

Use of Islamic Financing Instruments: Case study of selected Private Healthcare Providers

By

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Abstract

Demand for quality health care services in Malaysia is rising with improvements in per capita income, enhanced educational attainments, changes in demographic patterns and urbanization. People have become more conscious about their health and willing to pay for quality medical treatment. These factors accounted for the dramatic increase in the number of private hospitals from 10 in 1980 to 209 in 2009. In addition the government is promoting Malaysia as a medical tourism destination and halal hub in this region. Malaysia has been actively promoting its healthcare services to potential Muslim medical travellers especially from Middle East countries, Brunei, Singapore and Indonesia. Malaysia has the potential to be a preferred medical tourism destination among Muslim medical travellers as Malaysia is an Islamic country with a good infrastructure and medical facilities and offer high quality service at competitive cost. These developments augur well for existing and prospective Bumiputera/Muslim healthcare providers to expand capacity. Bumiputera/Muslim participation is relatively small but on the rise with the Kumpulan Perubatan Johor Corporation (KPJ) as the leader (20% market share of private healthcare sector in 2009). This paper reports the findings on the financing methods adopted by private Bumiputera/Muslim healthcare providers focusing on the use of Islamic financing instruments. The findings provide the basis for exploring and assessing alternative Islamic financing instruments to finance expansion in capacity.

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1. Introduction

Economic growth and financing are closely related (Levine, 1997; King & Levine, 1993; McKinnon, 1973; Goldsmith, 1969; Schumpeter, 1912). In today's business world, financing needs is irrefutable. Financing is a channel for businesses to provide the adequacy capital (and later turn into a form of the investment) to generate economic activities. The more bouyant economic activity is, the more is the need for financing. Financial intermediation plays important role to support the financing process (Greenwood & Jovanovic, 1990). The firms then will allocate these funds to the most productive use so that firms can operate at the most efficient capacity. Thus, the link between growth and financial development is a causal association. Finance does not just follow growth, but at the same time it leads to economic growth.

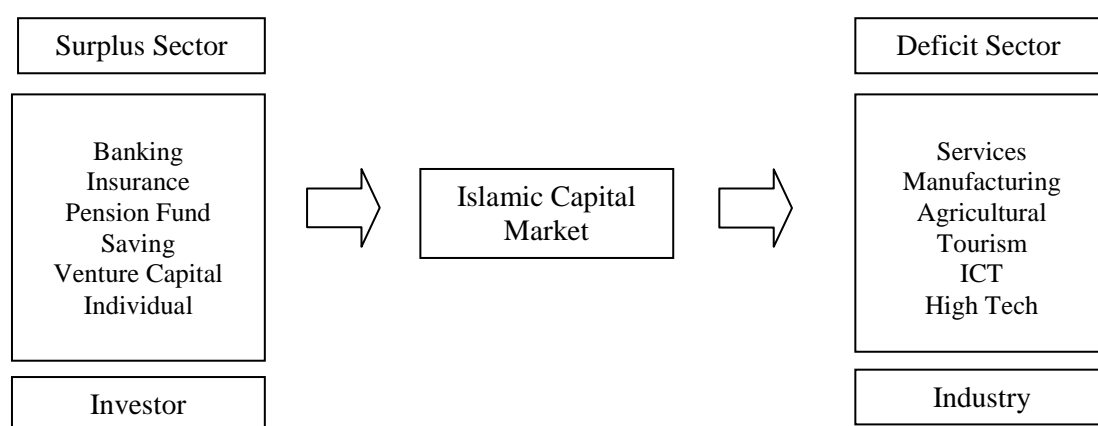
In Malaysia, besides the conventional financial system, the Islamic financial system also plays the same important role in the Malaysian economic development. This financial system also transmits the current excess funds to those who can use them for either consumption or investment purposes. However, in the Islamic financial system, any transformation of funds (wealth) or property has to be made through a valid contract ('aqad) which is based on the divine sources (Al-Quran and sunnah) and mutual consent (redha). Malaysian Islamic Financial System can be divided into three sectors namely as the Islamic banking sector, the takaful sector and the Islamic capital market sector.

The operation of Malaysian Islamic banking sector started in the early 1980s with the establishment of the Bank Islam Malaysia Berhad under the Islamic Banking Act 1983. In 1999, Bank Muamalat had been established as the second Islamic bank. Among services offered by the Islamic banking sector are *Al-Bai Bithaman Ajil* (BBA) house financing, *BBA/Murabahah/Ijarah* business financing, *Wadiah* and *Mudarabah* saving and investment and Islamic financial market. This positive development then followed on the other hand by the establishment of the Syarikat Takaful Malaysia Berhad under the Takaful Act 1984 using *Tabarru'* (charity) and *Mudarabah* (profit sharing) concepts. The establishment of Takaful

Nasional then followed after that. Family and medical Takaful, business Takaful and vehicle Takaful are among takaful plans offered by these takaful institutions (www.sc.com.my).

