Shariah-Driven Healthcare: Bridging Knowledge, Cost, and Compliance

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ABSTRACT

This study aims to investigate the reasons behind healthcare practitioners' limited knowledge of Shariah principles and analyse how high operational costs impact the proper functioning of Shariah-approved hospitals. Using qualitative methods, the study used semi-structured interviews and field observations with five purposively selected health care professionals, hospital management and clinical staff who were directly engaged in Shariah-compliant practices. The results unveil essential discrepancies resulting from the dearth of specialised training and the unavailability of systematic, actionable guidelines articulating the implementation of Shariah norms in clinical spaces. Moreover, sourcing halal-certified medical supplies has a financial burden, impacting operational efficiency. To address this issue, the study proposed an integrated approach with three interconnected pillars: designing and instituting systematic Shariah-mindset training programmes; the use of Shariah-compliant financial mechanisms such as zakat and waqf for strategic financial utilisation; and establishing standardised operational guidelines specifically to develop Shariah compliance in the healthcare management approach.

Keywords: Shariah-compliant Hospitals; Operational Costs; Training; Healthcare Practitioners.

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1. Introduction

Shariah-compliant hospitals are becoming a prominent feature across the health scene of Muslim-majority countries, especially in Malaysia, with the

national public institutions and their policy framework based on Islamic values (Shariff et al., 2016). Such hospitals are known for their incorporation of Islam through management, clinical and financial aspects which testify the need for faith-based health care (Ismail et al., 2024; Wilda et al., 2024). In Malaysia, this is consistent with an overarching policy disposition to embed Maqasid al-Shariah within the practical and ethical modalities of healthcare (Jamaluddin et al., 2023).

But it's difficult to operationalize this aspirational vision. It demands full institutionalisation of Maqasid al-Shariah not just theoretically but in practice in terms of governance and care delivery and workforce development (Shariff et al., 2018), (Razak et al., 2016; Shariff et al., 2016). In practise, initiatives such as the separation of genders during treatment, the provision of halal-certified medications, and spiritual consultation are implemented inconsistently—partly due to vague blueprints and the lack of training in Shariah-compliant ethics for health care providers (Padela et al., 2024; Shariff Harun, 2024). There are reasons to suspect that compliance is superficial, rather than deeply ingrained in hospital culture.

To overcome this, Shariah-compliant governance should be synergized with the regulatory agencies, for example National Shariah Council (NSC) and healthcare regulators (Indriani et al., 2024; Nadratuzzaman et al., 2021; Mardiyati et al., 2021; Harun et al., 2024; Jamaluddin et al., 2023). However, due to prevailing policy guidelines, hospitals face challenges aspiring high compliance cost and poor technical expertise (Ismail et al., 2018; Shariff et al., 2016). These are such as ongoing cost of infrastructure upgrade, shariah oriented staff training and purchase of halal certified equipment (Jamaluddin et al.,2025; Indriani et al., 2024).

Moreover, the existence of ongoing knowledge gap among health care providers complicates the issues of compliance. Ariffin et al. (2022) noted that despite the above the majority are not clear on how Shariah principles can be used practically in clinical settings. This leads to contradictions, such as confusion regarding the acceptability of treatment types or doubts regarding the halal status of medicines (Gallagher et al., 1983; Harun, 2024; Amrullah et al., 2024; Aulia, 2024; Sharrer et al., 2024). Lacking specific training and clear operating procedures, even well-intentioned individuals may fail to be ethical.

This research is very much grounded in the context of healthcare Malaysia. It explores the impact of inadequate practitioner knowledge and high costs of operation benchmarks on the sustainability of Shariah-compliant hospital models. Using a qualitative design - with semi-structured interviews and field observations - this article explores how institutional voids, tensions in decision-making, and fragmented implementation dynamics come together. In so doing, it offers practical solutions to narrow the distance between

Islamic ethical aspirations and the actual practice of health care in Malaysian Shariah-compliant hospitals.

2. Literature Review

Shariah-compliant healthcare services have become an important trend in the healthcare landscape, especially in Muslim-majority nations like Malaysia, Indonesia, and many Middle Eastern countries (Jamaludin et al., 2023). There is a rising interest in Shariah-compliant hospitals as it is a reflection of improved awareness of Muslim communities of balancing healthcare needs along with Islamic values (Harun, 2024; Mardiyati et al., 2021) while ensuring high quality of clinical excellence and patient care. These hospitals are supposed to deliver ethical medical care and the diversification and incorporation of the principles of Shariah in their financial practices, training of staff and operating business.

