CHAPTER 1

INTRODUCTION

1.1 Introduction

Waqf in the past, played a huge role as socio-economic development of the Muslim Ummah in many Islamic countries where the endowments were essential in the establishment of various public services to the people including educational institutions, health care services, construction of places of worship and other related welfare services (Babacan, 2011; Cizacka, 2000; Çizakça, 1998). Endowments given to hospital which constitutes the Islamic *waqf* (Sayili, 2006), was a sign of a more complete integration with Muslim culture and civilization and it was also a guarantee of the hospital's longevity. The endeavour towards realizing a *waqf*-based hospital in the Islamic medieval period meant that there was significant progress towards the development of a dynamic and organized *waqf* institution even so in that early period.

Hence, the purpose of this study is to explore a working corporate *waqf* framework for Malaysian public hospital inspired by past *waqf*-based hospitals in the Islamic Golden Era of 8th-14th century, with the present ones. It will explore a suitable working corporate framework whereby contributions from the *waqf* organizations can be accommodated and collaborated in a conducive partnership with a public hospital to provide better services for the general public especially for the poor and underprivileged, whilst deploying the mannerisms of the Malaysian Islamic Fatwa on *waqf* and abiding the laws of the Malaysian Government.

1.2 Background of Study

This study revolves around *waqf* of which property or money is endowed, in accordance with the Islamic principles and describing its potential implementations or applications in Malaysia. *Waqf* in history have occurred in numerous ways since the time of the Prophet Muhammad SAW (Ahmad, 2015) and continuously into this era. *Waqf* is practiced in social services of reducing poverty, building mosques, schools, universities and cemeteries in Malaysia particularly but nonetheless in the other parts of the world like Turkey (Mahamid, 2013) and Syria (Mahamid, 2013), *waqf* has played a huge role in the socio-economic development especially as an instrument of state and social policy where hospitals and education are the primary *waqf* applications.

Healthcare in the year 2020 has for the first time in history proved that our healthcare worldwide is not prepared to handle this kind of pandemic: an unpredictable, extensive health challenge requiring the application of resources which affects the whole world population. Healthcare during this pandemic has indeed shut down the world economy and has shown the importance of healthcare over economy of the country. The expensive spending for research and development of vaccinations, and healthcare services can indeed exhaust healthcare funding and public-private partnerships can help alleviate the problem and become the norm in the healthcare ecosystem. In planning the future beyond the pandemic Covid-19, the providence of affordable healthcare for the entire nation calls for research on how *waqf* can be an enabler and contribute to contextualize the futuristic healthcare system.

This study will investigate into the alternative applications of *waqf* in the public health service, hospitals in particular. Research will be conducted to show relations between *waqf*-based hospitals in the past and present and in moving to the future, to

discover other revolutionary approaches in *waqf* applications and finally provide a possible workable model for a *waqf*-based hospital in Malaysia.

In comparing the various models of *waqf*-based organizations in education, the banking and financial institutions and private healthcare, this research will propose a model of a *waqf*-based healthcare where the *waqf* institutions will corroborate or exist in partnership with a public hospital, exhibiting elements of corporatization, governance and sustainability.

1.3 Problem Statement

Good health and access to healthcare are fundamental human rights. People want to live in a secure and safe country where they promote good health. The government of Malaysia or the Ministry of Health (MOH) is expected to ensure that the health systems function to provide affordable and good healthcare, where universal access to good healthcare exists (Ministry of Health Malaysia, 2011). To achieve this can be an enormous drain on national resources and with so many issues, it can be extremely difficult to sustain in the long run. Therefore, the topic of issues involved includes, healthcare in Malaysia, the rising medical costs of healthcare in Malaysia, possible solutions to overcome them, *waqf*'s role in healthcare, the social-based hospitals in Malaysia, present *waqf*-based hospitals and elements of governance and sustainability in *waqf*-based hospitals.

