CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The purpose of this study is to explore a working corporate framework for Malaysian public hospital whereby contributions from *waqf* funding can be accommodated and collaborated in a conducive partnership with a public hospital. This will provide better healthcare services for the general public especially for the poor and underprivileged. Many theories have been discussed concerning *waqf* and its contributions to the socio-economic development of countries all around the world from the past and the present. Although the literature covers a wide variety of those theories, this review will focus on five major sub-chapters which emerge repeatedly throughout the literature reviewed. These sub-chapters are healthcare in Malaysia, present hospitals in Malaysia, *waqf* and its role in the healthcare service industry past and present, social-based hospitals (*waqf*-based in particular), highlights of governance and sustainability for a corporate *waqf* Malaysian hospital and the fundamental elements in the management of a *waqf*-based hospitals. This chapter will include an introduction, literature reviews and theoretical background, a theoretical framework and conclusion.

2.2 Literature and Theoretical Background

The literature review will include topics which are relevant to this research and they are healthcare in Malaysia, *waqf*, present hospitals in Malaysia, highlights of governance and sustainability for corporate *waqf* Malaysian hospital based on comparative analysis of past and present literature.

2.2.1 Healthcare in Malaysia

Health is one of the most important aspects of the socio-economic developments of a developing country where human capital plays an important role in the functioning of a nation and economic prosperity. Malaysian 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. Malaysians have accustomed themselves to easily available public healthcare services which are highly subsidized and hope it will continue to benefit the citizens (Onn, 2015). Access to healthcare is an important factor in ensuring the providence of good healthcare services for the general public as can be seen from the table below (Table 2.1).

Date	Highlighted Issues	Quoted from	Newspaper /Media
1 July, 2019	Access to Healthcare in Malaysia. "Ensuring that everyone, everywhere can access essential quality health services without facing financial hardship."	Datuk Dr Noor Hisham Abdullah	Office of the DG of Health Malaysia http://rmke12.epu.gov.my/ciopapers/1fb86018e0741fe3f9e59c97e42d0f35.pdf
February 2, 2020	The Malaysian government appears to be very committed to providing access to high-quality healthcare to everyone in Malaysia, which the Ministry of Health provides through clinics and hospitals nationwide.	-	Malaysia Healthcare https://www.mhtc.org.my/mhtc/2020/02/02/the-healthcare-system-in-malaysia/

Table 2.1: Newspaper/Media Reports on Accessibility of Healthcare in Malaysia

However, Onn (2015) reiterated that the main challenge is in its ability to continue, is hampered by 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 when the cost of providing healthcare is always on the rise. Onn believes that the financing burden will gradually shift from a taxation-based system of healthcare provided by the public sector to one where the national insurance scheme will increasingly become important to finance the health needs of the population provided by both the public and private healthcare sectors.

Therefore to improve, he concluded from his article is to reduce waiting times, to find ways to pay better salaries to medical staff in the hospital that corporatisation may be the way to go for some segments of the healthcare sector and to strengthen regulatory role of the government to create an environment that can capture the efficiencies of competitive healthcare enterprises while deterring the abuses that commercial entities may resort to in seeking to maximize profits. Onn emphasized accountability, transparency, and an open and fair tender system should be based on the criteria of experience, knowledge, and management capabilities achieve the effectiveness of the policy and improve the delivery of the healthcare service.

Concerning the Malaysian public health, it is beleaguered by the increasing public demand for better quality care, as well as changing demographics and disease burdens. Major health reforms were discussed within government involving social health insurance, a single purchaser and both public and private provision but nothing definite was resolved (Ng, 2015; Croke et al., 2019).

The Malaysian hospitals like other hospitals around the globe are facing new challenges in ensuring universal access, improving equity and efficiency and the quality of life of the public population. Merican, Rohaizat, & Haniza (2004) deduced that like other countries, Malaysia faces major challenges in meeting the increasing demands with limited resources, changes in demography, increasing consumer expectations, new technologies, the impact of globalisation and liberalisation and many others. The essential services in the health system of the future are information and education of individuals to support the wellness paradigm, consultations to maintain health or provide early treatment of illness. There is also a need to restructure the national health care financing and the health care delivery system. The roles and responsibilities of MOH also need to be reviewed to cater for these challenges and impending health

reforms. MOH recognises that health planning is a dynamic process and managing change requires the ability to anticipate challenges and threats and curbing them before they can cause a crisis in the health organisation.

The problems faced are basically the long waiting times, over consumption and high price differences between the public and private healthcare sectors. Malaysia's universal healthcare system is undergoing a structural reform to improve these and also the high price differences between the public and private healthcare sectors. According to Chee-Khoon (2014) the striking points responsible for these problems are: that the state has multiple roles such as funder and provider of public sector healthcare, regulator; key investor in for-profit health care, along with the inherent conflicts of interest; the public sector health care is underfunded and is plagued by a shortage and continuing outflow of senior experienced staff, thus affecting the quality of its care and its ability to restrain the escalation of charges in the private sector. Benign neglect of the public sector is unclear as health ministers have ironically argued that private health care is for the wealthy so that the public health services can be allocated for the 'truly deserving poor'. Resulting in a two-tiered healthcare system, private care for the rich, and public underfunded sector for the lesser privileged. An alternative solution (Chee-Khoon, 2014) suggested is a more progressive taxation regime to improve universal access to quality care on the basis of need but that too is too problematic to tackle and seems to be far off to hope for.

Thereupon, the Ministry of Finance Malaysia, MOF (2018) has promised to provide quality healthcare services and has allocated about RM27 billion for healthcare encompassing: RM2.5 billion for medical supplies, RM1.6 billion for consumable and medical support items; RM1.4 billion for upgrading and maintaining healthcare facilities, medical equipment and ambulances.: RM100 million to upgrade hospitals and

clinics, including wiring systems; RM50 million for haemodialysis assistance; RM10 million for the treatment of increasing cases of rare diseases and RM30 million for Healthy Community Empowers the Nation programme to create awareness about non-communicable diseases and RM50 million for Voluntary Health Insurance Scheme to enhance the health sector. The rising concern for healthcare services and other public services calls for alternative source of funding to improve these services without further increasing the government's expenditure.

According to Ambrose, Aslam, & Hanafi (2015), *waqf* can constitute a possible solution to unsustainable federal government debt by financing most of the federal government expenditure while the remaining tax revenue is allocated to pay down debt. In the past, history has shown how *waqf* financed the public expenditure. Non-Muslims are allowed to participate as founder, trustee, and beneficiaries in compliance to the *Shari'ah* laws. This will be discussed in Section (2.2.3) below.

There is certainly a need for other options or approaches in tackling our medical problems. Malaysians need more subsidized healthcare where this country is in the state of "excess demand", due to the great fee differentiation between public and private healthcare services, Ir M. et al (2011) wrote. Therefore, it is essential that other options are readily available to tackle this problem.

2.2.2 Present Hospitals in Malaysia

The present Ministry of Health in Malaysia provides the public with hospitals of public government-owned and privately-owned organizations and these in turn, are either for-profits private organizations and social-based organizations. The figure below shows a two-tiered healthcare services of public and private in Malaysia. The private

include for-profit and social-based which consists of three types: non-profit organization, *waqf*-based institution and social enterprise (fig. 2.1) (Atan et al., 2017).

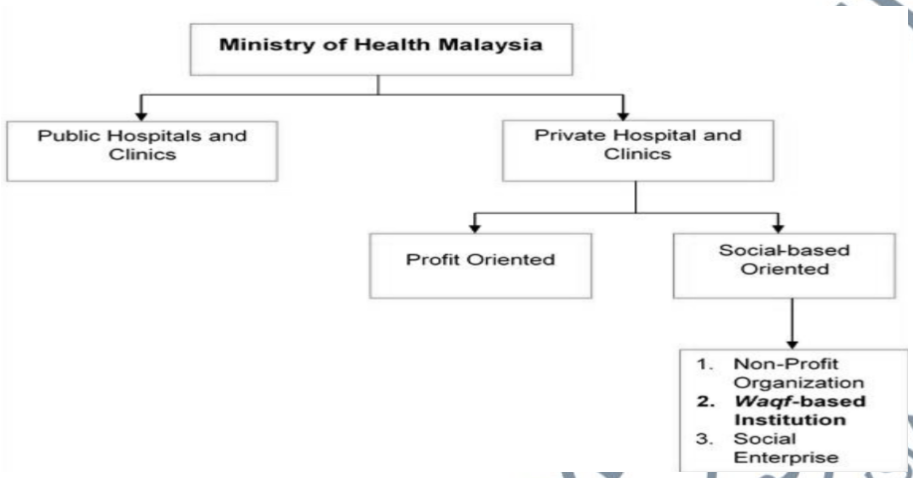


Fig 2.1: Structure of Healthcare Providers in Malaysia. Sourced from Atan et al. (2017)

2.2.2.1 Private Hospitals/Clinics: For-Profits and Not-for-Profit

There are basically two generic aspects of private hospitals, the for-profit (FP) and the not-for-profit (NFP) private hospitals where the not-for-profit hospitals are not investor-owned and they are usually decentralized, governed by a board of directors who give their service voluntarily, or do so because they are part of a religious group. Though they generally operate on the same basis as any other for-profit private hospitals, their mission is charity (Malaysian Productivity Corporation, 2014).

The public health care services and health care provider in Malaysia is complemented by the private sector which constitutes about 35 percent of the overall health care services (Abd Manaf et al, 2010) and from that percentage, not all private health care institutions in Malaysia solely are based on profit-orientation objective (see fig 2.9). Non-profit or not-for-profit (NFP) organizations have long provided benefits and made significant contributions to society. Among the private health care institutions, some of them can be categorized as a social-based health care institution

which includes a non-profit organization, *waqf*-based health care institutions and social health enterprise.

The differences between profit and non-profit hospitals lay the groundwork for a philosophical discussion about the merits and ethics of each approach. Here are some of the key distinctions between profit and non-profit hospitals (NFP).