The Islamic capital market, in other words, is a complement component to the Islamic financial system. The Islamic capital market refers to the market that applies Islamic principles in capital market transactions, which are free from the involvement of forbidden activities by Islam and free from *usury* elements, gambling and ambiguity (*gharar*). There are several factors that have been identified to explain on the need of the Islamic capital market. For instance, firstly, to manage Islamic excess fund (e.g. Lembaga Tabing Haji fund, Yayasan Pembangunan Ekonomi Islam Fund, Perbadanan Usahawan Nasional Berhad Fund, etc) to be more efficient and productive for long term period. Secondly, to provide infrastructure among investors and issuers who are more aware to use Islamic investment and financing instruments. Thirdly, to complement the role of Islamic banking and Takaful system. Subsequently, the Islamic capital market can play an equal important role with the conventional capital market. Finally, to provide a wider local investors' scope of niche for investment through the Islamic capital market instruments (Nik Mohamed Ruslin, 2001). In general, Islamic capital market presence perceived as intermediary or investment mediator from sectors that have surplus capital to the undercapitalized sector based on the Islamic law principle (Figure 1).

Figure 1: Capital flow from surplus sector to deficit sector



Source: Seminar Pasaran Modal Islam, 2000

Recently, Islamic capital market has been focusing on the most actively growing bond (*sukuk*) market. Bank Negara Malaysia reported that Malaysia is the biggest *sukuk* market in the world (39% of total world *sukuk* outstanding which is USD204.5 billion as at end of June 2009) (IFIS, 2009). In local market, Sukuk outstanding as the end of March 2010 amounted to RM245.3 billion compared with RM248.7 billion as at end 2009. Sukuks issued in first quarter 2010 were mostly those using *Murabahah* (27%) and *Musharakah* (36%) concepts. However it is anticipated that there will be more *sukuk* adopting other contract concepts that will be issued in the second half of 2010 (RAM, 2010). As at end of March 2010, majority of the *sukuk* issued in the market were from the infrastructure and utilities sector which commands 24% of the total issuances (or valued about RM142 billion). This evidence that in a case of financing other sectors business expansions, such as in property and real asset, plantation and agriculture and services sectors (including healthcare), this type of investment can be considered.

In the service sector, Malaysia identified medical tourism as one of the new national key economic areas in propelling the nation towards high-income status (10thMP, 2010). Thereby, it is also expected that *sukuk* can become one of the gates especially for private healthcare investment opportunity. Malaysia's private healthcare sector still needs more investments for future growth, especially for Bumiputra private healthcare providers. Currently, the number of Bumiputra private hospitals which providing medical services to the tourists are very limited. Hence, integrating the right investment instruments and high quality human capital can provide well managed hospital and further able to contribute to the rise in profit and increase in productivity. Accordingly, this indirectly can increase medical tourism's contribution to Gross Domestic Product's (GDP) country.

Thus, this paper discusses the potential of integrating Malaysian Islamic capital market instrument particularly *sukuk*, with Bumiputra private healthcare providers. Innovation of various *sukuk* is believed capable in providing suitable financial infrastructure needs of this sector. We investigate Islamic financing methods adopted by Kumpulan Perubatan Johor Cooperation (KPJ) and selected non- Bumiputra healthcare providers for comparisons. From their experiences, we propose recommendations that can be applied by other Bumiputra private healthcare providers in this country. Thus, this paper begins with the premise that financing is anticipated as a main constrain for Bumiputera/Muslim healthcare providers to

expand their capacity. The rest of the paper is organized as follow. The paper consists of five sections, which includes introductions as the first section. Section two gives an overview of private healthcare sector in Malaysia and defining the nature of problem at hand. Section three investigates the KPJ's and selected non- Bumiputra healthcare provider's Islamic financing methods. Section four gives an evaluation and determination of the potential of the use of Islamic financing instruments by other Bumiputra private healthcare providers. Recommendations and conclusions are provided in the final section.

2. Malaysian private healthcare sector and Medical tourism industry

In the recently unveiled Tenth Malaysia Plan (2011 – 2015), this country is being propelled towards becoming a high-income and high-productivity economy. In order to realize this vision, the central thrust to sustainable economic growth and development of the country is human capital. High quality of human capital is not measured solely on physical health, but also emotional, spiritual and intellectual aspects. Accordingly, the understanding that health represents the human capital, the demand for quality health care services is consequently rising. Besides that, among the factors that also contribute to the rapid rise of an effective demand for health has been fuelled primarily by the rapid rise in per capita income, changes in demographic patterns and urbanization. Dowling & Valenzuela (2004) stated that income has long been accepted as the major force driving improvements in health outcomes for many countries. The experience of many countries has shown that a dramatic drop in the death rate occur when countries become industrialized and living standards and income rise. In the case of Malaysia, between 1980 and 2000, per capita gross national product (GNP) of Malaysia more than doubled, from RM3,221 to RM7,593 (Table 1) (Chee Heng Leng & Barraclough, 2009). A high proportion of the population of Malaysia is in the economically age group. In 2009, based on population projections on the adjusted 2000 population census, 63.6% of the population is those between the age group of 15 – 64 years. The elderly above 64 years of age was 4.54% of total population (Department of statistics, 2009). This population distribution portrays the needs of high number of private medical facilities among Malaysians. Moreover, when people become more educated they tend to be more conscious about their health as well.

Table 1: Private medical facilities and national income

Year	No. of facilities	No. of beds	% of total beds ¹	*Per capita GNP (RM)
1980	50	1171	5.8	3221
1985	133	3666	14.5	3758
1990	174	4675	15.1	4426
1995	197	7192	19.4	5815
1998	216	9060	25.1	-
2001	224	10348	28.4	7593 ²
2003	219	10405	26.7	-

Source: Ministry of Health Annual Report, various years.