In Malaysia, healthcare began in the early years of 1958, and it continues to provide the people in providing good healthcare which is easily accessible to all races regardless of religious belief and income groups. Since 1958, Malaysia's healthcare has had generally an efficient, comprehensive health care system and they have a considerably good healthcare equipment and facilities apart from having specialists in

the field. However, the main challenge is in its ability to continue in spite of the steady increase in Malaysia's population ageing over time (with higher demands expected with greater longevity), rising per capita incomes, changing disease patterns, and particularly when the cost of providing healthcare is rising (Onn, 2015); the multi-roles of MOH (Ministry of Health) including its poor governance, mediocre health infrastructure and the need for reforms in health financing issues (Aljunid, 2016; Croke et al., 2019); the shortage of staff in ratio to the number of patients with long queues which are time consuming, the shortage of drugs, wastage and inadequate amenities amongst others (A. R. Mohamad, 2009) and the rising of the cost of providing healthcare and a rapidly changing operating environment (Shazali et al., 2013). The problem therefore lies generally with high medical costs.

As reported by the Willis Towers Watson Global Medical Trends Pulse Survey 2018, it confirms that the cost of medical care which continues to rise across the globe (Fig 1.1). It is reported that Malaysia has experienced a consistent increase in medical costs since 2016 resulting in the largest growth of all surveyed Asia Pacific countries (Watson, 2017). With the increase usage of innovative equipment and new technologies, the costs are passed on into the patients' bills. Medical tourism, not only increased middle/upper-class foreigners, but competition has driven up prices of medical providers (Rasiah, Noh, & Tumin, 2009). However, in 2020 the number of doctor visits and admissions decreased significantly due to the pandemic Covid-19 and the government-imposed lockdown (MCO), which has caused the overall trend to change for that particular period but is expected to rise again when under normal conditions (Willis Towers Watson, 2020).

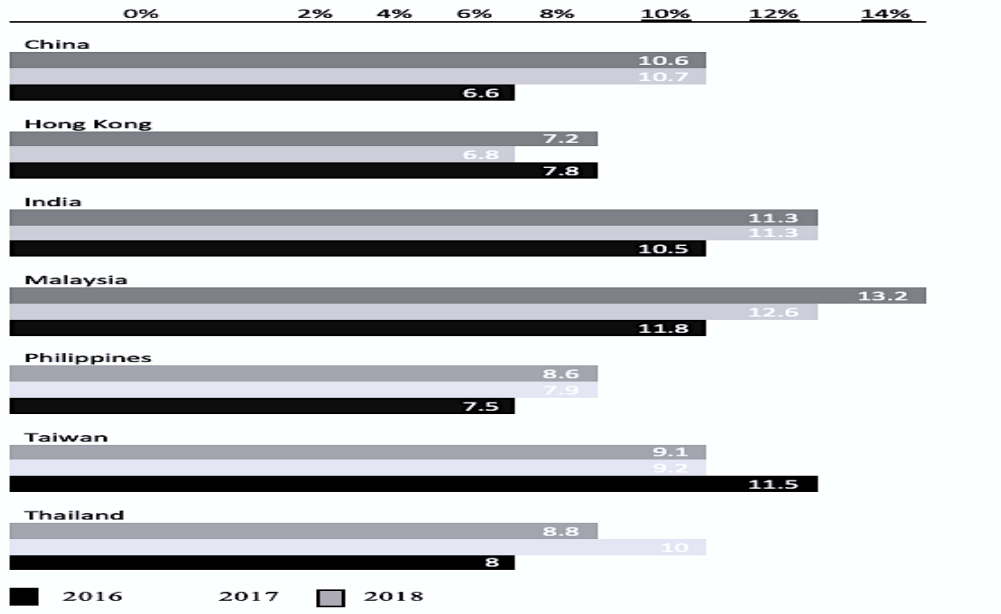

Figure 1.1: Average Gross Medical Cost Trends in Asia Pacific 2016 – 2018 (Willis Towers Watson, 2017)

From the newspaper reports below (Table 1.1), it shows that the time between Oct 2018 and June 2019, medical costs and medicines have continuously risen. The public complained; ministers acknowledged but healthcare inflation continued to rise. Even so, majority of Malaysians continue to seek treatment from public hospitals even when the waiting is long and may be fatal for some.

