily caused by weak implementation strategies rather than insufficient waqf asset potential. Nazir professionalism and institutional capacity emerge as the most critical determinants, followed by the development of integrated waqf-healthcare operational models and effective stakeholder coordination. The AHP results further highlight that strengthening nazir professionalization and establishing waqf-based healthcare units aligned with the national health insurance system represent the highest strategic priorities. This study contributes to the literature by providing an implementation-oriented and evidence-based framework that bridges Islamic social finance and health policy, offering practical guidance for policymakers and practitioners to enhance the role of productive waqf in sustainable healthcare financing.

Keywords: *Productive Waqf, Healthcare Social Security, National Health Insurance, Analytical Hierarchy Process (AHP), Islamic Social Finance, Indonesia.*

INTRODUCTION

The sustainability of healthcare financing has become a major concern for many countries striving to achieve Universal Health Coverage (UHC), particularly in developing economies with large vulnerable populations. In Indonesia, the National Health Insurance system

^AUniversitas Ibn Khaldun Bogor, Indonesia, Email: ripki_mulia.rahman@uika-bogor.ac.id

^BUniversitas Ibn Khaldun Bogor, Indonesia, Email: indupurnahayu@uika-bogor.ac.id

^CUniversitas Ibn Khaldun Bogor, Indonesia, Email: qurroh.ayuniyyah@uika-bogor.ac.id

^DUniversitas Ibn Khaldun Bogor, Indonesia, Email: hafidhuddin@yahoo.com

(*Jaminan Kesehatan Nasional – JKN*), administered by BPJS Kesehatan, has significantly expanded healthcare access but continues to face structural challenges, including financial deficits, uncovered medical services, and operational inefficiencies (World Health Organization [WHO], 2010; Agustina et al., 2019). These limitations highlight the need for complementary financing mechanisms that can strengthen health system resilience without increasing the fiscal burden on the state.

In this context, Islamic social finance, particularly productive waqf, has attracted growing scholarly and policy attention as a potential source of sustainable social funding. Unlike consumptive charitable instruments, productive waqf is designed to generate continuous returns that can be allocated for long-term public services, including healthcare (Cizakca, 2011; Ascarya, 2014). Indonesia, as the country with the world's largest Muslim population and substantial waqf asset potential, presents a unique opportunity to integrate productive waqf into the national healthcare financing architecture (Badan Wakaf Indonesia, 2023).

Despite its considerable potential, the implementation of productive waqf in Indonesia's healthcare sector remains fragmented and suboptimal. Empirical evidence suggests that the primary constraints are not related to the availability of waqf assets, but rather to weak operational strategies, low professionalism of nazir (waqf managers), inadequate governance structures, and limited coordination among key stakeholders such as regulators, healthcare providers, and Islamic financial institutions (Budiman & Pratama, 2021; Thaker & Thaker, 2019). As a result, productive waqf initiatives often operate in isolation and fail to achieve scale, sustainability, or systemic impact within the national health insurance framework.

Existing academic literature on waqf and healthcare has largely focused on normative, legal, and conceptual discussions, emphasizing the moral and religious foundations of waqf or proposing idealized models without sufficient operational grounding (Kahf, 2003; Cizakca, 2011). While several studies acknowledge the importance of governance and institutional capacity, few provide empirical tools for prioritizing implementation strategies under real-world constraints, particularly in health systems dominated by national insurance schemes (Mohsin et al., 2016). Consequently, there is a critical research gap concerning how productive waqf can be strategically operationalized to complement national health insurance systems in a measurable and policy-relevant manner.

Moreover, healthcare financing decisions inherently involve multiple actors with diverse interests and levels of influence, including government agencies, waqf authorities, hospital managers, and insurance administrators. Addressing such complexity requires a structured decision-making framework capable of accommodating multiple criteria and stakeholder perspectives simultaneously. The Analytical Hierarchy Process (AHP) has been widely applied in health policy and public sector management to support multi-criteria decision-

making and strategy prioritization based on expert judgment (Saaty, 2008; Liberatore & Nydick, 2008). However, its application in the context of productive waqf integration with national health insurance remains notably limited.

This study seeks to address these gaps by applying an AHP-based, multi-stakeholder framework to prioritize strategic implementation options for productive waqf in supporting Indonesia's national health insurance system. By focusing on operational dimensions, such as nazir professionalism, institutional coordination, regulatory alignment, and financing sustainability, this study moves beyond normative discourse and offers empirically grounded insights for policymakers and practitioners. In doing so, the study contributes to the emerging literature on Islamic social finance and health policy, while providing practical guidance for integrating productive waqf into contemporary healthcare financing systems.

