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Regulator insight on the establishment of social-based healthcare institutions in Malaysia

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Abstract Social innovation is gaining significant recognition in research and policy domains, including within the healthcare sector. Institutions based on trade and business principles have accumulated social capital to pursue social objectives. However, the sustainability of these social-based healthcare institutions remains uncertain. Regulatory insights are essential for the development and maintenance of these institutions in the future. This qualitative study aims to explore and understand the perspective of the Division of Medical Practice and Private Services (CKAPS) on the establishment and sustainability of social-based healthcare institutions. Consequently, primary data were collected through interviews with officers at the CKPAS, while secondary data were obtained from documentary analysis of Act 586 and related documents. The transcripts were analyzed inductively using NVivo software, with codes and themes developed based on a preestablished conceptual framework. The findings reveal no definitional distinction between social-based and profit-based private healthcare providers. Both types of institutions are governed by Act 586 and its subsidiary regulations regarding establishment, maintenance, and licensing. Practically, social-based healthcare can be identified through 1) self-declaration, 2) documents such as tax exemption letter from LHDN or the National Audit Department, and 3) information from the public. To ensure sustainability, social-based healthcare institutions must adhere to the principles outlined in Act 586, which emphasize comprehensive planning and robust proposals. Healthcare quality is the top priority and should not be forgotten to reduce the cost of healthcare in an attempt to serve the poor. Thus, these institutions need to be financially, socially, and environmentally sustainable, managed by qualified and experienced leadership teams. The key critical contribution of this study is that it presents new evidence regarding the impacts of government policies towards the establishment and sustainability of social-based healthcare institutions.

Keywords: social-based healthcare, sustainability concept, sustainability practices, regulator

1. Introduction

The concept of social innovation is gaining recognition in various fields, including healthcare (Pol & Ville, 2009; Cajaiba-Santana, 2014; Fougère et al., 2017; Avelino et al., 2019a). Questions about the existence and legitimacy of social-based healthcare institutions persist: What are they? Do they truly exist? Do they fulfill their objectives, and how do they survive? While waqf is associated primarily with Muslims, other religions have also established philanthropic institutions grounded in trade and business principles, aiming to pursue social objectives (Kay, 2006). These institutions, including social-based healthcare facilities, operate as nonprofit entities within the social economy, integrating social justice principles into their systems (Moulaert & Ailenei, 2005). The aims and objectives of institutions determine how these healthcare facilities differ from for-profit healthcare facilities.

In this research, a social-based healthcare institution actually refers to a private, nonprofit healthcare institution. It is derived from the concept of social economy, which is also known as the third sector, the solidarity economy, the nonprofit sector, the not-for-profit sector, the voluntary sector, and the idealist sector, and has been used in institutional practice for the past 150 years. In recent years, the idea of social innovation has become increasingly well-known in research and policy (Pol & Ville, 2009; Cajaiba-Santana, 2014; Fougère et al., 2017; Avelino et al., 2019a), and it has been studied across a variety of domains, such as the social economy, critical social studies, and entrepreneurship (Laville et al., 2015; Moulaert &

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MacCallum, 2019), as well as healthcare services. This type of healthcare institution is classified into a heterogeneous group of a wide range of providers with different motives (Aljunid, 1995). Although the classification namely refers to the term "private healthcare institution" which is usually related to profit maximization, in reality, many of these healthcare institutions are not entirely profitoriented and are classified as social-based healthcare institutions. Established based on 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 socially conscious healthcare facilities differ from for-profit healthcare facilities. In Malaysia, the Ministry of Health (MOH) oversees public healthcare, while the private sector, including social-based healthcare, contributes approximately 35% of healthcare services (Juni 1996, Moshiri, Aljunid & Amin, 2010). These institutions, funded by public donations, are managed by nonprofit entities such as foundations or social enterprises to address and cater to the healthcare needs of marginalized groups (Thaidi et al., 2022).