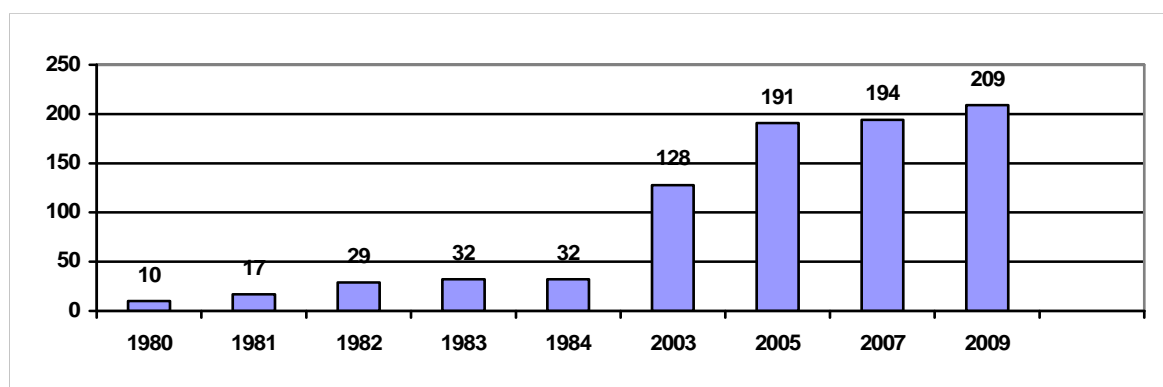
Note: * at purchasers' value, in 1978 prices.

¹ Total of acute beds in MOH hospitals and private hospitals

² For the year 2000

In the space of almost three decades, from 1980 to 2010, private medical facilities particularly private hospitals have shown tremendous growth. The number of private hospitals grew from 10 in 1980 to 209 in 2009 (Table 2). In 1980, private hospitals constituted 20% of total private facilities, whereas in 2003, they constituted 58%.

Table 2: Private Hospital in Malaysia



Source: MOH, various years

The proliferation of private hospitals in Malaysia has been dominated by for-profit private hospitals. In 2007, Kuala Lumpur (50 hospitals) was the state with the highest number of establishments of private hospitals. It was then followed by Selangor (38 hospitals) and Johor (22 hospitals) (MOH, 2009). In terms of expenditure, the private health expenditure on health is 46.2% of total health expenditure (Ninth Malaysia Plan, 2006). Accumulated number of

beds has increased from 1,171beds (1980) to 12, 216 beds (2009). The impact of the 1997 Asian financial crisis on the economy provided much of the impetus for this development.

During the Asian financial crisis of 1997, the Malaysian ringgit dropped rapidly before it was pegged to the U.S. Dollar at RM3.80 and affected every part of the healthcare sector. The purchasing power of local patients for healthcare provided by the private sector was badly reduced and they reverted to the public healthcare sector for their needs. Many private hospitals were closed, downsized or cut back their benefits for employees. The price of imported pharmaceuticals, medical supplies and medical equipment rocketed. In the prevailing economic climate then, private hospitals could not comfortably survive (Chee, 2007).

In 1998, Malaysia introduced health tourism as a response to the crisis in its search for new and sustainable growth areas. Private hospitals then increased their efforts to attract more foreign patients. From the year 2000 onwards, the number of private hospitals started to increase. They are now targeting more foreign patients through tourism package where people today tends to travels to other countries purposely to seek treatments that can enhancing their well-being of the mind, body and spirit individually, families or groups (MOH, 2002).

Since various policy steps were taken, the Malaysian health care system has undergone steady growth, supported by tourism activities that have helped Malaysia to position itself as one of the premier destinations for health tourism. In 2006, hospitals in Malaysia were hosts to 296,687 foreign patients, earning revenues of RM 203 millions. Malaysia expects to earn RM1.2 billion from medical tourism by 2010 (Financial Times, 2005). Table 3 below illustrates the potential of this tourism segment by showing the number of patients and income under the Health Tourism Program in Malaysia from 2002 to first half of 2009.

Table 3: Number of Patients and Income under Health Tourism Program

Year	2002	2003	2004	2005	2006	2007	2008	2009
Number of patients	84,585	102,946 (22%)	174,189 (69%)	232,161 (33%)	296,687 (27%)	341,228 (15%)	374,063	165,095*
Income (RM Million)	35.9	58.9 (64%)	105.0 (78%)	150.9 (44%)	203.7 (35%)	253.84 (25%)	299.10	142.30*

Source: Association of Private Hospitals Malaysia.