LITERATURE REVIEW

Productive Waqf and Healthcare Financing

Productive waqf has increasingly been discussed as a sustainable instrument within the broader framework of Islamic social finance, particularly for financing public goods such as healthcare. Unlike traditional consumptive waqf, productive waqf emphasizes asset utilization and revenue generation, enabling continuous funding for social services (Cizakca, 2011; Kahf, 2003). In the healthcare sector, productive waqf may take the form of hospitals, clinics, medical equipment, or business units whose returns are allocated to subsidize medical services for underserved populations (Thaker & Thaker, 2019).

Several empirical studies highlight the potential of productive waqf in improving healthcare access and reducing financial barriers for low-income groups. For instance, Mohsin et al. (2016) argue that waqf-based health institutions can complement public health financing by providing targeted support for vulnerable populations. Similarly, Ascarya (2014) emphasizes that productive waqf aligns with sustainable development principles by offering long-term financing mechanisms without relying on recurrent government expenditure. However, these studies largely focus on potential and conceptual feasibility rather than implementation strategies within existing national health insurance systems.

In the Indonesian context, productive waqf has been implemented primarily in asset-based forms, such as land and buildings for hospitals or clinics, while revenue-generating models remain limited in scale and scope (Budiman & Pratama, 2021). Consequently, the contribution of productive waqf to systemic healthcare financing remains marginal, particularly in comparison to dominant mechanisms such as national health insurance schemes.

Governance, Nazir Professionalism, and Institutional Capacity

Governance quality and managerial capacity are widely recognized as critical determinants of productive waqf performance. Nazir, as the

primary managers of waqf assets, play a central role in ensuring accountability, sustainability, and strategic development. Weak governance structures, lack of professional expertise, and insufficient performance monitoring have been consistently identified as major constraints in waqf management across Muslim-majority countries (Kahf, 2003; Cizakca, 2011).

Empirical evidence suggests that many nazir institutions operate with limited business orientation and inadequate financial reporting systems, which restrict their ability to scale productive activities or engage in strategic partnerships (Budiman & Pratama, 2021). In the healthcare sector, these limitations are further exacerbated by the complexity of medical service provision, regulatory compliance, and cost-control mechanisms required to maintain service quality and financial viability.

Recent studies emphasize the need to reconceptualize nazir roles from custodial asset keepers to professional managers capable of strategic planning, investment decision-making, and multi-sector collaboration (Thaker & Thaker, 2019). Without such transformation, productive waqf initiatives risk remaining symbolic rather than impactful contributors to healthcare financing systems.

Multi-Stakeholder Framework in Health Policy and Islamic Social Finance

Healthcare financing and service delivery inherently involve multiple stakeholders with diverse objectives and institutional mandates. Governments aim to ensure universal coverage and cost containment, healthcare providers focus on service quality and operational sustainability, while insurance administrators prioritize financial balance and risk management (WHO, 2010; Agustina et al., 2019). Integrating productive waqf into this ecosystem adds further actors, including waqf authorities, Islamic financial institutions, and philanthropic organizations.

The literature on health policy emphasizes that successful implementation of complex financing mechanisms depends on effective stakeholder coordination, clear role delineation, and aligned incentives (Ansell & Gash, 2008). Similarly, studies on Islamic social finance highlight the importance of cross-sector collaboration to maximize social impact and avoid fragmentation (Mohsin et al., 2016).

Despite this recognition, existing waqf-related studies rarely adopt a structured multi-stakeholder analytical framework. Most analyses treat stakeholders descriptively rather than systematically assessing their relative influence, priorities, and strategic roles. This gap limits the practical applicability of existing models, particularly in contexts where waqf is expected to complement large-scale national systems such as health insurance programs.

Analytical Hierarchy Process (AHP) in Health and Public Policy Decision-Making

The Analytical Hierarchy Process (AHP) is a multi-criteria decision-making method widely applied in health policy, hospital management, and public sector planning to prioritize strategies under complex and resource-constrained conditions (Saaty, 2008). By structuring problems into hierarchical levels, objectives, criteria, actors, and alternatives, AHP enables decision-makers to incorporate both quantitative and qualitative judgments in a consistent manner.

In healthcare studies, AHP has been used to prioritize health interventions, allocate limited resources, and evaluate policy alternatives involving multiple stakeholders (Liberatore & Nydick, 2008). Its strength lies in its ability to capture expert knowledge while maintaining methodological transparency through consistency ratio testing.

