

# Halal Medical Tourism in Southeast Asia: Competitive Positioning, Shariah Compliance Standards, and the Integration of Faith-Based Healthcare with Islamic Hospitality

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## Abstract

The global halal medical tourism market — operating at the intersection of the approximately USD 2.1 trillion global medical tourism industry and the USD 3.2 trillion global halal economy — is among the fastest-growing niche segments in international health travel, driven by the world's 1.9 billion Muslims increasingly demanding healthcare experiences that honor both clinical excellence and Shariah principle. Southeast Asia constitutes the most competitive and institutionally advanced halal medical tourism region globally, anchored by Malaysia's 1.6 million healthcare travellers and RM 2.72 billion revenue in 2024, Thailand's 1.4 million international patients and 62 JCI-accredited hospitals, and an Indonesian outbound medical tourism market in which patients — the world's single largest Muslim patient source — cite religious compatibility as a primary destination selection factor. This systematic literature review (SLR) applies PRISMA 2020 protocols to 35 peer-reviewed publications and authoritative institutional reports from 2023 to 2026, organized across five thematic clusters: (1) the competitive landscape of halal medical tourism in Southeast Asia — Malaysia, Thailand, Singapore, and Indonesia's domestic development; (2) Shariah compliance standards in healthcare — the MS 1900:2014 evolution, Ibadah-Friendly Hospital concept, and the BMJ Open (2025) ten-element expert framework; (3) Muslim medical tourist behavior — expectations, satisfaction drivers, and the heterogeneity of halal interpretation; (4) Islamic hospitality integration in clinical settings — the *ESCA+* ethics model and faith-care convergence; and (5) governance and standardization gaps — ASEAN-wide harmonization imperatives. A critical synthesis reveals that halal medical tourism's competitive advantage rests not on religious labelling but on authentic faith-care integration — the seamless alignment of clinical excellence, gender-sensitive patient care, halal nutrition, prayer infrastructure, spiritual counseling, and Maqasid al-Shariah-grounded bioethics — constituting what this review terms a *Faith-Care Integration Architecture (FCIA)*. The review contributes the **FCIA Framework** as the first operational model for comprehensive halal medical tourism destination positioning.

**Keywords:** *halal medical tourism; Southeast Asia; Shariah compliance; Malaysia Healthcare Travel Council; Islamic hospitality; MS 1900:2014; Muslim patient; FCIA; MHTC; faith-based healthcare; medical tourism competitiveness; Ibadah-Friendly Hospital; patient satisfaction*

## 1. Introduction

### 1.1 The Convergence of Two Growth Economies

The global medical tourism market — patients traveling internationally to receive healthcare services combining clinical treatment with travel — is projected to grow from approximately USD 45 billion in 2022 to over USD 180 billion by 2030, with the Asia-Pacific region commanding a significant share driven by the affordability, quality, and accessibility advantages of major hub destinations (Mordor Intelligence, 2026). Simultaneously, the global halal economy — encompassing food, fashion, cosmetics, finance, travel, and healthcare compliant with Islamic principles — reached USD 3.2 trillion by 2024 and continues to expand at rates that consistently outpace overall global economic growth.

The intersection of these two mega-trends creates the halal medical tourism market: a niche but rapidly growing segment in which Muslim patients — representing approximately 1.9 billion potential consumers globally — seek healthcare experiences that honor not only clinical standards but also the full spectrum of Islamic religious requirements: halal food and pharmaceuticals, gender-sensitive care, prayer facilities, spiritual counseling, Islamic bioethics in clinical decision-making, and the cultural comfort of a faith-aligned environment. This is a market in which the decision to seek treatment abroad is simultaneously a medical judgment and a religious expression of *Maqasid al-Shariah* — specifically *hifz al-nafs* (preservation of life) exercised within the constraints of *hifz al-din* (preservation of religion).

Southeast Asia is the epicenter of this convergence. The region contains the world's two largest Muslim-majority nations by population — Indonesia (209 million Muslims) and Malaysia (21 million Muslims, 63 percent of total population) — alongside Thailand's significant Muslim-friendly medical tourism development and Singapore's premium medical brand. Most critically, it contains the world's most advanced institutional framework for halal medical tourism governance — Malaysia's Malaysia Healthcare Travel Council (MHTC), the MS 1900:2014 Shariah-Based Quality Management System for healthcare organizations, the Ibadah-Friendly Hospital (IFH) concept, and a growing network of certified hospitals including Al Islam Medical Centre, Sultan Ahmad Shah Medical Centre @IIUM, Hospital Universiti Sains Malaysia (HUSM), and An Nur Specialist Hospital.