Note: Figures in brackets is an annual changes

* Up to 1st half 2009 only

Malaysia has many advantages to develop the medical tourism industry. These advantages included basic prerequisite for being medical tourism destination, for instance, a good physical infrastructure facilities such as an excellent communication networking (high quality road system, telephone network and airports) and extensive supply of clean water and electricity. Besides that, Malaysia is fortunate to be endowed with an abundance of natural and unspoiled environment which can be transformed into fascinating tourism products which can best be included in medical tourism package (Ministry of Tourism, Arts and Culture, 2002). Malaysia also has the required skilled human resources in the medical field and some of the best facilities in this region. In 2009, there were 30,536 doctors, 3,567 dentists and 59,375 nurses registered with Ministry of Health. While in the same year, the ratios of registered medical personnel over population were 1: 927, 1: 7 936 and 1: 477 respectively (MOH, 2010). Malaysia's medical specialists have no communication barrier as most of them are well-trained with having post graduate training abroad and they speak excellent English. Malaysia's health human resources also have been described as more compassionate and caring. In addition, according to the Association of Private Hospitals of Malaysia, most of these hospitals and healthcare facilities have been equipped with the latest high technology medical devices and obtained at least Malaysian Society for Quality in Health (MSQH) Accreditation which is has been recognized by World Health Organization (WHO). The government has been playing a very significant role to stimulate the growth and the development of the medical tourism and halal industries. The Malaysian government has organized a number of conferences, forums, exhibitions, road shows and marketing promotion efforts. Recently, the Malaysia Healthcare Travel Council (MHTC) was established on 3rd July 2009 as the primary agency to develop and promote the healthcare

travel industry and to position Malaysia as the healthcare destination of choice in this region (<http://www.myhealthcare.gov.my>). Malaysian External Trade Development Association (MATRADE), Ministry of Health (MOH) and Tourism Malaysia are the government bodies tasked with this responsibility. From 2001-2009, among the countries targeted for promotional efforts were United Arab Emirates, Bahrain, Saudi Arabia, Myanmar, Vietnam, Indonesia, Singapore, Brunei and China (APHM, www.hospitals-malaysia.org).

Even though it is more than 10 years since the health tourism industry was actively promoted by government in partnership with industry, the participation of Bumiputera/Muslim healthcare providers, especially hospital facilities is relatively small. The sizes of all types of private Bumiputera/Muslim healthcare facilities are relatively small as well. Kumpulan Perubatan Johor Healthcare Berhad. (KPJ) has been identified as the leader (20% market share of private healthcare sector in 2009) for Bumiputera/Muslim healthcare providers in particular sector. Through its subsidiaries, KPJ is engaged in the operation of specialist hospitals. The KPJ Group of hospitals is the largest private healthcare group in the country, after the MOH. With all the advantages that Malaysian has to offer and the potential of the medical tourism industry, it is seen as a great opportunity for Bumiputera/Muslim healthcare providers to venture. However, financing is anticipated as a main constrain for them to expand their capacity. Thus, KPJ is referred especially in terms of how they finance their hospitals development to achieve its success and leading position. Findings of this research provide the basis for exploring and assessing alternative Islamic financing instruments to finance expansion in capacity for other Bumiputera/Muslim healthcare providers.

3. Case study on Islamic Financing Methods.

The number of private hospitals in Malaysia which adopted Islamic financing methods is very limited. From reachable sources, KPJ (Al-Aqar KPJ Real Estate Investment Trust based on the contracts of al-bay' and al-ijarah), Columbia Asia Sdn. Bhd. (Islamic Syndicate based on Ijarah Muntahiah Bitamik principle) (The Star, 17 March 2010) and Sarawak Specialist Hospital & Medical Centre Sdn. Bhd.(SSHMC) (Istisna' Sukuk) (MARC, 2009) are recently among those identified. The subject of interest in this section sheds some light on the actual issuance of Islamic financing methods and its performance on two case studies namely, Al-Aqar KPJ Real Estate Investment Trust by KPJ and Istisna' Sukuk by SSHMC.

3.1 Al-Aqar KPJ Real Estate Investment Trust

Kumpulan Perubatan Johor Healthcare Berhad (KPJ) is a healthcare division of Johor Corporation (JCorp). KPJ started with one specialist hospital in Johor with twelve doctors in 1981. KPJ is currently known as the first and only homegrown healthcare group in Malaysia. The KPJ Group is also the only hospital group listed on Bursa Malaysia Main Board since 29 Nov 1994. KPJ has the largest network of private hospitals in Malaysia which consist 19 hospitals in Malaysia and 2 hospitals in Indonesia with more than 2,000 licensed beds and 700 full-time resident consultants (<http://www.washingtontimesglobal.com>). KPJ has been applying a centralized dispensing, billing and collection system to facilitate the recording of the necessary activities. In terms of mode of payment, it is seen that the common transactions used are either cash paying and using a top-up system (45%) or insurance and corporate credit (55%). The provision for doubtful debt is only 1% of total sales in 2009 (Siti Sa'diah, 2010).

KPJ has been practicing the Islamic Real Estate Investment Trusts (I-REITs) as a method of financing. KPJ had issued four funds of I-REITs called Al-Aqar KPJ Real Estate Investment Trusts (Al-Aqar) worth RM1,012 million to finance the construction of its 21 private hospitals. The Securities Commission of Malaysia defines REIT as 'an investment vehicle that proposes to invest at least 50% of its total assets in real estate, whether through direct ownership or through a single purpose company whose principal asset comprise real asset' (Securities Commission, 2005). The key difference between the conventional and I-REITs

lies in how the incomes from REIT are earned and how the fund is supposed to be managed (Asyraf, 2007). For I-REIT, these two aspects need to be based on the principles of Shariah. Thus, an I-REIT is a collective investment vehicle that pool money from investors who invests (buying, managing or selling real estate) primarily in income-producing Syariah compliant real estate, and/or single purpose companies which are Syariah compliant whose principal assets comprise Syariah compliant real estate. The incomes from the real estate or companies are used to provide returns to its unit holders (Ting & Abdul Rahman, 2007).