However, the application of AHP within Islamic social finance, and particularly in the context of productive waqf for healthcare, remains limited. Existing studies seldom integrate AHP with waqf governance issues or national health insurance systems. This methodological gap suggests a strong opportunity to employ AHP as a strategic tool for prioritizing productive waqf implementation options in complex healthcare financing environments.

Research Gap and Conceptual Positioning

Based on the reviewed literature, three key gaps can be identified. First, most studies on productive waqf and healthcare remain normative or conceptual, with limited attention to operational implementation strategies. Second, the role of governance quality and nazir professionalism is acknowledged but rarely translated into measurable strategic priorities. Third, there is a lack of structured, multi-stakeholder decision-making frameworks that integrate productive waqf into national health insurance systems.

To address these gaps, the present study applies an AHP-based, multi-stakeholder framework to prioritize strategic implementation options for productive waqf in supporting national health insurance. By doing so, it contributes empirically to the intersection of Islamic social finance and health policy, offering actionable insights for policymakers, waqf institutions, and healthcare providers.

METHOD

Research Design

This study employs a mixed-methods approach with a qualitative-dominant exploratory design, integrated with a quantitative decision-making tool, namely the Analytical Hierarchy Process (AHP). The mixed-methods design is selected to accommodate the complex and multidimensional nature of productive waqf implementation in healthcare-based social security systems, which involves institutional, managerial, regulatory, and socio-religious dimensions (Creswell & Plano Clark, 2018).

The qualitative component aims to explore and map key implementation challenges, stakeholder roles, and operational dynamics of productive waqf in healthcare services. Meanwhile, the quantitative AHP method is applied to prioritize strategic implementation alternatives based on expert judgments, ensuring systematic and measurable decision support (Saaty, 2008).

Data Sources and Informants

This study involved key informants selected through purposive sampling to capture diverse institutional perspectives on the implementation of productive waqf in healthcare-based social security. The selection criteria emphasized professional expertise, institutional roles, and direct involvement in waqf management, healthcare services, and social health insurance systems. In total, four primary informants participated in in-depth interviews.

The first group of informants consisted of waqf regulators and experts, representing national waqf institutions with extensive experience in policy formulation, governance, and strategic development of productive waqf in Indonesia. Their insights were essential in understanding regulatory constraints, institutional challenges, and strategic directions at the national level.

The second group included healthcare practitioners, particularly hospital managers and medical professionals involved in the operational management of healthcare institutions utilizing waqf-based support mechanisms. These informants provided empirical perspectives on the practical integration of productive waqf into healthcare service delivery and its interaction with the national health insurance system.

The third group comprised social health insurance experts, with professional backgrounds in BPJS Kesehatan and health financing systems. Their contributions focused on the structural limitations of the national health insurance scheme and the potential role of productive waqf as a complementary financing mechanism.

All interviews were conducted using semi-structured protocols to allow flexibility while ensuring consistency across informants. Data saturation was achieved as recurring themes emerged across interviews, indicating sufficient coverage of key analytical dimensions relevant to strategy formulation.

Table 1. Characteristics of Research Informants

Code	Institutional Role	Area of Expertise	Relevance to Study
I1	Waqf Regulator/Expert	Waqf governance and policy	Regulatory framework and strategic direction of productive waqf
I2	Waqf Regulator/Academic	Islamic social finance and waqf management	Institutional capacity and strategic

			implementation models
I3	Healthcare Practitioner	Hospital management and healthcare services	Operational integration of waqf in healthcare delivery
I4	Social Health Insurance Expert	Health financing and BPJS system	Alignment of waqf with healthcare social security mechanisms

Primary data were obtained through in-depth semi-structured interviews with key stakeholders directly involved in the management and regulation of waqf and healthcare social security in Indonesia. The informants consist of:

1. Waqf regulators and policy experts (e.g., representatives from national waqf authorities),
2. Nazir practitioners responsible for managing productive waqf assets,
3. Healthcare practitioners, particularly hospital managers involved in Islamic or waqf-based hospitals,
4. Social health insurance experts, including practitioners familiar with the national health insurance system.

This multi-stakeholder approach is essential to capture diverse perspectives and reduce single-actor bias in strategy formulation (Freeman, 2010). Secondary data were collected from policy documents, regulatory frameworks, previous empirical studies, and official reports related to waqf governance, healthcare financing, and social security systems in Indonesia.