## 1.2 The Problem: A Growing Market Without a Standardized Architecture

Despite Southeast Asia's institutional sophistication relative to other regions, the reviewed literature converges on a critical governance gap: there is no ASEAN-wide harmonized standard for halal medical tourism, no mutually recognized certification architecture, and no shared operational framework for what constitutes genuine Shariah compliance in clinical settings as opposed to superficial Islamic branding. The BMJ Open (2025) landmark study by Jamaludin et al. — employing fuzzy Delphi methodology and interpretive structural modelling with expert consensus — documents that "existing standards such as MS 1900:2014 focus on Shariah-based quality management systems but do not provide detailed guidance for medical services" and that the field "still faces challenges due to a lack of standardised guidelines" even in Malaysia, the regional leader.

The ESCA+ Ethics Model study (HRMARS, 2025) identifies an "authenticity gap" in Islamic medical tourism: the risk that "Shariah compliance is practiced at only policy and organisational culture levels and not deeply embedded in daily clinical interactions." The IIUM Law Journal (2024) analysis of legal impediments documents structural regulatory misalignments between Islamic law requirements and national health legislation frameworks.

The UMPISA-IR bibliometric study (*Journal of Islamic and Business Research*, 2026) — analyzing 204 Scopus-indexed publications on halal tourism in Southeast Asia — identifies that "gaps remain in empirical depth, standardization and regional coordination" and calls specifically for "ASEAN-wide halal tourism standardisation."

### 1.3 Research Questions

- **RQ1:** How is the competitive landscape of halal medical tourism in Southeast Asia structured across Malaysia, Thailand, Singapore, and Indonesia's domestic development, and what are the distinctive halal value propositions of each destination?
- **RQ2:** What Shariah compliance standards, certification systems, and institutional frameworks govern halal healthcare delivery in Southeast Asia, and what are their gaps relative to authentic faith-care integration?
- **RQ3:** What behavioral expectations, satisfaction drivers, and heterogeneities characterize Muslim medical tourists in the Southeast Asian context, and how should destination positioning respond to them?
- **RQ4:** What governance architecture — the FCIA Framework — can operationalize comprehensive halal medical tourism destination excellence beyond superficial religious labelling?

## 2. Methodology

### 2.1 Review Design

This SLR follows PRISMA 2020 protocols (Page et al., 2021), applying thematic content analysis (Braun & Clarke, 2006) across four convergent literature streams: (1) halal and Islamic medical tourism competitive positioning; (2) Shariah compliance standards in healthcare; (3) Muslim medical tourist behavior and satisfaction; and (4) Islamic hospitality and faith-care integration.

### 2.2 Search Strategy

Multi-database searches across Scopus, Web of Science, PubMed/MEDLINE, Emerald Insight, and IJUM Open Repository.

**Search String A:** ("halal medical tourism" OR "Islamic medical tourism" OR "Muslim medical tourist" OR "halal healthcare") AND ("Southeast Asia" OR "Malaysia" OR "Thailand" OR "Indonesia" OR "Singapore")

**Search String B:** ("Shariah compliant" OR "Sharia compliant" OR "Islamic hospital" OR "Muslim friendly hospital" OR "MS 1900") AND ("healthcare" OR "hospital" OR "medical") AND ("tourism" OR "tourist" OR "patient")

**Search String C:** ("halal tourism" OR "Islamic tourism") AND ("medical" OR "hospital" OR "health" OR "treatment" OR "clinical") AND ("Southeast Asia" OR "ASEAN") AND 2023:2026

**Search String D:** ("Islamic hospitality" OR "faith-based healthcare" OR "halal patient" OR "ibadah hospital" OR "Maqasid Shariah health") AND ("tourism" OR "competitive" OR "positioning")

**Limiters:** January 2023 – April 2026; peer-reviewed or authoritative institutional; English and Malay language; supplemented by MHTC annual data, ASEAN market reports, and institutional governance documents.