In this research, fifteen identified social-based healthcare institutions are listed in Table 1.

Table 1 Fifteen Social-based Healthcare Institutions Identified in Malaysia.

No	Healthcare Institutions Category/ Name	Year of Establishment	Period of Establishment (Years)
1	Waqf An-Nur Hospital	1998	26
2	USIM Specialist Clinics	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	1924	100
8	Assunta Hospital	1954	70
9	Mawar Renal Medical Centre	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 Centre	1980's	44
14	Perak Community Specialist Hospital (PCSH)	1904	120
15	Lam Wah Ee Hospital	1876	148

Source: Nur Atika (2022).

This study focuses on social-based healthcare institutions (typologically placed under the private healthcare sector), which comprises waqf and social-based healthcare institutions (nongovernmental organizations (NGOs), foundations, and other nonprofit institutions) (refer to Figure 1). The two-tier healthcare system in Malaysia serves as the foundation for this study. These healthcare institutions assist the government in addressing and solving pertinent issues related to patient congestion in public healthcare institutions and serve as an alternative for providing affordable healthcare services amidst rising healthcare costs.

The health sector plays a crucial role in society's economy, environment, and social well-being (Smith, 2012). Since the 1990s, scholars have emphasized sustainable development in public health due to rising healthcare challenges such as an aging population, technological advancements, and increased consumer expectations (Weisz et al., 2011; Thomson et al., 2009). Financial sustainability is a major challenge for healthcare organizations, particularly social organizations, due to dwindling donor funds and economic instability. Olsen (1998) highlights how the development and performance of social-based healthcare institutions are influenced by factors such as organizational support, governance, and capacity. Hospitals must foster a positive and conducive work environment and provide ongoing training to staff to ensure quality care and competitiveness (Smith, 2012).

The MOH Malaysia's perspective on healthcare institution establishment is crucial, given the differences between social-based and for-profit settings. Charitable entities in Malaysia can adopt various legal forms and benefit from tax exemptions under specific federal lists and government provisions (George, 2001). This classification reflects the power distribution between federal and state lists, affecting social-based healthcare institutions' access to tax benefits, including waqf institutions with similar objectives. An integrated institutional go approach offers a comprehensive understanding of complex social phenomena.

2. Review of Social-based Healthcare Institutions

Social-based healthcare institutions, aligned with the social economy objective, aim to provide healthcare services across all societal levels (Atan, 2022). This sector often termed the third sector or solidarity economy, encompasses various forms, such as nonprofit organizations (NPOs) and voluntarism (Moulaert & Ailenei, 2005; Pel et al., 2020). It combines market, redistribution, and reciprocity economics, extending beyond mere market principles (Moulaert & Ailenei, 2005; Pel et al., 2020). In health economics, welfare concepts are central, with a focus on maximizing human health in society (Coast, 2004; Mannion & Small, 1999; Small & Mannion, 2005). Derived from ancient practices, social-based healthcare institutions prioritize

societal health maximization through welfare economics or alternative approaches (Coast, 2004; Cameron, Ubels & Norström, 2018). 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) and usually represents a wide range of initiatives and organizational forms, that is, a hybridization of market, non-market (redistribution), and non-monetary (reciprocity) economics, showing that "the economy is not limited to the market, but includes principles of redistribution and reciprocity" (Moulaert & Ailenei, 2005).

