CHAPTER 1

INTRODUCTION

1.1 Research Background

Islamic history records that waqf eases the difficulties faced by the destitute and the poor, and promotes the social welfare of Muslim communities at large (Ahmed, Mohammed, Faosiy & Daud, 2015). Since the era of prophet Muhammad SAW reign and his companions, waqf has become an important institution in the Islamic socio-economic system, and has played diverse and remarkable roles throughout Islamic civilization (Razali, 2014; Rohayu Abdul-Ghani & Razali Othman, 2014; AbulHasan M. Sadeq, 2002; Bulliet & Hodgson, 1978; Hoexter, 2002; Makdisi, 1961). Various waqf properties, institutions, organizations, infrastructures, and facilities had been developed (Razali, 2014) including healthcare facilities that remain to this day. Although developments in the health sector had existed since the days of the Roman Empire (Aljunid, 2015), the idea of a hospital as an institution for patient treatment only existed after the presence of Islam (Razali, 2015; Hussain Nagamia, 2010). During that era, Islam established its healthcare institution by using the concept of waqf, whereas the West funded and organized the establishment of its healthcare institution via the concept of philanthropy under the Church.

Although waqf-based healthcare institutions are still growing in Malaysia compared to other social-based healthcare institutions, in reality, it has existed throughout the history of Islamic civilization. It is considered one of the oldest charitable institutions globally (M.Salleh, Mohamad & Adham, 2014; Bremer, 2004), and its impact in uplifting and

fulfilling societal needs has been proven. Both waqf and philanthropy are derived from the concept of social economy, also known as the third sector, solidarity economy, alternative economy, non-lucrative sector, the non-profit sector, the not-for-profit sector, voluntary sector, and idealist sector. This economic concept has been used in institutional practice since 150 years ago and focuses on social innovation in the economy by incorporating social justice principles into production and allocation systems (Moulaert & Ailenei, 2005) which use trade and business principles and acquire social capital to pursue social aims (Kay, 2006). The difference between social and for-profit healthcare institutions lies in the purposes and goals of the organization where the former provides services to the public, while the latter aims to maximize profits (Green, 1987).

Since social-based healthcare institutions fall under the private healthcare provider category, they often suffer from broad generalisations where they have been described as flexible, autonomous, innovative, and cost-effective institutions. Additionally, they are at times viewed as an alternative to the failed, unplanned, and inefficient public healthcare system (Green, 1987; Roemer, 1984). According to Bennett (1991), the private sector is defined as all organisations and individuals working outside the direct control of the state, either for-profit companies and individuals or not-for-profit private organizations. To further clarify the differences between public and private health institutions, Claquin (1981) defined private practitioners from the perspective of an employer, that is, "an individual who is perceived by the community to provide resources and assistance in illness but was not employed by the government health service". These types of healthcare institutions are classified as a heterogeneous group consisting of a wide range of providers with different motives (Aljunid, 1995). Although the classification was named "private" which is usually

related to profit maximization, in reality, some of these healthcare institutions are not entirely profit-oriented and are classified as "social-based" healthcare institutions. These healthcare institutions are engaged in providing health services for a specific purpose, typically providing health services with religious, humanitarian, or charitable motives (Aljunid, 1995).

In Malaysia, social-based healthcare institutions also acquire funding from public or individual donations, either one-off or continuously. These healthcare institutions are usually managed by non-profit institutions, such as foundations, non-government institutions, social enterprises, or waqf institutions. Some of them are identified as benefactors that can provide funding to develop and finance healthcare services for the less-fortunate as well as the poor and low-income groups, to meet their healthcare needs (Ismail & Possumah, 2015; Farhat Nazirul Mubin, 2015). Consequently, given their complex internal and external roles that are quite similar to those in other sectors, social-based healthcare institutions should also focus on providing quality healthcare services to patients and act as business entities (Smith, 2012).

In recognition of this reality, Sultan Nazrin Shah, the Sultan of Perak, in his speech at the Third Annual Symposium on Islamic Finance 2017, emphasized the importance of Islamic financial instruments which comprise a number of social financing tools such as zakat, sadaqah, and waqf in addressing the economic crisis and promoting sustainability, responsibility, and generosity globally. The financing tools offered by Islamic finance would be used to support a given organization’s operations, raise funds and mobilize contributions from various sources, including corporations, investors, and social

entrepreneurs. These donators would provide vital assistance in the midst of a crisis and sustain financial support (News Strait Times, 2017).

Besides that, the existence of social-based healthcare institutions assists the government in resolving patient congestion issues in public healthcare institutions. It serves as an alternative in providing affordable healthcare services in the face of rising healthcare costs. Even though the Ministry of Health (MOH) is the primary provider of healthcare services in Malaysia and its services are widely available and accessible to the general public, the Malaysian healthcare system is also supported by the private sector which accounts for approximately 35% of total healthcare services in the country (Mohamed, Daud & Ab Rahman, 2017) and has been recognized internationally as one of the best in the world. However, there are many obstacles and challenges in maintaining this sector which increase the burden of illness, including infectious and non-infectious diseases, high population expectations in the healthcare delivery system, and a scarcity of health resources. Thus, the MOH not only plans and regulates the majority of public healthcare services but also has some regulatory power over the private sector, including social-based healthcare institutions (Juni, 1996). According to information gathered from the Malaysian medical resources website, fifteen hospitals and clinics including two waqf-based healthcare institutions have been identified as social-based healthcare institutions. This healthcare facility will be discussed in greater detail in Chapter 3 of this research.

As the health sector has a significant impact on several different sectors of society including the economy, the environment, and social welfare, thus an effective resource utilization is critical to the continued advancement of this industry (Smith, 2012). Scholars have included the discussion of sustainable development in public health or health

promotion since the 1990s due to the increase in healthcare issues that are threatening the sustainability of the healthcare delivery system, such as the aging population, modern technology, and consumer expectations on healthcare coverage and quality (Thomson, Foubister, Figueras, Kutzin, Permanand & Bryndová, 2009). However, the majority of empirical, theoretical, and practical contributions, on the other hand, are primarily concerned with the development and implementation of healthcare innovations, with little consideration on the long-term viability of healthcare institutions and care services (Olsen, 1998). Such behavior will result in the depletion of the already limited resources, lower stakeholder satisfaction, and the restriction of benefits to specific segments of the population (Stirman, Kimberly, Cook, Calloway, Castro & Charns, 2012).