Date	Highlighted Issues	Quoted from	Newspaper/Media
Oct 19, 2016	The Health Ministry was allocated RM23.31 billion in Budget 2015, but this was later reportedly slashed by RM300 million when the government budget was revised, while the RM23 billion allocated for this year's spending was reduced by nearly RM250 million in this January's revision. Any further cuts to the RM23 billion that was allocated to the ministry for this year would make it challenging for it to serve the public. The ministry was already moving from branded drugs to the cheaper generic medicine to cut costs.	Deputy Health Minister Datuk Seri Dr Hilmi Yahya	Malaymail https://www.malaymail.com/

Feb 1, 2017	The Cabinet has decided to review some charges for first and second class patients in government hospitals. Only 1.6 percent of the total number of patients would be affected by the increase while the remaining would enjoy full subsidy.	Health Minister Datuk Seri Dr S. Subramaniam	The New Straits Times https://www.nst.com.my/
Aug 13 2018	1. Patients referred from private hospitals to public hospitals are paying more for cancer treatment and drugs. 2. It will be investigated. The public complained.	Deputy Health Minister, Dr Lee Boon Chye	The Star Online https://www.thestar.com.my/
Aug 28, 2018	It should be noted that medical inflation in Malaysia is one of the highest in the region. A report last year claimed Malaysia's healthcare inflation was 11.5 per cent in 2016 and rose to 12.7 per cent last year, higher than the Asian average of 10.7 per cent.	President of Consumers Association of Penang (CAP) S.M. Mohamed Idris	The New Straits Times https://www.nst.com.my/
June 16, 2019	Four reasons why Malaysia's healthcare system is ailing: incompetence of 'gatekeepers', breakdown of primary healthcare system, overcrowded government clinics and hospitals, long waiting time and more… Healthcare system shortcomings: Main causes are insufficient funds,, neoliberal approach, privatisation, liberalisation of global economy with so-called 'experts'.	Dr. Michael Jeyakumar Devaraj Pollitician from Socialist Party Malaysia	Aliran Online https://aliran.com/aliran-csi/four-reasons-why-malaysias-healthcare-system-is-ailing/

Table 1.1: Newspaper Reports. Sourced from various newspaper/media articles on Malaysian Healthcare and rising costs

The problem of 'excess demand' faced by the Malaysian healthcare is due to the great fee differentiation between public and private healthcare services (Ir M. et al., 2011; Onn, 2015; Zamzaireen et al., 2018). The continuous increase in demand for improved health services over the years has reportedly placed strains on the public healthcare system. In overcoming this, Malaysian policymakers perceive privatization (Barraclough, 2000; Jaafar et al., 2013; Nambiar, 2009), corporatization (Quek, 2014), and social healthcare insurance (Onn, 2015) as possible solutions to ease the crunch in healthcare provision while privatization has been hailed to improve efficiency (and reduce costs). However, in reality, privatization has resulted in a less optimal outcome manifested by higher costs (Onn, 2015). Others have suggested full integration of

private-public healthcare sectors with better partnership and collaboration of services (Quek, 2014). Whilst WHO recommends a merger of some successful models involving monitory parties and governed by privatization/corporatization services which could possibly promote competition and cooperation to thrive and succeed (Cutler et al., 2017) and social-based or welfare-based healthcare (Chen, 2016; Coast, 2004).