The Maqasid al-Shariah framework is central to the Shariah-compliant healthcare model, encompassing five essential objectives: (i) Protecting religion (*hifz al-din*), (ii) life (*hifz al-nafs*), (iii) intellect (*hifz al-aql*), (iv) lineage (*hifz al-nasl*) and (v) property (hifz al-mal) (Bin Don et al., 2022; Baharuddin et al., 2019). This is a philosophical and legal underlining forming a combo road map; it is chartered to lead the individual and society objectives while further moulding how institutions are crafted (Umar & Mat, 2024). Adli et al. Maqasid al-Shariah remains a foundational concept in Islamic law (2024), and its significance lies in the notion that Maqasid application should be context sensitive and integrative, allowing legal rulings to be adaptable and responsive to changing demands of modern life.

It can be witnessed in the healthcare setting in various operational and clinical aspects in Shariah-compliant hospitals through Maqasid principles. Basic religious practices such as gender segregation, halal food, and halal medication and equipment are an integral part of a hospital's commitment to Islamic ethics (Shariff et al., 2016; Shariff et al., 2018; Ismail et al., 2020; Mardiyati et al., 2021). In addition, spiritual care services including religious counseling and spiritual assistance are needed to answer the emotional and faith questions of both patients and families, especially patients who are Muslim (Arifin et al., 2012; Riyadi et al., 2019; Ismail et al., 2020; Wulandari et al., 2023). However, even with growing community support and recognition from policymakers, implementation of Shariah-compliant hospitals does come with one or two significant challenges. This reduces not only knowledge of the Shariah principles among health practitioners, but also the economic costs of compliance (Sulistiadi et al., 2020). While these challenges are well known, the complex interconnections between these challenges and the

deeper structural and systemic constraints that drive them have yet to be closely examined.

2.1 Understanding of Sharia Principles Among Healthcare Practitioners

Significant research highlights the poor knowledge of Sharia rules among healthcare practitioners as one of several barriers to successful implementation of Sharia hospitals. A study by Ariffin et al. (2022) has shown that a multitude of health care practitioners lacks guidance in the application of Sharia principles in clinical practice. This is especially true in relation to gender segregation, halal-certified medication, and religious counseling. This unstructured training leads to inconsistency in service delivery and deteriorates the overall quality of health services in hospitals working under Sharia guidelines (Amrullah et. al, 2024). However, the gap in knowledge could be due to different factors. While Ariffin et al. (2022) ascribe the phenomenon to deficiencies of medical education, Alfarizi et al. (2023), believe that the issue lies in the absence of structured guidelines and enforcement mechanisms at the institutional level. This discrepancy indicates that providing more knowledge to healthcare practitioners is not sufficient; organisational and operational changes are also needed.

2.2 High Operational Costs and Financial Challenges

A major challenge facing Sharia-compliant hospitals is the high operational costs. At the same time, adherence to Sharia standards necessitates large financial investments such as in infrastructure design, staff training, and acquisition of halal-certified medical items (Nadratuzzaman et al., 2021; Shariff et al., 2016; Jamaludin et al., 2025). These added expenses generate financial pressures on privately run medical facilities that do not have governmental or Islamic sources of financing. Hospital management will face challenges with costs incurred for procurement of Halal certified medical equipment, conducting Sharia compliance auditing at periodic times and training of employees in Sharia related subject matters and domains.

However, studies differ on how the financial consequences of Sharia compliance are perceived. While Nadratuzzaman et al. (2021), Shariff et al. (2016), and Jamaludin et al. (2022) that focus only on financial barriers, Al-Daihani et al. (2023) find that Islamic instruments such as zakat, waqf, and sukuk can provide sustainable solutions. Funding training for personnel, turning infrastructure halal, and procuring halal medical equipment may ease the operations of Sharia-compliant hospitals without compromising on service quality (Daud et al., 2024) by utilizing zakat and waqf funds (Baqutayan et al.,

2018). Furthermore, Hospital management should improvise their financial system based on the Islamic financial system (Hidayah et al., 2024).