Nevertheless, the new insight on the role of social economic institutions in tackling sustainability issues for the well-being of individuals and societies has started to be debated recently. There are 2.8 million social economic entities in the EU alone, accounting for 6.3 percent of EU employment across diverse economic sectors, from health and education to banking and utilities, to satisfy pressing social needs where the impact goes far beyond those numbers (OECD, 2020). The United Nations General Assembly's Sustainable Development Goals which took effect in 2016 suggested the provision and development of good healthcare facilities to promote community well-being by emphasizing large-scale economic and social reforms that enable businesses to operate and healthcare patients to meet their needs while preserving the sustainability agenda. The focus on sustainable and inclusive economic practices is a defining element of the social economy itself: (i) by addressing societal (i.e. social and/or environmental) requirements, (ii) by arranging economic operations based on local roots and utilizing participatory and democratic

governance, and (iii) by collaborating closely with other economic players and relevant stakeholders (OECD, 2020). These new perspectives call for new sustainable business models (Boons & Lüdeke-Freund, 2013; Seelos & Mair, 2005, 2007; Tukker, 2004). Thus, the sustainability of the health sector is crucial, as it is a major contributor to economic, environmental, and social balance (Smith, 2012) as well as a mechanism for improving social welfare (Kay, 2006). In addition, Islam recognizes the protection of life as one of the main objectives of Shariah (Al-Ghazali, d. 1111 CE).

Meanwhile, Agenda 21 i.e. the United Nations' comprehensive plan of action established during the Rio Declaration on Environment and Development in Brazil in 1992, emphasized the role of institutions as a tool for implementing the plan in order to achieve the goal of sustainable health development (United Nations for Sustainable Development, 1992). The declaration outlined goals and tasks for promoting sustainable health development through institutional empowerment and strengthening mechanisms for improving cross-sector coordination at the intergovernmental, regional, national, and sub-national levels (Pfahl, 2005). However, in the aspects of institutions that predetermine activities and policies which are always neglected (Pfahl, 2005), sustainability is seen as either a compliance issue, an economic issue, or a situation to reduce inefficiency without considering the environmental aspect (Hubbard, 2009). In essence, this sector is similar to other businesses, with quality issues that need to be addressed while providing care, enhancing health, maintaining affordable costs, and remaining competitive (Dahlgaard, Chen, Jang, Banegas & Dahlgaard-Park, 2013).

Overall, the relationship between sustainability development concept in the Malaysian healthcare system and institutions can be illustrated through the framework

shown in Figure 1.1. The Brundtland Report by WCED (1987) is the origin of the concept and definition of sustainability development. The report has become the main reference for almost every sustainability concept from various contexts and fields of study. Meanwhile, the United Nations Development Program (UNDP) established the Sustainable Development Goals (SDG) as a universal call to action for a path towards sustainable development. Health sustainability is included in the third goal, which aims to provide universal health coverage by providing all people access to safe and affordable healthcare services. The Malaysian two-tier healthcare system is the basis for this research. This study focuses on social-based healthcare institutions (typically classified as part of the private healthcare sector), such as waqf and other socially based healthcare institutions (NGOs, foundations, and other non-profit institutions). Despite their importance to society, they are frequently ignored by the government.