NFP hospitals are viewed as charities, do not pay federal income or state and local property taxes and because of their charitable purpose and community focus, they are usually affiliated with a particular religious belief. As for FP hospitals, they are owned either by investors or the shareholders of a publicly traded company and are usually located in communities with less poverty, higher incomes, and fewer uninsured patients. While the NFP however, tend to serve lower-income populations (Meador, 2014). One other notable difference in NFP and FP hospitals is that FP hospitals allocate more resources to advertising and marketing. However, both these two types of hospitals bear the same mission of providing good healthcare to patients and there should be no difference in the quality and management of a hospital regardless of their status. Their status is only important to its management, staff and to the community it serves, so that they can understand how the hospital operates and allocates resources. Patients, on the contrary, can should only expect the best of health and medical care.

Amongst the important elements for a NFP hospitals are its mission (Murphy, 2010), the governance (Glaeser, 2002; Jamali, Hallal, & Abdallah, 2010) and sustainability (Murphy, 2010; Valentine, 2014; Weerawardena et al., 2010).

2.2.2.2 Present Social-based Hospitals

The not-for-profit hospitals such as the Tung Shin Hospital and the Lam Wah Ee Hospital were founded early in the history of the Chinese community, tracing their

beginnings to the late nineteenth century. Lam Wah Ee Hospital and Tung Shin Hospital began from the year 1876 and 1881 (Chee & Barraclough, 2007), and still function to provide good healthcare to the public to this day. While Lam Wah Ee Hospital is financed by direct donations from the public and rents collected from a number of properties which were donated by philanthropists or purchased by the Board of Directors and put under the trust of this charitable organisation ("Lam Wah Ee Hospital," 2018). Tung Shin Hospital was founded by Yap Kwan Seng and is a non-profit community hospital established in 1881. Tung Shin is a non-profit organization and is dependent on the generosity of the public and the Malaysia government (Tung Shin Hospital, 2018). Tung Shin Hospital is a private hospitals but give treatment to the poor from their charity mobile clinic frequently (Chee & Barraclough, 2007). The Penang Adventist Hospital which were run by Seventh Day Adventist Christians, started before the Second World War, while Hospital Fatimah and Mount Miriam Hospital were established by Christian missionaries in the post-war period. Recent growth in the number of non-profit hospitals has deteriorated since the increase of for-profit hospitals (Chee & Barraclough, 2007; Malaysian Productivity Corporation, 2014), as can be seen from the graph below (fig. 2.2).

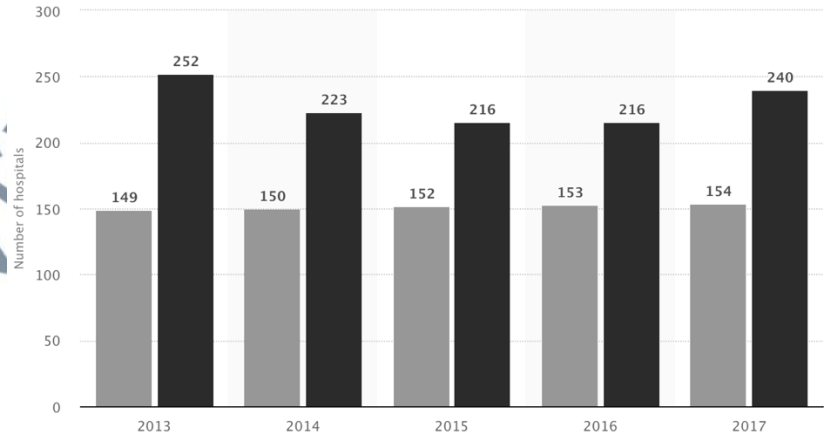


Fig 2.2: Number of public and private hospitals in Malaysia from 2013 to 2017. Sourced from Statista (2019).

Social entrepreneurs are those who try to create a better society by changing the way things work, creating and transforming ideas or programmes that can help improve the social living conditions of focused groups. It combines the passion of a social mission with an image of business-like discipline, innovation, and determination commonly associated with high-technology pioneers (Dees, 1998). Non-governmental organisations generally have the same target groups and concepts as social enterprises, but their objectives and visions generally differ.

Social enterprises are basically businesses that are set up to help the community while NGOs' are non-profit groups set up to help or run a programme that helps the community. Social enterprises generally run a business model and employs commercial strategies that will earn them some profit, but they would role that profit into their cause, so their programmes become self-sustaining while NGOs run on donations that are solicited from the public or their own member (Entrepreneur Insight, 2019). Some data has been retrieved from literature reviews regarding social-based hospitals and these were then tabulated in a comparison table (table 2.2) below. The table shows amongst others, the hospitals' important elements in their criteria consisting of mission, sustainability, governance and revenue generation.

Briefly, a comparison table of the criteria of present social-based hospitals (Table 2.2) was tabulated above to show the similarities and differences in the management and structure of these social-based hospitals, particularly those in Selangor. The table shows the mission is basically either for non-profit or for corporate social responsibility. Their sustainability and governance are two important elements in providing proper management, longevity and stability of these organizations.

Name of Hospitals	Social-based Status	Founders	Mission	Sustainability	Governance	Revenue Generation
1. Assunta Hospital (ASSIS, 2018)	Social Enterprise	A group of missionaries from the Franciscan Missionaries of Mary (FMM) in 1954.	A not-for-profit establishment, social entrepreneurship.	70% reinvested for further expansion of the hospital, investment in new equipment and technology, renovation and modernization of the facilities and also to cover the operational costs of the hospital. 30% to the Social Welfare Fund, patients from the lower social economic group and those who qualify for medical aid, based on criteria set by the Social Welfare committee.	The management comprise of a Board of 28 Directors.	Free to the poor and needy
2. Wakaf An-Nur Clinics (Saad et al., 2017)	Waqf-based	In 2006, Jcorp launched the idea of "Corporate Waqf" which involved the transfer of 12.35 million-unit shares to Kumpulan Waqaf An-Nur Bhd as trustee	Not-for-Profit, Charity, to provide healthcare and dialysis services to the less fortune segment of the society	Nominal charge of RM5 with medicines, dialysis treatment at a subsidized price of RM90	Board of Directors of Jcorp WanCorp as 'Maukuf Alaih' or the manager of the 26ndowment.	Minimum payment of RM5 with medicines, RM90 for dialysis

		(Jcorp, 2007).				
3. Tung Shin Hospital ("Tung Shin Hospital, " 2018)	Non-profit Institution	Was founded in 1881 by Kapitan Cina Yap Kwan Seng.	Committed to provide high quality and affordable healthcare services to enrich lives and improve health of our community.	Provide free medical services and/or affordable medical care to the needy;	Board of Directors	Free to the poor and needy
4. Kasih Special-ist Centre, Cyber-jaya	Waqf	Dr Mohd Zaqrul Razmal Mohd Podzi	Social entrepreneurship	Waqf-based Institutions, donations	Board of Directors	Discounted costs for regular patients and Free for poor.
5. Avisena Special-ist Hospital	Corporate Social Responsibility (CSR)	President & Chief Executive Officer is Dato Dr. Omar, and the hospital began from 1996.	Private Hospital	Private hospital with a CSR, Yayasan Avisena to provide free medical service twice monthly.	Board of Trustees	Free

Table 2.2: A Comparison Table of the Criteria of Present Social-based Hospitals

2.2.2.3 Present *Waqf*-based Hospitals

Altruism through *waqf* contributions worldwide has exhibited their diverse experiences in view of the differences in the amount of their endowments and practised in different corporate management models. Despite the slowdown in the global economy, charitable giving activities has indicated an increase in total contribution worldwide. According to World Giving Index 2018, the philanthropic behaviour specifically in donating money, volunteering and helping strangers are found to be increasing. Malaysia however, is ranked at 13 scoring with 51% (Charities Aid

Foundation, 2018). However, in terms of donating money, Malaysia is placed at 42 with 59% score. It is found that the level of giving is still low with the trends of giving among Muslims in Malaysia who are focused more on giving to worship places, charity homes and the poor (Awang, Muhammad, Borhan, & Mohamad, 2015). Regarding corporate philanthropy, they are noticed to be usually diffused and unfocused (Michael E. Porter & Holes, 2002).

The Deputy Prime Minister, Dr. Wan Azizah urged that initiatives to establish the *waqf* adhered to the Islamic principles and values of emphasising the competitive spirit in doing good and welfare (Bernama, 2018). This could be advantageous to the present government as according to Çizakça (1998), numerous public services such as health, education, municipal, etc., were provided in history at no cost whatsoever to the government and therefore can significantly be emulated in the present times.

An example is *waqf* in Turkey particularly, as it has proven that contrary to the suggestions that Islamic institutions inhibit economic development, *waqf* in Turkey proves how religious institutions can be local solutions to the challenges of economic development of the country. There are many personalities in Turkey who are responsible of the huge contributions to *waqf,* but this study wishes to focus on one amazing contributor, Vehbi Koc who is the founder of the Vehbi Koç Foundation, and is considered to be one of the main architects of the post Ottoman foundation sector in Turkey. Vehbi Koc was found to be the key advocate and one of the first successful businessmen in the new Turkish Republic who founded the earliest the vakif foundation in 1996 which eventually was named The Vehbi Koç Foundation governed by a board of directors (Koç Holding A.Ş, 2021; Vehbi Koç Vakfi, 2013) and focused on three main areas; education, health and culture, which are among the basic requirements of

life for a modern and developing Turkey and has been a model for philanthropists since its establishment (Bikmen, 2008; Cizacka, 2013; Çizakça, 1998; Zencirci, 2015).

The foundation also focused particularly in the area of healthcare which they established such as the Semahat Arsel Nursing Education and Research Center (SANERC) founded in 1992, VKV American Hospital (1995), Koç University School of Nursing (1999), Koç University School of Medicine (2010), Koç University Health Sciences Campus and Med American Ambulatory Care & Surgery Center (Vehbi Koç Vakfi, 2015).

