The Journal of Muamalat and Islamic Finance Research
ISSN: 1823-075X e-ISSN: 2948-5266
Vol. 21, No. 2, Dec 2024, Pp. 118-134
DOI: https://doi.org/10.33102/jmifr.574

UNIVERSITI SAINS ISLAM MALAYSIA
ISLAMIC SCIENCE UNIVERSITY OF MALAYSIA

Article

Beyond Charity: A Comparative Analysis on *Waqf* and Social-Based Healthcare Institutions in Malaysia

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ABSTRACT - *Waqf* and social-based healthcare institutions have existed for more than 150 years and were derived from the social economy concept, which emphasises social innovation in the economy. While Muslims are well-known for developing *waqf*, other religions, particularly Christianity, used philanthropic methods to create a diverse range of institutions that benefit the community. However, the three distinctive features prescribed by the Shariah law to prevent *waqf* assets from being sold or transferred to other parties have distinguished *waqf* from other institutions. The abundance of challenges in the economic and health sectors has threatened the sustainability of *waqf* and other social-based healthcare. Thus, this research aims to explore the philosophies underlying the establishment of each *waqf* and social-based healthcare institution through a qualitative methodology involving an in-depth investigation. Six of the fifteen identified *waqf* and social-based healthcare institutions participated in the interviews, and the transcripts were then analysed inductively using the NVivo software. Each code and theme produced is based on the conceptual framework that has been formed. The themes were compared to observe the similarities and differences in terms of the institutions' background and philosophy of the establishment. The findings of this research reveal that despite the crucial roles of *waqf* healthcare institutions, the fact remains that they are still far behind in fulfilling the healthcare needs of the Muslim community. Meanwhile, the analysis of the institutions' background philosophy revealed that the establishment of *waqf* and social-based healthcare is motivated by religion.

ARTICLE HISTORY

Received: 24th Apr 2024
Revised: 13th Oct 2024
Accepted: 21st Oct 2024
Published: 01st Dec 2024

KEYWORDS

Waqf healthcare, social-based healthcare, sustainability.

INTRODUCTION

During the glory days of Islam, the *waqf* concept was utilised to support the establishment of healthcare institutions, whereas the West used the concept of philanthropy under the church to fund the establishment of its own. Both healthcare institutions have existed for more than 150 years and were derived from the social economy concept, which emphasises social innovation in the economy by incorporating social justice principles into the production and allocation systems (Moulaert & Ailenei, 2005; Pel et al., 2020). The idea of social innovation is becoming increasingly well-known in research and policy (Pol & Ville, 2009; Cajaiba-Santana, 2014; Fougère et al., 2017; Avelino et al., 2019) which it has been studied in a variety of domains, such as social economy, critical social studies, entrepreneurship (e.g., Laville et al., 2015; Moulaert & MacCallum, 2019),

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including healthcare services. While *waqf* is primarily associated with Muslims, other religions, especially Christianity, have also used philanthropic methods to establish various institutions that have benefited the community, including healthcare institutions. Notably, established on the basis of trade and business principles, these institutions have amassed social capital to fund their pursuit of social objectives (Kay, 2006; Serrano et al., 2023). The aims and objectives of the institutions determine how *waqf* and socially conscious healthcare facilities differ from for-profit healthcare facilities. According to Islamic history, *waqf* financing has made it possible to construct various assets, establishments, organizations, infrastructure, and amenities, including medical facilities (Razali, 2014). Furthermore, while public sector entities primarily aim to provide services that benefit society as a whole by focusing on public interest and welfare, whereas private sector organizations are driven by profit motives, seeking to generate returns for their owners or shareholders (Green, 1987; Bayliss & Van Waeyenberge, 2018). However, in social healthcare institutions, the distribution of profits, such as providing above-market salaries to founders, trustees, or employees, is prohibited. This restriction serves as a credible commitment to ensure that the value created is directed toward meeting the institution's objectives rather than serving personal interests (Gee et al., 2023; Hansmann, 1980; Luo & Kaul, 2018). Since *waqf* and social-based healthcare institutions fall under the private healthcare provider category, they often suffer from broad generalizations where they have been described as flexible, autonomous, innovative, and cost-effective institutions (Green, 1987; Roemer, 1984).

In this third-sector economy, organizations are usually guided by the principle of not making profits as the overriding motivation of their activities (Moulaert & Ailenei, 2005; Wolpert & Reiner, 1985). Moreover, they usually represent a wide range of initiatives and organizational forms, such as a hybridization of the market, non-market (redistribution), and non-monetary (reciprocity) economics. This suggests that "the economy is not limited to the market but includes principles of redistribution and reciprocity" (Moulaert & Ailenei, 2005). The sector encompasses both the philanthropy economy of private assistance and the economy of public services. In the context of this study, *waqf* and social-based healthcare institution, or provider, refers to any healthcare organization or institution that focuses on the health maximization of society through the implementation of welfare economics, or non-welfare approaches, to achieve the goal of serving the needs of society (Coast, 2004). It sits in the middle of both sectors and is more known as the solidarity economy among economists (Moulaert & Ailenei, 2005). Usually, the institution is run and managed by a Non-Profit Organization (NPO), a Non-Government Organization (NGO), a social enterprise, a foundation, or a *waqf*-based institution. This type of healthcare institution is classified as a heterogeneous group consisting of a wide range of providers with various motives (Aljunid, 1995; Joudyian et al., 2021). Even though the classification was given the moniker "private," which is typically associated with maximizing profit, some of these healthcare facilities are really designated as socially based healthcare facilities since they are not solely focused on profit. The purpose of this category of healthcare services is to achieve universal health protection in accordance with the objectives delineated by the sustainable development goal. In many low- and middle-income nations, the issue of providing suitable, high-quality healthcare to everyone in need is especially apparent, as accomplishing this goal necessitates the utilization of all available human resources for health (both public and private) (Kleinert & Horton, 2017). Nevertheless, many countries continue to struggle with the transition to universal health coverage and lack access to preventative and curative healthcare services, even with the infusion of financial resources into their health systems (Sanadgol et., 2021; Laokri et al., 2013; Pannarunothai et al., 2004; Reeves et al., 2015; Tangcharoensathien et al., 2011; Saleh et al., 2014; Wang et al., 2014).

In the context of Malaysia, although the Ministry of Health (MOH) is the major provider of healthcare services and is widely available and accessible to the population (Mohamed et al., 2015), it is also complemented by the private sector. It constitutes about 35 percent of the overall healthcare services (Moshiri et al., 2010). Thus, MOH not only plans and regulates most of the public healthcare services but also exerts some regulatory power over the private sector (Juni,

1996), including social-based healthcare institutions. These *waqf* and social-based healthcare institutions acquire funding from public or individual donations, either one-off or continuously. In addition, they are usually managed by NPOs, such as foundations, NGOs, social enterprises, or *waqf* institutions, some of which were identified as benefactors. They can provide funding to develop and finance healthcare services for the less-fortunate group of society, that is, the poor and low-income group, to meet their healthcare needs (Thaidi et al., 2022; Atan, 2016 & Farhat Nazirul Mubin, 2015). The existence of *waqf* and social-based healthcare institutions helps the government solve issues related to patient congestion in public healthcare institutions and serves as an alternative to providing affordable healthcare services amidst the rising healthcare costs. As such, the two-tiered healthcare system in Malaysia serves as the foundation for this study. This study focuses on social-based healthcare institutions (typologically placed under the private healthcare sector) comprising *waqf* and social-based healthcare institutions (NGOs, foundations, and other NPOs) (refer to Figure 1).