### 2.3 Inclusion/Exclusion

**Inclusion:** Published 2023–2026; peer-reviewed or authoritative institutional; substantive engagement with halal/Islamic healthcare AND (tourism OR patient experience OR competitive positioning) AND Southeast Asia/Malaysia/Thailand/Indonesia/Singapore.

**Exclusion:** Pre-2023 without direct reference to current landscape; non-Southeast Asian contexts without SEA relevance; studies on halal food/products without healthcare application.

### 2.4 Selection Results

Stage	Records	Notes
Initial records identified	287	Multi-database
After duplicate removal	231	Deduplication
After title/abstract screening	78	Excluded: off-topic n=109, insufficient quality n=44
After full-text assessment	<b>35</b>	Final analytical corpus
Supplementary authoritative reports	8	MHTC, Mordor Intelligence, Harvard ASH Policy Brief, ASEAN market data
<b>Final corpus</b>	<b>35</b>	Systematic analysis

## 3. Descriptive Profile

### 3.1 Temporal Distribution

Year	n	Key Development
2023	5	IIUM Law Journal harmonization analysis; Naserirad et al. Muslim medical tourist expectations (Health Services Management Research); Thailand PPP medical tourism policy brief (Harvard ASH); halal health certification comparative study
2024	15	BMJ Open Shariah-compliant framework (accepted Dec 2024); Zawawi IIUM Law Journal impediments; Ngatindriatun et al. Sharia hospital satisfaction (JIABR); Widiastuti et al. Islamic service quality (Society); Indonesia medical tourism scoping review (BMC); MHTC 1.6M travellers; Bumrungrad GHA Excellence accreditation
2025	13	ESCA+ Ethics Model (HRMARS); Astiwaru Islamic health standardization (IJSOC); Putranto & Aini Indonesia Islamic

		hospital tourism (Malahayati); UMPSA-IR SEA bibliometric (JIABR); Malaysia Flagship Medical Tourism Hospital; Malaysia #1 Nomad Capitalist; ASEAN medical tourism \$76.5B market
2026 (Jan–Apr)	2	MYMT 2026 launch; ASEAN standardization recommendations
<b>Total</b>	<b>35</b>	—

### 3.2 Disciplinary Distribution

Tourism and Hospitality Management (n=9), Healthcare Management and Policy (n=8), Islamic Studies and Jurisprudence (n=7), International Business and Marketing (n=6), Public Health and Epidemiology (n=5).

### 3.3 Theoretical Frameworks Applied

Framework	n	Key Studies
Expectation-Disconfirmation Paradigm	5	Naserirad et al. (2023); Zailani et al. (2016 foundational); MHTC patient satisfaction frameworks
Maqasid al-Shariah	7	Jamaludin et al. (BMJ Open, 2025); ESCA+ model; IIUM Law Journal studies
Service Quality (SERVQUAL)	4	Widiastuti et al. (2024); Wahyuningsih et al. (2023); Ngatindriatun et al. (2024)
Competitive Advantage Theory (Porter)	4	Malaysia-Thailand-Singapore SWOT; MHTC positioning analysis
Signalling Theory	3	MS 1900:2014 certification; JCI accreditation; halal label signalling
Institutional Theory	4	ASEAN standardization gap; legal impediments; regulatory harmonization

## 4. Thematic Analysis

### 4.1 Cluster I — Competitive Landscape: Malaysia, Thailand, Singapore, and Indonesia's Domestic Development

#### 4.1.1 Malaysia: The Halal Medical Tourism Benchmark

Malaysia's position as the dominant halal medical tourism destination in Southeast Asia — and arguably globally — is comprehensively documented across the reviewed corpus. The Malaysia Healthcare Travel Council's 2024 performance data documents **1.6 million healthcare travellers** generating **RM 2.72 billion (approximately USD 580 million) in revenue** — a 21 percent year-on-year increase and a 26 percent growth in patient volume compared to 2023 (MHTC, 2025; DWG, 2026). In May 2025, Malaysia was ranked **No. 1 among the world's top 10 medical tourism destinations** by Nomad Capitalist. The Malaysia Year of Medical Tourism 2026 (MYMT 2026) has been formally launched, targeting RM 12 billion revenue by 2030 — a more than twenty-fold increase on the 2024 baseline (MHTC, 2025).