On their official webpage Vehbi Koc Vakfi (2015) reported that Vehbi Koç Foundation has invested more than 200 million USD to renovate and expand the VKV American Hospital to provide the highest international standards with its healthcare personnel, medical technologies and administrative systems, while contributing to the development of Turkey's healthcare system. VKV also boasts of Koç University Hospital which became operational in September 2014 as a research and training hospital. As of 2016, the hospital has increased its capacity to 404 single inpatient rooms and 73 intensive care units (366 adult and 111 paediatric). With 13 Operating Rooms and 14 Intervention Rooms, more than 4000 operations have been performed. It also has a Health Sciences Campus which spans over an area of 220.000 metre square includes the school of medicine, the school of nursing, research laboratories and the Advanced Learning Centre. The Health Sciences Campus aims to contribute to the creation of qualified human capital in the healthcare sector with its innovative approach and dynamic team at North American standards.

Besides VKV in Turkey, another remarkable contributor to *waqf* worth mentioning in this era, is the Hamdard Corporation in India, Pakistan and Bangladesh. According to Abdel Mohsin (2015) , Hamdard was the brainchild of an eminent Unani

Practitioner who owned a small clinic in a small hometown village to help the poor neighbouring villagers. In 1922, after the father passed away, his two sons Hakeem Abdul Hameed and Hakeem Hafiz Muhammad Said took over the administration.

After the partition which created the three sovereign states of India, Pakistan and Bangladesh, the institution of *waqf* remained under one founder. The eldest son stayed in India, the second son went to Pakistan and the grandson went to Bangladesh propagating Hamdard Foundation concept in these countries. Hayat & Naeem (2014) recorded that Hamdard Laboratories contributes 85%, whilst (Magda Ismail (2015) informed 100% of their profits are contributed into Hamdard National Foundation (HNF), which distributes the funds for charity across various Hamdard institutions. Jamia Hamdard (2017) documented the inauguration of The Majeedia Hospital in 1985 on its official webpage, which is one of those institutions mentioned above, built on a sprawling complex of Hamdard Nagar and is a modern hospital.

Majeedia Hospital was later renamed to the Hakeem Abdul Hameed Centenary Hospital (HAH Centenary Hospital) and was attached to a newly established medical Institute named Hamdard Institute of Medical Sciences of Research (HIMSR). HAH Centenary Hospital has 650 teaching beds currently housing all broad clinical disciplines with blood bank and hospital laboratory services. It provides consultancy services in Unani medicine. Hayat & Naeem (2014) and Jamia Hamdard (2017) both wrote that the hospital also runs the Rufaida School of Nursing, which was established in 1983 by Hakeem Abdul Hameed and has since become a full-fledged Faculty of Nursing with an efficiency-oriented architectural planning of its various Departments and Faculties. The wards, operation theatres, examining rooms, laboratories and so on radiate across concentric corridors from central control units on each of its three floors.

The Hamdard Laboratories (*Waqf*) Bangladesh(N. A. Khan & Jareen, 2015), had one of the largest *waqf* which included several social development enterprises which consists besides universities, pharmaceutical drugs, laboratories for scientific research, 200 free health centres and hospital. From the website of Hamdard Foundation (2018), it was reported that in 1947, Pakistan was founded and Hakeem Mohammed Said, at the age of 28 migrated to Pakistan to established Hamdard Pakistan in Karachi which he later converted Hamdard into a *waqf*. In 1985 the entire profits of Hamdard Pakistan were used in the development of health, education, and similar nation building and philanthropic fields. Hamdard Foundation Pakistan was created to manage these funds. Hamdard Foundation also supports Hamdard University Hospital (Taj Medical Complex) which is a teaching hospital provides treatment to patients at subsidized rates and this in turn serves as training to its under graduates /graduates and postgraduates medical students. Under the new health programme "Free Patient Scheme" in Karachi at mid of 2017, they now provide free treatment facilities to the poor and patients from low-income.

The late Hakim Mohammed Said started Hamdard Free Mobile Dispensaries in 1963 with a single vehicle to provide free medical treatment to the poor & needy patients in remote areas of Karachi. Hamdard Foundation Pakistan gradually expanded and enhanced this philanthropic activity with Hamdard Free Mobile Dispensaries which are treating more than 500,000 poor & needy patients, annually in 11 major cities including Karachi, Lahore, Hyderabad, Faisalabad, Rawalpindi, Peshawar, Sargodha, Multan, Sukkur, Quetta and Azad Kashmir. Presently, the Hamdard Foundation Pakistan which is governed by it Majlis-e-Nozuma or a board of directors (Hamdard.com, 2021), has a fleet of 20 equipped vehicles with Hamdard's medicines with experienced doctors and pharmacists' dispensers. They also provide free

consultancy and medicines through this programme and seriously ill patients will be referred to Hamdard University Hospital (Taj Medical Complex), under the "Free Patient Scheme" programme. Unfortunately, these hospitals lacked studies about them. Most of the data collected about Hamdard were from their webpages online and article journals regarding them were lacking.

The circumstances in a country like Malaysia, the social heterogeneity of multiracial, multi religions and multi ethnicity could possibly pose a hindrance in the collaboration of an Islamic entity like *waqf* with a public Government healthcare service. In the endeavour to have *waqf* contribute effectively in Malaysia, it is therefore necessary to mention that Malaysia's spirit of *Muhibbah* can come together to exhibit a positive attitude despite their differences even in the cultural societies, for when there is a dire need, unity prevails.

Aljuneid (2017) clearly explained this across-culture and social boundaries in Malaysia when addressing the humanitarian problems in the home country. Malaysians exhibit a positive attitude towards these differences and adopt a mind-set of broad-mindedness when called upon to overcome human-related difficulties. Therefore, humanitarian need will permit this partnership of necessity where good healthcare and their services are in great demand.

2.2.2.3.1 Waqaf An-Nur Hospital/Clinics

Presently in Malaysia, among the *waqf*-based health care institutions established are the hospital and clinics of Waqf An-Nur (Norizah Mohamed@ Daud & Asmak Ab Rahman, 2015) which is a collaboration with Waqaf An-Nur Corporation Berhad and KPJ Healthcare Berhad, and USIM Medical Specialist Clinic with the collaboration of Majlis Agama Negeri Sembilan (MAINS). It was established on February, 2013. Both health care institutions were administrated by an appointed corporate entity to manage

the operation of health care institution. The establishment of both institutions has received full cooperation and approval from each Religious Council of the State (Rosli et al., 2018; Wan Ismail et al., 2019).

For the health care institution under Johor Corporation, it has to date developed 21 units of Klinik Waqaf An-Nur (KWAN) nationwide and a Hospital Waqaf An-Nur (HWAN) in Pasir Gudang, Johor. The Waqaf An-Nur Corporation Berhad was established by Johor Corporation Berhad and was officially launched in 1998. Through this mechanism, part of the benefits received by the Johor Corporation Berhad in the form of annual dividends from its investee companies, are allocated for *waqf* and distributed for social and religious activities (Johor Corporation Berhad, 2006).

It was reported from their annual report that (WANCORP, 2018) that WANCorp contributes 14% of the total received to health care (HWAN and KWAN) which amounts approximately to RM274,400 from the total endowments of RM274,400 and approximately RM74,400 to individuals who are poor or disabled. A periodical article by Bank Muamalat (2012) reported the accumulated total assets of WANCorp to be RM 538m. Hashim (2012) informed that altogether WANCorp operated 17 clinics in Malaysia, which have served more than 800,000 patients with a small charge of RM 5 per patient that covers the doctor's fee and medicines (Allah Pitchay et al., 2018).

The annual report of Johor Corporation (2018) also reported that since its launch, Johor Corporation has to date developed a total of 28 Waqaf An-Nur Clinics (KWAN) throughout Malaysia and one Waqaf An-Nur Hospital in Pasir Gudang, Johor. The chain of clinics owns a total of 68 dialysis machines as of 2018 (as compared to 64 units in 2014) and has treated 350 kidney patients at a minimum charge of RM90. Outpatients from the clinic consists of all levels of the multiracial public and they are

charged with a minimum fee of RM5. As of 31st December 2018, KWAN clinics had treated 1.75 million patients, including 154,282 non-Muslim patients.

The Wakaf An-Nur Clinics have indeed contributed tremendously to patients who are needy in Malaysia (Mohamed@ Daud & Ab Rahman, 2015). Their services include a nominal fee of RM5 for basic consultation and medicines (Table 2.3). Treatment for dialysis is subsidized and charged at approximately RM70-RM90 (Kauthar et al., n.d.).

TYPES OF TREATMENTS	*RATES*
OUTPATIENT	RM5 (not inclusive of procedural charges)
WARDED PATIENTS	For those with salary less than RM1500: RM10/day For those with monthly salary of more than RM1500: RM50/day
ACCIDENT & EMERGENCY	RM5 (procedural charges not included)
DIALYSIS	RM90 per session X 13 sessions per month
MOBILE CLINIC	RM5

Table 2.3: Rate of Charges for KWAN (Mohamed@ Daud & Ab Rahman, 2015)

However, there have been reports by the patients that some of the clinical services were not available in the clinics or added costs (Abdul Rahman & Ahmad, 2013; Mohamed@ Daud & Ab Rahman, 2015) which include blood tests, antibiotics, certain selected medicines, dialysis and other health services. Amongst other shortcomings reported were the location of these hospitals which were inconvenient, the scarcity, and a demand for a more comprehensive health service, as most other laboratory tests had to be taken elsewhere.

Overall, the studies on *waqf*-based hospitals in the past and present were not only scarce but lacking. Studies to show connections between the past *waqf*-based hospitals to the present *waqf*-based hospitals indicated research gaps. Furthermore, for some of the

present *waqf*-based hospitals, there were issues and arguments regarding the sustainability, the size and location etc.

2.2.3 *Waqf*

The specific conditions of *waqf* are different for Muslims in various parts of the world, in different eras and in the diversified school of thoughts. Nevertheless, since during the 19th century, the fundamentals of *waqf* have shown some consistencies. The law which states that the owner of a property had to make declaration orally, is also allowed but documentation is preferred (Kuran, 2001). The specifications are provided by the solicitors, and this will hold the property of *waqf* where perpetuity is a prerequisite element. The pillars of *waqf* comprises of four principles which are *waqif* (the donor/founder), *mauquf* (corpus or property), *sighah* (contract), and *mauquf 'alaih* (beneficiaries). All the principles must be stated clearly before the contract of *waqf* is considered valid. The *Mutawalli* is the trustee/manager of the trust assets (Hassan & Rashid, 2015). It is a privilege with a responsibility and accountable to not only the donor/*waqf* but holds a sacred accountability to Allah SWT (Nahar & Yaacob, 2011). The beneficiaries from *waqf* institutions are not only limited to the Muslim poor and needy recipients, but it crosses the racial and economic background of the receiver as has been documented from a hadith[1] (Atan & Johari, 2017).