Earlier studies have identified several gaps in research. The first was that the majority of previous studies have not really focused on approaches to improve the knowledge of healthcare practitioners regarding the Shariah aspects (Ariffin et al., 2022). Second, the integration of Shariah elements, financial management, and service quality within the operational framework of Shariah-compliant hospitals is not clearly defined. Finally, previous studies have concentrated on theoretical and conceptual behaviours, however, these studies have failed accounting for practical strategies or implementation challenges that could have improved the workings of Shariah-compliant hospitals.

This study aims to identify the causes that lead to healthcare practitioners' weaknesses in understanding the principles of Shariah and to examine whether high operational costs have an impact on the effectiveness of the implementation of a Shariah-compliant hospital framework. The outcome of this study serves as guidance to the government, health care practitioners and community about the management and operation of Syariah-compliant hospitals in Malaysia.

2.3 Cross-National Benchmarks and Institutional Best Practices

To advance beyond localised narratives, this study situates Malaysia's Shariah-compliant healthcare framework within a comparative regional lens. In Indonesia, for instance, Shariah-compliant hospitals operate under the National Shariah Hospital Accreditation system, a standardised and government-endorsed model that formalises both ethical and operational compliance (Ismail et.al,2018). Brunei embeds Shariah mandates in its public healthcare policy via the Ministry of Religious Affairs, allowing alignment between state regulation, medical education, and hospital governance (Fauzi,2020).

These comparative models reveal that Malaysia's current voluntary and decentralised compliance mechanisms could benefit from clearer legal instruments and centralised oversight bodies. Equally important is a shift in discourse from merely identifying constraints to showcasing adaptive successes. An-Nur Specialist Hospital pioneered as the first private Shariah-compliant hospital, implementing guidelines from MS 1900:2014 and establishing a Shari'ah Advisory Council to ensure adherence to Islamic principles (Shariff & Rahman, 2016; Shariff et al., 2018). These institutions exemplify how compliance becomes sustainable when integrated into clinical routines and incentivised through governance systems.

This study contributes by synthesising these insights into a locally adaptable framework. Rather than viewing financial or knowledge constraints in isolation, the study explores how decentralised knowledge, fragmented management, and lack of systemic embedding interact to hinder realisation of Maqasid al-Shariah in healthcare. By drawing on international benchmarks and institutional best practices, the study offers scalable, context-sensitive pathways to bridge ethical aspirations with operational realities.

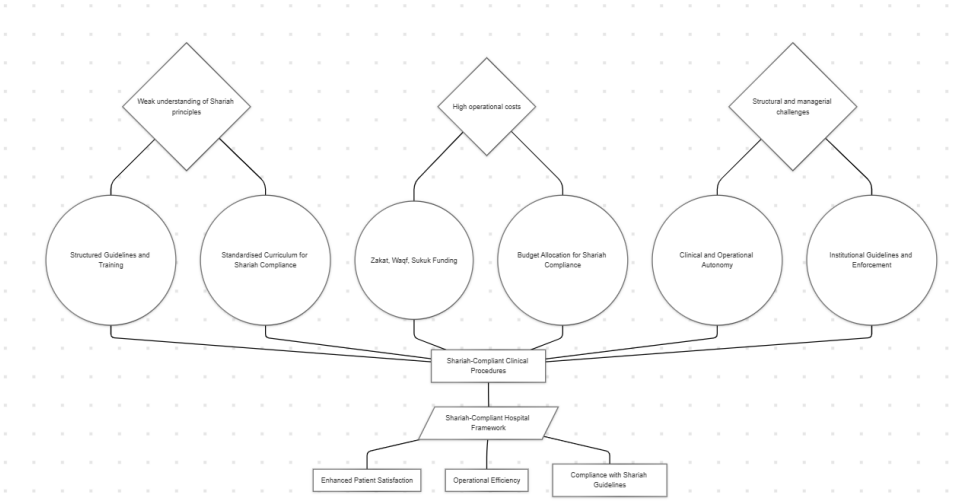

Diagram 1: Conceptual Framework for Strengthening Shariah Compliance in Healthcare: An Exploratory Model

3. Methodology

Qualitative research is a robust approach for exploring complex and contextual processes such as the establishment of Shariah compliant hospitals (Mantula, 2024), and this study adopted a qualitative research approach. Through this method, the researcher interviewed five participants to obtain a deeper and more thorough understanding of the obstacles associated with the application of Shariah principles in a hospital setting. We used a Basic Qualitative Inquiry design in the study which is more interested in rich context and explores how this Shariah principles are woven into the fabric of healthcare institutions.