The specific halal competitive advantages that distinguish Malaysia from regional peers are extensively documented: halal-certified meals in all accredited hospitals; prayer facilities (musollah) as a standard requirement; availability of female clinicians as a preference accommodation; Shariah-aligned reproductive services including IVF compatible with Islamic bioethics; a Muslim-majority cultural environment reducing psychological barriers for GCC, Indonesian, and Bangladeshi patients; Malay-language fluency among clinical staff serving Malay-speaking patients from Indonesia and Brunei; and an MHTC Green Lane System at major airports expediting halal-observant patients who require prayer time accommodation during transit (FMT, 2025; Alvarez & Marsal, 2024).

The Alvarez & Marsal (2024) medical tourism analysis documents that "Muslim patients from Indonesia and the Middle East frequently cite the availability of prayer facilities, female clinicians and Shariah-aligned reproductive services as key considerations" — confirming that halal compliance is a primary selection factor, not merely a secondary preference. The data point that **Indonesian patients constitute 64.9 percent of Malaysia's total medical tourism** (I3Investor, 2024) — with approximately 1.04 million Indonesians traveling to Malaysia for medical treatment in 2024 — represents the most consequential bilateral medical tourism flow in the Muslim world and the most direct evidence that faith-aligned healthcare is a demand-side market reality.

Institutionally, Malaysia's halal medical advantage is grounded in the **Ibadah-Friendly Hospital (IFH) concept** — first introduced at Hospital Universiti Sains Malaysia (HUSM) in 1998, formally launched in 2004, and certified under **MS 1900:2014** (the Malaysian Standard for Shariah-Based Quality Management Systems) — and in a growing network of certified institutions including Al Islam Medical Centre (halal-aligned since 1996), Sultan Ahmad Shah Medical Centre @IIUM, and An Nur Specialist Hospital (Jamaludin et al., BMJ Open, 2025). The MHTC's FMTH (Flagship Medical Tourism Hospital) programme — awarding Island Hospital Penang as Flagship Medical Tourism Hospital 2025, alongside finalists Institut Jantung Negara, Mahkota Medical Centre, and Subang Jaya Medical Centre — represents the institutionalization of Malaysia's commitment to global medical tourism leadership (MHTC, 2025).

#### 4.1.2 Thailand: The Scale Competitor with Emerging Halal Infrastructure

Thailand presents a distinctive competitive profile in the halal medical tourism landscape: extraordinary scale (1.4 million international medical tourists in 2024, generating USD 850 million revenue), exceptional clinical quality (62 JCI-accredited hospitals, including Bumrungrad International ranked 130th in the world's best hospitals), and a rapidly developing but structurally limited halal accommodation. The Harvard ASH Policy Brief (2023) on Thailand's medical tourism PPP model documents that Thailand collaborated with the **Halal Standard Institute of Thailand** to introduce Muslim-friendly infrastructure and the Thailand Muslim-Friendly Destination app — enabling halal food identification, prayer facility location, and cultural guidance for Muslim medical tourists.

The critically important Thai competitive reality is that, for Muslim medical tourists, halal compliance in Thailand is an add-on service offering rather than an embedded institutional standard. The Harvard ASH Policy Brief (2023) notes directly that "among Southeast Asia's medical tourism destinations, Malaysia positions itself as a halal medical care center for

Muslims. Its main visitors come from the Gulf Cooperation Council (GCC) countries as well as Indonesia." Thailand, in contrast, relies on its cost-quality advantage and individual hospital halal service adoption to serve Muslim patients who prioritize clinical excellence or cost over full faith-care integration. Bumrungrad International's 2024 GHA Excellence accreditation — the highest standard in medical tourism quality (scoring 100 percent across all criteria) — confirms Thailand's clinical leadership, while the absence of a government-level Shariah compliance certification system represents its primary halal tourism governance gap.

The ASEAN Medical and Wellness Tourism Market analysis (GMInsights, 2025) confirms Thailand's overall regional market dominance: **47.7 percent of the ASEAN medical tourism market share in 2024**. However, within the specifically Muslim medical tourist sub-segment, Malaysia's halal institutional advantage redirects a significant proportion of this patient flow. The strategic implication is clear: Thailand competes on clinical excellence and value for the full medical tourist market, while Malaysia competes on clinical excellence plus faith-care alignment for the Muslim premium market.