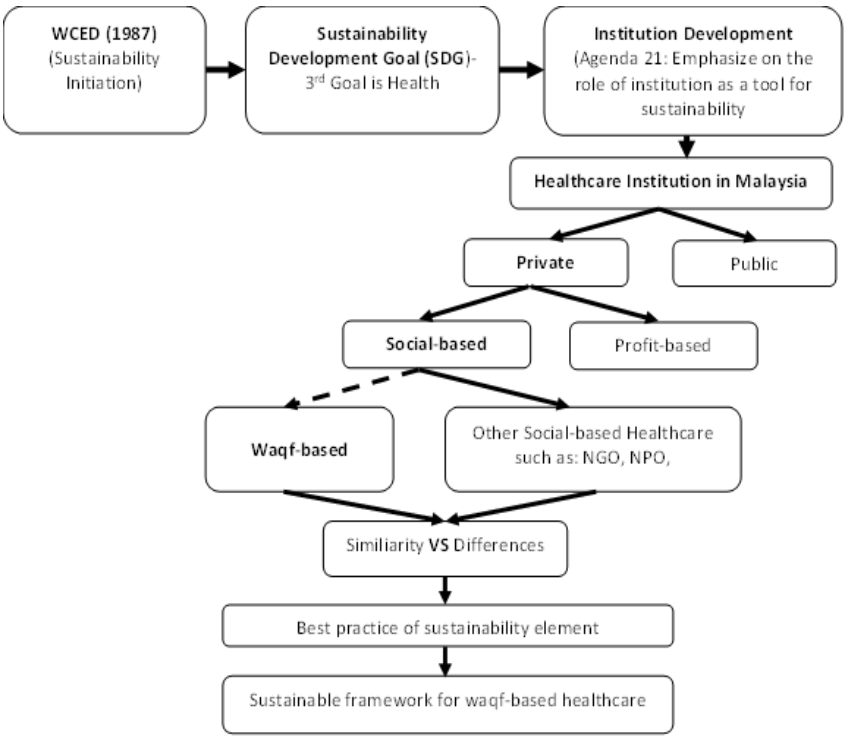

Figure 1 Social-based healthcare setting.

These institutions, often managed by NPOs, respond to crises in mass production systems and strained welfare states (Moulaert & Ailenei, 2005; Weerawardena et al., 2010). Moreover, mission-driven enterprises require financial support to operate effectively (Tuckman & Chang, 2006). The concept of "mission drift" underscores the balance between mission goals and profit-making endeavors (Tuckman & Chang, 2006). Each social based healthcare is distinguished by its objective and focus on 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 primary motive should focus in providing access to health services, which is defined as the ease with which individuals can obtain care in proportion to their needs (Mathialagan & Kuthambalayan, 2023; Olsen, 1998).

Sustainability for social-based institutions involves fulfilling commitments to clients, patrons, and communities while maintaining trust and serving societal needs (Weerawardena et al., 2010). In the context of Malaysia, social-based healthcare institutions are not solely run and managed by NPOs, which may be NGOs, social enterprises or foundations, but also by waqf institutions. Understanding the ecosystem is crucial for sustaining social-based healthcare institutions (Gee at al., 2023; Olsen, 1998). Contextual factors such as organisational structure, governing boards, and support functions, especially regulators, play key roles in identifying and implementing necessary adjustments to frameworks in order to suit different organizational environments (Olsen, 1998). The crucial importance of support function has also been emphasized by Bird (2020; 2021) which asserts the involvement of funding bodies, patient communities, and government initiatives as essential factors for achieving meaningful changes in key patient research outcomes. Other strategies that have been emphasized by Sarkar and Mateus, (2022) in ensuring the sustainability of social healthcare systems is through the integration of 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 diverse groupings, some adjustments on the framework are necessary (Olsen, 1998) to suit the different organizational environment and contexts of establishment.

3. Methodology

This study adopts a qualitative research design involving interviews with representatives from the Division of Medical Practice and Private Services (CKAPS). The primary information gathered in this chapter came from an interview session with

officers at CKAPS, whereas secondary resources came from a documentary analysis of Act 586 and other related documents. CKAPS was interviewed due to its role as a regulator of the private health sector, including private nonprofit healthcare institutions. Data were collected via two methods: interviews with representatives of the regulator (CKAPS) and document analysis, to strengthen the validity of the findings. The interview session with CKAPS's representatives was held in January 2020 at the Ministry of Health, Federal Government Administrative Centre, Putrajaya. CKAPS was represented by three officers (Table 2). This research design is best used to provide a deeper understanding of the establishment of social-based healthcare institutions from the regulator's perspective.