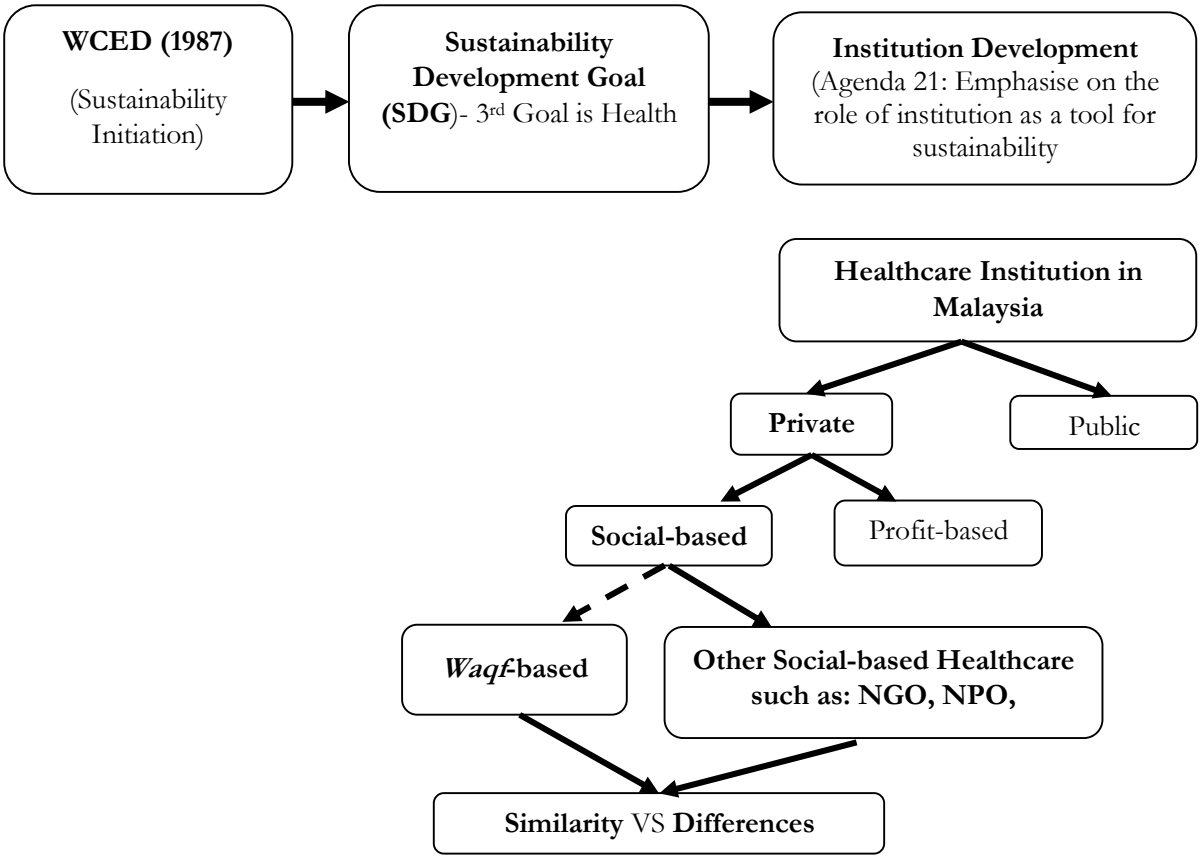

Figure 1: *Waqf* and Social-based Healthcare Setting

It is the main challenge of healthcare organizations, especially social ones, in many countries to sustain and support their activities financially due to decreased donor funding and unstable economic conditions. Meanwhile, under the Malaysian constitution, charities may exist as either a trust, society, or company limited by guarantee that is listed under List 1 of the Federal List, which enables these institutions to be exempted from the provisions of the income tax legislation, where applicable (George, 2001). However, *waqf* is dealt with under List II of the State List. This classification indicates the clear distribution of power between the Federal and State Lists, which lifts out *waqf* institutions to obtain the same privileges as social-based institutions from the aspect of tax exemption. However, its establishment has the same purpose, objective, and aim as the social-based healthcare institution. Thus, understanding the topic through an integrated

perspective of institutional theory, *waqf*, and social-based institution development from both conventional and Islamic viewpoints is a novel approach that enables the holistic understanding of complex social phenomena. This method runs counter to traditional research, which typically concentrates on single problems rather than the intricate bigger picture that is made up of various viewpoints and interactions. Given the institution-focused nature of the study, this research contributes to the body of knowledge on modern *waqf* and social-based institution management models, thereby contributing to the field of institutional theory. The topic of private, non-profit healthcare services, as first introduced by Olsen (1998), is further explored in this study, which is essential reading for researchers in the future. As the vital role of *waqf* and social-based healthcare institutions is widely recognised, it is imperative that the government supports the operations and development. Furthermore, the principles of perpetuity, irrevocability, and inalienability are the three distinctive features prescribed by the Shariah law to prevent *waqf* assets from being sold or transferred to other parties (Salleh et al., 2014) have distinguished *waqf* from other forms of philanthropic or charity institutions. This includes foundations, NPOs, or social enterprises, as their assets can be disposed of by their shareholders (Dafterdar, 2011). However, depending on the three principles alone is insufficient to sustain *waqf* institutions, considering the abundance of challenges in the economic and health sectors that threaten their sustainability. Therefore, this research is trying to explore the research question of this study, which is:

Research Question: What are the philosophies that underlie the establishment of *waqf* and social-based healthcare institutions?

The investigation into the development of *waqf* and social-based healthcare institutions is necessary to address this significant gap and assess the importance of these impacts. This will enable the *waqf* healthcare institution especially to continuously benefit society as a whole and focus on recipients whom the waqif designates. In addition, the study's conclusions could offer policymakers crucial insight into how best to support *waqf* and social-based oriented healthcare facility operators by introducing more benevolent laws that will encourage their further growth.

LITERATURE REVIEW

Waqf healthcare institutions

Waqf is one of the economic sources of social economy, yet it has its own uniqueness compared to other forms of philanthropy. Moreover, Kahf (2003) stated that *waqf* is a term used in Shariah terminology that describes the ownership of certain property and its preservation for the restricted purposes of specific philanthropy. The author also stated that its prohibition against any use or disposal for purposes other than those specified applies to non-perishable assets that can be used for other purposes without depleting them. The meaning denotes the irreversible commitment of a part of one's wealth to apply its usufructs to charitable causes, benevolent purposes, or morally upright objectives, with the primary goal of moving closer to God (Mahmud & Shah, 2010; Azmi et al., 2019). Meanwhile, Ab Rahman (2009) described *waqf* as a type of wealth submission in which the asset is held for personal use, and the benefit is distributed to others or society per the owner's wishes. Once an asset is designated as *waqf* property, it becomes immune to transactions of any kind, such as sales, inheritance, grants, *hibah*, and *wasiyyah* (wills). Only the advantages should be extracted from its physical source, which should stay unaltered (Zakaria et al., 2012; Latif et al., 2018).