Waqf has been said to be a solution to our dilapidating public healthcare (Sanusi & Mohd Shafiai, 2015; Atan, Johari, & Kefeli@Zulkefli, 2017). More so, *waqf* had played a prominent role in the economy in the past since the times of the Prophet Muhammad SAW from the case of the orchards of a Jew named Mukhayriq (Atan & Johari, 2017; Mahmud & Shah, 2010) who later embraced Islam after Hijra (N. A. Mohamad, 2018), and *waqf* continuously evolving its services into the Companions' RA era, the Islamic medieval era and into the present times. Presently, *waqf* is involved in education, healthcare, community development, building of mosques and other social services (Elasrag, 2017) .

In 1998, *waqf* healthcare services was first introduced in Malaysia by Klinik Waqaf An-Nur (KWAN) which was launched by Johor Corporation and continued to create a chain of hospitals with 22 clinics. However, study has shown that the present *waqf*-based hospitals have numerous inadequacies and left room for improvements, such as eliminating costs. The consultation fees, medicines and major medical treatments such as dialysis fees amounted up till RM90 (Saad, Kayadibi, & Hamid, 2017). Though this is a much lower cost compared to other government and private hospitals, it can be free, at no cost. Other Islamic or Shariah-compliant hospitals (N. M. Alias & Zulkifli, 2011), are not from *waqf* contributions or in collaboration with any *waqf* institutions as investigated in the Table (1.2) below.

Kumpulan Perubatan Johor Healthcare Berhad	Beds	Federation of Islamic Medical Association	Beds
1. KPJ Johor Specialist Hospital	215	1. Al-Islam Specialist Hospital	65
2. KPJ Ipoh Specialist Hospital	260	2. Hospital Pusrawi	250
3. KPJ Ampang Puteri Specialist Hospital	217	3. Pusat Rawatan Islam Az-Zahrah	
4. KPJ Damansara Specialist Hospital	155	4. Hospital Danau Kota	10
5. KPJ Selangor Specialist Hospital	172	5. Pusat Perubatan KOHILAL	n/a
6. KPJ Tawakal Specialist Hospital	147	6. Pusat Rawatan Mahsuri	n/a
7. KPJ Penang Specialist Hospital	236		
		TDM Berhad	
8. KPJ Kajang Specialist Hospital	n/a	6. Kuala Terengganu Specialist Hospital	200
9. Puteri Specialist Hospital	150	2. Kuantan Medical Center	84
10. Perdana Specialist Hospital	83	3. Kelana Jaya Medical Center	23
11. Kuching Specialist Hospital	75		
12. Seremban Specialist Hospital	130	**Independent**	
13. Damai Specialist Hospital	250	1. Hospital Penawar	50
14. Kedah Medical Center	106	2. Pusat Rawatan Islam Ar-Ridzuan	n/a
15. Sentosa Medical Center	212	3. Damansara Damai Medical Center d. Putra Medical Center	11
16. Taiping Medical Center	48	4. Selasih Specialist	8
17. Kuantan Specialist Hospital	81	5. Shah Alam Specialist Hospital	60
18. Kluang Utama Specialist Hospital	30	6. Senawang Specialist Hospital	101
19. Sabah Medical Center	134	7. Pusat Perubatan Naluri	n/a
20. Sibu Specialist Medical Center	35		
Total number of beds are 3,638 beds in 2010			

Table 1.2: Private Islamic Hospitals in Selangor.
Sourced from N. M. Alias & Zulkifli (2011)

The Islamic hospitals above (Table 1.2), are Bumiputera/Muslim owned and several of which are private Shariah-compliant hospitals. How *waqf* is contributed and distributed with these hospitals, there have been no records. These Islamic hospitals (Alias & Zulkifli, 2011) have had their own challenges and issues such as a limited allocation of beds for the poor, few facilities, limited specialists, and services which are inadequate. Their focus is mainly on maternity and non-critical diseases. KPJ's Hospitals is the only exception in providing a wide range of promotive, preventive and curative procedures with sophisticated and updated medical machinery and services, but it is expansive as they are private hospitals.