Analytical Hierarchy Process (AHP) Framework

AHP is used as the core analytical tool to determine priority strategies for implementing productive waqf in healthcare-based social security schemes. The AHP framework in this study consists of three hierarchical levels:

1. Goal: Identifying the most effective strategy for implementing productive waqf to support healthcare social security.
2. Criteria: Key factors influencing implementation, including:
 - a. Institutional and regulatory readiness,
 - b. Professionalism and capacity of nazir,
 - c. Financial and operational sustainability,
 - d. Stakeholder coordination and integration.
3. Alternatives: Strategic implementation options derived from qualitative findings, such as:
 - a. Strengthening nazir professionalization and certification,
 - b. Developing integrated waqf-healthcare operational models,
 - c. Enhancing regulatory alignment between waqf institutions and health insurance systems,

- d. Establishing strategic partnerships between waqf institutions and hospitals.

Pairwise comparisons were conducted using expert judgments based on Saaty's fundamental scale (1–9). Consistency ratios (CR) were calculated to ensure logical consistency of judgments, with $CR \leq 0.10$ considered acceptable (Saaty, 2008).

Data Analysis Procedure

The data analysis was conducted in four stages:

1. **Qualitative Coding and Thematic Analysis**
Interview transcripts were coded thematically to identify dominant implementation barriers, enabling factors, and strategic options related to productive waqf in healthcare (Braun & Clarke, 2006).
2. **Hierarchy Construction**
Based on qualitative findings, an AHP hierarchy was constructed, linking implementation goals, criteria, actors, and strategic alternatives.
3. **Pairwise Comparison and Priority Weighting**
Expert judgments were quantified through pairwise comparison matrices, generating priority weights for each criterion and alternative strategy.
4. **Synthesis and Interpretation**
Final priority strategies were interpreted by integrating quantitative AHP results with qualitative insights, ensuring contextual relevance and practical applicability.

Validity and Reliability

To ensure methodological rigor, this study applies triangulation of data sources and stakeholders, combining perspectives from regulators, practitioners, and experts. The reliability of AHP results is ensured through consistency ratio testing, while qualitative validity is strengthened through member checking and iterative interpretation (Lincoln & Guba, 1985).

Ethical Considerations

All informants participated voluntarily and were informed about the research objectives. Data confidentiality and anonymity were strictly maintained throughout the research process, in accordance with ethical standards for social and policy research.

RESULTS AND DISCUSSION

Productive Waqf as a Complementary Mechanism in Healthcare Social Security

The findings indicate that productive waqf in Indonesia is not positioned as a substitute for the national health insurance system (Jaminan Kesehatan Nasional, JKN), but rather as a complementary mechanism designed to address financing and service gaps that remain uncovered by BPJS Kesehatan. Stakeholders consistently emphasized

that productive waqf functions most effectively when integrated into a blended financing framework, particularly for vulnerable populations whose healthcare needs exceed formal insurance coverage.

Empirical evidence from interviews with waqf practitioners, healthcare managers, and social insurance experts shows that productive waqf has been utilized to subsidize BPJS premiums for low-income patients, finance medical services excluded from BPJS benefit packages, and provide bridging funds during delayed reimbursement periods. These practices demonstrate that waqf can enhance system resilience by reducing financial pressure on both hospitals and patients. This finding supports earlier arguments that Islamic social finance instruments can serve as stabilizing mechanisms in public service provision when appropriately institutionalized (Cizakca, 2011; Mannan, 2018).

However, the study also finds that the scale and complexity of healthcare institutions significantly influence the feasibility of waqf integration. Productive waqf models are more viable in clinics and small-to-medium hospitals than in large referral hospitals, where operational costs, regulatory compliance, and managerial complexity are considerably higher. This suggests that implementation strategies must be context-sensitive rather than uniformly applied across healthcare institutions.

Nazir Professionalism and Institutional Capacity as Critical Determinants

One of the most salient findings of this study is the central role of nazir professionalism in determining the success or failure of productive waqf implementation in the healthcare sector. The data reveal a clear distinction between conservative nazir, who prioritize traditional custodial roles, and progressive nazir, who adopt a social enterprise orientation supported by professional management practices.

Progressive nazir demonstrate greater capacity to develop revenue-generating waqf assets, establish partnerships with healthcare providers, and maintain transparent financial reporting systems. In contrast, conservative nazir often lack the managerial skills and institutional frameworks necessary to sustain productive activities, resulting in underutilized waqf assets. This pattern confirms previous studies emphasizing that weak governance and limited human capital remain systemic challenges in waqf institutions (Abdul Rahman & Goddard, 2003; Kasri, 2021).