Although the word "*waqf*" is not mentioned in the Quran, *waqf* is a sort of philanthropy that uses permanent assets for charitable purposes; the practice of *waqf* is the same as charity (Laldin et al., 2006). In addition to being an act of selfless charity constrained by Shariah laws, *waqf* serves as an instrument of the Islamic economy to accomplish the goals of Maqasid (Atan, 2022). Moreover, Islamic scholars have reported that *waqf* is a form of motivated charity practiced by

Rasulullah s.a.w and was prioritised by the Prophet's companions (Al-Ansari, 2013). Some Muslim scholars agree that although it is not obligatory, *waqf* is regarded as a *mukmilat* (perfection) due to its role in fulfilling *daruriyyah* (essential) needs. Before it can be labeled as such, *waqf* must fulfil four pillars (*rukn*), which are 1) people who give *waqf* (*waqif*); 2) people who receive *waqf* (*mawqūf ʿalayh*); 3) endowment (*mauquf*); and 4) pledge (*sighah*) (Razali, 2014; Al-Ansari, 2013). Furthermore, *waqf* should be made willingly, and the receiver should be clearly defined or mentioned in the *waqf* pledge to avoid future problems. The needs of the community will determine where the *waqf* property is channelled. As explained by al-Dahlawi, "*waqf* is among the types of contracts of "*tabarru*'," which comes from the word *tabarra'a*, meaning donation, gift, or charity (Atan, 2022). In Islamic commercial law, *tabarru*' is defined as a unilateral declaration of unilateral intention, which is considered a contract (Laldin et al., 2006). This characteristic distinguishes *waqf* from other charity practices (Atan, 2022).

The function of *waqf* as a catalyst and source of funding for socio-economic development has impelled the non-Islamic community to adopt the model. It is later known as an endowment, foundation, public trust, public land trust, environmental trust fund, planning estate, or philanthropic organization (Razali, 2014; Sago, 1989; Gerber, 1983). This institutional practice uses the term 'social economy' to evaluate various relevant concepts and analyse the dynamics of social economics and its contribution. This attempts to understand social innovation in the contemporary globalised economy and co-concept development over the past 150 years (Moulaert & Ailenei, 2005). According to Hassan and Jamaluddin (2022) and Fauzi et al. (2023), Islamic wealth ethics in *waqf* has a significant impact on society's health and well-being by promoting justice and equality in wealth distribution. It also provides an ethical wealth management model that includes practical resources that provide solutions to allocations for societal benefits. Notably, history also proves that the institution of *waqf* functioned as a source of funding and contributed to the socio-economic development during the reign of the Ottoman Caliphate (Razali, 2014; Hassan & Jamaluddin, 2022). Through the contribution of *waqf*, every basic need and infrastructure development in the Muslim community during that time can be fulfilled. From the perspective of Maqasid Shariah, the provision of hospital facilities or health centres can be categorised as *hajiyyah*, which is to achieve the necessity of life-saving (Laldin et al., 2006).

Social-based healthcare institutions

Social-based healthcare institutions are part of private healthcare providers established on the social economy objective, which aims to provide healthcare services for all levels of society. Social economy is known as the third sector and is commonly synonymous with non-profit and voluntarism. As per Moulaert and Ailenei (2005) and Pel et al. (2020), this third sector, also known as "solidarity economy," "alternative economy," "non-lucrative sector," "non-profit sector," "not-for-profit sector," "voluntary sector," and "idealist sector," coexists with the private and public sectors. It represents a wide range of initiatives and organizational forms, that is, a hybridization of the market, non-market (redistribution), and non-monetary (reciprocity) economics. This suggests that "the economy is not limited to the market, but includes principles of redistribution and reciprocity." Furthermore, Hansmann (1980) and Gee et al. (2023) argued that in diverse societies, where monitoring the production and distribution of goods is complex. Conflicts of interest are challenging to resolve through contractual means, non-profit organizations (NPOs) mitigate "contract failure" by acting as fiduciaries and serving as reliable representatives for affected parties (Luo & Kaul, 2018).

In normative health economics, the welfare concept is vital to normative and behavioural assumptions and serves as the theoretical foundation (Coast, 2004; Mannion & Small, 1999; Small & Mannion, 2005). This is with the primary emphasis on societal objectives concerned with the maximization of human health (Coast, 2004; Cameron et al., 2018). The term was derived from the ancient roots of Egyptian corporations, Greek funds for the organization of ritual funerary ceremonies, and Roman colleges of craftsmen (Sahakian & Dunand, 2015). Additionally, the

social-based healthcare institution, or provider, itself refers to any healthcare organization or institution that focuses on the health maximization of society through the implementation of welfare economics, or non-welfare approaches, to achieve the goal of serving the needs of society (Coast, 2004; Cameron et al., 2018). Usually, the institution is run and managed by an NPO, which may be an NGO, social enterprise, foundation, or *waqf*-based institution. Initiatives in this area are, on the one hand, focused on reactions to the mass-production system crisis. On the other hand, they also respond to a burdened welfare state (Moulaert & Ailenei, 2005) due to inadequate public funding that cannot meet the needs of the poor (Weerawardena et al., 2010). However, Tuckman and Chang (2006) highlighted that while "mission is the soul of NPOs, money is the facilitating agent that enables them to perform their work." The phrase "mission drift" highlights this ongoing conflict among NPOs, especially those with a significant commercial component to their revenue, ensuring that mission goals are not subordinated to profit-making endeavours (Tuckman & Chang, 2006). Note that each social-based healthcare is distinguished by its objective of fulfilling a specific mission rather than generating profits for investors. They often function in areas where public goodwill is essential, and as tax-exempt entities, they are required to publicly articulate their social purpose (Salamon, 1999; Ballesteros & Gatignon, 2019). Thus, the motive should focus on providing access to health services that are defined as the ease with which individuals can obtain care in proportion to their needs (Mathialagan & Kuthambalayan, 2023; Olsen, 1998).

As a social-based institution, sustainability means being able to survive to ensure that it can continue to serve its constituency and fulfil its commitments to its clients, its patrons, and the community in which it operates. It also enables the stakeholders to depend on and place their trust in its commitment to serve the needy and to deliver on the promise of its mission, in addition to the fulfilment of essential societal needs (Weerawardena et al., 2010). To sustain a social-based healthcare institution or organization, the understanding of the ecosystem is vital. Olsen (1998) and Gee et al. (2023) have highlighted the contextual factors for a non-profit healthcare institution or organization, consisting of health unit structure, support functions, some governing board, and other units within the organization. At the same time, Bird (2020; 2021) has also emphasised the support function, asserting that funding bodies, patient communities, and government initiatives are essential factors for achieving meaningful changes in key patient research outcomes. Other strategies that have been emphasised by Sarkar and Mateus (2022) in ensuring the sustainability of social healthcare systems are integrating innovative financing mechanisms, improving resource allocation, and fostering community engagement to maintain long-term viability and effectiveness. Since each social-based institution or organization has its own unique structure of establishment and different broad groupings, additional adjustments to the framework are required (Olsen, 1998) to suit the different organizational environments and establishment contexts.

METHODOLOGY

This study is qualitative in nature, with the aim of discovering the philosophies that underlie the establishment of *waqf* and social-based healthcare institutions. The goal is to fully comprehend the phenomena, interpretations, and values associated with the situation by delving into the reality of the field of study (Nur Sa'adah, 2016). Moreover, it aims to provide fresh insights into well-known topics by providing more detailed information that is challenging to quantify (Samad, 2018; Holmes et al., 2005). In this study, the focus is on the *waqf* and social-based healthcare institutions that were established in Malaysia. Hence, investigating a phenomenon that is still poorly understood is the rationale behind conducting a qualitative study (Knight & Cavusgil, 2004; Sekaran & Bougie, 2009).

Sample criteria

To determine which *waqf* and social-based healthcare institution should be selected as the sample, it should fulfil at least one of the following criteria:

1. The social-based healthcare institution has social aims, that is, to serve the community and to solve, ameliorate, and provide an alternative for unfortunate groups, such as the poor and homeless, in fulfilling their basic needs for healthcare services.
2. The initial establishment of the healthcare institution should be based on social economic principles, implementing a philanthropic or volunteerism concept, which can either be *waqf*, endowment, NPO or NGO, or social enterprise.