Table 2 Interviewees' Profiles.

Interviewee	Designation
Interviewee 1	Deputy Director, UD56
Interviewee 2	Senior Assistant Director, UD54
Interviewee 3	Senior Assistant Director, UD54

For the document analysis, the legal basis for the authority of CKAPS is the Private Healthcare Facilities and Services Act 1998 (Act 586), as explained by Interviewee 1:

> *Therefore, our main Act is the Private Healthcare Facilities and Services Act 1998 for secretaries cross-referral with the Mental Health Act 2001. In terms of professionalism, we need to cross-reference it. Therefore, when we want to enforce this Act, it will also relate to other Acts in terms of establishment, operation, etc. As for the Act itself, if I were to explain briefly, we now have 13 facilities that we regulate under this Act. This information is included in sections 4 & 5 of Act 586. This act was called 586 shortly. Because of its full length, "private health and facilities". Therefore, it should be simple. My scope is related to Act 586.*

Act 586 has been comprehensively designed to ensure the sustainability of private healthcare institutions. Specifically, it intends to achieve the following purposes:

i. Impose and ensure minimum standards in private healthcare facilities and services (PHFS).
ii. The integrity and professionalism of healthcare professionals should be ensured.
iii. The quality of the PHFS, e.g., quality assurance, mortality review, etc., should be ensured.
iv. Address social and national interests.

In addition to Act 586, several other documents related to the establishment and sustainability of private healthcare facilities are used as references for this research:

1. Guidelines on the application process for certificates of approval and licenses for private hospitals.
2. CKAPS Governance Framework.
3. Documents or forms related to the procedures of CKAPS.

4. Data Analysis

The data were organized on the basis of primary and secondary sources. The analysis process included familiarization, transcription, organization, coding, and report writing. The raw data underwent four stages: 1) comparing the incidents for each category; 2) integrating the categories and their properties; 3) delimiting the theory; and 4) writing the analysis (Glaser & Strauss, 1967). NVivo software was used to code and categorize the interview transcripts into topics for thorough analysis. The emerging categories or concepts were compared across stages.

The primary information was obtained from interviews with officers at CKAPS, and the secondary data were sourced from a documentary analysis of Act 586 and related documents. Data collection involved interviews with the regulators, and document analysis to validate the findings. The main themes were identified, compared, and aligned with the conceptual framework.

5. Results

Based on the interviews and document review, several themes and category concepts were developed. The themes and categories that were constructed were guided by the conceptual framework and the theory that had been established. Table 3 and Figure 2 show the themes from the NVivo analysis.

5.1. The establishment of a social-based healthcare institution from the CKAPS perspective

To define social-based healthcare institutions in Malaysia, it is important to understand the regulator's perspective. This study's conceptual definition emphasizes the social benefits of such institutions. Therefore, the interviewees were asked about their view on social-based private healthcare and how it differs from for-profit healthcare. Interviewee 1 started by describing the types of healthcare providers in Malaysia, which include public and private healthcare providers. She defined private healthcare facilities in reference to Act 586, which governs the establishment, maintenance, and licensing of private healthcare facilities and services.

The Private Healthcare and Facilities Act 1998 (Act 586) was enacted in 1998 and enforced in 2006. The MOH administers and implements this Act, with CKAPS as the designated enforcing agency. According to Section 2 of Act 586, there is no distinction, in terms of definition, between a social-based and a profit-based private healthcare provider:

"Private healthcare facility" means any premises, other than a government healthcare facility, used or intended to be used for the provision of healthcare services or health-related services, such as a private hospital, hospice, ambulatory care center, nursing home, maternity home, psychiatric hospital, psychiatric nursing home, community mental health center and hemodialysis. " (Section 2, Act 586: Private Healthcare and Facilities Act 1998).