This design was chosen as it has the potential to study lived experiences without the predetermined parameters of a solidified hypothesis or theoretical structure (Chamberlain, 2009; Allen, 2015). Basic Qualitative Inquiry provides a framework that enables researchers to unlock the meanings, beliefs, and social determinants of the Islamic healthcare systems implementation. This is important because what is going on is not solely about financial or technical issues but also the knowledge, values and attitudes of

practitioners. As such, a Basic Qualitative Inquiry technique was used, which was ideal in representing the various lived and context-specific experiences of those directly managing the operations of the Shariah-compliant healthcare practices (Percy et al., 2015; Tandon et al., 2021).

In-depth data collection was performed through semi-structured interviews and field observations. The semi-structured interview mode was chosen for its ability to enable exploring their life journeys and understanding personal perspectives through stories of their lives. The interview guide was developed to explore participants' perception of Shariah principles in health care, the practical challenges they face in ensuring compliance, and the impact of operational costs on the successful implementation of Shariah. Interviews were conducted individually in a comfortable environment that promoted discussion (Peters et al., 2016; Boyce & Neale, 2006). Interviews were audio recorded (with permission) to help ensure (Mason, 1996) accurate transcribing and analysis (Hutchinson et al., 2005; Lester, 2015) and lasted from 45 to 60 min.

In addition to interviews, field observations were conducted to catch real time instances of how Shariah principles were implemented in hospital settings. These observations also focused on administrative processes, the use of halal-certified medications, gender segregation practices, and healthcare personnel-patient interactions. Although I had asked about Shariah compliance in terms of the verbal narrative, the data obtained from direct observation added another layer of texture in terms of the implementation of Shariah guidelines and the routine operations that highlighted a clearer insight (Westen et al., 2022; Eldh et al., 2020). For instance, observing how the care was gender-sensitive and how staff dealt with Shariah challenges provided insights that interviews could not convey.

Purposive sampling was employed for this study, as the main objective was to select subjects that are directly relevant to the research problem (Campbell et al., 2020; Jalali, 2013). Of the five selected participants, the individuals were professionals playing key roles in managing or overseeing Shariah-compliant hospitals. Such a sample size is adequate for qualitative research which prioritises depth of insight over breadth of data. As Crouch and McKenzie (2006) and Barbour (2022) highlight, smaller, well-focused samples allow for greater engagement with participant experience while continuing to capture a range of perspectives.

Participant ID	Position	Role Description	Reason for Selection	Insights Provided
Participant 1	Director/CEO	Overall hospital management and strategic decision-making	Pivotal role in strategic decisions and hospital management	High-level managerial perspectives on Shariah compliance
Participant 2	Financial Manager	Oversees financial operations and resource management	Responsible for financial implications and resource management	Financial challenges and Islamic financial guidelines
Participant 3	Quality Officer	Monitors service quality standards and compliance	Responsible for quality standards and compliance monitoring	Service quality standards and Shariah operational framework
Participant 4	Medical Specialist	Provides clinical care and applies Shariah principles in patient treatment	Direct involvement in clinical practices and patient care	Clinical practices and direct application of Shariah principles in patient care
Participant 5	Shariah Officer	Ensures Shariah compliance across all hospital operations	Expertise in Islamic jurisprudence and responsibility for Shariah compliance	Islamic jurisprudence and Shariah compliance in hospital operations

Table 1: Profile of Study Participants and Rationale for Selection

Purposive sampling was used for the selection of participants in order to obtain rich and context-relevant data. Anchoring in their various roles and extensiveness of involvement in day-to-day functioning of Shariah-compliant hospitals, these participants offered fruitful insights on the joy and challenges of working as healthcare professionals owning both the strategic decision-making components and practicalities of implementing operations in Islamic healthcare landscape.