These criteria are crucial to be listed in order to distinguish between social and for-profit healthcare institutions, which usually lie in the purposes and goals of the organization that place the objective of serving the public as the ultimate goal rather than maximizing profit. Table 1 summarises the list of *waqf* and social-based healthcare institutions.

Table 1: Sample of social-based healthcare institutions in Malaysia

No	Healthcare Institutions Category/Name	Year Establishment	Period of Establishment
1	*Waqf* An-Nur Clinics	1998	26
2	USIM Specialist Clinic	2015	9
3	PUSRAWI Hospital	1984	40
4	MUIP Healthcare	2003	21
5	Hospital Fatimah	1974	50
6	Mount Miriam Cancer Hospital	1976	48
7	Penang Adventist Hospital (PAH)	1924	100
8	Assunta Hospital	1954	70
9	Mawar Renal Medical Center	2008	16
10	Tung Shin Hospital	1881	143
11	Hospital Pakar Al-Islam	1996	28
12	NS Chinese Maternity Hospital	1932	92
13	Kinta Medical Center	1980's	44
14	Perak Community Specialist Hospital (PCSH)	1904	120
15	Lam Wah Ee Hospital	1876	148

The sample size of this study aligns with Eisenhardt's (1989; 2021) proposition that theory building requires a range of four to ten cases. A small sample size will enable the researcher to be more specific, draw fewer broad conclusions, and recognise the distinctive characteristics of every healthcare facility. All fifteen social-based healthcare facilities are regarded as the research sample since the research includes a limited population. Notably, the two aforementioned criteria have been used to identify the fifteen healthcare institutions from secondary sources. Each healthcare institution's official website, annual reports, evaluation reports, and other institution-related papers provided background information for the preliminary study. Furthermore, it is crucial for a researcher to build examples using various data sources, as recommended by Yin (1994). These hospitals' lists and preliminary data were obtained from the Malaysia Medical Resources website.

Data collections and analysis

Meanwhile, a qualitative methodology was employed to explore the philosophies that underlie the establishment of *waqf* and social-based healthcare institutions. Through in-depth research, as well

as observation and examination of issues and problems that arise in the real world, researchers can gain focus and a comprehensive understanding of a phenomenon through exploratory work that investigates a new or rare social phenomenon about which there is minimal information (Merriam, 2015; Holmes et al., 2005; Sekaran, 2003). The primary objective of qualitative research is to accurately depict the reality of the field being studied in order to fully comprehend specific phenomena, interpretations, and values attached to the circumstances (Merriam, 2015). Yin (1994) noted that this methodology lacks well-defined and structured processes. However, this approach is appropriate to obtain a new perspective on something already known but to obtain more in-depth information that is difficult to express quantitatively (Holmes et al., 2005). This research design is best used to provide a deeper understanding of the background and philosophies of social-based healthcare institutions and their philosophies towards institutional sustainability since this study aims to explore the philosophies that underlie the establishment of *waqf* and social-based healthcare institutions.

The data was presented and organised based on the primary and secondary data collected. The process of analysing data starts with familiarization, continues with transcription, organizing, and coding, and concludes with report authoring. During the analysis process, the raw data goes through four stages: 1) comparing incidents applicable to each category; 2) integrating categories and their properties; 3) delimiting the theory; and 4) writing the analysis or theory (Glaser & Strauss, 1999). To expedite the analysis process, this study coded and categorised all interview transcriptions into a topic using NVivo software prior to subjecting them to a thorough analysis procedure using the same program. Categories or concepts that emerge from one analysis stage are compared with those that emerge from the previous stage. This process is repeated until saturation is attained and no new significant categories or concepts emerge. The main 'themes' of the construct were identified, integrated and compared with one another. This process is called comparative analysis and was used to analyse the findings of this research. It was conducted through the concept of comparative features selected based on the similarities and differences between *waqf* and social-based healthcare institutions, as proposed by Max Weber (Johari & Ibrahim, 2010). At this stage, the emergent constructs were also affirmed through iterating the extant theory and data.

RESULT

The result of this study represented the discussion on the background of six healthcare institutions that were successfully interviewed out of the fifteen identified. The explanation of the background of the six healthcare institutions is a detailed description with the aim of answering the research objective of this study, which is:

Research Objective: To explore the philosophies that underlie the establishment of *waqf* and social-based healthcare institutions.

Similarities in the background and philosophy of the healthcare institutions

In-depth interviews and document analysis on the background and philosophy of these six healthcare institutions have revealed that they share a similarity in the motive of establishment, which was driven by religion (Table 2).

Table 2: Similarity in the Motive of Establishing Healthcare Institutions

Healthcare Institution Name	Philosophy/ Mission
Waqf An-Nur clinic chain	*Business Jihad* – "creating wealth through business activities based on the Islamic principles of integrity, honesty, shared goals, and community spirit while aiming for the higher purpose."
USIM Specialist Medical Centre (USMC)	To become the leading provider of Shariah-compliant health services in Malaysia
Al-Islam Specialist Hospital	To become a hospital with professional services to realise *da'wah bil-hal*.
PUSRAWI Hospital	To become a pioneer in the development and well-being of Muslims through its mission of implementing the ummah development agenda in a planned and comprehensive manner
MUIP Healthcare	To become the most efficient and superior administration institution of Islamic affairs
Penang Adventist Hospital	To demonstrate the love and healing ministry of Christ by providing comprehensive, competent, and excellent healthcare for all.

This finding aligns with Chalcraft and Harrington's (2001) statement that religion is a powerful force that creates a psychological motivation that can influence action; "*belief does not exist independently of action; thus adherers of a religion are united by their beliefs and accordingly actions*." As the table indicates, although these healthcare institutions differ in form and structure, their establishment is motivated and guided by religious teachings or philosophy, specifically Islamic and Christian teachings. Historical records indicate that even prior to the arrival of Islam, healthcare centres were influenced by religious messages. These centres were appendages of religious institutions and monasteries administered by welfare agencies and charities under the bishops; some were even funded by the people (Lev, 2005; Turner, 2010; Al-Ansari, 2013). Religious beliefs and values have shaped the healthcare institution culture, forcing the institution to change and act forever as an intermediary element that coordinates human action (Clegg et al., 2005). For centuries, religious motivation and movement, whether Christian or Islamic, have motivated the establishment of such healthcare institutions. Thus, this similarity is not something new. In Malaysia, *waqf* healthcare institutions are still growing; however, they have existed throughout the history of Islamic civilization.

Differences in background and philosophy of the healthcare institutions

The differences in the background and philosophy between the sample institutions can be grouped into seven themes: 1) registered institution; 2) type of institution; 3) broad healthcare grouping; 4) source of funding; 5) auspice organization; 6) initiator; and 7) type of healthcare services provided. Table 3 below summarises the differences. The first aspect that differentiates these six healthcare institutions is the registered institution or company. Since they are registered as different types of organizations, their institutional or organizational settings differ. The *Waqf* An-Nur clinic chain is registered under WANCorp as a part of JCorp's CSR activities. WANCorp itself is a company limited by guarantee established by JCorp to manage its endowed assets and shares, as discussed in detail above. Meanwhile, Penang Adventist Hospital is registered as a public limited company under the name of Adventist Hospital & Clinic Services (M). The hospital is a part of a global network of Adventist healthcare services. In the Southeast Asian network, the hospital branches are also available in Indonesia and Thailand. However, there is no shareholder under this type of company registration, but it does have a board of members. In line with the Private Healthcare Facilities and Services Act (Act 586), this type of organization is considered as a non-profit, as stated below:

"So in law (Act 586), does stipulate, if the applicant is an organization, it cannot be for-profit."