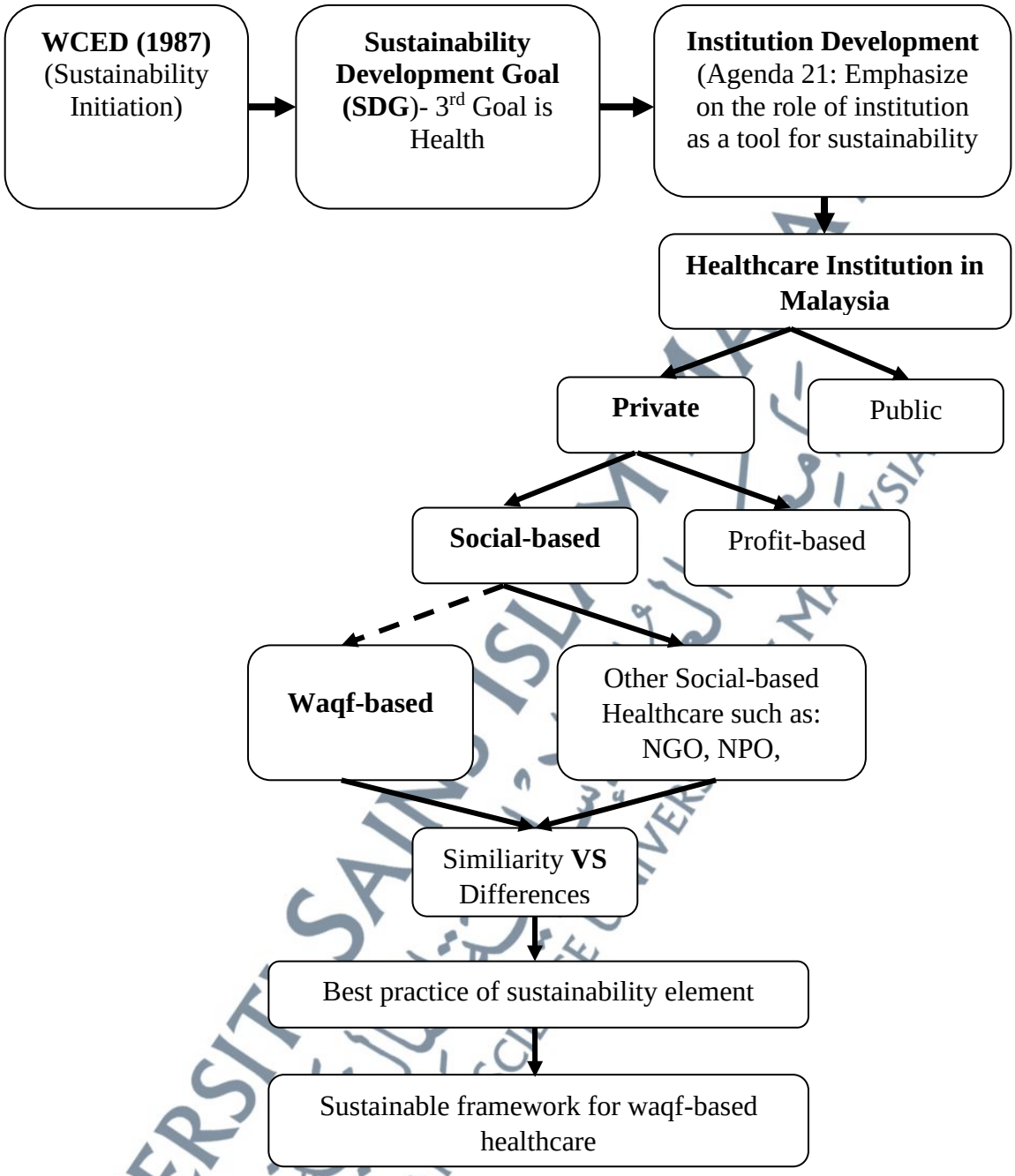

Figure 1.1: Waqf-based Healthcare in Social-based Healthcare Setting

1.2 Problem Statement

The underlying sustainability issue that has become the main deliberation of economists, policymakers, researchers, and most importantly, public and private healthcare providers is the issue of balancing the pressure of rising healthcare costs and the limited resources available for healthcare services. This concern is in addition to other related problems, such as the aging population, new healthcare technologies, and consumer expectations for healthcare coverage and quality (Thomson, Foubiser & Mossialos, 2010). These circumstances are not only plaguing developing and poor countries, but also developed countries especially those in Europe and the United States. The focus of discussion in health financing is on balancing the rising costs of the sector, both in trade within the industry and between the health sector and the whole economy, especially within the context of the current fiscal crisis (Smith, 2012). The health sector should perform effectively and consistently making progress towards achieving the healthcare system objective, which is to achieve sustainability in improving the health status of the society and to provide protection against the financial costs of illness (Bredenkamp & Gragnolati, 2007) even in the face of economic pressure.

It is the main challenge of healthcare organizations, especially social ones, in many countries to financially sustain and support their activities due to the decrease of donor funding and unstable economic condition. In Malaysia, the rise of burden of diseases, uneven distribution of medical professionals, and surge of financial costs for public healthcare services which is projected to increase by 8.2 percent in local currency and USD terms from RM42 billion (USD13 billion) in 2014 (BMI Research, 2015) will continue to increase each year. Government spending has been inflicted with the burden of

accommodating the growing needs of patients. Subsequently, healthcare sustainability surfaces as an issue, since the government finances for public healthcare services are made through the Consolidated Revenue Fund under the Ministry of Finance (Thomas, Beh & Nordin, 2011). From 1997 to 2019, the National Health Expenditure for health in Malaysia has increased by an average of 6.8 percent per annum where in 2018, the total expenditure had increased from RM60,377 to RM64,306 million in 2019 (see Table 1.1).

Table 1.1: Total Expenditure on Health (TEH), 1997-2019
(RM Million, Nominal & Constant)

Year	TEH, Nominal (RM Million)	TEH, Constant (RM Million)*
1997	8,556	15,448
1998	9,162	15,261
1999	9,960	16,590
2000	11,753	18,617
2001	12,711	20,544
2002	13,649	21,405
2003	17,212	25,965
2004	18,210	25,986
2005	18,243	24,910
2006	22,080	28,990
2007	24,426	30,599
2008	27,774	31,604
2009	29,380	35,503
2010	32,889	38,059
2011	35,953	39,468
2012	39,448	42,876
2013	41,647	45,188
2014	46,780	49,535
2015	50,194	53,345
2016	51,534	53,876
2017	56,264	56,679
2018	60,339	60,377
2019	64,306	64,306

Note:*Constant values estimated using MNHA derived GDP deflators (splicing method with 2010 base year)
TEH: Total Expenditure on Health
Source: Malaysia National Health Accounts Health Expenditure Report 1997-2019, published by Mesyuarat Jawatankuasa Pemandu, Ministry of Health, Malaysia (8/12/ 2020)

The recent global monetary crisis has affected global trade and economic growth, resulting in a decline in government revenue. In turn, the government's ability to provide additional resources to finance the development of the social sector will be affected (Mohammad & Fuadah, 2014). Meanwhile, private health services in Malaysia cannot be provided by all levels of society, particularly the poor and low-income households. The mean monthly household consumption expenditure has rose at an average rate of 3.9 percent per annum at nominal value which is equivalent to an increase from RM4,033 in 2016 to RM4,534 in 2019. As for the urban household, the increment was at a rate of 3.7 percent annually from RM4,402 to RM4,916 meanwhile for the rural household the increment was at a rate of 3.6 percent annually from RM2,725 to RM3,308 during the same period i.e. 2016 to 2019. These figures not only comprise the main consumption expenditures such as housing, water, electricity, and gas and other fuels, but also health (Department of Statistics Malaysia, 2019) (see Table 1.2). For that period of time, DOSM also reported that the expenditure for both health and education had rose to 0.2 percent. The increment of household expenditure has affected the well-being of the society, especially among the poor and low-income household groups and B40 who receive a monthly gross income of between RM4,850 and below (Economic Planning Unit Malaysia, 2016).