Al-Aqar is the first I-REIT in the world and first Islamic hospital REIT in Asia which the initial transaction involves sale and lease back mechanism based on the contracts of al-bay' and al-ijarah (Asyraf, 2007). The first fund injected on 28 June 2006, owned and invested in six KPJ's private hospitals which were first acquired for KPJ and its subsidiaries. These properties worth a total market value of RM481 million include Ampang Puteri Specialist Hospital Building, Damansara Specialist Hospital Building, Johor Specialist Hospital Building, Ipoh Specialist Hospital Building, Puteri Specialist Hospital Building and Selangor Medical Centre Building (Idris, 2006). The following injections of tranches are shown in Table 4 with the latest had been exercised in early 2010.

Table 4: Al-Aqar tranches schedule

Injection	No. Of Hospitals	No. of Nursing Colleges	Total Value	Injection / Completion Date
1st	6	0	RM481 million	Aug 2006
2nd	5	0	RM170 million	Mar 2008
3rd	7	1	RM292 million	Mar 2009/Dec 2009
4th	3	0	RM139 million	2010

After 3rd injection, total assets will be RM1.08b with 580m Reit units issued.

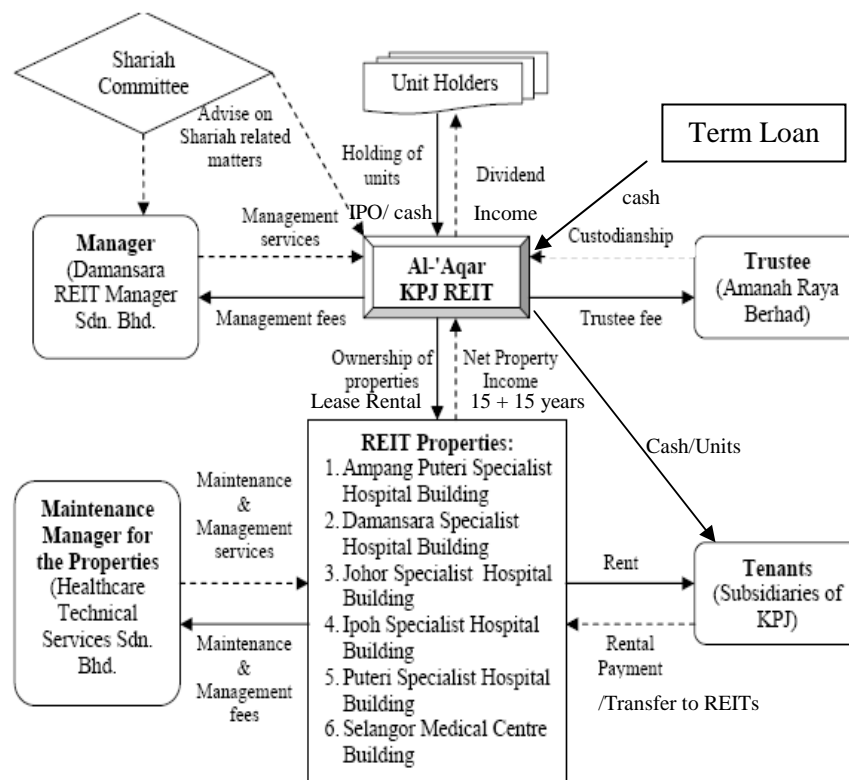
The KPJ's Islamic REIT financing structure is illustrated in the following diagram (Figure 1).

These acquired properties are then leased back to KPJ and its subsidiaries for the period of 15 years. In other words, the performance and operation of the KPJ Group are main factors to the Al-Aqar KPJ REIT's revenue. KPJ and its subsidiary companies is a specialist healthcare group which operates with normal hospital management, healthcare technical services, hospital development and commissioning activities. Besides that, their portfolio of businesses also includes nursing and healthcare professional continuous education, pathology services,

central procurement and retail pharmacy (KPJ REIT, 2006). Being a single tenant of the properties and long term player in the healthcare industry, KPJ Group is anticipated to be able to provide stable rental income to the Al-Aqar KPJ REIT (Asyraf, 2007).

Meanwhile, as the trustee to protect the unit holder's interests, Amanah Raya Berhad (ARB) was appointed. As required by the Securities Commission Guidelines, ARB shall actively monitor the administration of the fund by the management company, Damansara REIT Manager Sdn. Bhd., is in accordance with the objective of the fund, the deed, Islamic REIT Guidelines and acceptance and efficacious business practices within the real estate investment trust industry. This task is to ensure that the interests of unit holders are upheld at all times. At the same time, ARB is also responsible to avoid any potential conflict of interests arising from future acquisition of Shariah-compliant properties among the tenants, the sponsor and the manager which all are subsidiary of Johor Corporation (JCorp) (Asyraf, 2007).

Figure 1: KPJ's financing programme structure



Sources: Siti Sa'diah, 2010 and Asyraf, 2007.