According to Interviewee 1, the concept of social-based healthcare should be understood based on the definition and context established by the Act itself. The term private health sector includes all privatized healthcare institutions and specialized government healthcare establishments, whether for-profit or not-for-profit, and NGOs or NPOs. Meanwhile, Interviewee 2 perceived the social-based healthcare concept as either purely nonprofit, waqf, or any entities established under similar concept, but still profit-generating. However, the profit itself is not returned to the shareholders; instead, it is used to operate hospitals and subsidize healthcare costs. The nonprofit aspect refers to the nondistribution of profit to shareholders. However, the amount of profit retained by healthcare institutions cannot be measured.

Interviewee 3 stressed that social-based healthcare initiatives are not equivalent to philanthropic initiatives in other industries. According to her, there are certain aspects of the healthcare industry where standards could not be compromised. The primary concerns in the healthcare domain are patient safety and quality of care. Therefore, the basic principles of healthcare should remain the same, regardless of whether the private healthcare provider is social-based or profit-based. Healthcare facilities, services, and personnel must comply with the standards and quality standards outlined by the regulator. Therefore, the cost incurred by the profit-based healthcare institution should be similar to the cost borne by its social-based counterpart. She also noted that a healthcare operator, especially a philanthropic or social-based operator, cannot provide cheaper or free healthcare solely because it is established on the basis of the philanthropic or social-based principles. The philanthropic or social-based institution will likely bear more costs in order to provide free or cheaper healthcare services.

5.2. Categories of private healthcare facilities based on Act 586

Act 586 does not distinguish between the different types of private healthcare facilities. The stipulations regarding the establishment of private healthcare institutions, according to Section I (3) of Act 586, apply to every type of healthcare facility:

No person shall establish or maintain any of the following private healthcare facilities or services without approval being granted under paragraph 12(a) or operate or provide any such facilities or services without a license granted under paragraph 19(a):

(a) a private hospital;
(b) a private psychiatric hospital;
(c) a private ambulatory care center;
(d) a private nursing home;
(e) a private psychiatric nursing home;
(f) a private maternity home;
(g) a private blood bank;
(h) a private hemodialysis center
(i) a private hospice;
(j) a private community mental health center;
(k) any other private healthcare facility or service or health-related service as the Minister may specify, from time to time, by notification in the Gazette; and
(l) a private healthcare premises incorporating any two or more of the facilities or services.

5.3. Differences between nonprofit and for-profit healthcare providers

The interviewees were asked to specify the differences between a nonprofit healthcare provider and a for-profit healthcare provider. Interviewee 1 responded that, according to Act 586, they are treated as equivalent, except for hemodialysis centers and hospices. Both can be registered by a partnership with at least one medical practitioner or company whose Board of Director member(s) is a medical practitioner. Additionally, they can also be licensed to a civil society organization registered under the Societies Act 1966 as a nonprofit healthcare institution.

5.3.1. Registration of a private hemodialysis center and hospice services as a nonprofit organization

Act 586 specifies that private hemodialysis centers and hospices under the action of a civil society organization, such as a voluntary or charitable organization, can be registered as nonprofit healthcare facilities. However, Act 586 does not differentiate between for-profit and nonprofit institutions for hospitals, care centers, or clinics. In other words, these facilities

cannot be legally recognized as nonprofit healthcare institutions. Only private hemodialysis centers and standalone hospices can be legally recognized as nonprofit. Section 6(4) of Act 586 stipulates the following:

> *"(4) Notwithstanding subsection (1), approval to establish or maintain or a license to operate or provide a private hospice or a private hemodialysis center, on a voluntary or charitable basis, may be issued to a society registered under the Societies Act 1966 [Act 335]."*

Interviewee 1 also explained that, on the basis of the above provisions, CKAPS, as the designated health regulator for private health entities in Malaysia, only recognizes hemodialysis centers and hospices as nonprofit institutions. Interviewee 3 added that any healthcare institutions established by any institution, including social-based institutions, are still considered private healthcare institutions and required to obtain registration and operational licenses by CKAPS.