Table 1.2: Mean Monthly Household Consumption Expenditure (RM)

Year	Malaysia	Urban	Rural
2016	4,033	4,402	2,725
2019	4,534	4,916	3,308
CAGR (%)	3.9	3.7	3.6

Note: Compounded Annual Growth Rate (2016-2019)
Source: Report on Household Expenditure Survey 2016, Department of Statistics Malaysia

While the high cost of for-profit healthcare institutions may deter some socioeconomic groups, a part of the society still depends on private healthcare institutions due to the congestion issue of public healthcare, as indicated in the Health Expenditure Report (2019) (see Table 1.3). The report shows that one of the highest sources of financing for healthcare expenditure, behind the Ministry of Health Malaysia's RM28,860 million (44.9%), is the private household Out-of-Pocket expenditure (OOP), which constituted of RM22,492 million (35.0%). This amount has increased compared to previous year which constituted of RM21,127 million.

Table 1.3: Total Expenditure on Health by All Sources of Financing, 2018-2019

MHNA	Source of Financing	RM Million	
		2019	**2018**
MS1.1.1.1	Ministry of Health (MOH)	28,860	26,499
MS2.4	Private household Out-of-Pocket expenditure (OPP)	22,492	21,127
MS2.2	Private insurance enterprise (other than social insurance)	4,889	4,313
MS1.1.1.9	Other federal agencies (including statutory bodies)	1,862	2,134
MS 2.6	All corporations (other than health insurance	2,117	2,564
MS1.1.1.2	Ministry of Education (MOE)	1,579	1,347
MS2.3	Private MCOs and other similar entities	983	914
MS1.1.2.2	Other state agencies (including statutory bodies)	453	419
MS1.2.2	Social Security Organization (SOCSO)	394	410
MS1.1.3	Local Authorities (LA)	212	194
MS1.1.1.3	Ministry of Defense (MOD)	150	103
MS1.1.2.1	(General) State Government	139	150
MS2.5	Non-Profit institutions serving household (NGO)	90	92
MS1.2.1	Employee Provident Funds (EPF)	83	67
MS9	Rest of the world	4	5
	Total	**64,306**	**60,399**

Source: Malaysia National Health Accounts Health Expenditure Report 1997-2019, published by Mesyuarat Jawatankuasa Pemandu, Ministry of Health, Malaysia (8/12/2020)

This data indicates that Malaysian households still rely on their own expenses instead of health insurance. Such behavior will lead to the risk of inability to pay for future medical expenses, should medical costs continue to rise and subsidies from the government decline.

Eventually, issues of affordability and patient congestion in public healthcare will negatively affect the overall health of the society, especially the poor and low-income groups. Patients could then either reluctantly go for treatment or ignore the illness altogether, risking their ability to work (WHO, 2013).

Another important concern threatening the healthcare sector in Malaysia, especially the development and performance of social-based healthcare institutions, is environment sustainability issues which are related to issues arising within the organization setting such as the institution or organizational system, support function, governing board, relationship with the regional and national organization that usually involves the regulator or the sufficient capacity of healthcare services/activity profile (Olsen, 1998). These issues focus on the aspect of internal and external healthcare institution setting which is usually very closely related to the competitiveness and reputation of the hospital or healthcare institution (Smith, 2012). Hospitals need to provide a conducive workplace environment for its staff and ensure that all employees receive adequate training. They should also use up-to-date modern healthcare service technologies.

However, previous studies on waqf management have revealed several managerial, administrative, and governance issues including poor structure, mismanagement, corruption, abuse, neglect, and other administrative lapses that warrant recommendations for the revision of the waqf administration system (Sulaiman & Zakari, 2015; Siti Mashitoh 2006a; Abdul Rahman, Bakar & Ismail 1999; Zainuddin 1998). The issues that arise within the waqf administration and management aspect, as mentioned above, will threaten the sustainability and development of waqf-based healthcare institutions in Malaysia. In the other aspect, legislative limitations are also seen as one of the main causes for the failure

of waqf asset management in Malaysia. In the 1950s and earlier, the management and administration of waqf assets were left to the prerogative of community leaders, such as the *kadi*, *imam*, *bilal*, and *penghulu* (Razali, 2014). These assets were held by their trustees and were not officially documented, leading to countless issues, one of which was missing assets (Razali, 2014; Azha et al., 2013; Muhammad Zain, 1982). Waqf seems to be abandoned after the British occupation. Although Malaysia is a Muslim-majority country, it still adopts secular democratic administration (Fuadah & Patmawati, 2010), keeping religious and state affairs separate.

The primary sources of the Malaysian law of charitable trusts are under the Federal Constitution, local legislation, local cases, and customs. Under the constitution, there are several statutes dealing with not-for-profit organizations which were passed both before and after independence (George, 2011). Among the statutes under the Federal Constitution, equity and trusts are governed by section 4(e) (i), Schedule 9, List 1 of the Federal List. Charities, charitable institutions, and trustees, excluding waqf and Hindu endowments, fall under section 15(c), Schedule 9, List 1 of the Federal List. Hindu endowments are covered by section IX, 1 –15 (c), while waqf is dealt under List II of the State List. As for charitable trusts in Sabah and Sarawak, they are governed by section 15, Schedule 9, List III A of the Supplement to Concurrent List. This classification indicates the clear distribution of power between the Federal and State Lists; however, in the case of the Concurrent List, should a conflict arise, the matter will be resolved in favor of the federal government. Under the Malaysian constitution, charities may exist as either a trust, society, or company limited by guarantee; thus, some of these institutions may be exempted from the provisions of the income tax legislation, where applicable (George, 2011).

Nonetheless, Selangor's successful attempt in enacting a law for waqf property in 1952 welcomed changes to the waqf management system. It has also motivated other states in Malaysia to enact similar laws for waqf property, among others in Malacca (1959), Terengganu (1965) and Johore (1978) (Razali, 2014). To establish a waqf-based healthcare institution, an agreement from the State Islamic Religious Council (SIRC) is required, seeing that waqf is regulated under the Administration of Islamic Law Act. Essentially, though, all establishment of private healthcare institutions, including social institutions, is subject to the jurisdiction of the Ministry of Health (MOH) under the Private Healthcare Facilities and Services Act 1998 (Act 586).