For this type of institution, the profits are redistributed to society through charitable works. The shareholders do not receive any of the profits. These practices have allowed PAH and WANCorp to be tax-exempt. PAH itself has collaborated with various local and international NGOs to carry out various charitable programs. For PAH, good community relations through charitable work are a tradition that has begun since its inception. The charitable work has continued until today and has become the sustainability enabler for this healthcare institution. Other healthcare institutions are registered as private companies. For instance, USMC is registered under USIM Tijarah Holdings Sdn. Bhd.; Al-Islam Specialist Hospital under Syifa Sdn. Bhd.; PUSRAWI Hospital under Hospital PUSRAWI Sdn. Bhd.; and MUIP Healthcare under Klinik Al-Amin Sdn. Bhd. and Pahang Medical Center Sdn. Bhd. These institutions are registered as private companies to generate profits from their healthcare services. However, they do not seek profit maximization; rather, the profits are used to sustain and expand the institutions. Some of the profits are channelled into the community through volunteer activities in cooperation with NGOs. For instance, Al-Islam Specialist Hospital conducted such activities with Angkatan Belia Islam Malaysia (ABIM) and the Malaysian Relief Agency (MRA). These healthcare institutions are controlled and governed by their auspicious organizations. For example, the *Waqf* An-Nur clinic chain is under WANCorp; USMC under USIM and MAINS; Al-Islam Specialist Healthcare is related to ABIM; PUSRAWI Hospital under MAIWP; MUIP Healthcare under MUIP; and PAH is governed by the Seventh Day Adventist Church.

The category of broad healthcare grouping refers to Green's (1987) three healthcare institutions, PUSRAWI Hospital, MUIP Healthcare, and PAH, which are grouped under the category of religious institution. Meanwhile, two other healthcare institutions, *Waqf* An-Nur Clinic Chain and USMC, are recognised as *waqf* institutions, and Al-Islam Specialist Hospital is grouped into the local NGO category. Five of the six sample healthcare institutions are directly or indirectly related or affiliated with religious institutions. PUSRAWI Hospital, MUIP Healthcare, and PAH are subsidiaries of their respective religious institutions. For *waqf*-based healthcare institutions, MAIN is the sole trustee with authority to appoint a *mutawalli* to manage *waqf* property. In the case of the sample institutions, MAIN appointed their auspice institutions or the institutions themselves as *mutawalli*. As stated by Green (1987), healthcare institutions categorised under religious organizations, especially those related to the church, can sustain for a longer period due to their ability to obtain funding. The results of this study support Green's suggestion, as PAH is the most sustainable healthcare institution. By 2022, PAH has operated for 98 years. Similarly, PUSRAWI and MUIP Healthcare, which are subsidiaries of MAIWP and MUIP, receive more sustainable funding from their auspice organizations. With regards to the source of funding, three themes were formed: 1) charity/*waqf* fund (*Waqf* An-Nur clinic chain and PAH); 2) Baitulmal (PUSRAWI Hospital and MUIP Healthcare); and 3) combination of loan and charity or *waqf* (Al-Islam Specialist Hospital and USMC). Additionally, the differences between the social-based healthcare institutions lie in the services that they offer. Since *waqf* healthcare institutions in Malaysia are still relatively new, they offer only out-patient services. Though they are still a novel concept in Malaysia, *waqf* healthcare institutions have been present throughout Islamic history, and some are even still in operation to this day.

Table 3: Differences in background and philosophy between the social-based healthcare institutions

No	Healthcare Institution	Registered Institution	Type of Institution	Broad Healthcare Grouping	Source of Funding	Auspice Organizations	Initiator	Type of Healthcare Services
1	Wakaf An-Nur Clinics Chain	Waqaf An-Nur Corporation Berhad	CSR Activity under WANCorp	*Waqf* Institution	*Waqf* shares	WANCorp	Tan Sri Ali Hashim	• Out-patient services • Dialysis center • General Practices • Mobile Clinic
2	USIM Specialist Medical Center (USMC)	USIM Tijarah Holdings S/B	Partnership USIM-MAINS. Subsidiaries USIM	*Waqf* Institution	*Waqf* and Qardhul Hassan	USIM	MAINS & USIM	• Out-patient services • Dialysis center • General Practices • Specialist Clinic • Mobile Clinic
3	Al-Islam Specialist Hospital	Syifa S/B	Partnership with ABIM	Local NGO	Charity and personal fund	Al-Islam Specialist Hospital	Dr. Ishak Mas'ud & Dr. Suhaimi	• Out/In-Patient services • Specialist Hospital • Dialysis Center • Mobile Clinic
4	PUSRAWI Hospital	Hospital PUSRAWI S/B	MAIWP Subsidiaries	Islamic Religious Institution	Baitulmal	MAIWP	MAIWP, Dr Suhaimi & Dr. Kamaruddin	• Out/In-Patient services • Specialist Hospital • Dialysis Center
5	MUIP Healthcare	• Klinik Al-Amin S/B • Pahang Medical Center S/B	MUIP Subsidiaries	Islamic Religious Institution	Baitulmal	MUIP	MUIP	• Out/In-patient services • Specialist/General Practices • Dialysis center
6	Penang Adventist Hospital	Adventist Hospital & Clinic Services (M)	Seventh Day Adventist Subsidiaries	Christian Religious Institution	Charity	Seventh-Day Adventist Church	Dr. J Earl Gardner	• Out/In-Patient services • Specialist Hospital • Dialysis Center

CONCLUSION

Using a qualitative study methodology with a sample of six *waqf* and social-based healthcare institutions in Malaysia, this study discovered that the establishment of these institutions was driven by religious motives. It has become a powerful force that creates a psychological motivation that could influence action. In contrast, each *waqf* and social-based healthcare institution has a diverse range of establishment settings and standard operations. This feature may contribute to the future sustainability of *waqf* and social-based healthcare, which eventually leads these institutions to continue to exist and benefit the targeted community. The critical contribution of this study is that it offers new evidence regarding the impacts of government policies and societal support towards *waqf* and social-based institutions' sustainability. Through the existence of *waqf* and social-based healthcare institutions not only helps the government solve issues related to patient congestion in public healthcare institutions but also provides an alternative for affordable healthcare services. Since the vital role of *waqf* and social-based healthcare institutions is widely recognised, it is imperative that the government supports the operations and development of social-based healthcare institutions, especially those that are *waqf*-based. The development and sustainability of *waqf* healthcare institutions can only be achieved through a good relationship between the operator or management of such institutions and the *mutawalli*. Although Malaysia has enacted the Federal *Waqf* Act, *waqf* healthcare institutions are still far from being recognised and understood by the regulator itself. In a broader context, the importance of *waqf* institutions can be observed through integration with the Sustainable Development Goals (SDGs) and the concept of Maqasid Shariah. The integration of *waqf*, SDGs, and Maqasid Shariah in the healthcare industry can create a powerful mechanism for addressing healthcare challenges in Malaysia. The big potential of integration is in the following aspects:

i. Establishing healthcare *waqf* funds: Create *waqf* funds dedicated to healthcare, where the income generated from these endowments can be used to fund healthcare infrastructure, services, and research.
ii. Expanding healthcare access: Use *waqf* resources to build and maintain healthcare facilities in underserved areas, ensuring that healthcare services reach marginalised populations.
iii. Research and innovation: Allocate *waqf* funds to support medical research, healthcare technology development, and innovations that improve healthcare delivery and outcomes.
iv. Partnerships: Collaborate with international organizations, governments, and non-profits to leverage *waqf* resources effectively in line with SDGs, fostering partnerships for sustainable healthcare development.
v. Ethical healthcare delivery: Ensure that healthcare services supported by *waqf* adhere to ethical principles outlined in Maqasid Shariah, such as fairness, equity, and compassion in patient care.