As noted earlier, even the entire income of Al-Aqar is derived from KPJ's own subsidiaries, but the portfolio of their businesses is wide in range. KPJ as a parent company also has been underlined several strategies for its subsidiaries to be more opportunity-driven for long term sustainable competitive advantage. Among these strategies are to expand the existing business, create new areas of excellence, generate new revenue streams, have a high margin, enhance clinical professionalism and develop human capital (Siti Sa'diah, 2010). Table 5 below shows the KPJ's key performance Statistics for the last five years. The table shows double digit in growth of revenue and pre tax profit with average yearly changes is 22% for last five years and 35% for last four years respectively. Besides that, net profit figures achieved the highest margin in 2009 translating into 18.9% growth. Accordingly, MIDF RESEARCH (March, 2010) reported, KPJ's performance is in line with the overall market over the next 12 months. These performances have led KPJ to plan the expansion of the new hospital and the extension of its existing hospitals. The new potential hospitals developments will be located somewhere in Muar, Klang and Kuantan for the next 2 year plans. While KPJ Ampang Puteri, Damansara, Seremban and Kajang are plans to increase their beds capacity. With the expansion plans and company's future prospects, KPJ optimist to achieve 2billion in 2012.

Table 5 shows the KPJ's key performance Statistics

Year	2005	2006	2007	2008	2009
No of hospitals	15	17	17	19	19
Outpatients	1,162,585	1,556,172	1,733,500	1,956,303	1,978,669
Inpatients	117,539	158,412	179,227	196,291	206,907
Turnover (RM'000)	659,643	831,455	1,108,024	1,267,305	1,446,370
Profit Before Tax (RM'000)	42,301	60,060	85,255	114,052	141,956
Net Profit Attributable To Equity					
Shareholders (RM'000)	32,657	40,962	74,237	85,644	101,869
Earnings Per Share (sen)	16.25	20.30	36.02	41.41	49.01
Share capital (RM'000)	201,050	203,999	207,745	209,461	263,813
Shareholders' Fund (RM'000)	410,292	442,590	508,828	581,041	622,846

Sources: Siti Sa'diah, 2010

3.2 Istisna' (Construction) Sukuk

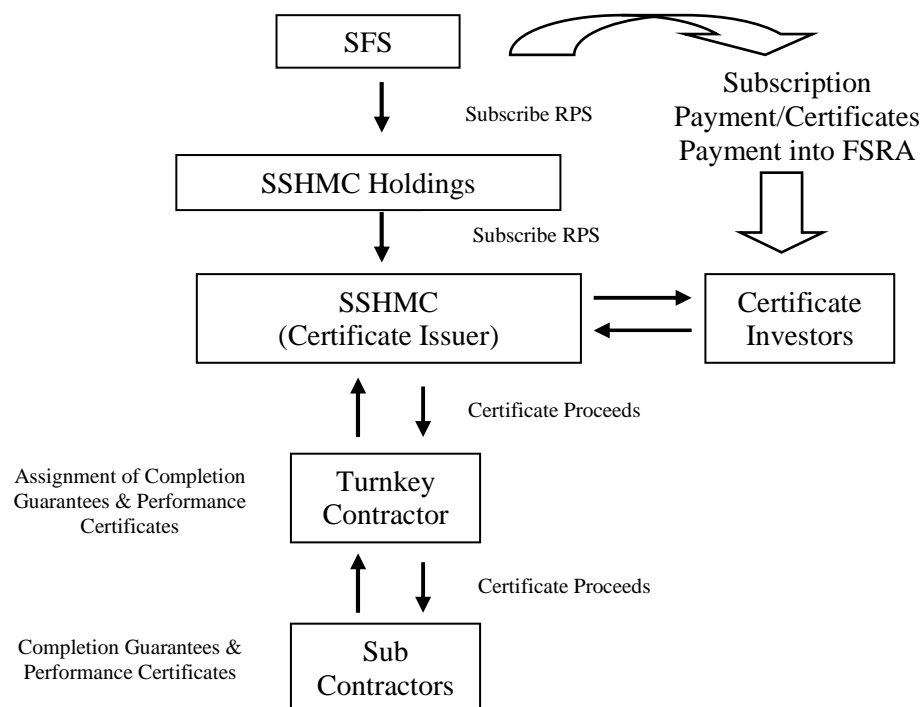
The similarity between KPJ and SSHMC is that each being controlled by state government, Johor and Sarawak respectively. Sarawak International Medical Centre (SIMC), located in Kota Samarahan, Sarawak is to be built by SSHMC. The latter has commenced operations in July 2003. To facilitate the construction of the SIMC, SSHMC was incorporated on 12 July 2001 which is indirectly wholly-owned subsidiary of State Financial Secretary Incorporated (SFS); a statutory body established under the State Financial Secretary (Inc) Ordinance under the laws of Sarawak and controlled by the state government. SIMC includes 166 beds in its three-storey hospital podium complex which attached with eight-storey inpatient accommodation building. SSHMC has been issuing eight tranches of istisna'sukuk worth RM425 million as a method of financing of the construction of SIMC private hospital. The substantial completion date, after an extended period of delay was in 2009. However, in June 2009, it was reported that overall physical construction was 99.4%, but a final completion and handover date has yet to be set. It is not the purpose of this paper to discuss on project's failure to achieve timely completion; however the paper focus on the objective of the Islamic financing method adopted by the private hospital and its implementation results.