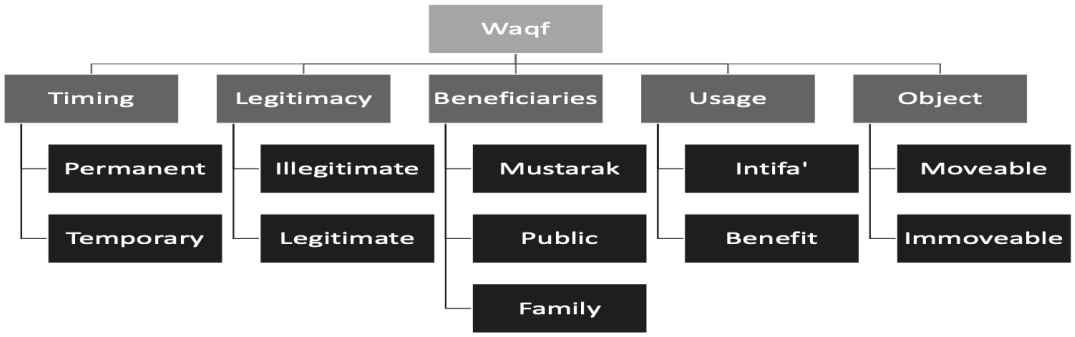


Fig 2.3: *Waqf*'s Categorization in Islamic Jurisprudence (Ahmad, 2015)

[1] Sahih al-Bukhari 2737

The Figure (2.3) displays in brief, the many prerequisites of *waqf*. These elements categorized them on five aspects which are the duration/timing of permanence and temporary, legitimacy of legal and illegal, beneficiaries/receivers of public, family or *mushtarak* (both), usage of *waqf* goods which can be *intifa'* (timesharing) and benefit (profitable), and the type of tangible object of *waqf* which can be moveable or immoveable like a building (Ahmad, 2015).

Waqf plays an important role as a socio-economic contributor, Çizakça (1998) wrote, as it is an important Islamic institution whereby alms, donations and contributions are transformed into public services in perpetuity. He added that public goods such as health, education, municipal, etc., were provided in history at no cost whatsoever to the government resulting in a reduction in budget deficit. This could be the solution to the under-supply of public goods in the modern world of conventional economies. According to Saduman & Aysun (2009), during the Ottoman era, the cash *waqf* fund complements the *zakat* (Islamic tithe) fund and was used as financial aid to the poor and needy, besides financing the development of public infrastructures. The *waqf* system can be the ultimate goal of every modern economist as a massive reduction in government expenditure which can result in a reduction in budget deficit.

2.2.3.1 *Waqf* and its Applications

Altruism is encouraged in Islam especially towards the poor and underprivileged. In ensuring that these groups are taken care of, *zakat* is made compulsory and obligatory upon predetermined groups of Muslims, while *waqf* is a religious endowment with specific requirements and *sadaqah*, a voluntary almsgiving. Though *waqf* is one of the potential tools to encourage the economic and social

development of the society, the contributions from *waqf* have not been fully utilised (Ambrose et al., 2015; Bank Negara Malaysia BNM, 2014; Rashid, 2012).

Waqf can be defined as the holding of certain physical assets and retaining it so that the benefits continuously flow to a specified group of beneficiaries according to the trustees. The dominant feature of *waqf* is perpetuity, and typically *waqf* assets are in the form of real estate. These two fundamentals of permanence and perpetuity and with its own legal framework and set of regulations provide management within the confines of *Shari'ah* (Alam, Shahriar et al, 2018).

The purposes of *waqf*, however, are not confined to one's posterity, helping the poor and the needy and spending on the Qur'an and mosques, but can extend to cover schools, students, libraries, orphanages, attending to children, marriage, repatriation of strangers to their homeland, building hospitals, digging water wells, caring for animals, protection of environment and more other activities related to social development and solidarity (Elasrag, 2017). *Waqf* has played a multi-faceted role in the socio-economic development of the Muslim Ummah in many Islamic countries in the past (Çizakça, 1998; Frenkel, 2009; Kahf, 2003; M. T. Khan, 2014; Orbay, 2013). In explaining this role mentioned above, the Figure (2.4) below (Al-Ahmad, 2014), shows the durable mechanism of *waqf* for public services which consists of the rental of *waqf* properties and its income or usufruct spent on the sustainability of other *waqf* projects.

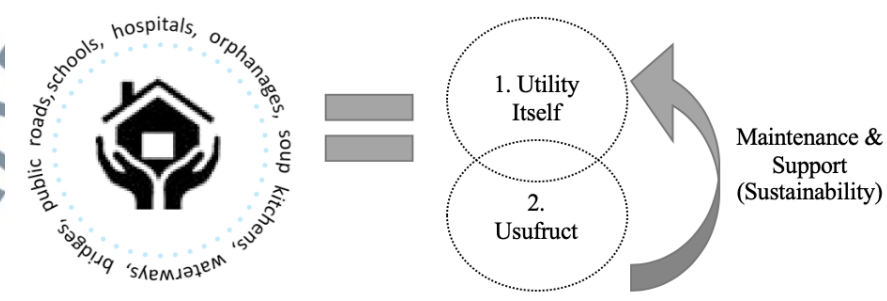


Fig 2.4: The Mechanism of *Waqf* (Al-Ahmad, 2014)

During the Ottoman period, Habūs (as they were referred to in North Africa) or *waqf,* played an important role in the urban and municipal management and the properties donated were managed by trustees or *Mutawallis* (Hamouche, 2007). The collected incomes received were spent for the provisions of municipal services (potable water, streets pavements, city-wall) and public utilities (education, health, social welfare, worship). These services were given to the public for free. *Waqf* in the medieval period not only was a dynamic contribution to the development and advancement of Muslim societies (Chapra, 2008) but it supplied a vast array of social services such as education, health, science laboratories, the construction and maintenance of mosques, orphanages, lodging for students, teachers and travellers, bridges, wells, roads and hospitals (Raimi et al., 2014).

While *waqf* played a major role in the socio-economy in the past especially in the Golden Islamic era of 8th-14th CE, in the areas of education, health and other public services but in other contemporary systems these services had been the principle or sole responsibility of the state.

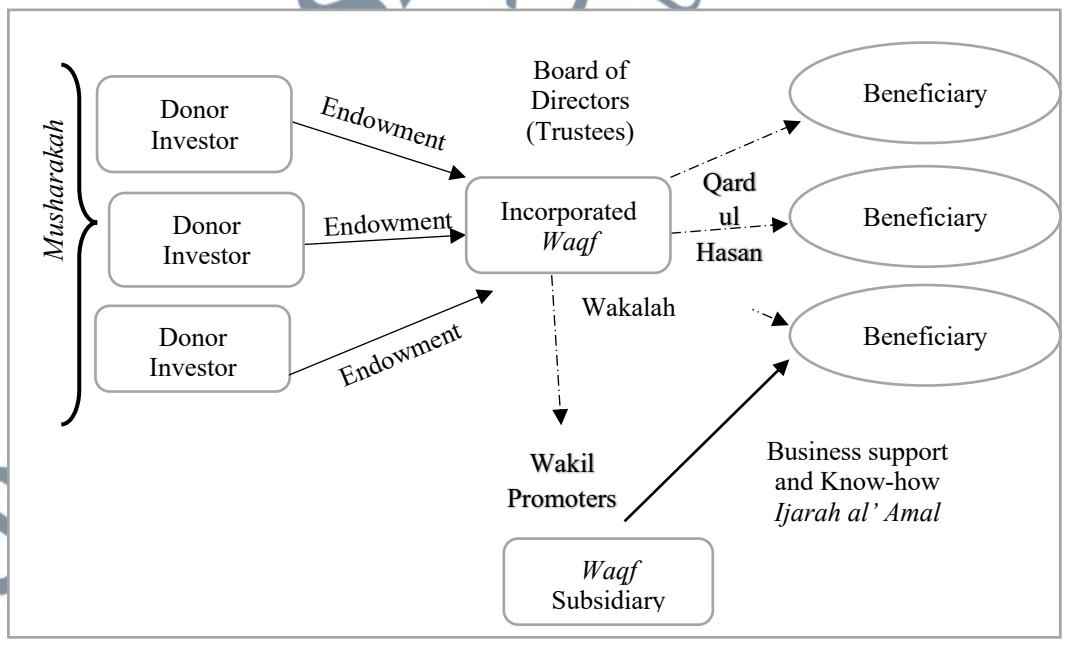


Fig 2.5: Enterprise *Waqf* Fund Model. Sourced from Alias (2015).

The rapid development of *waqf* in Malaysia has reached great lengths in these recent years. There are many models wherein *waqf* is used such as in education, religious purposes, philanthropy and others. The rise of corporate *waqf* in the recent years provides a new dimension of *waqf* practices. Venture philanthropy (Alias, 2015) is an example and it is a *waqf* mechanism in an enterprise *waqf* fund model (fig. 2.5) which is illustrated above.

The following below, are structures of the other *waqf* models such as those in education (Fig 2.6), a corporate banking model (Fig 2.7) and in private healthcare such as the Jcorp corporate model (Fig 2.8). They show how they differ and their similarities in their structural elements.