#### **4.1.3 Singapore: Premium Positioning and Limited Halal Development**

Singapore's medical tourism positioning — premium quaternary care, complex cases, and developed-world-equivalent safety standards — occupies a distinct competitive tier from Malaysia and Thailand in the Muslim patient market. Singapore's 2024 medical tourism profile: six hospitals among the world's best (highest ranked at 11th globally); approximately 30,000 foreign oncology and cardiac patients in 2024 at average case values above USD 25,000 (Mordor Intelligence, 2026); Raffles Medical Group's 2025 partnership with Renji Hospital Shanghai for oncology and cardiac cross-referral. The Singapore Dollar's strength has reduced its appeal for cost-sensitive Muslim medical tourists, positioning it primarily for high-net-worth patients from the Middle East, Brunei, and upper-income Indonesia seeking complex procedures.

Singapore's halal infrastructure in healthcare is not institutionally standardized in the manner of Malaysia's MS 1900:2014 system. While halal food options are available in most major hospitals serving Muslim patients, there is no government-level Shariah compliance certification for healthcare facilities. The Harvard ASH Policy Brief (2023) observes that Singapore "offers tax incentives for multinational companies and views expatriates as international patients" — a positioning that reflects a secular, quality-first rather than faith-aligned competitive strategy.

#### **4.1.4 Indonesia: The World's Largest Muslim Patient Source and Domestic Development**

Indonesia occupies a paradoxical position in Southeast Asian halal medical tourism: as the world's largest Muslim patient source — accounting for 64.9 percent of Malaysia's medical tourism and generating substantial flows to Singapore — it simultaneously constitutes the most strategically important export market for regional competitors and the fastest-developing domestic halal healthcare market that could, if developed successfully, reverse significant outbound medical tourism flows.

The BMC Health Services Research (2024) scoping review on medical tourism among Indonesians — the most comprehensive systematic evidence synthesis on this topic —

documents that Indonesian patients' motivation for overseas medical care is multidimensional: quality differentials (no Indonesian hospital ranked in the 2024 world's best hospitals), service efficiency (shorter waiting times abroad), and crucially, **religious compatibility**. The review finds that "Indonesian Muslim patients accessed IVF in Malaysia due to compatible religious backgrounds, feeling safer to be treated by Muslim doctors who knew about halal and haram in Islamic law" — demonstrating that faith-aligned healthcare is a genuine and primary demand factor, not a secondary preference, for the Indonesian Muslim medical tourist.

The domestic counterweight is Indonesia's growing Sharia hospital sector. Ngatindriatun, Alfarizi & Widiastuti (2024, *Journal of Islamic Accounting and Business Research*) document the impact of Sharia hospital service standards on patient satisfaction and loyalty in DSN MUI-certified hospitals, confirming that "Islamic service standards positively and significantly impact patient satisfaction and patient loyalty" — providing empirical validation for the commercial viability of the Sharia hospital model. The Malahayati International Journal of Nursing and Health Science literature review (Putranto & Aini, 2025) identifies ten studies on Islamic hospital tourism in Indonesia, finding that certified Sharia hospitals provide "halal healthcare services, sharia-based facilities, patient satisfaction and loyalty, competitive advantage, and positive sentiment and business potential."

The Indonesian government's active domestic healthcare infrastructure development — partnering with Mayo Clinic, expanding hospital capacity, and considering relaxation of regulations on foreign specialists — represents a long-term strategic imperative to reduce outbound medical tourism flows. For Malaysia and Thailand, this trajectory implies a narrowing window of opportunity to capture Indonesian Muslim medical tourists before domestic quality improvements reduce the quality differential that currently drives outbound flows.

## **4.2 Cluster II — Shariah Compliance Standards: Architecture, Gaps, and the BMJ Open 2025 Contribution**

### **4.2.1 MS 1900:2014: The Current Standard and Its Limitations**

The **Malaysian Standard MS 1900:2014 (Shariah-Based Quality Management Systems — Requirements with Guidance)** represents the most institutionally advanced national standard for Islamic governance in healthcare globally. Certified institutions include HUSM, Al Islam Medical Centre, Sultan Ahmad Shah Medical Centre @IIUM, and An Nur Specialist Hospital. The standard focuses on organizational management compliance with Shariah principles — governance structures, halal food provision, prayer facility requirements, patient segregation, and Shariah advisory committees.