In the healthcare context, the importance of nazir professionalism is further amplified by the technical and regulatory demands of medical service delivery. The findings suggest that strategies aimed at expanding waqf assets without parallel investment in institutional capacity are unlikely to produce sustainable outcomes. Therefore, professionalization through certification, continuous training, and performance-based evaluation emerges as a strategic priority.

Regulatory and Policy Environment: Enabling but Insufficient

The regulatory framework governing waqf in Indonesia provides basic legal legitimacy for waqf management but remains insufficiently adaptive to the operational requirements of productive waqf in healthcare. Informants highlighted several regulatory gaps, including limited support for digital waqf mechanisms, constraints on asset utilization, and the absence of sector-specific policies linking waqf to healthcare social security.

Although regulations such as Law No. 41/2004 establish formal governance structures, they do not adequately facilitate innovation or cross-sector integration. Moreover, coordination between waqf authorities, healthcare regulators, and BPJS Kesehatan remains fragmented. This fragmentation constrains the development of standardized operational models and limits the scalability of successful initiatives.

These findings align with institutional theory perspectives, which argue that formal regulations alone are insufficient to ensure effective implementation without complementary organizational capabilities and incentive structures (Scott, 2014). Consequently, regulatory reform should focus less on rule expansion and more on implementation readiness and inter-institutional alignment.

AHP-Based Strategic Priority Analysis

Building on the qualitative findings, the Analytical Hierarchy Process (AHP) was employed to prioritize implementation strategies for productive waqf in healthcare social security. The AHP results indicate that nazir professionalism and institutional capacity constitute the most influential criterion, followed by healthcare financing effectiveness, stakeholder coordination, regulatory support, and public literacy and participation. The consistency ratio confirms the reliability of expert judgments.

At the strategic level, the highest-priority alternative is the development of waqf-based healthcare units integrated with the national health insurance system, particularly clinics and hospitals capable of operating within BPJS reimbursement mechanisms. This strategy is perceived as the most practical and impactful, as it directly addresses service delivery gaps while remaining compatible with existing health system structures.

Other priority strategies include revitalizing idle waqf assets through productive business units, strengthening nazir competency frameworks, and promoting innovative social finance models such as blended finance and waqf-based crowdfunding. Importantly, the results indicate that no single strategy is sufficient; rather, a combination of institutional strengthening and operational integration is required.

The results collectively demonstrate that productive waqf can play a meaningful role in strengthening healthcare social security systems when implementation strategies are grounded in institutional capacity and operational integration. The dominance of nazir professionalism over

asset availability challenges the prevailing emphasis on waqf accumulation and underscores the need for a paradigm shift toward performance-oriented governance.

From a policy perspective, the findings suggest that national waqf development agendas should prioritize capacity building, standardized operational models, and cross-sector collaboration. For practitioners, the results highlight the importance of aligning waqf initiatives with healthcare system requirements rather than operating in parallel or isolation.

Theoretically, this study contributes to the literature by integrating Islamic social finance with health policy analysis through a structured decision-making framework. The use of AHP enables the translation of qualitative insights into measurable strategic priorities, addressing a key methodological gap in existing waqf research.

CONCLUSION

This study demonstrates that the limited role of productive waqf in supporting healthcare-based social security in Indonesia is primarily attributable to weak implementation strategies rather than insufficient waqf asset potential. The findings reveal that issues related to nazir professionalism, institutional governance, and stakeholder coordination constitute the main barriers preventing productive waqf from functioning as an effective complementary mechanism within the healthcare system.

By applying the Analytical Hierarchy Process (AHP), this study systematically identifies priority criteria, dominant actors, and strategic alternatives for productive waqf implementation. The results indicate that strengthening nazir institutional capacity is the most critical factor, followed by the development of integrated operational models linking waqf management with healthcare service delivery. Regulatory alignment, while necessary, is shown to be insufficient in the absence of robust operational capabilities.

From an academic perspective, this study contributes to the literature by moving beyond normative and conceptual discussions of waqf toward an evidence-based and strategy-oriented implementation framework. The integration of Islamic social finance and healthcare social security through a structured decision-making approach fills an important empirical gap in both waqf studies and health policy research.

This study is subject to several limitations. First, the AHP analysis relies on expert judgments, which, although systematically processed, may reflect contextual biases. Second, the study focuses on institutional and strategic dimensions without conducting a full financial impact assessment of waqf-based healthcare models. Future research should explore quantitative impact evaluations of productive waqf in healthcare outcomes, comparative studies across different institutional settings, and the integration of other Islamic social finance instruments—such as zakat and sadaqah—within healthcare social security frameworks. Longitudinal studies would also be valuable to assess the sustainability of waqf-based healthcare initiatives over time.

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