Comparatively, in other Muslim countries with *waqf*-based hospitals, such as those found in Turkey, for example, their *waqf* funds are considerably huge (Holding,

2016) and has managed to establish an effective private *waqf* hospital such as Vehbi Koç Vakfi's VKV American Hospital and Koç University Hospital (Vehbi Koç Vakfi, 2015) compared to WANCorp (WANCORP, 2017). Hence, ample funding or good financial sustainability is one of the issues for our present hospitals (Atan et al., 2017) and more so for *waqf*-based hospitals (Saad et al., 2017).

In gauging the elements pertinent for a *waqf*-based hospital, the practices from non-profit organizations (NPOs) in building sustainable organizations has emerged as a critical need for its survival and longevity (Weerawardena et al., 2010). Frank & Salkever (1991) addresses the issue of the amount of free care such as in cross-subsidization which is a reduction in the prices paid to the hospitals on behalf of paying patients would therefore increase the care for indigent care or care for the needy.

With the development of the corporate *waqf* working model, a sound governance system of accountability, transparency and professionalism in accumulating and distributing waqf assets (Jalil, 2011) can be established and attract Government-link companies/Government-link investment companies, private corporations and individuals to involve in *waqf* (N. M. Ramli & Muhamed, 2013).

Incidentally, an earlier study (Puad et al., 2014), had proposed for future projects of *waqf* to be on the leverage of mega projects that can benefit both Muslims and non-Muslims and should not be limited to education and religious facilities. He proposed MAIS to oversee future *waqf* projects to be developed in other infrastructures benefitting the public goods including healthcare. It is timely to invest *waqf* on health to improve *maslahah* (Puad et al., 2014).

The public government hospitals costs are nominal as RM1 is charged inclusive of medication. However, the poor in the suburbs still cannot afford to travel to the hospitals for treatment. Hence, this research will focus only on the collaboration with

the public government hospitals because the public government hospitals have a more sturdy and comprehensive infrastructure (Khan et al., 2020) than private hospitals which can bring better and efficient results. When collaborated with a public hospital, follow-up treatments of patients from mobile clinics will be cheaper and convenient (as the information can be easily transferred) for the underprivileged. For private mobile clinics as in Avisena Mobile Clinic (Avisena, 2019), offering free healthcare on their terms, the follow-up treatments are usually referred to the main private hospital and treatments are costly. On requests, they may be transferred to public hospitals too.

Previous research on *waqf*-based hospitals found that there is limited data about the management of the said hospitals. Those that were found, focused on the beautiful architectural design of buildings, the usufructs from buildings endowed for sustainability and the provision of free healthcare (Hamouche, 2007; Nour, 2012, 2015). There was no documentation found on how the hospitals were managed aside from delegating the responsibility to the *Mutawalli*. Nevertheless, there is a need to research the differences and similarities in literature between the past *waqf*-based hospitals and current *waqf*-based hospitals' practices.

Therefore, to support this argument, a conceptual framework based on the literature review of past and present *waqf* hospitals' perspective is drawn (in the following chapter) and with that, the following questions are raised, which are to be the subject of research.

1.4 Research Questions

1. What is the criteria of past *waqf*-based hospitals in the 8th-14th CE from the Arab/Islamic World?

2. Which are the main elements of *waqf*-based hospitals that can be identified through comparative analysis from the past and current models from literature (preliminary working model)?
3. What are the issues and challenges faced by hospitals of private/public and *waqf*-based models, and how can they be solved?
4. How to develop a working corporate *waqf* framework in collaboration with public hospitals in Malaysia?

1.5 Research Objectives

1. To explore the criteria and their exclusive elements in *waqf*-based hospitals in the Islamic Golden era of 8th to the 14th CE from the Arab/Islamic World.
2. To investigate and compare the criteria between the past and contemporary *waqf*-based hospitals identified to justify their practices.
3. To identify issues and challenges identified of private/public hospitals in this era, *waqf*-based hospitals in particular and to find solutions.
4. To identify the final elements to develop a working corporate *waqf* framework for Malaysian public hospitals in Malaysia.