The integration of *waqf*, SDGs, and Maqasid Shariah in the healthcare industry can lead to sustainable and ethical healthcare development that aligns with Islamic values while contributing to global efforts to improve health and well-being. This approach can help address healthcare disparities, promote access to quality healthcare, and drive innovation in the healthcare sector. Therefore, *waqf* healthcare institutions in Malaysia need much guidance and attention from the government. For instance, their contributors must be tax-exempt, as these institutions also contribute to society and redistribute their profits toward social welfare through healthcare services and charitable activities. Other than that, *waqf* operators should form *waqf* healthcare institutions in various organizational structures such as NGOs, corporations, or even subsidiaries of religious organizations. *Waqf* healthcare institutions need to establish their own unique structure, distinct from other social-based healthcare institutions, to ensure their sustainability in the future.

ACKNOWLEDGEMENT

We would like to thank the healthcare institution representatives: USIM Medical Specialist Clinic, *Waqf* An-Nur Clinic, Pasir Gudang, Al-Islam Specialist Hospital, PUSRAWI Hospital, MUIP, and Penang Adventist Hospital. This article is an extract from part of the original thesis titled "*Developing Sustainability Framework for Waqf-based Healthcare: A Comparative Analysis among Social-based Healthcare Institutions in Malaysia,*" in which it has been granted an approval from the Research Ethics Committee from both Universiti Sains Islam Malaysia (USIM/ JKEP/ 2019-43) and Adventist Clinical Research Centre (ACRC) in 2019. This study also has been registered under The Malaysia National Medical Research Register (NMRR)- NMRR-18-3919-40073.

REFERENCES

Ab Rahman, A. (2009). Peranan wakaf dalam pembangunan ekonomi umat Islam dan aplikasinya di Malaysia. *Jurnal Syariah*, *17*(1), 113–152. https://ejournal.um.edu.my/index.php/JS/article/view/22746

Al-Ansari, M. (2013). *Bīmāristāns and waqf in Islam: Case studies of hospital endowment during 9th to 13th century ce in the Muslim World* [Bachelor's Thesis, University of Sydney]. Acedemia.edu. https://Www.Academia.Edu/6955050/B%C4%Abm%C4%81rist%C4%81ns_And_Waqf_In_Islam_Case_Studies_Of_Hospital_Endowment_During_9th_To_13th_Century_CE_In_The_Muslim_World

Aljunid, S. (1995). The role of private medical practitioners and their interactions with public health services in Asian countries. *Health Policy and Planning*, *10*(4), 333–349. https://doi.org/10.1093/heapol/10.4.333

Atan, N. A. B. (2016, October 19–20). *Waqf as a risk pooling method for the poor and low-income household in funding the healthcare cost* [Paper presentation]. 11th ISDEV International Graduate Workshop (INGRAW2016), Universiti Sains Malaysia, Penang.

Atan, N. A. B. (2022). *Developing a sustainability framework for waqf-based healthcare: A comparative analysis among social-based healthcare institutions in Malaysia* [Doctoral dissertation, Universiti Sains Islam Malaysia]. USIM Research Repository. https://oarep.usim.edu.my/jspui/handle/123456789/15858

Avelino, F., Wittmayer, J. M., Pel, B., Weaver, P., Dumitru, A., Haxeltine, A., Kemp, R., Jørgensen, S., M., Bauler, T., Ruijsink, S., & O'Riordan, T. (2019). Transformative social innovation and (dis) empowerment. *Technological Forecasting and Social Change*, *145*, 195–206. https://doi.org/10.1016/j.techfore.2017.05.002

Azmi, A. S. M., Hanif, N. R., Mahamood, S. M., & Ali, S. N. M. (2019). Synthesizing the maqasid al-Syariah for the waqf property development. *IOP Conference Series: Earth and Environmental Science*, *385*, 1–7. https://doi.org/10.1088/1755-1315/385/1/012051

Ballesteros, L., & Gatignon, A. (2019). The relative value of firm and nonprofit experience: Tackling large-scale social issues across institutional contexts. *Strategic Management Journal*, *40*(4), 631–657. https://doi.org/10.1002/smj.2968

Bayliss, K., & Van Waeyenberge, E. (2018). Unpacking the public private partnership revival. *The Journal of Development Studies*, *54*(4), 577–593. https://doi.org/10.1080/00220388.2017.1303671

Bird, M., McGillion, M., Chambers, E. M., Dix, J., Fajardo, C. J., Gilmour, M., Levesque, K., Lim, A., Mierdel, S., Ouellette, C., Polanski, A. N., Reaume, S. V., Whitmore, C., & Carter, N. (2021). A generative co-design framework for healthcare innovation: development and application of an end-user engagement framework. *Research involvement and engagement*, *7*(1), 1–12. https://doi.org/10.1186/s40900-021-00252-7

Bird, M., Ouellette, C., Whitmore, C., Li, L., Nair, K., McGillion, M. H., Yost, J., Banfield, L., Campbell, E., & Carroll, S. L. (2020). Preparing for patient partnership: A scoping review of patient partner engagement and evaluation in research. *Health expectations: an international*

journal of public participation in health care and health policy, *23*(3), 523–539. https://doi.org/10.1111/hex.13040

Cajaiba-Santana, G. (2014). Social innovation: Moving the field forward. A conceptual framework. *Technological forecasting and social change*, *82*, 42–51. https://doi.org/10.1016/j.techfore.2013.05.008

Cameron, D., Ubels, J., & Norström, F. (2018). On what basis are medical cost-effectiveness thresholds set? Clashing opinions and an absence of data: a systematic review. *Global health action*, *11*(1), 1–14. https://doi.org/10.1080/16549716.2018.1447828

Chalcraft, D. J., & Harrington, A. (Eds.). (2001). *The Protestant ethic debate Max Weber's replies to his critics, 1907-1910*. Liverpool University Press. https://doi.org/10.5949/upo9781846313868

Clegg, S., Kornberger, M., & Pitsis, T. (2005). *Managing and organizations: An introduction to theory and practice*. SAGE Publications.

Coast, J. (2004). Is economic evaluation in touch with society's health values? *BMJ, 329*(7476), 1233–1236. https://doi.org/10.1136/bmj.329.7476.1233

Dafterdar, M. H. (2011). Toward effective legal regulations and an enabling environment for inalienable Muslim endowments. *ICR Journal*, *2*(4), 654–668. https://doi.org/10.52282/icr.v2i4.604.

Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of management review*, *14*(4), 532–550. https://doi.org/10.2307/258557

Eisenhardt, K. M. (2021). What is the Eisenhardt Method, really? *Strategic Organization, 19*(1), 147–160. https://doi.org/10.1177/1476127020982866

Farhat Nazirul Mubin, B. (2015, December 8–9). *The potential of healthcare waqf in Malaysia.* Proceedings of IDMAC 2015, 9th ISDEV International Islamic Development Management Conference, 282–305. https://www.Slideshare.Net/Idmac2015/Farhat-Nazirul-Mubin

Fauzi, M., Efendi, F., Bundo, M., Eriawati, Y., & Rahmat, F. (2023). Tinjauan literatur terkini tentang wakaf. *Jurnal Iqtisaduna*, *9*(2), 232–252. https://doi.org/10.24252/iqtisaduna.v9i2.41811

Fougère, M., Segercrantz, B., & Seeck, H. (2017). A critical reading of the European Union's social innovation policy discourse: (Re) legitimizing neoliberalism. *Organization*, *24*(6), 819–843. https://doi.org/10.1177/1350508416685171

Gee, I. H., Nahm, P. I., Yu, T., & Cannella, A. A. (2023). Not-for-profit organizations: A multi-disciplinary review and assessment from a strategic management perspective. *Journal of Management, 49*(1), 237–279. https://doi.org/10.1177/01492063221116581

George, M. (2001). Corporate philanthropy and social responsibility in Latin America: An overview of issues in charity litigation in Malaysia 2001. *The International Journal of Not-for-Profit Law*, *4*(1). https://www.icnl.org/resources/research/ijnl/an-overview-of-issues-in-charity-litigation-in-malaysia-2001-2

Gerber, L. (1983). *Hospital restructuring: Why, when & how*. Pluribus Press.

Glaser, B., & Strauss, A. (1999). *Discovery of grounded theory: Strategies for qualitative research* (1st ed.). Routledge. https://doi.org/10.4324/9780203793206

Green, A. (1987). The role of non-governmental organizations and the private sector in the provision of health care in developing countries. *The International Journal of Health Planning and Management*, *2*(1), 37–58. https://doi.org/10.1002/hpm.4740020106

Hansmann, H. B. (1980). The role of nonprofit enterprise. *The Yale Law Journal Company, 89*(5), 835–901. https://doi.org/10.2307/796089

Hassan, R., & Jamaluddin, K. F. (2022). Waqf to support healthcare well-being mission: the proposed model for corporate waqf for healthcare (CWFH). In Hassan, M.K., Muneeza, A. and Sarea, A.M. (Ed.), *Towards a Post-Covid Global Financial System: Lessons in Social Responsibility from Islamic Finance* (pp. 129–142). Emerald Publishing Limited. https://doi.org/10.1108/978-1-80071-625-420210007

Holmes, E. A., Brown, R. J., Mansell, W., Fearon, R. P., Hunter, E. C., Frasquilho, F., & Oakley, D. A. (2005). Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical psychology review*, *25*(1), 1–23. https://doi.org/10.1016/j.cpr.2004.08.006

Johari, F., & Ibrahim, P. (2010). The dynamism in the implementation of al-Kharaj during the Islamic rule (634-785AD). *Jurnal Syariah*, *18*(3), 629–658. https://ejournal.um.edu.my/index.php/JS/article/download/22658/11249/49095

Joudyian, N., Doshmangir, L., Mahdavi, M., Tabrizi, J. S., & Gordeev, V. S. (2021). Public-private partnerships in primary health care: a scoping review. *BMC health services research*, *21*(4), 1–18. https://doi.org/10.1186/s12913-020-05979-9

Juni, M. H. B. (1996). Public health care provisions: Access and equity. *Social Science & Medicine*, *43*(5), 759–768. https://doi.org/10.1016/0277-9536(96)00120-7

Kahf, M. (2003, January 6–7). *The role of waqf in improving the ummah welfare* [Paper presentation]. The International Seminar on Waqf as a Private Legal Body, Islamic University of north Sumatra, Medan, Indonesia. https://monzer.kahf.com/papers/english/ROLE_OF_WAQF_IN_THE_WELFARE_OF_THE_UMMAH.pdf

Kay, A. (2006). Social capital, the social economy and community development. *Community development journal*, *41*(2), 160–173. https://doi.org/10.1093/cdj/bsi045

Kleinert, S., & Horton, R. (2017). From universal health coverage to right care for health. *The Lancet*, *390*(10090), 101–102. https://doi.org/10.1016/S0140-6736(16)32588-0

Knight, G. A., & Cavusgil, S. T. (2004). Innovation, organizational capabilities, and the born-global firm. *Journal of international business studies*, *35*, 124–141. https://doi.org/10.1057/palgrave.jibs.8400071

Laldin, M. A., Mahmud, M. W., & Sawari, M. F. (2006). Maqasid Syari'ah dalam pelaksanaan wakaf. In Abdul Majid, M. Z. A. M., Mahmud, M. W., & Abdul Aziz, A. Z. A. A. (Eds.), *Maqasid Al-Syari'ah* (pp. 259–290). IIUM Press. http://irep.iium.edu.my/28549/1/Maqasid_Waqaf.pdf

Laokri, S., Weil, O., Drabo, K. M., Dembelé, S. M., Kafando, B., & Dujardin, B. (2013). Removal of user fees no guarantee of universal health coverage: observations from Burkina Faso. *Bulletin of the World Health Organization*, *91*, 277–282. https://doi.org/10.2471/BLT.12.110015

Latif, S. A., Din, N. M. N., & Mustapha, Z. (2018). The role of good waqf governance in achieving sustainable development. *Environment-Behaviour Proceedings Journal*, *3*(7), 113–118. https://doi.org/10.21834/e-bpj.v3i7.1292

Laville, J. L., Young, D. R., & Eynaud, P. (Eds.). (2015). *Civil society, the third sector and social enterprise: Governance and democracy* (1st ed.). Routledge. https://doi.org/10.4324/9781315795317

Lēv, Y., & Lēv, Y. (2005). *Charity, endowments, and charitable institutions in medieval Islam*. Univ. Press of Florida.

Luo, J., & Kaul, A. (2018). Private action in public interest: The comparative governance of social issues. *Strategic Management Journal*, *40*(4), 476–502. https://doi.org/10.1002/smj.2961

Mahmud, M. W., & Shah, S. S. (2010). Optimization of philanthropic waqf: The need for Maqasid-based legislative strategies. *Shariah Law Reports*, *2*, 45–59. http://irep.iium.edu.my/6791/

Mannion, R., & Small, N. (1999). Postmodern health economics. *Health Care Analysis*, *7*, 255–272. https://doi.org/10.1023/A:1009400926449

Mathialagan, R., & Kuthambalayan, T. S. (2023). Sustainable value co-creation in healthcare systems in the context of reduced ease of access. *Journal of Cleaner Production*, *422*. https://doi.org/10.1016/j.jclepro.2023.138545

Merriam, S. B. (2015). Qualitative research: Designing, implementing, and publishing a study. In V. Wang (Ed.), *Handbook of research on scholarly publishing and research methods* (pp. 125–140). IGI Global. https://doi.org/10.4018/978-1-4666-7409-7.ch007

Mohamed, N., Daud, H., & Ab Rahman, A. (2015). Wakaf Penjagaan Kesihatan: Kajian Kes di Hospital Waqaf An-Nur. *Jurnal Syariah*, *23*(3), 401–434. https://doi.org/10.22452/js.vol23no3.3

Moshiri, H., Aljunid, S. M., & Amin, R. M. (2010). Hospital efficiency: Concept, measurement techniques and review of hospital efficiency studies. *Malaysian Journal of Public Health Medicine*, *10*(2), 35–43. https://search.bvsalud.org/gim/resource/fr/wpr-626532

Moulaert, F., & Ailenei, O. (2005). Social economy, third sector and solidarity relations: A conceptual synthesis from history to present. *Urban studies*, *42*(11), 2037–2053. https://doi.org/10.1080/00420980500279794

Moulaert, F., & MacCallum, D. (2019). *Advanced introduction to social innovation*. Edward Elgar Publishing. https://doi.org/10.4337/9781785360381

Nur Sa'adah, M. (2016). *Transformative social service of organizations: Strategies and process of development* [Doctoral dissertation, Universiti Kebangsaan Malaysia]. UKM Learning and Research Repository. https://ptsldigital.ukm.my/jspui/handle/123456789/513659

Olsen, I. T. (1998). Sustainability of health care: a framework for analysis. *Health policy and planning*, *13*(3), 287–295. https://doi.org/10.1093/heapol/13.3.287

Pannarunothai, S., Patmasiriwat, D., & Srithamrongsawat, S. (2004). Universal health coverage in Thailand: Ideas for reform and policy struggling. *Health Policy*, *68*(1), 17–30. https://doi.org/10.1016/S0168-8510(03)00024-1.