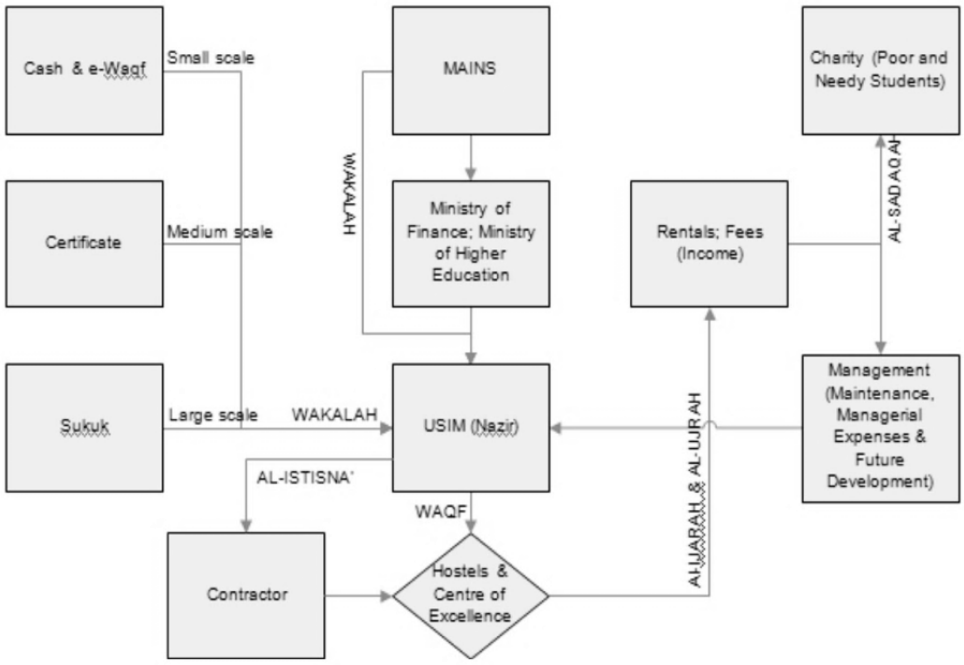


Fig 2.6: The Structure of Corporate *Waqf* University Model
Sourced from Alias (2015)

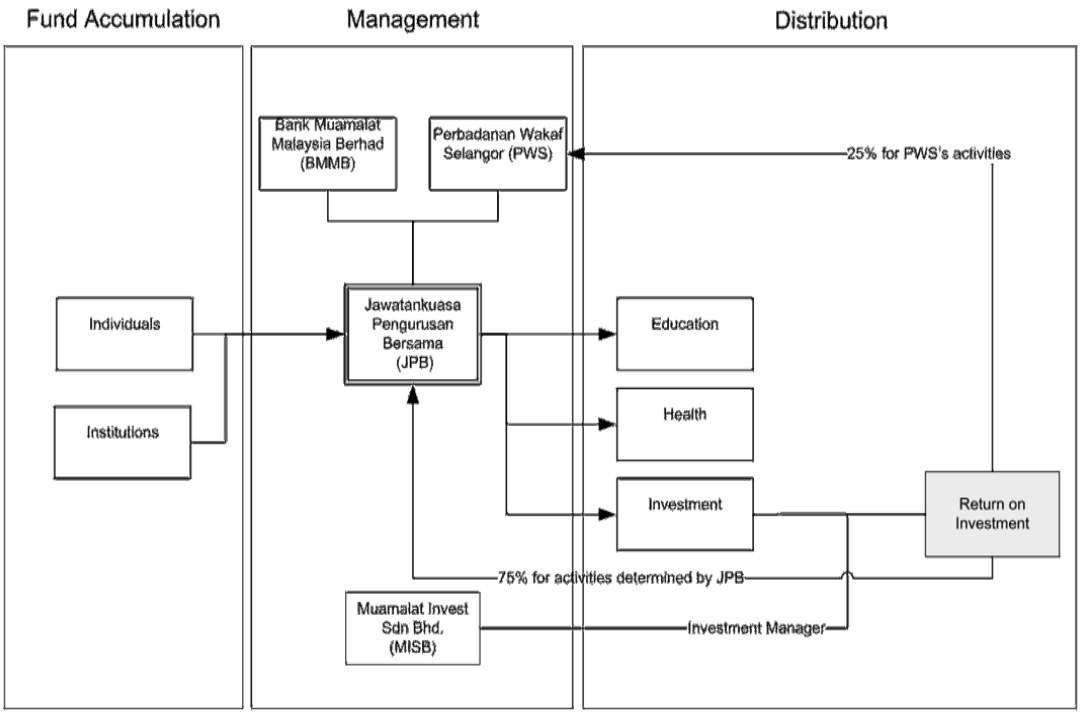


Fig 2.7: Structure of Banking and Financial Institution Model. Sourced from Alias (2015)

Islamic *Waqf* Bank models were discussed from the early 21st CE about how the *waqf* bank can play significant in education (Yusof, Ab Aziz, & Ramli, 2014). Later, the Islamic Banks conferred a significant role in cash *waqf* such as Bank Muamalat with the cash *waqf* scheme which was in collaboration with Perbadanan Wakaf Selangor (PWS) (Selangor Waqf Corporation), Maybank Islamic with the Federal Territory Islamic (Abdul Aziz et al., 2019) and eventually in the discussion of the legal framework and structure of the *waqf* banks in 2020 (Gabil, Bensaid, Tayachi, & Jamaldeen, 2020)

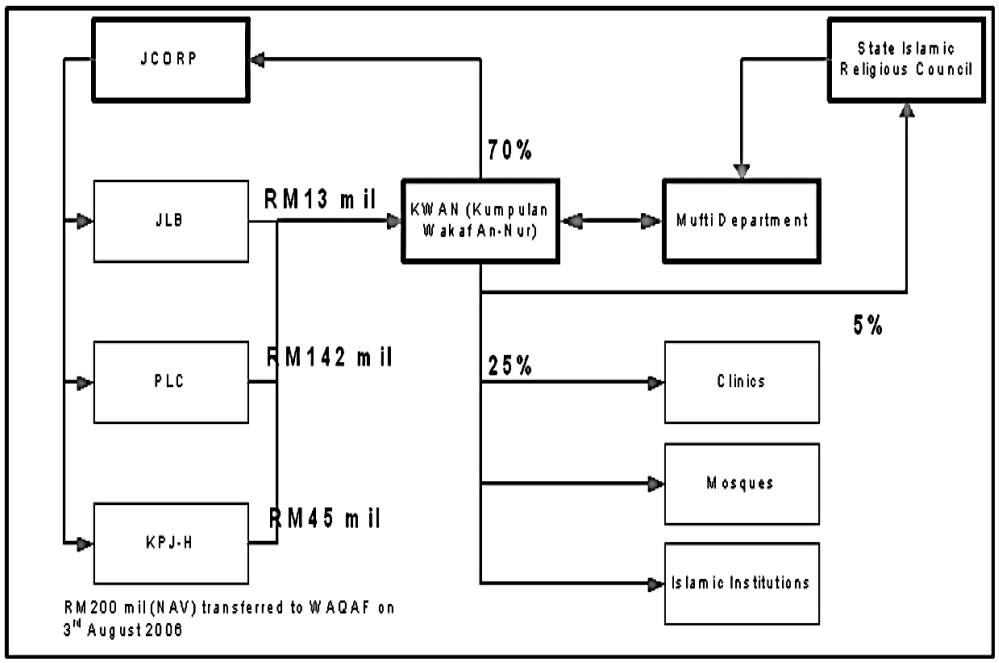


Fig 2.8: Structure of *Waqf*-based Private Healthcare (Jcorp) Model
Sourced from Alias (2015)

However, a model has yet been to be designed to incorporate *waqf* in a public healthcare where this could also be a core design in incorporating *waqf* with a government public service.

2.2.3.2 *Waqf*-based Hospitals in the Past (8th-14th CE)

The history of the applications of *waqf* has been recorded in innumerous journal articles and books. Health services began as early as during the Prophet's SAW era and has continued to serve the public in giving free healthcare to the general public and especially to the poor and destitute up until the present. Health services began in a mobile military tent where Rufaydah was the first female nurse to take care of wounded patients during the *Ghazwah Khandaq* (Battle of the Ditch) (al- Bukhari, 1375; Ibn Ishāq, 2004; Jaljuji, 1965), an Islamic Medical Heritage and it began as early as during the Prophet's SAW era.

The first Muslim hospital which was a specialized leprosarium—an asylum for lepers— was constructed in the early eighth century (88H) in Damascus under Umayyad Caliph Walid ibn ‘Abd al-Malik (Abouleish, 1979; Aydin Sayili, 1980; David W. Tschanz, 2017). During this medieval era of 8th-14thCE, the *waqf*-based hospitals were successful in their endeavor to serve the public. These *waqf*-based healthcare services showed the earliest stage to integration between the Islamic culture and civilization which has resulted in a dynamic and organized institution.

Ibn Jubayr, the Andalusian historian (MEDOC, 2001) and Ibn Batutah (Circa 756H) (H. Ahmed, 2004) reported innumerable objectives of *waqf* during their era. As early as the middle of the 2nd century of Hijrah, *waqf* had ventured into the healthcare services. According to Ahmed (2004), during the times of the Abbasids (1258 CE/655H), hospitals were founded and financed by the *waqf*. Al Ma’mun (832H) built several hospitals which specialized in the fields of ophthalmology, leprosy, mental health and handicapped as the *waqf* in most of the major cities were from his large Empire. He also invested the *waqf* funds for the operational expenses of these institutions. These *waqf* included agricultural lands and business and residential rental buildings. The *waqf* was also used for dispensing medicines to patients, research on medicines and pharmacology, for individuals hired to encourage patients to recover, for abused wives until they reconciled with their husbands, and there were also *waqf* for veterinarian research and animal care. Khan (2014) added that the revenue of endowment (*waqf*) would even pay for the maintenance and running costs of the hospital, and even upon discharge sometimes a small stipend to the patient.

Islamic Civilization according to Modanlou (2015), steered in the Golden Age of Islam with amazing accomplishments in humanistic sciences including medicine by many physicians/authors whose knowledge were recorded, written and used for

centuries in the incessantly expanding medical schools in Europe. The medical texts written during the Golden Age of Islamic Medicine were recorded in an organized and systematic fashion where there were sections, chapters about the clinical conditions, diseases and medical care of children showed its high standards. The Golden Islamic era of the 8th-14th CE brought about the development of Islamic medical hospitals which became the pinnacle of Islamic civilization and where the humanitarian features of *waqf* was integrated with the best available medical knowledge practiced (Sayili, 2006). The Islamic hospitals has been called as a practical example of social solidarity where Islam is not just rituals but a relationship with others within communities and about support and caring for others. The word 'bimaristan' is of Persian origin which means hospital, with 'bimar' meaning disease and 'stan' meaning location or place; hence, the location or place of disease (ʿIsā, 1981).