Furthermore, after the fall of the Turkish Ottoman Empire in 1922, waqf institutions began to be slowly forgotten (Razali, 2014). Today, whenever waqf is mentioned, Muslims especially in Malaysia recognize them only in the form of non-economic contributions, such as the endowment of land for cemeteries or mosques. Waqf is limited to strictly worship purposes, firmly excluding wealth creation from its goals. This understanding is due to the prevalence of traditional waqf management, where the impact of waqf institutions to the society is not maximized and their operations unsustainable due to insufficient funding. No wealth is created from these waqf assets, and they soon become totally depleted as a result of mismanagement and inefficiency (M.Salleh et al., 2014; Çizakça, 1998). Therefore, some previous research on the record-keeping and documentation of waqf has come out with the suggestion to develop waqf accounting standards, in addition to accountability, transparency, and performance standards for waqf institutions. It is essential for these institutions to manage these issues in order to prevent

the endowed assets from being idle due to insufficient revenue streams (Chowdhury, Ghazali, & Ibrahim, 2011).

While in the aspect of environment management policy, since the operation of large scale healthcare in the economy involves using huge amounts of resources to meet the objectives, goals, and requirements of the external and internal standards of healthcare institutions, clinical waste management is vital considering the high risk that may affect workers and patients' physical and psychological health (Smith, 2012; Sadler et al., 2011). Issues relating to clinical waste has not attracted the same level of attention as other types of waste (Birpinar, Bilgili & Erdoğan, 2009) due to the existence of concrete policies and laws that regulate the management of clinical waste in Malaysia. However, over the past few years, there has been an increment in the disposal of clinical waste due to a number of factors, such as the lack of training, awareness, and financial resources, all of which contribute to the mismanagement of clinical waste (Razali & Ishak, 2010).

Table 1.4 below shows the total amount of scheduled waste relative to clinical waste between 2017 and 2019. The quantity of scheduled waste generated in 2019 increased from 2.0 million tonnes in 2017 to 4.0 million tonnes which shows a two fold increment. While clinical waste also increased from 29.1 thousand tonnes in 2017 to 33.8 thousand tonnes in 2019. The press released the report of Compendium of Environmental Statistic in November 2020 which state that out of the overall 4.0 million tonnes of scheduled wastes in 2019, healthcare services industry (clinical waste) contribute an increment of 7.5 percent compared to the previous year. This report suggests that the health sector is among the major contributors of waste, in addition to other sectors such as agriculture and manufacturing.

Table 1.4: Schedule Waste and Clinical Waste between 2017 and 2019

Year	Schedule Waste (million tonnes)	Clinical Waste (thousand tonnes)
2019	4.0	33.8
2017	2.0	29.1

Source: Department of Statistics Malaysia Report, 27 November, 2020

The term clinical or medical waste usually refers to all infectious and other hazardous or obnoxious waste generated in various health sectors (Goren, Demir, Yaman & Yildiz, 2011). It may consist of general, pathological, radioactive, chemical, infectious and potentially infectious, and pharmaceutical wastes. It also includes pressurized containers (Uysal & Tinmaz, 2004) containing sharp objects such as needles, human tissues or body parts, and other infectious materials that are dissimilar to any other wastes produced by the hospital due to their hazardous potential (Baveja, Muralidhar & Aggarwal, 2000). Approximately 15 to 25 percent of the overall clinical waste is considered harmful to the environment and human health (Shinee, Gombojav, Nishimura, Hamajima & Ito, 2008) as it may contain pathogenic agents.

Failure to manage and properly dispose of clinical waste may not only impose significant risks to the human health and environment, but will also cause problems to healthcare institutions and threaten their operations. Exposure to clinical waste can lead to the spread of communicable diseases among humans, while the environment may be damaged by toxic and hazardous chemicals (Jang, Lee, Yoon & Kim, 2006). Moreover, the performance standards and regulations regarding the operational, social, and environmental aspects of healthcare institutions have become increasingly stringent for the industry (Smith, 2012). Any oversight on the proper management of clinical waste may halt the activities and operations of a given healthcare institution. Especially for social-based

healthcare institutions, the eventual result will prevent the society from benefiting from their services.

Meanwhile, in sustaining a social institution especially relating to healthcare services, performance and achievement in the aspects of economy, financial, and environment could not be achieved without support from the society. In order for a social or waqf-based healthcare institution to sustain, it needs to meet certain social expectations as the type of services offered are comparable to typical for-profit businesses (Smith, 2012). The establishment of these institutions is largely dependent on community contributions such as charity, alms, and waqf. Though some social-based healthcare institutions have adopted a new social business structure by commercializing its core programs and gaining a profit, most still rely on donations from the public. This situation suggests the importance of societal support and awareness in aiding the social sector to develop and sustain itself. Failure to ensure the sustainability of waqf institutions will deplete waqf assets (M.Salleh et al., 2014), which in turn will result in two losses: loss of social benefits for the waqf recipient (mauquf alaih), and loss of God's promised rewards for the benefactor (waqif).

The main aim of this research is to develop a sustainability framework for waqf-based healthcare institutions in Malaysia by comparing the sustainability concepts and practices implemented by various social-based healthcare institutions. To achieve this goal, some questions are raised: How do these institutions describe the sustainability concept within their respective institutions and express it in their management framework or procedure? How do these healthcare institutions remain in existence and continue to develop? How do these healthcare institutions fund their operations and manage their organizations? Are the sustainability concepts and practices framework of each institution similar or different to

those of other institutions? To answer all these questions and to bridge the gap in sustainability studies on healthcare institutions, qualitative methodology was used to reveal the similarity and differences of sustainability concepts and practices between waqf and other social-based healthcare institutions as well as the philosophies that underlie the establishment of each institution. The findings of this research are expected to provide information on how a social-based healthcare institution, especially waqf, can develop and sustain in the future

1.3 Research Questions

The main focus of this research is to develop a sustainability framework for waqf-based healthcare institutions by comparing the sustainability concepts and practices implemented by social-based healthcare institutions in Malaysia. The research questions that guide this research are:

Research Question 1: What are the underlying philosophies for the establishment of each social-based healthcare institution?

Research Question 2: How does each social-based healthcare institution describe its sustainability concept?