The data collected through interviews and field observations were analysed using manual coding and thematic analysis supplemented with Microsoft Word to organise and manage the data. This process began with word-for-word transcriptions of the interview sessions and systematic field notes (Stuckey, 2014; Bell-Nolan, 2015). All transcripts were rigorously coded to reflect emergent themes with particular attention to healthcare practitioners' understanding of Shariah principles as well as the financial constraints associated with Shariah compliance. Thematic analysis was selected as a method for identifying such patterns, similarities, and differences across participants' stories that could be grouped into meaningful categories or themes (Lochmiller, 2021). This manual coding allowed for more nuanced contextual detail to be recorded. Coding results were checked multiple times to ensure that an analysis was both consistent and comprehensive (William et al., 2019).

The study was designed according to strict ethical research standards. Institutional research ethics committee provided ethical clearance prior to data collection. This study also provided participants with distinct and

comprehensive information on the aims of this study, how data would be gathered, and their rights (Denny, 2022; Palinkas, 2014). Prior to each interview session, informed written consent was obtained. All identifiers were stripped from transcripts and reports prior to analysis to protect participant confidentiality and maintain their privacy and integrity (Badampuri et al., 2022).

Methodological triangulation was employed to validate and confirm the findings. This included checking data from different sources—interviews, observations, and related documents—to ensure consistency and depth of interpretation (Campbell et al., 2018; Jespersen et al., 2017). To reduce bias and verify the reliability of the analysis results, the thematic coding and interpretation process was peer reviewed by colleagues (Belotto, 2018). Relying on more than one data source not only added credibility but also enhanced the trustworthiness of the study as it was confirmed through cross-validation with multiple sources.

4. Findings

This study's findings provide a general insight of the main obstacles and potential solutions in establishing a Shariah-compliant hospital model, particularly from the perspective of healthcare professionals. Amongst these, two prominent challenges that stood out to me were — (1) practitioner's deep limited understanding of Shariah principles; and (2) ever-increasing heavy operational costs for compliance. This data was obtained through semi-structured interviews with five senior staff of a Shariah-compliant hospital: Director/CEO, Financial Manager, Quality Officer, Medical Specialist, and Shariah Officer.

Through thematic analysis and manual coding, the study identified the main patterns and recurring themes. It identifies significant structural, financial, and operational impediments to the full realization of Shariah-compliant healthcare provision. But they also flag some areas that could benefit from targeted interventions to increase effectiveness and to help ensure long-term sustainability.

Participants	Key Responses (Quotes)	Coding	Theme
CEO	"Mmm... Our staff, aaa, still lack structured Shariah training... we notice this during patient care decisions."	Lack of Structured Training	Insufficient Shariah Knowledge
Financial Manager	"Ehhh... The operational cost is too high, especially buying halal-certified medication and equipment."	High Cost of Halal Supplies	High Operational Costs
Quality Officer	"Sometimes aaa... compliance is not consistent across departments... some do, some don't."	Operational Inconsistency	Structural and Managerial Challenges
Medical Specialist	"Hmm, we depend heavily on the Shariah officer... without them we often hesitate on clinical decisions."	Over-reliance on Shariah Officer	Insufficient Shariah Knowledge
Shariah Officer	"Ehhh, the guidelines are there, but enforcement is weak... so compliance is still lacking."	Weak Enforcement of Guidelines	Structural and Managerial Challenges