The following hospitals chosen for this literature review will give examples and clarify their criteria. The historical *waqf*-based hospital models chosen as exemplary are Ahmad ibn Tulun Hospital, Bīmāristān Al-ʿAḍudī (8th CE), Bīmāristān Al-Nūrī (12th CE) and Manṣūrī Hospital, Cairo (13th CE). These *waqf*-based hospitals were meticulously planned buildings and their management of these hospitals included in determining the strategic position of their *waqf*-based hospitals that would provide optimum health conditions for patients and they were preferably built on hills or by rivers, their sustainability, overall cleanliness and other important aspects.

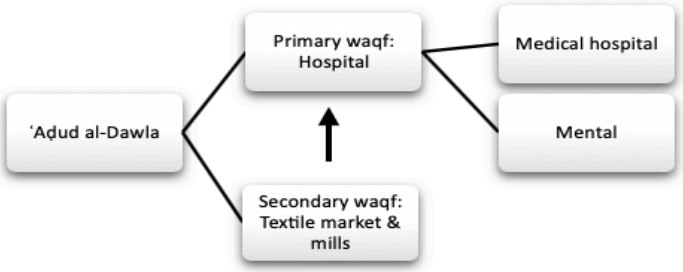
1. Ahmad ibn Tulun Hospital

A famous *waqf* in the pre-Cairo era is that of Ibn Tulun. It was mentioned that the Mosque of Ahmad Ibn Tulun and the hospital attached to it were funded by its extensive properties endowed by the founder, Ahmad ibn Tulun, the `Abbasid governor of Egypt in 872 AD, 1100 years ago (Al-Maqrīzi, n.d.; Hamed A. Ead, 1998; Ibn Abī

Usaibaʿah, 1882; Nour, 2012; Tschanz, 2014). The hospital was extraordinarily advanced in design, which included pharmacies, libraries, lecture-rooms for medical students, and separate wards for men and women(Al-Maqrīzi, n.d.). It also had a library with 100,000 books, kept records of patients and their medical care, treatment at the hospital was divided into 2: in and out-patient. On admission the patients were given special uniform while their clothes, money, and valuables were stored until the time of their discharge. On their discharge, each patient received five gold pieces to support himself until he could return to work (Syed, 2002).

2. Bīmāristān Al-ʿAḍudī

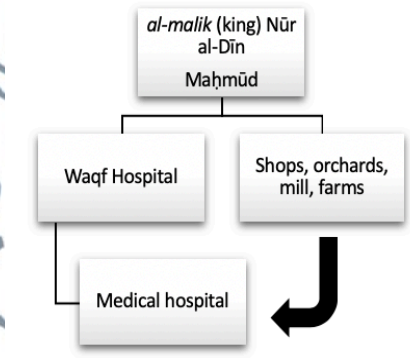
Bīmāristān Al-ʿAḍudī was constructed around the year 980 CE during the reign of al-Muqtadir (Abouleish, 1979; ʿIsā, 1981; Khalkān, n.d.; Nowsheravi, 1983; Sayili, 2006). It employed a total of 25 physicians including oculists (kaḥḥālūn), surgeons (jarrāḥūn) and bonesetters (mujabbirūn). ʿAḍud al-Dawla Fanākhusrū was the ruler of Persia and Iraq in the 10th century CE, ʿAḍud al-Dawla endowed the bīmāristān in Baghdād with a mixture of urban and rural properties. The hospital was erected amid a multi-dimensional economic system to include a textile market which was recognized to endow towards the hospital along with several arḥāʾ (mills) in Zubaydiyya on Nahr (river) ʿĪsā. ʿAḍud al-Dawla endowed numerous other properties to fund the bīmāristān and hence provide it with all necessary equipment for all types of medical supplies(Ibn Abī Usaibaʿah, 1882). This was a clever plan as the hospital would be located perfectly to benefit from the source of the funds. Figure (2.9) below shows the model of Bīmāristān Al-ʿAḍudī.



Fig, 2.9: Funding of Bīmāristān Al-ʿAḍudī
(Abouleis, 1979; Ibn Abī Usaibaʿah, 1882; Nowsheravi, 1983; Sayili, 2006)

2. Bīmāristān Al-Nūrī

The Bīmāristān Al-Nūrī in Damascus was constructed in 1174 CE in Damascus by an ophthalmologist named Shihāb al-Dīn who established this bīmāristān in the al-Siqqatiyyīn market (sūq) in the year 1171 CE but unfortunately, it went through some financial problems and soon after was closed. Later, Badr al-Dīn al-Ṭabīb continued to develop further bīmāristān al-Nūrī by privately procuring nearby properties and making them more organized and efficient in the year 1237 CE (ʿIsā, 1981). The figure (2.10) below are summarizations of the literature reviews and depict the funding structure of the Bīmāristān Al-Nūrī.



Fig, 2.10: Funding of Bīmāristān Al-Nūrī (Adapted from Ansari M, 2013; ʿIsā, 1981)

During that era, the rich and influential were the main financiers who supported and established the hospitals and they comprised of physicians, rulers and government

officials. Even though the bīmāristān were founded based on a combination of political, medical, religious, and social motives, nonetheless the hospitals were able to be established.

3. Bīmāristān Al-Manṣūrī

The King of Egypt Mansur Qalāwūn (1279-1290) when he was still a prince, he fell sick during a mission and was treated by the Nuri hospital of Damascus. He was impressed by their medical treatment that he promised to establish a similar institution as soon as he became the King (Al-Maqrīzi, n.d.). The famous Mansuri Hospital of Cairo was then built in 1282 to accommodate 800 persons. Bīmāristān Al-Manṣūrī is one of the best built, best equipped, and scientifically planned hospital of the world then. The beds were well furnished, the diets well-planned and the fever-wards had even fountains as cooling effects (Al-Maqrīzi, n.d.; ʿIsā, 1981; Nowsheravi, 1983; Sayili, 2006).

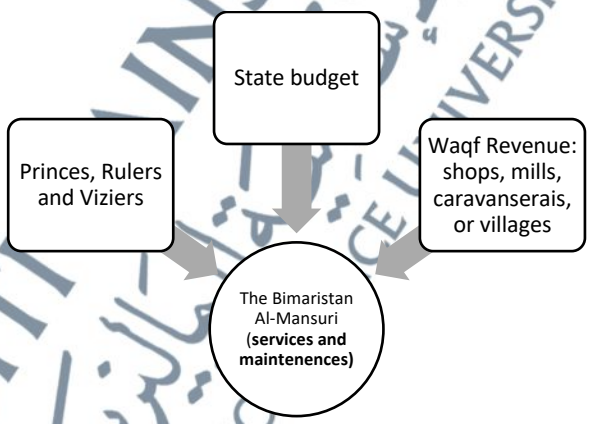


Fig 2.11: Funding of Bīmāristān Al-Manṣūrī
(Adapted from Ansari M, 2013; ʿIsā, 1981)

The figure (2.11) above shows the funding structure of Bīmāristān Al-Manṣūrī where funds to support the bīmāristān were from the state funds and from the proceeds of *waqf* properties of the princes, rulers and viziers (ʿIsā, 1981). The endowments were also encouraged by Mamlūk state policies (Frenkel, 2009; Sabra, 2000) which then

allowed the offspring the approval to inherit any excess funds from charities endowed by their parents and thus making *waqf* profitable in two ways: tax exemption and benefit for descendants after the endower's death.

The Bīmāristān Al-Manṣūrī was a major part of a huge complex built in the centre of Cairo in 1285 by Mamluk Sultan al-Manṣūr Qalāwūn (Ibn Baṭūṭah, 1987), who was the founder of the Qalāwūnid dynasty/*dawlah* that ruled the Mamluk empire for over a century. In addition to the hospital, the complex included a madrasa, where lessons of jurisprudence on the four schools of law were given, and mausoleum, where the Sultan and two of his sons and successors were buried and where lessons of Qurʾān and prophetic traditions were given. Bīmāristān Al-Manṣūrī Hospital was established as a charitable act by the ruler, al-Manṣūr Qalāwūn 1281 CE in Cairo (ʿIsā, 1981).

In studying the criteria of the *waqf*-based hospitals in the medieval era, research was found to be limited only in the field of the structural-functional approach (Al-Maqrīzi, n.d.; ʿIsā, 1981), architectural and urbanism (Al-Ahmad, 2014; Dāhir, 2015) which focused on *waqf* in the social, political and economic dimensions. Research however, fell short in addressing and studying the business framework and administrative management of these past *waqf*-based hospitals.

A certain criterion was documented by Nour (2015) which identified the main basic elements for the *waqf* development in the urban level for past *waqf*-based hospitals which are- time and context consciousness. He also added that for *waqf* to be successful in its implementation, comprehensiveness and pattern of management is of utmost importance. Another criterion which was documented (Dāhir, 2015), was some technical specifications for the *waqf*-based hospitals. The technicalities in building the medical complexes in Islam, included criteria such as: choosing the best location for the best of health which includes appropriate climate; good ventilation and lighting; easily

accessible; availability of water; spacious with good view; strategically located for good infrastructure etc. In addition, large open-air courtyards and adjoining patient wards with corridors were features of Bimaristan during that era (Jiang & Verderber, 2017). On that note, it explains why the Al-Adudi Hospital was built near Baghdad's Dejlah River in 981 AD. Cleanliness too was of importance during the times of Caliph Harun Al-Rashid, when Al-Razi had pieces of meat hung in various quarters of the city, observed for putrefaction (ʿIsā, 1981; David W. Tschanz, 2003; Miller, 2006). Dāhir (2015) also reported the use of Quranic verses to position the buildings and the architectural design of the medical complexes during the past.

Literature reviews (Al-Maqrīzi, n.d.; ʿIsā, 1981; Ibn Abī Usaibaʿah, 1882) also included other elements besides structural and management standards, such as having separate quarters for men and women, different diseases should be separated and the allocation of chief physicians for a group of doctors etc.