According to Accounting and Auditing Organisation for Islamic Financial Institutions (AAOIFI), sukuk is a certificate that represents an equal value upon closing subscription, receipt of the value of the certificates and putting it to use as planned, common title to shares and rights in tangible assets, usufructs and services, or equity of a given project or equity of a special investment activity (Nathif, Abdulkader & Nathif, 2005). Therefore, Istisna' sukuk are certificates that are issued purposely to mobilize the funding for required investment activities that are owned by the subscriber.

In the case of SIMC construction financial structure (Figure 2), SSHMC, is initially a certificate issuer. State Financial Secretary Inc. (SFS) and SSHMC Holdings are the buyers of the intended product (SIMC) called subscribers. Two Certificates Subscription Agreements were issued between SSHMC and SSHMC Holdings (SA1), and between SSHMC Holdings and SFS (SA2). The SA2 stipulates that SFS has to make subscription payment to SSHMC Holdings directly into the Finance Service Reserve Account (FSRA), an account jointly managed by SSHMC and the facility agent for the purposed of certificate

repayment. While the cost of the product represent the funds realised from subscription worth RM425 million. Later, the SSHMC and SSHMC Holdings are certificate subscribers who own the product. They are entitled to the sale price of the certificates or the sale price of the product sold on the basis of Istisna’.

Figure 2: The SSHMC’s financing structure.



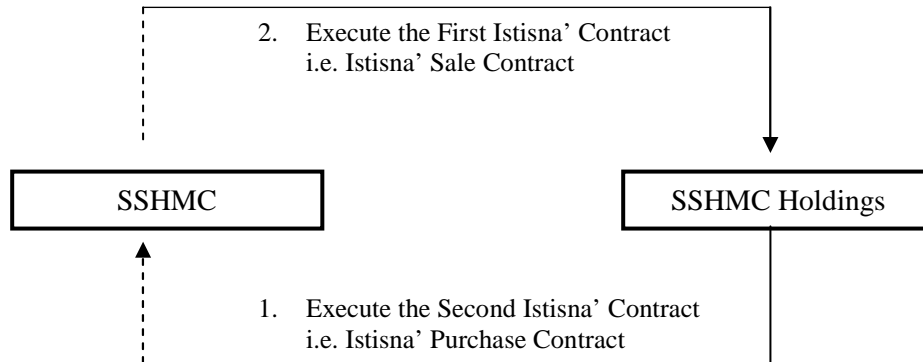
Source: MARC Credit Analysis – SSHMC, 2009

The istisna’ financing concept is based on a sale and purchase contract involving a certificate issuer and subscribers, and the asset then will be delivered in the future according to the agreement specifications (Figure 3). SSHMC entered the first Istisna’ Contract with SSHMC Holdings under which the latter agrees to construct and deliver the assets in the future at the Istisna’ Sale Price which is equivalent to the aggregate Istisna’ Purchase Price plus profit. The second Istisna’ Contract was entered into between the same parties, with SSHMC agreeing to construct and deliver the same asset in the future at the Istisna’ Purchase Price. The asset will eventually reside with SSHMC as the delivery of the asset will be from SSHMC to SSHMC Holdings (Second Istisna’ Contract) and from SSHMC Holdings to SSHMC (First Istisna’ Contract). The parallel Istisna’ contract ensure that all the risks associated with the asset remain with SSHMC, the Certificate Issuer and the project owner.

Figure 3: Transaction Mechanism for SSHMC Istisna' Certificates

1 (a) Satisfies Istisna' Sale Price via Issuance of Istisna' Certificate directly to the Lead Arranger Evidencing SSHMC's payment obligations toward the Istisna' Sale Price.

2 (b) Deliver the asset once it is constructed.



2 (a) Execute Istisna' Purchase Price via proceeds from the issuance of Istisna' Certificate in 1(a).

2 (b) Deliver the asset immediately after receiving it from SSHMC.

Source: MARC Credit Analysis – SSHMC, 2009

Even though, the SIMC has not started its operation yet, in arriving at the financial projections, all available government and private industry data on healthcare were utilised. According MARC report (2009) on SIMC, the assumption and projections made during the construction phase of SIMC may not reflect the current developments in the health industry. Revenue is mainly derived from medical fees for outpatients and in-patients treatment, and diagnostic treatment (Table 6). The largest contributor of SIMC revenue is expected to be diagnostic treatment, while investment income will constitute a small portion of the revenue. Revenue is expected to rise in tandem with the increase in the number of occupied beds.

Table 6: SIMC's Profitability Projections from 2010 - 2021

	Average 2010-2011	Average 2012-2013	Average 2014-2015	Average 2016-2017	Average 2018-2019	Average 2020-2021
No. Of occupied beds	43	57	73	100	126	132
Revenue	29.75	40.58	56.04	81.26	109.09	122.77
Net Profit/(loss)	(47.89)	(45.39)	(0.65)	2.78	6.61	7.58

Source: MARC Credit Analysis – SSHMC, 2009

4. Evaluation and determination of the potential Islamic financing instruments.

As mentioned earlier, Malaysia has been positioning itself as a preferred medical tourism destination and as halal hub in this region. Accordingly, Association of Private Hospital Malaysia (APHM) has set certain criteria for private hospitals that are interested to join medical tourism industry as providers. Among these criteria are: the private hospital must be licensed, have recognized accreditation, have at least 100 beds for general private hospital and 50 beds for specialists hospital and easily accessible (TTG Asia, 2007). However, most of Bumiputera/Muslim private hospitals are still far from satisfying these requirements. Financing is acknowledged as a main constraint for Bumiputera/Muslim healthcare providers to expand their capacity. This factor's intended not only in the terms of financing sources but also the type of available financing, contribute to the failure to operate efficiently.