Table 2: Thematic Coding and Analysis from Interviews

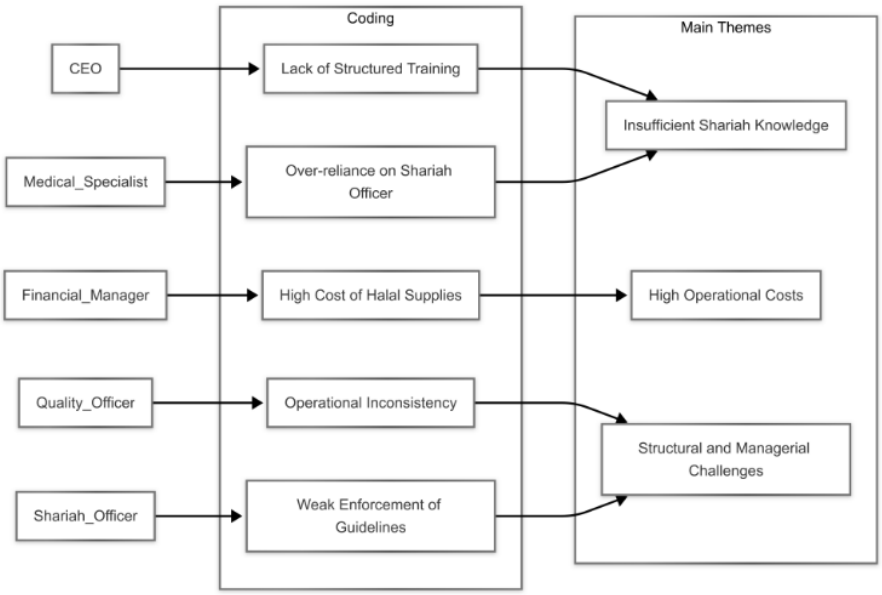

Diagram 2: Visual Representation of Themes and Coding

Each participant was asked broad questions, but the themes shown reflect what each emphasized most. For instance, the CEO's input focused primarily on staff training and knowledge gaps—issues aligned with his leadership role in institutional development. This focus is not a limitation but

an intentional strength of the qualitative method, which allows individuals to speak deeply on areas most relevant to their professional responsibilities, rather than forcing equal commentary on all themes.

Three themes emerged from this analysis: 1) a poor understanding/implementation of Shariah; 2) high operating costs; and 3) structural/managerial impediments. Although healthcare staff are generally aware of what constitutes Shariah principles, there seems to be a clear deficiency in their ability to implement Shariah compliant principles in clinic and administration. To add to this, the higher cost of procuring halal certified consumables, the extra cost of infrastructure and the cost of providing specialised training further burdens hospital operation. Structural issues, such as lack of standardised guidelines and over-dependence on Shariah officers, further compound the challenges for compliance.

These insights are reinforced by participants comments, highlighting the nuance and intensity of the challenges encountered. However, the Director/CEO noted that while the staff do have a basic level of knowledge about Shariah, uncertainty still reigns about what to do in a clinical setting. He elaborated:

"We know our team doesn't know halal food and privacy is an issue, but when it comes to medical procedures, the question is often, 'Is it permissible to use this medicine? Is it halal?' But, unfortunately, there is no clear training on this."

The issue is not unique to healthcare staff. The Financial Manager mentioned their challenges in procuration, most notably in obtaining halal-certified medicines and equipment:

"The procurement team sometimes asks us whether a particular drug is halal, but we don't have a conclusive answer. We have to go back to the Shariah officer, and that's very inefficient."

These comments highlight the importance of structured training and well-defined operational frameworks that can provide practical lense on Shariah principles to the healthcare professionals. The high operational costs are also another challenge which often hinders implement full Shariah compliance. The Financial Manager indicated that halal certified products are more expensive:

"Halal medicines are not just hard to come by, but they're expensive too. "We sometimes have to import them, which increases costs even more."

This concern was echoed by the Director/CEO who related how financial constraints limited compliance efforts:

"We want to have separate male and female wards, but we do not have enough space. Consequently, we sometimes have to place men and women together, which goes against Shariah principles."

These economic pressures indicate a broader need for better access to Islamic financial tools such as zakat and waqf that could help alleviate some of the financial burden.

The third major theme involves structural and managerial challenges very true the reliance on Shariah officers. The Medical Specialist was concerned about making independent Shariah related clinical decisions:

"I sometimes don't know if a certain treatment is Shariah-compliant. "Well, if the officer of the Shariah is not present, then we need to use the best judgment available to us, which is dangerous."

This indicates an absence in information transfer and decision-making power. In addition, the Quality Officer found inconsistencies in compliance to guidelines across different departments:

"Some are Shariah compliant and others are not. This inconsistency has made it difficult to ensure consistent compliance overall."

These responses can be read together as a call for a kind of capacity building for the institution, in two aspects: decentralizing Shariah-related knowledge and incorporating it in the various departments of the institution.

Though the findings were consistent with prior studies, some surprising findings emerged. Where participants anticipated financial constraints to be the largest barrier to development, they reported staff knowledge gaps to be a much greater issue. The Financial Manager noted,

"If all staff were trained adequately in Shariah principles, a lot of problems could be solved with no additional funding needed."