5.4. Recognition of healthcare facilities as nonprofit organizations

To gather more details about the concept of philanthropic or social-based healthcare, the interviewees were asked how CKAPS identifies a nonprofit healthcare provider. Interviewee 1 explained that the application process for approval certificates and licenses for private hospitals includes several clauses to identify NPOs:

i. During license application or renewal and title transfer, clauses 5.1.4 (vii), 5.2.4 (vii), and 5.4.4 (vii) require two copies of supporting documents confirming nonprofit status.
ii. Clause 5.2.4 (xxii) requires two copies of documents confirming the latest social or welfare contributions.

Applicants usually declare their nonprofit status before submitting relevant documents to support and strengthen their application, although CKAPS is not particularly strict in this matter. For dialysis centers, providing free or pro bono services increases the likelihood of application approval and being established. During the preestablishment phase, applicants have the option to declare that services will be free or low-cost for the poor, supported by third-party sponsorships, although such declarations are not mandatory.

Act 586 only allows the registration of philanthropic or social-based hemodialysis centers and hospices by NPOs. However, applications from companies promising bono services for the poor are still considered on the basis of social issues. For hospitals and other healthcare facilities, CKAPS treats all establishments equally and identically, regardless of whether they serve wealthy or poor individuals, ensuring that all meet the minimum standards set by authorities for services, medication, facilities, and patient safety.

CKAPS recognizes healthcare institutions as philanthropic or social-based according to the applicant's self-declaration and the submitted documents. CKAPS may also inspect and review other documents, such as tax exemption notices from the Inland Revenue Board (LHDN) or reports from the National Audit Department, which provide strong evidence of an organization's status. Additionally, patient or public complaints regarding charges higher than those declared can also be used to confirm the institution's status.

Table 3 CKAPS Understanding of Social-based Healthcare Establishment.

Research Objective	Regulator (In-depth Interview)
Regulator understanding of the establishment of the social-based healthcare institutions	Social-based Healthcare Concept i)Private healthcare facility definitions are based on Act 586. i)Private healthcare facility categories are based on Act 586. i)Nonprofit and for-profit healthcare provider differences. v)Private hemodialysis and hospice registration under a nonprofit organization. v)Recognition of healthcare facility category for a nonprofit organization.

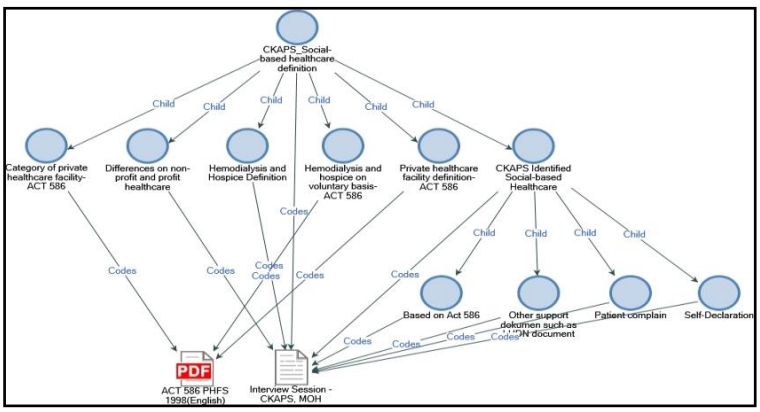

Figure 2 Establishment of social-based healthcare institutions from the CKAPS perspective.

6. Discussion

This study aims to understand the establishment and sustainability of social-based healthcare institutions from a regulatory perspective. Under Section 2 of Act 586, there is no definitional distinction between social-based and profit-based private healthcare providers. The term "private health sector" includes all privatized health institutions and corporatized government establishments, whether for-profit or not-for-profit, and whether they are NGOs or NPOs.