1.6 Significance of Study

The study addresses a gap that has been noted in *waqf* 's role in the public healthcare industry literature which is a working corporate *waqf* framework that collaborates with a public hospital. This study examines *waqf*-based hospital within a specific context, a suitable working working corporate *waqf* framework whereby contributions from the *waqf* organizations/funding can be accommodated and collaborated in a conducive partnership with a public hospital to provide better services

for the general public especially for the poor and underprivileged, whilst deploying the mannerisms of the Malaysian Islamic Fatwa on waqf and abiding the laws of the Malaysian Government.

This research is focused on the proposed framework in Malaysia only as the *fatwa* regarding the usage of cash *waqf* differs from one country to another. The Fatwa Committee of Selangor stated that proceeds from the Waqf Share Schemes shall be expended for the purpose of fixed asset purchases. The benefits received can be used to give help and other expenses that the Selangor Islamic Regulation Council deems acceptable (Sanusi & Mohd Shafiai, 2015).

This purpose of this research is to give the different perspectives on how the varied *waqf* knowledge from the historical and current practises can enhance the understanding of past *waqf* institutions' successes and thus, can enhance and further develop the application for current and future practises. The study of this research is also important for the government of Malaysia as this can be a possible precedence to a public-private partnership between *waqf* institution and the public services which can result in a reduction in budget deficit. The public would be able to enjoy better healthcare services, affordable for all and with upgraded equipment to handle the many challenges of good healthcare.

This research is also a respond to a call for further study (Ansari, 2013) to examine *waqf* and *bimaristan*'s applicability to today's developing Muslim-majority nations. It also answers to the call for *waqf* to participate in developing a healthcare service of good quality at a reasonable cost (Mohd Puad et al., 2014; Baqutayan & Mahdzir, 2018) and the pandemic Covid 19 has certainly urged *waqf* to play a bigger role in healthcare in view of the importance of the significance of good and extensive

providence of health services to the public (Ab Rahman et al., 2020; Ainol-Basirah & Siti-Nabiha, 2020).

Public health is becoming increasingly complex, with important roles performed by public and private sector which are imperative in sustaining and improving the communities' health, partnerships or coalitions are often essential to progress (Frieden, 2014). Hence, developing a corporate *waqf* model for a Malaysian public hospital through historical and contemporary comparative practises may possibly help to provide better quality health care, improved care at lower cost and upgrade of quality equipment, advance and updated. This will further enhance the role of Malaysian healthcare where it plays an important role in fulfilling the society's needs (S. Mohamad et al,, 2018) and lighten the financial burden to the country in the coming years (Ali, 2016).

It is, therefore, undoubtedly a timely proposition to propose a *waqf*-based hospital in Malaysia where health is considered wealth and the costs for good medical care is on the rise. Malaysians presently live in an era of rising costs of living and the vast differences in facilities available to most people are vast. *Waqf* can play a significant role in the country's health industry besides already active in the education and religious arenas. To address poverty, deprivation and the provisions of health and education, Islam has instituted social support mechanisms such as *zakat, waqf* and *sadaqah* for the deprived and underprivileged.

Islam encourages mankind to help the poor and needy people to gain His pleasure as helping the poor and needy by giving charity is considered as one of the virtuous acts in Islam (Qur'an 70: 24-25). Islam promotes the generosity of giving and providing which is hoped to inspire others. Numerous hadith are about being kind and considerate and this can create a ripple effect which can result in positive consequences

and influence others to do good and contribute more in the *waqf* projects in our community.