Pel, B., Haxeltine, A., Avelino, F., Dumitru, A., Kemp, R., Bauler, T., Kunze, I., Dorland, J., Wittmayer, J., & Jørgensen, M. S. (2020). Towards a theory of transformative social innovation: A relational framework and 12 propositions. *Research Policy*, *49*(8), 1–13. https://doi.org/10.1016/j.respol.2020.104080

Pol, E., & Ville, S. (2009). Social innovation: Buzz word or enduring term? *The Journal of socio-economics*, *38*(6), 878–885. https://doi.org/10.1016/j.socec.2009.02.011

Razali, O. (2014). Penggunaan wang dalam wakaf tunai: Satu penilaian semula. In Sunarko, B. S., & Bahari, Z. (Eds.), *Konferensi Internasional Pembangunan Islami* - I (pp. 243–268). https://ejournal.um.edu.my/index.php/JS/article/download/22746/11291/49308

Reeves, A., McKee, M., & Stuckler, D. (2015). The attack on universal health coverage in Europe: recession, austerity and unmet needs. *The European Journal of Public Health*, *25*(3), 364–365. https://doi.org/10.1093/eurpub/ckv040

Roemer, M. I. (1984). Private medical practice: Obstacle to health for all. *World Health Forum*, *5*(3), 195–210. https://apps.who.int/iris/handle/10665/49243

Sago, D. B. (1989). *The relationship between marketing effectiveness and fund raising at institutions of higher education* [Doctoral dissertation, United States International University]. ProQuest Dissertations & Theses Global. https://www.proquest.com/docview/303732697

Sahakian, M. D., & Dunand, C. (2015). The social and solidarity economy towards greater 'sustainability': Learning across contexts and cultures, from Geneva to Manila. *Community development journal*, *50*(3), 403–417. https://doi.org/10.1093/cdj/bsu054

Salamon, L. M. (1999). The nonprofit sector at a crossroads: The case of America. *International Journal of Voluntary and Nonprofit Organizations, 10*(1), 5–23. https://doi.org/10.1023/A:1021435602742

Saleh, S. S., Alameddine, M. S., Natafgi, N. M., Mataria, A., Sabri, B., Nasher, J., Zeiton, M., Ahmad, S. & Siddiqi, S. (2014). The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen. *The Lancet*, *383*(9914), 368–381. https://doi.org/10.1016/S0140-6736(13)62339-9

Salleh, A. H. M., Mohamad, N. S., & Adham, K. A. (2014). *Managing Waqf for Societal Well-Being* (1st ed.). Penerbit Universiti Putra Malaysia.

Samad, R. R. (2018). *Developing a Shariah framework for cooperative banks in Malaysia* [Doctoral dissertation, Universiti Sains Islam Malaysia]. USIM Repository. https://oarep.usim.edu.my/

Sanadgol, A., Doshmangir, L., Majdzadeh, R., & Gordeev, V. S. (2021). Engagement of non-governmental organizations in moving towards universal health coverage: A scoping review. *Globalization and health*, *17*(129), 1–19. https://doi.org/10.1186/s12992-021-00778-1

Sarkar, S., & Mateus, S. (2022). Doing more with less-How frugal innovations can contribute to improving healthcare systems. *Social Science & Medicine*, *306*, 1–12. https://doi.org/10.1016/j.socscimed.2022.115127

Sekaran, U. (2003). *Research Methods for Business: A Skill Building Approach* (4th ed.). John Wiley and Sons.

Sekaran, U., & Bougie, R. (2009). *Research methods for business: A skill-building approach* (5th ed.). Wiley.

Serrano, N., Realmuto, L., Graff, K. A., Hirsch, J. A., Andress, L., Sami, M., ... & Devlin, H. M. (2023). Healthy community design, anti-displacement, and equity strategies in the USA: A scoping review. *Journal of Urban Health*, *100*, 151–180. https://doi.org/10.1007/s11524-022-00698-4

Small N, & Mannion R. (2005). A hermeneutic science: Health economics and Habermas. *Journal of Health Organization and Management*, *19*(3), 219–235. https://doi.org/10.1108/14777260510608952

Tangcharoensathien, V., Patcharanarumol, W., Ir, P., Aljunid, S. M., Mukti, A. G., Akkhavong, K., Banzon, E., Huong, D., B., Thabrany, H. & Mills, A. (2011). Health-financing reforms in southeast Asia: challenges in achieving universal coverage. *The Lancet*, *377*(9768), 863–873. https://doi.org/10.1016/S0140-6736(10)61890-9

Thaidi, H.' Azeemi, Nazarie, W. N. F. W., Nazarie, A. R. Z., & Mohd Mahyeddin Mohd Salleh. (2021). Integrasi Takaful Mikro dan Wakaf Ketika Pandemik: Analisis Potensi dan Cabaran. *Ulum Islamiyyah*, *33*(3), 135–150. https://uijournal.usim.edu.my/index.php/uij/article/view/439

Tuckman, H. P., & Chang, C. F. (2006). Commercial activity, technological change, and nonprofit mission. In G. Sonnevi, *The nonprofit sector: A research handbook* (pp. 629–644). Yale University Press. https://doi.org/10.12987/9780300153439-030

Turner, H. R. (2010). *Science in Medieval Islam: An Illustrated Introduction*. University of Texas Press.

Wang, J. Y., Wang, C. Y., Juang, S. Y., Huang, K. Y., Chou, P., Chen, C. W., & Lee, C. C. (2014). Low socio-economic status increases short-term mortality of acute myocardial infarction despite universal health coverage. *International Journal of Cardiology*, *172*(1), 82–87. https://doi.org/10.1016/j.ijcard.2013.12.082.

Weerawardena, J., McDonald, R. E., & Mort, G. S. (2010). Sustainability of nonprofit organizations: An empirical investigation. *Journal of World Business*, *45*(4), 346–356. https://doi.org/10.1016/j.jwb.2009.08.004

Wolpert, J., & Reiner, T. (1985). The not-for-profit sector in stable and growing metropolitan regions. *Urban Affairs Quarterly*, *20*(4), 487–510. https://doi.org/10.1177/004208168502000406

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Sage Publications.

Zakaria, A. A. M., Samad, A. R. R., & Shafii, Z. (2012). Venture philanthropy-waqf practices and its implementation: Scenario in Malaysia. *International Journal of Business, Economics and Law*, *1*, 108–115. http://ijbel.com/wp-content/uploads/2014/06/Venture-Philanthropy-%E2%80%93-Waqf-Practices-And-Its-Implementation-Scenario-In-Malaysia-Azliza-Azrah-Mohd-Zakaria-Rose-Ruziana-Abd.-Samad-Assoc.Prof_.-Dr.-Zurina-Shafii.pdf