In summary, the reviews have managed to uncover some exclusive elements of which the decentralization structure is mentioned in numerous occasions with regards to the management of *waqf* in institutions. The justification of decentralized management of *waqf* in buildings such as in hospitals (Nour, 2012) was to protect the buildings from deterioration and to maintain sustainability. The decentralizing authority and power in the 'pious foundations' (Hamouche, 2007), down-sizes the role of the central authority in managing the city and allowed proper spending on the foundations according to donor's clauses in the contract. The Ottoman period (1399-1922) had hospitals decentralized and managed independently (Shefer-Mossensohn, 2014) as under such a system, various links in the administrative chain could counter check other links, thus allowing transparency, less mistakes and failures. These hospitals were

managed efficiently and effectively, which explains the institutions' longevity in the Ottoman empire.

Another exclusive element compatible with the prerequisites of *waqf* found in past *waqf*-based hospitals is the comprehensiveness or multidimensional interventions (Nour, 2015) comprising of sustainability (Hamouche, 2007; Nour, 2012) in terms of architectural design, environment and economics. This exclusive element describes how the *bimaristan* or medical healthcare facility is developed or established with some considerations such as financial security, accessibility, strategic etc. This is how the *bimaristan* exists in physical 'harmony' (Al-Tabba, 1982; Nour, 2012) with what is important for its longevity and remain beneficial to the people.

This 'harmony' is aptly described by Sharaai & Mahmood (2012), who stressed the regulating of human social and economic relationships with the environment in ensuring the equilibrium of nature and the use of resources and life cycle of all species. This 'Mizan' underlines the aspects of economic, social and environment. Therefore, 'Mizan' from a Quranic perspective (Al-Quran, 55:7-9) is a balanced, justice and harmonious setting. A supporting version (Alias, 2015), describes it in the viewpoint of engineering which is everything that stands at a balanced equilibrium to maintain its status quo. This exclusive element then stands in tandem with the prerequisites of *waqf* which are the establishment and sustainability (Hamouche, 2007).

The criteria for the past *waqf*-based hospitals or *bimaristans* will be listed and drawn into the theoretical framework. The specific criteria and framework for a *waqf*-based hospital in the golden era was found in a limited number of journals. Studies were lacking about them and comparative research about the past and present *waqf*-based hospital models are limited.

The Ottoman Empire in the 15th century approved the endowments of *waqf* and by the 16th centrury it had become a dominant endowment formation especially around Anatolia and the Balkans (Çizakça, 1998; Toraman et al., 2007). Waqf financing was used for building mosques, education and others including health. An example of a health *waqf* is the Sisli Children's Hospital in Istanbul which was founded in 1898.

2.2.4 Highlights of Governance and Sustainability for a Corporate *Waqf* Malaysian Hospital Based on Comparative Analysis of Past and Present Literature.

Important aspects in the application of *waqf* in the contemporary are the sustainability and governance of *waqf* institutions. For the past waqf hospitals, sustainability is of great importance as the factor of comprehensiveness was to ensure that the hospital services were kept running. The elements of comprehensiveness (Nour, 2012, 2015), included building the hospital nearby so as to be easily maintained by the revenues of the real estates (*waqf*). The hospitals even rented a part of the building so as to be able continue to sustain their services as it held a position in the community, a heritage to be proud of and to maintain for the sake of the community. The three most popular *waqf*-based hospitals in the past which were the *bimaristan* al-ʿAḍudī, *bimaristan* al-Nūrī, and *bimaristan* al-Manṣūrī proves their ability to sustain and survive for many years at their respective times (Ansari M, 2013) through funds from the state, usufructs from waqf properties and from individuals who were rich and also wealthy royal families. The sustainability of *waqf* institutions greatly depends on prudent management and administration. As the *mutawalli*'s responses towards prudent management and transparent reporting greatly affect the sustainability of *waqf* institutions, accounting and reporting are therefore considered as the most important

device for mutawalli to discharge his/her accountability obligations (Yaacob, Petra, Sumardi, & Nahar, 2015). Therefore, the *mutawalli* (Abd Jalil et al., 2016), is to oversee and manage the sustainability of *waqf* organizations and improve *mutawalli* information disclosure and communication to ensure transparency and trust.

To also ensure sustainability according to Dafterdar (2011), *waqf* organisations in the present era, have to expand their revenue base to include steadier forms of income from commercial activity and investment because to have profitable operations is to ensure their long-term sustainability and ability to realise their mission well into the future. As a lack of surplus funds may impede operating costs and future capital costs which may eventually result in the withdrawal of a much-needed community service. Concurrently adopting the corporate governance with a sustainable development is crucial in achieving transparency and accountability in their funding and operations.

According to Dafterdar (2011), sustainability is complimented by profitability. Thus, seeking profits could create surplus which can help in expanding or at least sustaining the net of social services adequately. Dependent solely on cash donations and not safeguarding against declining purchasing power of money in a cash *waqf*, could increase the risk of non-sustainability. As the institutional sustainability moves in unison together with financial sustainability in providing good healthcare services, Frank & Salkever (1991) suggests that a reduction in medical fee to the hospital on behalf of paying patients (from subsidization) can increase the indigent care or healthcare for the needy. This may help with the sustainability of endowment-based hospitals.

The success of *waqf* during the Ottoman reign and the development of *waqf* in Singapore are excellent examples of successful exploitation of *waqf* which have been attributed to good governance (Abd Jalil et al., 2016). Therefore, developing a good

governance framework is crucial as this could be a prelude to a more improved transparency and accountability in the role of a *mutawalli*.

The current *waqf* reporting practice is based on the conventional accounting system and has inherent drawbacks as it recognises and reports only annual financial information (Masruki et al., 2017). Hence in surpassing this weakness, Ramli & Muhamed (2013) suggests a proper *Shari'ah* Governance (SG) which is a means of Corporate Governance (CG) that will ensure the compliance of the business entities with *Shariah*. An effective SG can improve the credibility of corporate waqf towards its stakeholders as the principles of *Shariah* safeguards the rights of all stakeholders. While, the accountability concept is essential in conventional endowment setting, *waqf* institutions are expected to embrace a more holistic accountability connotation, the sacred accountability (Nahar & Yaacob, 2011). This unique attribute and the socio-economic implications deserve due attention; especially the strategic role of accounting and reporting as accountability tools to enhance ummah's confidence in current *waqf* practices.

In the development of a corporate *waqf* governance framework, Ramli & Muhamed (2013) believes that a sound governance system can be established and attract Government-link companies/Government-link investment companies, private corporations and individuals to collaborate in *waqf.* The future may yet discover some other revolutionary approaches in *waqf* applications to assist in the economy of the country.

2.2.5 Identifying the Fundamental Elements in the Management of *Waqf*-based Hospital, Past and Present.

Three structural models of *waqf*-based hospital models were obtained from Nour (2015) and Dāhir (2015)and a management model (Hamouche, 2007; Nour, 2012; Shefer-Mossensohn, 2014) of past *waqf*-based hospitals.

From the Table (2.3) below, the criteria from Nour (2015), detailed a more comprehensive list needed for the management of a *waqf*-based hospital in the past but did not include the financial or business aspects or in the mechanism of regulation in its management structure. While for Dāhir (2015), it highlighted the technical specifications from an architectural perspective which was crucial for the physical infrastructure and did not add anything significant for the final criteria needed to understand in the management criteria of past *waqf*-based hospitals. The decentralization in the management of *waqf* foundations according to sources (Hamouche, 2007; Nour, 2012; Shefer-Mossensohn, 2014), was present as one of the exclusive elements in the longevity of the aforementioned past *waqf*-based foundations.

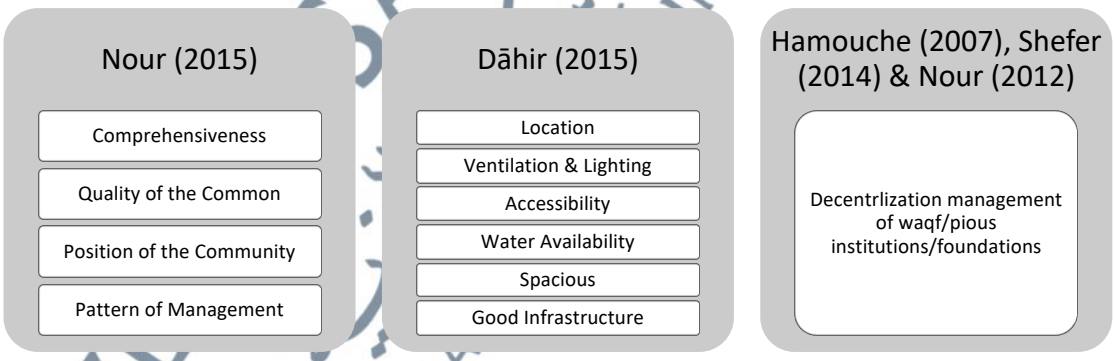


Table 2.4: A Comparison Table of Criteria from Past *Waqf*-Based Hospitals

Guidelines for general hospitals in the present era in Malaysia, is based on WHO (WPRO, 2017) and Malaysian Society for Quality in Health (MSQH, 2017). MSQH is for the Malaysian hospital's criteria (MSQH, 2017) and these are tabulated below (table 2.4) for comparisons. The health systems from WHO framework (WPRO, 2017)

describes in six core components or “building blocks” which are the service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. Whilst our own Malaysian Hospital Accreditation Standards (MSQH, 2017) are grouped into six (6) major areas of concerned which include organisation and management, human resource development and management, policies and procedures, facilities and equipment, quality improvement activities and safety and special requirements.

The Malaysian Society for Quality in Health (MSQH) which is a non-governmental and not-for-profit organisation established and registered with the Registrar of Societies in 1997 is the brainchild of the Ministry of Health (MOH) in partnership with the Association of Private Hospitals Malaysia (APHM) and Malaysian Medical Association (MMA). MSQH develops standards, plans and implements accreditation programmes, promotes safety and quality improvement in healthcare facilities, and organises opportunities for communication of ideas and exchange of experiences on current and best practices in health care.