This indicates that though economic support is essential, specific education programs may result in faster enhancements related to Shariah compliance.

Another interesting finding was that Islamic financial institutions have had a very limited role in funding Shariah-compliant hospitals. This was the [Shariah] Officer's response on untapped potential of zakat and waqf:

"If we could use zakat and waqf funds for training and to purchase halal medical supplies, it would greatly relieve the financial burden."

This suggests an opportunity missed for institutionally supported intercession for a more seamless connection between the financial considerations and the compliance objectives.

The data also show a consistent tension between operational efficiency and religious compliance. The Director/CEO used an example to demonstrate the difficulty of attempting to balance both priorities:

"*We hope to balance modern medical needs with Shariah compliance, but addressing both sides can be a tough task****."***

The continuing push-pull relationship between spiritual obligations and finite resources underscores the need for a more robust and integrated solution. This is instrumental in aligning financial, operational, and religious needs for managing Shariah-compliant hospitals.

The paper highlights three key areas requiring strategic effort: (1) education and training, (2) financing, and (3) consistency of operations. First and foremost, the training of healthcare staff by Shariah specialists in a structured training that provides clinical trainings on the use of the principles of Shariah will breed confidence amongst hospital staff, reduce over-reliance on Shariah officers and in return enhance decision-making mechanisms across hospitals and various departments. Second, providing access to greater financial resources—especially through Islamic financial institutions—could provide hospitals with some relief from juggling high operational costs, freeing up funds to increase Shariah-compliant infrastructure and medical supplies. Finally, standardised operational guidelines would reduce inconsistencies in service delivery, creating uniform Shariah-compliant practices across all departments.

In conclusion, our research suggests that in order to realize a Shariah-compliant hospital model, we need to take a multidimensional approach to address knowledge barriers, financial limitations and infrastructure inefficiencies simultaneously. Healthcare institutions can streamline and facilitate the compliance of shariah compliant services through improved training programs, improved access to shariah-based financial awareness and compliance of a standardised practice. The conclusions provide a solid basis for future studies and policymaking to strengthen Islamic health-care systems in general.

These findings clearly align with the research objectives by offering strong empirical evidence on the key issues identified: limited practitioner

knowledge of Shariah principles and the rising operational costs associated with halal compliance. Participants consistently emphasised these two themes. For instance, the Financial Manager highlighted the burden of acquiring halal-certified medication, reflecting financial constraints noted in the problem statement. Similarly, the Medical Specialist's uncertainty when confronted with Shariah-related clinical decisions confirms the presence of critical knowledge gaps. These responses reinforce the study's design and validate its focus.

Beyond addressing real-world challenges, this study contributes meaningfully to theoretical and institutional discourse. It positions Maqasid al-Shariah not just as a legal framework but as a guiding principle for healthcare governance, capable of shaping institutional design when applied intentionally. On a practical level, the study recommends clear interventions: structured Shariah training, formalised guidelines, and the integration of zakat and waqf into healthcare financing. These strategies provide not only operational clarity but also ethical integrity. Such insights are invaluable for policymakers and administrators in Malaysia and other Muslim-majority nations seeking to build sustainable, Shariah-compliant healthcare systems grounded in both principle and performance.

5. Conclusions

This study explored how Shariah principles are implemented in Islamic hospitals, as viewed by healthcare professionals directly involved in service delivery. It identified three major, interconnected barriers: limited practitioner knowledge of Shariah principles, the high operational cost of maintaining halal compliance, and over-reliance on centralised Shariah officers. These issues show that while Shariah compliance is formally acknowledged, its practical execution is often weak—especially in clinical decision-making, procurement, and cross-departmental coordination.To overcome these constraints, the study recommends a realignment of strategy that includes structured, practice-based Shariah training for healthcare staff, utilisation of zakat and waqf for financial sustainability, and the establishment of clear governance protocols to reduce confusion in applying Shariah guidelines. The study not only contributes academically but also proposes a realistic framework for enhancing institutional resilience, aligning religious integrity with operational functionality.

These findings are valuable to policymakers, hospital leaders, and scholars striving to balance Islamic ethics with healthcare demands. Future research should compare Malaysian experiences with models in Indonesia,

Brunei, and the Gulf, and examine how Islamic financial institutions can support long-term sustainability of Shariah-compliant healthcare.

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