Research Question 3: How does each social-based healthcare institution interpret the sustainability practices in its management framework?

Research Question 4: How does the sustainability practices in each healthcare institution's management framework differ, or resemble, from that of another institution?

Research Question 5: What are the best sustainability practices that is feasible for future waqf-based healthcare institution framework?

Building on the above research questions, exploratory research has been conducted to examine the understanding of the sustainability concept and practices of each healthcare institution and determine how the sustainability practices of an institution are similar or different to those of another. An in-depth interview was conducted to gather a deep understanding of the institutions' sustainability, beginning with the examination of the philosophy that underlies the establishment of the institution. The findings of the field study were then analyzed and compared to find any similarities or differences in the sustainability concepts and practices, from which the sustainability framework for future waqf-based healthcare institutions is developed and evaluated.

1.4 Research Objectives

Based on the above research questions, five specific research objectives were established. They are expressed as follows:

Research Objective 1: To examine the underlying philosophies for the establishment of each social-based healthcare institution.

Research Objective 2: To identify sustainability concept from each social-based healthcare institution perspective.

Research Objective 3: To investigate the sustainability practices in the management framework of each social-based healthcare institution.

Research Objective 4: To analyze the similarities and differences in the sustainability practices in each social-based healthcare institution's management framework.

Research Objective 5: To evaluate the best sustainability practices that are feasible for future waqf-based healthcare institution framework.

1.5 Significance of the Study

This research allows new and established social and waqf-based healthcare institutions to investigate and apply the elements of sustainability within their institutional framework to enable them to serve the society for a long period of time. The importance of this research can be grouped into three main categories, which are:

1.5.1 Theoretical Contribution

Recent developments in the field of healthcare sustainability and social economy, especially on waqf development, have led to a renewed interest in this topic. In general, this research enriches the body of knowledge on healthcare sustainability concepts and practices as well as social organization theory such as non-profit, philanthropic, and waqf organizations by converging these different streams of research. Sustainability is an important aspect for waqf institutions since the main principles of waqf itself are perpetuity and trusteeship. The principles of perpetuity, irrevocability, and inalienability are the three distinctive features prescribed by the Shariah law to prevent waqf assets from being sold or

transferred to other parties and of which allows a continuous benefit to be provided to the society or to specific recipients desired by the waqif (M.Salleh et al., 2014).

These features distinguish waqf from other forms of philanthropic or charity institutions such as foundations, non-profit organizations, or social enterprises, as their assets can be disposed of by their shareholders (Dafterdar, 2011). However, depending on the three principles alone is not enough to sustain waqf institutions, considering the abundance of challenges in the economic and health sectors that threaten their sustainability. Analyzing the sustainability of social-based healthcare organizations can ensure that they will be able to grow. These institutions should be able to procure novel health facilities and current technology, recruit expert health professionals, and obtain sufficient medical supplies. These elements are required to provide better health services to meet the needs of the community, regardless of the economic capability of its members.

Since the study context is on the institution, this research provides further understanding of the various establishment types of healthcare institution in Malaysia's social-based settings, especially waqf-based healthcare institutions. As for the sustainability concepts and practices, this research provides insight into the literature's sustainable practices framework and expands the discussion on private not-for-profit healthcare services proposed by Olsen (1998), which has been identified as critical for future research. Understanding the topic through an integrated perspective of institutional theory, healthcare sustainability, and social and waqf development from both conventional and Islamic viewpoints is a novel approach that enables the holistic understanding of complex social phenomenon.

This approach is contradictory to the traditional research that tends to focus on individual issues rather than the complex larger picture which comprises multiple perspectives and interrelationships. Even so, sustainability studies are discussed more from a conventional perspective since research on sustainability issues, especially concerning institutional sustainability, from the Islamic perspective is still limited. Nonetheless, the findings of this research will provide an in-depth understanding on the sustainability concepts and practices of waqf-based healthcare for future implementation.

1.5.2 Stakeholder Contribution

Stakeholders or benefactors of social-based healthcare institutions require information on the impact, achievement, or progress of their investments: do the investment bring long-term benefits to the society or not? As highlighted by Livit and Wandersman (2004) and Scheirer (2005), funders who support the start-up of a new organization that houses a new program may consider the sustainability of both the program activities and the organization. Complementary to the government, the objective of the social sector is to aid the community to satisfy their basic needs in healthcare services (Juni, 1996). Funders understand this aim, and so they are adamant that the institutions be able to carry out their reason or justification of existence. At the same time, achieving the main objective of the organization will increase stakeholders' confidence and trust toward social- and waqf-based institutions, motivating them to give more in the future.

1.5.3 Government Policy

In Malaysia, social-based healthcare institutions are categorized under the private healthcare provider, which constitutes 35 percent of the overall healthcare services in the country. The existence of social-based healthcare institutions not only helps the government to solve issues related to patient congestion in public healthcare institutions, but also provides an alternative for affordable healthcare services. Since the important role of social-based healthcare institutions is widely recognized, it is imperative that the government supports the operations and development of social-based healthcare institutions, especially those that are waqf-based.

The sustainability of waqf-based healthcare institutions can only be achieved through a good relationship between the operator or management of such institutions and the mutawalli. In Malaysia, waqf is regulated under the Islamic Administration Enactment. The State Islamic Religious Council (SIRC) is appointed as the sole trustee for waqf assets, and it is responsible for the mandatory registration, uses, and ownership of the properties and all requirements stated by the Federal Gazette relating to the activities of waqf assets (Md. Dahlan, 2006). Without the consent and support from the SIRC, sustainable waqf-based healthcare institutions could not be developed. Thus, by identifying the sustainability concepts and practices of social-based healthcare institutions, the government, which in this case is the SIRC, can provide support for operators of waqf-based healthcare institutions via the introduction of more conducive regulations to facilitate their further development.