Interviews with CKAPS officers revealed that regulators in Malaysia are aware of the establishment of social-based healthcare institutions. These can be nonprofit, waqf-based, or similar entities that generate profit, which is used to operate the hospital and subsidize healthcare costs, rather than being returned to shareholders. According to Act 586, social-based healthcare is treated the same as profit-based healthcare, except for hemodialysis centers and hospices.

The study revealed that social-based healthcare initiatives cannot be equated with philanthropic initiatives in other industries because of the high standards required in healthcare. The primary concerns are patient safety and quality of care, which must remain consistent regardless of the profit orientation of the provider. Consequently, both social-based and profit-based institutions must comply with the same standards and incur similar costs.

In practice, social-based healthcare providers should declare their organizational status when submitting relevant documents to strengthen their applications. CKAPS recognizes an institution as philanthropic or social-based based on the applicant's self-declaration and submitted documents. Dialysis centers offering free or pro bono services are more likely to receive approval for establishment. Moreover, Act 586 only allows the registration of philanthropic or social-based hemodialysis centers and hospices by NPOs. The CKAPS may verify the status of an organization through tax exemption notices or audit reports and can identify discrepancies through patient or public complaints.

As for the impact of the existence of social-based healthcare institutions, they not only assist the government to solve issues related to patient congestion in public healthcare institutions, but also provide an alternative solution for affordable healthcare services. This approach is consistent with Malaysia's healthcare reform initiatives, which aim to increase access to affordable care and ensure sustainability through collaborations with regulatory bodies such as CKAPS and partnerships under the Sustainable Development Goals (SDGs) framework (World Health Organization, 2023). The growth and long-term viability of these institutions are dependent on a solid partnership between healthcare operators and regulatory organizations. Through integration of SDGs in healthcare management and administration, it can serve as a powerful mechanism for addressing healthcare challenges in Malaysia and in line with the 12th Malaysia Plan (RMK-12) that hightlights in improving healthcare access and sustainability through resource mobilization and cooperation with international organizations (Economic Planning Unit, 2021). This includes establishing healthcare endowment funds and promoting ethical healthcare delivery, which mirrors broader national and global strategies for sustainable healthcare development (Palozzi, 2020). The key potential strategies for integration involve the following aspects:

i. Establishing healthcare endowment funds: Forming endowment 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: Using endowment resources to build and maintain healthcare facilities in underserved areas, ensuring that healthcare services reach marginalized populations.
iii. Research and innovation: Allocating a portion of the endowment funds to support medical research, healthcare technology development, and innovations that improve healthcare delivery and outcomes.
iv. Partnerships: Collaborating with international organizations, governments, and non-profits to leverage endowment resources effectively in line with SDGs, fostering partnerships for sustainable healthcare development.
v. Ethical healthcare delivery: Ensuring that healthcare services supported by endowment adhere to ethical principles such as fairness, equity, and compassion in patient care.

To ensure the sustainability of their establishments, social-based healthcare institutions should emphasize and focus their efforts on strategic planning, robust proposals, and operational expertise from the early stage of the development. Sustainable practices are similar for both social-based and profit-based institutions because of the regulations stated in Act 586. Both entities must adhere to the same procedures and minimum standards to ensure patient safety and quality of care are optimally met. Therefore, social-based healthcare institutions in Malaysia require substantial guidance, attention and support from the government.

7. Conclusion

Overall, the sustainability concept for social-based healthcare institutions should be based on the principles outlined in Act 586, which emphasizes comprehensive planning and robust proposals. The pre-establishment proposal should prioritize three important aspects: 1) types of service, 2) facilities and equipment, and 3) healthcare professionals involved. Additionally, the party that intends to develop or operate the healthcare facility must be knowledgeable about the management and operations of the facility. There are three ways to determine whether a healthcare institution is social-based: 1) self-declaration from the social-based healthcare institution, 2) documents such as tax exemption letters from LHDN or the National Audit

Department, and 3) information and feedback from the patients or public. To ensure the sustainability of their establishments, these healthcare institutions should not only be financially viable, socially responsible, and environmentally robust, but also to have a reliable management team and leadership with pertinent qualifications and commendable experience. Healthcare quality is the top priority and should not be compromised in the efforts to reduce the cost of healthcare when attempting to serve the poor.