World Health Organization (WPRO, 2017)	The Malaysian Society for Quality in Health (MSQH, 2017)
Leadership/governance	Governance, Leadership & Direction
Health care financing	Environmental And Safety Services
Health Workforce	Facility And Biomedical Equipment Management And Safety
Medical Products, Technologies	Nursing Services
Info & research	Prevention And Control Of Infection
Service Delivery	Patient And Family Rights
	Health Information Management System

Table 2.5: A Comparison of Guidelines from WHO and MSQH

The comparison table (Table 2.4) above shows some differences and similarities of both MSQH and WHO. Basically, it shows the importance of governance, workforce, service delivery, and information and research.

WHO's Health System Framework(WPRO, 2017)	MSQH standards (MSQH, 2017)	*WAQF* HOSPITAL (8TH-14TH CE)	Wakaf An-Nur	Hamdard 2017	Koç University Hospital	Malaysian Gov Hospital (2017)
GOVERNANCE	Policies and Procedures	Qadi of the Shari'ah Courts (Hamouche, 2007)	Corporate governance (WANCORP, 2017)	Hamdard National Founda-tion (Hamdard.com, n.d.)	Corporate Governance (Vehbi Koç Foundation, 2013)	Ministry of Health (Ministry of Health Malaysia, 2011)
HEALTH FUNDING	Not relevant	*Waqf* funds from Individuals and state funds (Frenkel, 2009; Hamouche, 2007)	*Waqf* funds (WANCORP, 2017)	Hamdard Foundation ("Hamdard National Foundation,"	Vehbi Koç Foundation (Vehbi Koç Vakfi, 2013)	Malaysian Government: Taxation (Onn, 2015)
HEALTH WORKFORCE	Human Resource Development and Management	Muslims and Non-Muslims specialists' doctors (M. T. Khan, 2014)	Muslims and Non-Muslims specialists' doctors	Doctors and medical students. (Hamdard Foundation, 2018)	Specialists with over 1100 staff. (Orion Health, 2016)	Multiracial Specialists Local and foreign
MEDICAL PRODUCTS	Facilities and Equipment	Prophetic meds (Linda S. Northrup, 2013); Galenic-Humoral medicine (Shefer-Mossensohn, 2014)	Western meds (Norizah Mohamed@ Daud & Asmak Ab Rahman, 2015)	Ayurvedic, *Yunani* and Islamic meds (N. Hayat & Naeem, 2014)(Hamdard Unani Medical College & Hospital, 2017)	Western medicines (Vehbi Koç Vakfi, 2015)	Western and Eastern Meds
INFORMATION AND RESEARCH	Safety and Special Requirements Quality Improvement Activities	Bimaristan (H. D. Modanlou, 2011) House of Wisdom (Algeriani & Mohadi, 2017) Contributions of al-Razi (Ayduz, 2007) Ibnu Sina (Murad Ahmad Khan, Raza, & Khan, 2015) Surgeon al-Zahrawi Ibn Rashad(Luisa & Arvide, 2016) Medical Universities (Isā, 1981; Nowsheravi, 1983)	Not relevant	Bait al-Hikmah Research Inst conducts research in the history of medicine, sciences and social sciences. (N. Hayat & Naeem, 2014) Hamdard Institute of Medical Sciences of Research (HIMSR).	It includes, nursing school, Medical university, research lab etc. (Orion Health, 2016; Vehbi Koç Vakfi, 2013)	Hospitals are also teaching hospitals and churn our many doctors and specialists. (Rani, 2012) National Institutes of Health (NIH)
More Information to show association between sustainability and management (Faguet, 2011)						
COST OF MEDICAL HEALTH-CARE	Not relevant	FREE	Minimal fee of RM5, meds are charged. (Norizah Mohamed@ Daud & Asmak Ab Rahman, 2015)	FREE for the poor and for others only meds are charged. (N. Hayat & Naeem, 2014)	Paid by insurance. (private and public)	Free for 3rd class patients and a fee for others
SOURCES OF FUNDING	Not relevant	Royalty, Politicians and the Intellectuals (Ansari M, 2013)	Wancorp Sdn Bhd (Saad et al., 2017)	Hamdard Foundation (N. Hayat & Naeem, 2014)	Vehbi Koç Foundation (Bikmen, 2008)	Government of Malaysia-Ministry of Health (Health Informa-tics Centre Planning, 2013)
STRUCTURE OF ORGANIZA-TION	Organisation and Management	Autonomous and Decentralized	Hierarchy	Hierar-chy	Hierarchy	Hierarchy and Centralized

Table 2.6: Health Services Standards: Comparison Table

The table (2.6) above shows the health standards of the past and present *waqf*-based hospitals, locally and globally, against the Malaysian Public Hospital. The elements also showed management structure and sustainability to show some associations (Faguet, 2011). Evidently, they all comply with the basic fundamentals of WHO. It is also remarkable to note that in spite of being in different eras, the hospitals past and present fundamentally comply with the standards of WHO. It also shows the elements of importance in the past is also present in this era and it supports the application of the medieval/classical epistemology as a basis for a current and future developments especially in the application of *waqf* with a public healthcare service organization (Adnan et al., 2020). The table also revealed some important exclusive elements for the ultimate working framework for this thesis such as the management structure and the importance of sustainability and governance.

2.3 The Theoretical Framework

The figure (2.12) drawn below is a summarization of literature reviews and depicts the preliminary theoretical framework which lists the elements in the criteria of past and present *waqf*-based hospitals which comprises of architectural designs (Dāhir, 2015) consisting of location, accessibility and basically good infrastructure, etc., the elements from the guiding principles (Nour, 2015) of comprehensiveness, pattern of management, etc., the element of decentralization management (Hamouche, 2007; Nour, 2012, 2015; Shefer-Mossensohn, 2014), the element of sustainability (Asharaf & Abdullaah, 2013; Ur Rahman et al., 2017), the intent of the mission (Saad et al., 2017; Omar et al., 2018; Sapuan et al., 2018) and finally the governance (Jamali et al., 2010; Saad et al., 2013; Omar et al., 2018).

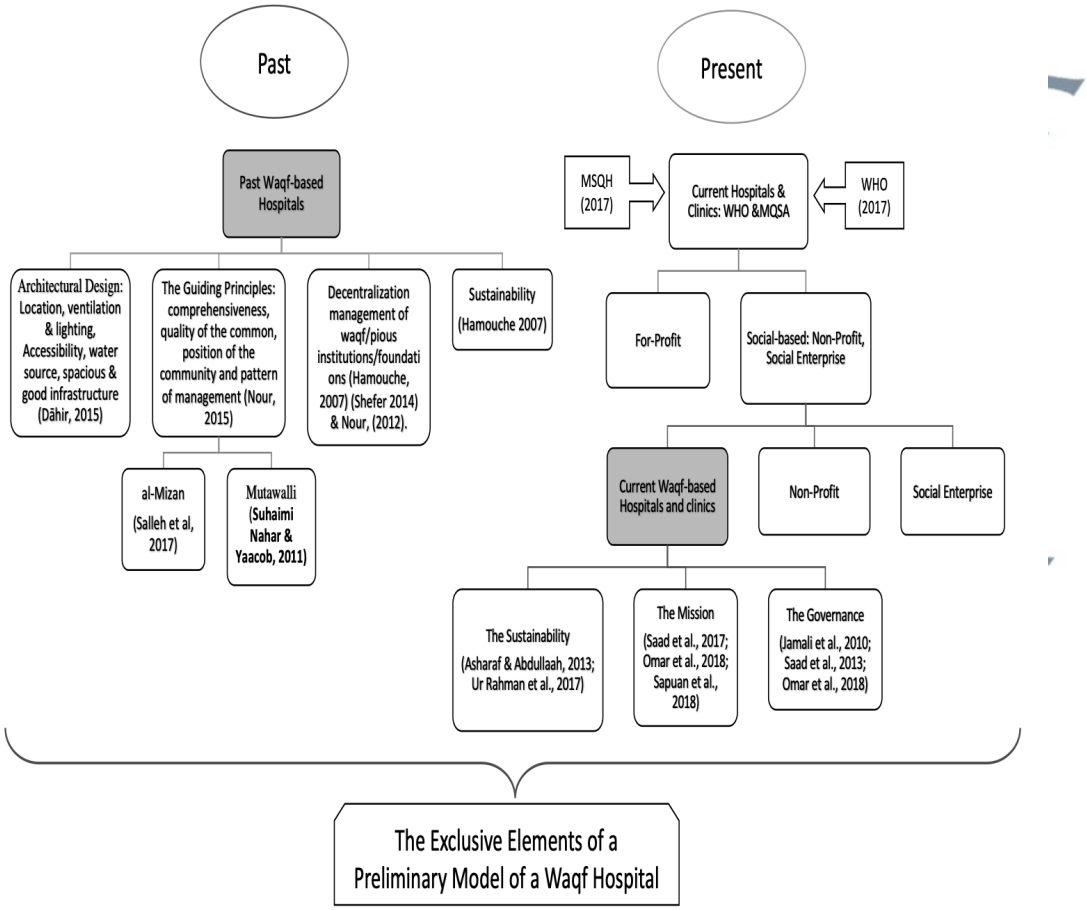


Fig 2.12: The Theoretical Framework

Throughout the review, the data showed information that were either useful, crucial, dated or lacking and resulted in the above variables which were identified to be relevant and pertinent to this research. Figure (2.12) above is a result from literature review of healthcare in Malaysia, *waqf* in the healthcare service industry past and present, fundamental elements in the management of *waqf*-based hospital and highlights of sustainability and governance for a *corporate waqf Malaysian hospital* based on comparative analysis of past and present literature. The proposed theoretical framework is developed to create a corporate *waqf* framework for Malaysian hospital through historical and contemporary comparative practises, a collaboration of a *waqf* institution/funding and a government public hospital institution.

2.4 Conclusion

Reviews of the relevant literature pointed out several gaps pertaining to proposing a corporate *waqf* framework for Malaysian hospital and the literature review explored into the Malaysian healthcare, revisiting *waqf*-based hospitals through historical and contemporary comparative practices in Malaysia and worldwide, discovering connections from the past to the present and finally, uncovered some vital variables and information. To fill the gaps, this research has drawn out a research process in the following chapter and has listed out a preliminary theoretical framework showing the specific variables to support this research.