1.6 Scope and Limitations of the Study

This research concentrates on the development of a sustainability framework for waqf-based healthcare institutions via a comparative analysis to investigate and analyze the best sustainability practices among social-based healthcare institutions in Malaysia. The overall population of social-based healthcare institutions as gathered from the Malaysian Medical Resources website is fifteen institutions. Two of these institutions are classified as waqf-based institutions, while the remaining thirteen are categorized as either non-profit and non-government organizations and foundations, or social health enterprises. These social-based healthcare institutions were selected based on two criteria, which will be clarified in the research method section of this chapter.

The aim of this research is to examine the philosophies that underlie the establishment of social-based healthcare institutions and to gain better understanding on the sustainability concept and practices of the institutions. Although the period of establishment for each institution is dissimilar to the other, Savaya, Spiro and Elran-Barak (2008) demonstrated that it should not be an issue because based on the research of Savaya et al. (2008), a comparative analysis between social programs that still exist and those that had already ceased has been done. Thus, this research will use the comparative research method to analyze the similarities and differences between the opposing units (Neuman, 2014). The unit of analysis for this research is social-based healthcare institutions with distinct social settings. The rationale behind this selection is to cover a wider range of variables and gain in-depth understanding on the concepts and practices of healthcare sustainability.

However, this research faces some restrictions. The limited literature discussing healthcare sustainability means that most reference materials are rather dated. The

discussions on sustainability issues themselves are too broad, as most focus on the aspect of sustainable development. Furthermore, the concept of healthcare sustainability is nascent; as a result, the number of authors concentrating on the subject is rather small (Smith, 2012). To counter these limitations, the interviews will be conducted using a interview protocol or guideline to gain as many information as possible, and to encourage a free-flowing discussion between the researcher and respondents. As the research is a comparative one, it does not intend to test any theory and its results will have limited generalizability since the population consists of only a small number of cases and each case is seen as unique (Neuman, 2014).

As a caveat, the concepts and practices of sustainability discussed in this thesis are not meant to directly outline a specific step-by-step practice to realize a sustainable healthcare institution, considering that every organizational structure is unique. This research simply sets a preliminary and general path towards establishing a sustainable framework for waqf-based healthcare institutions in Malaysia by comparing the sustainability practices of various social-based healthcare institutions.

1.7 Operational Definitions

There are some keywords that are commonly used throughout this study. The operational definitions of these keywords are as follows.

- ***Sustainability Concept***: In this study, the sustainability concept is defined according to both conventional and Islamic perspectives. The concept of sustainability for social-based healthcare institutions in this research is defined as an understanding on

the overall concept of sustainability or continuation of social-based healthcare institution within the healthcare sector or industry without compromising the quality of the environment in which resources are acquired while fulfilling the needs of its patients, employees, and social community without neglecting the spiritual aspect.

- ***Sustainability Practices***: The definition of sustainability practices is similar to Olsen's (1998) definition of sustainability for the healthcare sector as below:

  "a health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information and finance) for the activities that meet individual or public health needs or demands."

  It relates to the practices and implementation of sustainability within the structure and environment of the social-based healthcare institution. Oxford Dictionary defines practice as the application or implementation of an actual idea, belief, or method as opposed to the theories associated with it. From the Islamic perspective, sustainability practices are the incorporation of religion into the factors of sustainability in three ways: i) through the values it offers, ii) through its potential role in ecological, social, and political activism, and iii) through its ability to enable self-development (Narayanan, 2013; Dariah, Salleh & Shafiai, 2016). Thus, based on the definitions of both conventional and Islamic perspectives, sustainability practices in this research refers to the process of maintaining a social-based healthcare institution that involves the engagement between organizational activities and its capacity within a given context and for a period of time; the practices within the institutional ecosystem

contain financial, environmental, and social elements, and they aim to fulfil the objective of Shariah of preserving human life. Religious principles become the pillars supporting the institution's engagement with its ecosystem through the value it offers, its role in social activism, and its capacity to enable self-development.

- ***Framework:*** According to Oxford Dictionary, the word framework means a basic structure underlying a system, concept, or text. It is an entity between a 'model' and a 'method' that contains a (not completely detailed) structure or system for the realization of a defined result/goal which usually comprise one or more models based on the modelling techniques mentioned above and often based on (best) practices (Verbrugge, 2016). Meanwhile, framework in this research refers to the best practice of sustainability from the comparative analysis on the sustainability practices model of each social-based healthcare institutions.

- ***Sustainability Element:*** Based on the definition of sustainability development, past scholars have recognized and agreed upon three core elements of sustainability namely economic/financial, social, and environment. In this research, these elements are defined as below:

    - ***Financial Sustainability:*** Financial sustainability is defined as all economic or financial activities of the social-based healthcare institution that can be defined based on its financial source and financial distribution practices. In terms of the institution's financial source practices, it may came from any philanthropy or charity and waqf activities, or other instruments of financing. As for the financial distribution practices, they are related to investment strategy, administration

procedures that focus on the decision of financial planning and the operating cost of the healthcare institution.

- ***Environment Sustainability:*** Environment sustainability relates to the context of the institution's environment setting including the internal (staffing, governing board, services or facilities provided, environment management policy etc.) and external (regulators, supplier, etc.) factors as stated by Olsen (1998). In the aspect of environment management policy, it refers to the environment management procedure as required by CKAPS, MOH under Act 586.
- ***Social Sustainability:*** Social sustainability practice in this research is defined as an engagement and feedback that relate to the social-based healthcare institution's services, activities, initiative or programme to its own employees, patient and local community.

- ***Healthcare Institution:*** The Oxford dictionary defines the term as the organized provision of medical care to an individual or community. However, as stated by Smith (2012), healthcare institution is not only limited to one single institution, but also to a cluster of medical care facilities, caring for the sick or injured and healthy people, and offering a wide range of health services from dentistry and emergency care to dermatology and traumatology. Departing from the definition above, healthcare institution in the context of this research refers to any healthcare institutions, established under the philanthropy or volunteerism concept, that provide healthcare related services but limited to the provision of in-patient and out-patient care.