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Ethical considerations

Ethical approval to conduct the study was obtained from the Universiti Sains Islam Malaysia ethics committee with approval reference USIM/JKEP/2019-43, and from the Medical Research and Ethics Committee, Ministry of Health (MOH) Malaysia with approval reference NMRR-18-3919-40073 (IIR). In addition, informed consent was obtained from the respondents prior to the interview.

Conflict of interest

The authors of this study disclose that they have no conflicts of interest to declare.

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References

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. (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

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.

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), 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), Article 1447828. https://doi.org/10.1080/16549716.2018.1447828

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

Economic Planning Unit (2021). *The 12th Malaysia Plan (RMK-12), 2021-2025*. Government of Malaysia.

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. An overview of issues in charity litigation in Malaysia. *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

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

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

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

Malaysia., (2006). Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006. (P.U.(A)138/2006). Kuala Lumpur. National Printers Malaysia Berhad. Government of Malaysia

Malaysia.,(1998). Private Healthcare Facilities and Services Act 1998 (Act 586).Kuala Lumpur. National Printers Malaysia Berhad. Government of Malaysia.

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*, Article 138545. https://doi.org/10.1016/j.jclepro.2023.138545

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

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

Palozzi, G., Schettini, I., & Chirico, A. (2020). Enhancing the sustainable goal of access to healthcare: findings from a literature review on telemedicine employment in rural areas. *Sustainability*, *12*(8), 3318. https://doi.org/10.3390/su12083318

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), Article 104080. 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

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

Sarkar, S., & Mateus, S. (2022). Doing more with less-How frugal innovations can contribute to improving healthcare systems. *Social Science & Medicine*, *306*, Article 115127, 1–12. https://doi.org/10.1016/j.socscimed.2022.115127

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*(1), 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

Smith, M. E. F. (2012). Sustainable healthcare: a path to sustainability. Lund University University of Manchester, University of the Aegean, and Central European University. *Accessed from*. https://lup.lub.lu.se/luur/download?func=downloadFile&recordOId=3126175&fileOId=3126182

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: [The Intergration of Micro Takaful and Waqf During Pandemic: Potentials and Challenges]. *Ulum Islamiyyah*, *33*(3), 135–150. https://doi.org/10.33102/uij.vol33no3.439

Thomson, S., Foubister, T., Figueras, J., Kutzin, J., Permanand, G., Bryndová, L., & World Health Organization. (2009). *Addressing financial sustainability in health systems* (Policy Summary). https://d1wqtxts1xzle7.cloudfront.net/43742366/E93058-libre.pdf

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

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 https://ideas.repec.org/a/eee/worbus/v45y2010i4p346-356.html#author-abstract

Weisz, U., Haas, W., Pelikan, J. M., & Schmied, H. (2011). Sustainable hospitals: A socio-ecological approach. *GAIA-Ecological Perspectives for Science and Society*, *20*(3), 191-198. https://nachhaltigwirtschaften.at/resources/fdz_pdf/sustainable_hospitals_gaia_2011_3_weisz.pdf

Wolpert, J., & Reiner, T. (1985). The not-for-profit sector in stable and growing metropolitan regions. *Urban Affairs Quarterly*, *20*(4), 487-510. https://journals.sagepub.com/doi/pdf/10.1177/004208168502000406?casa_token=-iG9GpvQZ1kAAAAA:kVg0R5a6WhMaj2c7IFk96UQrdkNsX_rFQvaL2-aVgFQFcRT6_veIkbupYGrdrfD3_fKsK8vfUylKXw

World Health Organization (2023). Sixth Meeting of the Technical Advisory Group on Universal Health Coverage in the Western Pacific Region, Virtual meeting, 22-24 November 2022: meeting report.