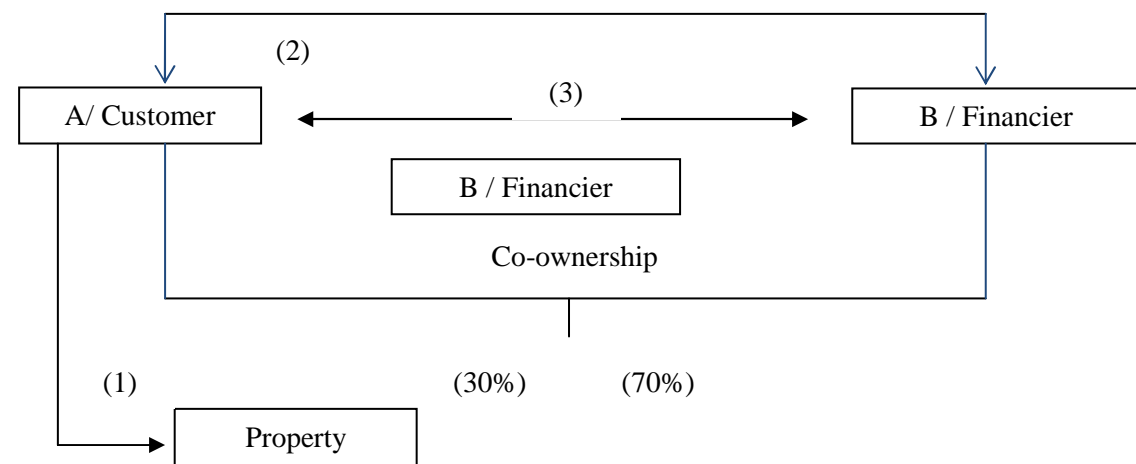
Based on the above two selected private hospitals' experience, either I-REITs or sukuk have their own advantages and disadvantages based on the syariah compliance needs. I-REITs offer investors the opportunity to hold diversified listed real estate certificates, which are expensive if they want to invest directly. While sukuk, on the other hand, is capable to spread the risk beyond the investors. Sukuk is also able to force investors to focus on the projects or venture, rather than relying on the 'overnight market'. As highlighted, due to small scale company they may deal with a faster-maturing yield, which is probably, be more successful compared with the longer-maturity yields. However, both, I-REIT and sukuk can achieve their great benefits if only they are issued and traded on large scale.

Besides the above examples, there is also other Islamic financing instrument that can be used as a means of financing especially of asset acquisitions and refinancing such as building or medical equipments. From a limited survey research conducted among Bumiputera/Muslim private hospitals, they support the potential use of Islamic venture capital or partnership; based on *musyarakah mutanaqisah* (diminishing partnership) principle.

Sukuk Musyarakah Mutanaqisah principle

This type of sukuk can be applied to the corporate finance and real estate. The transaction involves at least two or more people who agree for the process of acquiring property. One person (A) will be the financier who has decided not to own the property for long term; the other person (B) will be the owner of the property. There are two portions of the contract. First, the contract is a partnership agreement between A and B. Initially, A will pay for a certain amount which will present its ownership of the property, for example 30%, while, B will pay the rest of the amount which gives him 70% equity. Subsequently, A then gradually redeem B's share at an agreed portion until the property is fully-owned by A. Under the second agreement, B agrees to lease the property to A under the principle of Ijarah. A agrees to pay a rental to B for using its share of the property. Figure 4 illustrates the sukuk using musyarakah mutanaqisah principle. The potential of this type of sukuk has been seen as an alternative of Bai Bithaman Ajil principle that has been claimed by some parties as the same as conventional financing instrument.

Figure 4: Structure of musyarakah mutanaqisah principle.



Source: Noreeta Mohd Nor (2008)

- (1) A identified the property with 30% of the purchase price being paid by A and 70% by B. A and B therefore own 30% and 70% of the property respectively.
- (2) A's monthly instalments for the financing paid to the B will increase A's ownership of the asset/property.
- (3) The ownership of the asset/property will progressively move towards the customer and the financing ends when the customer owns 100% of the asset/property.

5. Conclusion

It is an undeniable fact that service (particularly, healthcare) sector will play a very important role in future economic development of Malaysia. The rising trend in earnings received by the medical tourism industry is a convincing testimony to the importance and potential of this sector. However, Bumiputera/Muslim private healthcare providers are still left behind. Availability of financing for this sector has become one of the main problems that need to be solved. Perhaps, by integrating Islamic capital market with this sector can be one of the suitable solutions since this industry has the potential to mobilize the fund needed. In this paper, sukuk musyarakah mutanaqisah is proposed as a potential Islamic financial instrument to be used for Bumiputera/Muslim private hospitals owner to finance their capacity expansion.

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