1.7 Scope of Study

In the proposed study, this research will investigate the past and current *waqf*-based hospitals to be able to develop a framework of a corporate *waqf* for a public hospital. It will explore the interplay between the past and present *waqf* hospitals and how these hospitals compare in the management of *waqf* hospitals in the new era of healthcare especially the ones already operating in Malaysia; and that this study is an effort towards exploring, explaining and justifying other important components of a *waqf* based hospital and provide a relevant working model of *waqf*-based hospital. This will be done through an in-depth study on a selected number of *waqf*-based hospitals and other medical institutions that claims to be *waqf*-based. Findings from the analysis study will be based on the preliminary theoretical framework of *waqf*-based hospitals that have been developed in the past and present. This will lead to a clear understanding on the potential hospital of *waqf*-based hospitals that should be applied in Malaysia.

This research also focuses into a public hospital as there are many existing private *waqf*-based hospitals in Malaysia such as Waqaf An-Nur and Cyberjaya Waqf hospital and others. A public hospital is chosen as it has already an excellent infrastructure for a healthcare facility and the collaboration with *waqf* funding can reach out to more poor people in villages who are far away from important amenities such as healthcare. Besides providing for more people, the extra funding can upgrade medical machinery and provide good quality medicines.

This research on the proposed framework of a *waqf*-based hospital herein applies only to a Malaysian one as the Islamic Fatwa needed for the administration and

management of *waqf* pertains to the national and state laws of each particular state and country. In Selangor, Negeri Sembilan and Malacca, the laws on waqf are provided under the Wakaf (State of Selangor) Enactment 1999, Wakaf (State of Negeri Sembilan) Enactment 2005 and Wakaf (State of Malacca) Enactment 2005. While the other states, such as Kedah, Perlis, Johor, Pahang, Perak, Sabah, Penang, Terengganu and Kelantan are governed by the states' administration of Islamic law (S. A. Hassan & Rashid, 2015).

This research may pave a new path of innovation in the nonprofit organization (Dover & Lawrence, 2012) such as of endowments, social trusts and charity organizations for the present and future in the healthcare industry.

1.8 Outline of Study

This thesis is organised into five chapters. Chapter 1 focuses on an overview of the problems of healthcare system in Malaysia, background of the study, the significance of the study, the research questions and objectives and the outline of the study. Chapter 2 is the literature reviews of the past *waqf*-based *hospitals* in the 8th-14th CE whilst explaining the management styles of those hospitals and their services of healthcare, current *waqf*-based hospitals in Malaysia and around the world, some important features of the criteria such as sustainability and governance. Chapter 3 discusses on the research methodology used. Chapter 4 will explain findings and discuss the analysis of data. Finally, chapter 5 provides the summary, implications of study, limitations of the study and finally suggestions for future research.

1.9 Conclusions

The present world is identified by macroeconomic uncertainty, rapid social change, and technological innovation and the citizens' expectations of what government are expected to deliver are ever-increasing. Governments are consistently faced with unsustainable debt burdens and cutbacks in budgets. In generating progress on one of society's biggest problems not only requires governments to make better use of information, involve citizens, invest in employees, and collaborate with other sectors but also to implement and apply any other approaches so long as results are achievable and successful.

Hence, the Islamic system of *waqf* extends a tool which can help revolutionize the non-profit sector and its role in the social welfare. It creates a permanent, cumulative, and ever-increasing capital base and infrastructure for the altruistic activities. Health is an important sector where *waqf* can play a major role in providing affordable and accessible healthcare services for the public especially the underprivileged. From our insights into the Islamic history, *waqf* has indeed proved a very reliable charitable institution, which has fulfilled the need of education and medical care in the past and reliable in the spreading of education, the provision of medical facilities for health improvement and in the welfare of the poor and destitute. The proposed framework of a corporate *waqf*-based hospital will subsequently require a higher standard of strategic thinking for alternative options and a realistic assessment of costs and benefits of mergers and collaboration, as well as a more careful consideration on how to create mergers or partnership with *waqf*-based organization which is not only workable but also sustainable and beneficial.