- ***Healthcare Services:*** The term of healthcare services in this research refers specifically to the definition provided by the Private Healthcare Facilities and Services Act 1998 or better known as Act 586 whereby in this Act under Part I, Section 2, healthcare services are defined as below:

  "healthcare services" includes-

  (a) medical, dental, nursing, midwifery, allied health, pharmacy, and ambulance services and any other service provided by a healthcare professional;

  (b) accommodation for the purpose of any service provided under this Act;

  (c) any service for the screening, diagnosis, or treatment of persons suffering from, or believed to be suffering from, any disease, injury or disability of mind or body;

  (d) any service for preventive or promotive health purposes;

  (e) any service provided by any healthcare para-professional;

  (f) any service for curing or alleviating any abnormal condition of the human body by the application of any apparatus, equipment, instrument or device or any other medical technology; or

  (g) any health-related services;

- ***Social-based Healthcare Institutions:*** Social-based healthcare institution in this research refers to any private healthcare facilities as defined by Act 586 as:

  " premises, other than a Government healthcare facility, used or intended to be used for the provision of healthcare services or health-related services, such as a private hospital, hospice, ambulatory care centre, nursing home, maternity home, psychiatric hospital, psychiatric nursing home, community mental health centre, haemodialysis centre, medical clinic, dental clinic and such other healthcare or health-related premises as the Minister may from time to time, by notification in the Gazette, specify"

  The basis for the social-based term came from Al-Junid's (2015) definition of a not-for-profit private health firm, which refers to healthcare institutions that are engaged

in providing healthcare services for a specific purpose but not to maximize profits for its shareholders. These firms typically offer services with religious, humanitarian, or charitable motives. The establishment of such institutions is derived from the social economy concept, which emphasizes on the social innovation in the economy by applying the principles of social justice into the production and allocation systems whilst the motive of the establishment places societal benefits as it main objective. Instead of profit, it is concerned with maximizing human health, and the establishment of these institutions is based on philanthropic and volunteer-based activities. Such institutions may come in the form of non-profit (NPO) or non-government organizations (NGO), foundations, waqf institutions, social health enterprises, or even profit institutions (Green, 1987).

- ***Waqf Institution***: In this study, waqf institutions are defined as institutions of which establishment was granted, appointed, or acknowledged by the State Islamic Religious Council under each state's enactment, and of which acts as the sole trustee in having the authority to:
    i. Appoint or authorise in writing any party to manage and administer any mawquf on his behalf.
    ii. Recognize the appointment of any manager or administrator in a situation where the waqif has already appointed himself, other than MAIN, and
    iii. Terminate the appointments in paragraphs (i) and (ii) above.

- ***Waqf-based Healthcare Institution:*** The term "waqf-based healthcare institution" in this research refers to any private health facility as defined by Act 586, in which the establishment including the capital expenditure (such as equipment or construction expenses of the building) and operating expenditure (such as income, services charge, donation or expertise) are covered or related to the element of waqf sources or activity, or built on waqf land or under the supervision or management of a waqf institution appointed as mutawalli by the State Islamic Religious Council according to the enactment of each state.

1.8 Structure of Research Writing

This research is divided into eight chapters, covering the introduction, review of past research literature, research methodology, regulator perspective, healthcare institutions' background, exploring sustainability concept and practices, context of findings, and conclusions and recommendations for future research. Details for each chapter are explained in the following paragraphs.

Chapter 1 of this thesis presents the introduction of this research, which discusses the background of research, problem statement, research questions and objectives, research method, scope and limitations of the study, ethical procedure and operational definitions.

Chapter 2 discusses past literature related to sustainability, encompassing the concept, definition and practices of sustainability in conventional and Islamic perspective, health and healthcare development based on maqasid perspective, waqf definition and the

development of waqf-based, social-based healthcare institutions throughout history, theory related to healthcare institution sustainability and conceptual framework for the research.

Next, in **Chapter 3**, the discussion focuses on the research methodology. It consists of the research design, sample of the study, instruments, and data analysis. This research adopts a qualitative study design to obtain better understanding of the concept and practices that contribute to the sustainability of social-based healthcare institutions. For the first phase of this research, an extensive search of the literature has been conducted. Information was also collected from the Malaysian Medical Association (MMA) and each social-based healthcare institution's official website and annual reports, as well as government websites, such as the Ministry of Health.

Chapter 4 describes the process and findings of the interview session with CKAPS, MOH as the regulator for private healthcare institutions in Malaysia.

Chapter 5 focuses on the social-based healthcare institutions' background. In this research, six social-based healthcare institutions' representatives were successfully interviewed and every healthcare institution background was explained in three contexts: 1) early establishment, 2) philosophy, vision and mission of the institution, and 3) healthcare institution services and achievement. The in-depth explanation on the healthcare institution background and philosophy is to answer research objective 1 as outlined in this chapter.

Chapter 6 presents the research findings from the field study process, which comprise data gathered from the interview sessions focusing on the exploration of the sustainability concept and practices of six social-based healthcare institutions. This chapter analyses the findings of the research based on the similarities and differences in the sustainability concept and practices of the selected social-based healthcare institutions as outlined in objectives 2, 3 and 4.

Chapter 7 presents the contextualization of the findings in Chapter 5, Chapter 6 and Chapter 7 that were obtained from the in-depth interview and the analyzed and compared documents. The discussion in this chapter focuses on the sustainability framework for social-based healthcare institution that has been developed and the proposed framework for future waqf-based healthcare institutions.

In **Chapter 8**, overall conclusions from the previous chapters are presented. Recommendations and proposals for future research are also included.

1.9 Conclusion

This exploratory research focuses on the sustainability practices carried out by social-based healthcare institutions which are based on conventional and Islamic perspectives. The aim of this research is to determine the best sustainability practice for social-based healthcare institutions, which are established under the philanthropic and volunteerism concepts of waqf institutions, foundations, non-profit or non-government organizations, and social-enterprises, among others. Through the findings, a sustainable framework for waqf-based healthcare institutions will be developed though the framework but of which

would still require further improvements. This research is also expected to provide information concerning the sustainability of philanthropic healthcare institutions in Malaysia, and also to ensure that these institutions can grow in terms of facilities, technology, expertise, and sufficient medical supplies so as to provide better healthcare services to the community, regardless of their economic capability.