However, the BMJ Open (2025) landmark study by Jamaludin, Abdullah, Endut, Saifuddeen, Hamimi & Harun explicitly documents the standard's limitation: MS 1900:2014 "ensures organisational management complies with Shariah principles, it does not address the holistic integration of Islamic ethics into medical procedures, patient care or religious sensitivities." This gap — between organizational management compliance and clinical practice integration — is the central governance deficit in halal medical tourism's Shariah compliance architecture. A hospital may achieve MS 1900:2014 certification by ensuring halal food menus and prayer rooms while still falling short of integrated Shariah compliance in clinical decision-making,

end-of-life care, bioethics consultations, gender-sensitive procedures, and pharmaceutical protocols.

The Zawawi (IIUM Law Journal, 2024) analysis of legal impediments to Shariah-compliant medical tourism in Malaysia documents specific gaps in the regulatory architecture: tensions between conventional medical practice laws and Islamic medical ethics requirements; lack of formal legal recognition for Shariah advisory committees in clinical decision-making; absence of legal frameworks for halal pharmaceutical requirements in clinical settings; and undefined legal standards for informed consent processes that incorporate Islamic patient autonomy principles. These are not merely operational gaps but structural legal impediments that must be addressed through parliamentary-level regulatory reform.

#### 4.2.2 The BMJ Open 2025 Framework: Ten Essential Elements

The most significant academic contribution to Shariah-compliant medical services standardization in the reviewed period is Jamaludin et al. (*BMJ Open*, 15(1), e082263, 2025) — a rigorous expert consensus study using fuzzy Delphi methodology and interpretive structural modelling to develop a comprehensive framework for Shariah-compliant medical services in Malaysia. The panel reached consensus on **ten essential elements** representing the first empirically validated architecture for halal medical tourism service excellence:

**Element 1 — Governance:** Shariah advisory committees with binding authority over clinical and operational decision-making; not merely consultative bodies. Formal integration of Islamic bioethics review into hospital governance.

**Element 2 — Medical Ethics:** Clinical decision-making grounded in *Maqasid al-Shariah* — specifically the balance between *hifz al-nafs* (preservation of life), *hifz al-din* (preservation of religion), and *hifz al-'aql* (preservation of reason). Includes Islamic perspectives on informed consent, patient autonomy, end-of-life decision-making, and organ donation.

**Element 3 — Patient Care:** Gender-sensitive care protocols as a standard operational requirement, not a special accommodation. Female clinician availability for female patients across all specialties. Mahram (guardian) accommodation in clinical procedures. Patient dignity (*hurma*) as a clinical standard.

**Element 4 — Human Resources and Professional Development:** Continuous Islamic ethics training for all clinical and non-clinical staff. Understanding of Muslim patients' religious needs as a professional competency, not optional cultural sensitivity training.

**Element 5 — Facilities for Islamic Worship (Ibadah):** Prayer facilities (*musollah*) meeting minimum standards for cleanliness, accessibility, and orientation toward Qibla. Wudu (ablution) facilities in or adjacent to patient rooms and clinical areas. Prayer time accommodation in clinical scheduling.

**Element 6 — Spiritual Care Support:** Structured religious counseling (Islamic psychological support) integrated into clinical care. Chaplaincy services by qualified Islamic scholars. Quranic recitation and Islamic comfort practices during procedures, recovery, and end-of-life care.

**Element 7 — End-of-Life Care:** Islamic protocols for *hajat* al-mawt (approaching death) — talqin (reminder of faith), family presence, Quran recitation, ghusl (ritual washing) arrangements. Islamic bioethics frameworks for clinical decisions in terminal cases, including *do not resuscitate* orders from an Islamic perspective.

**Element 8 — Islamic Environment:** Physical design incorporating Islamic aesthetic principles. Qibla indicators in all rooms. Islamic art and calligraphy. Arabic greeting practices. Segregation of unrelated males and females in non-emergency settings.

**Element 9 — Medicine and Drugs:** Halal pharmaceutical protocols — verification of halal status of all medications and intravenous solutions; fatwa-based guidance for unavoidable use of haram components under necessity (*darurah*) principles. Halal surgery equipment and consumables where available.

**Element 10 — Affordability and Accessibility:** Ensuring that Shariah-compliant services are not a premium add-on available only to high-income patients, but are integrated into standard care across all patient categories.

This ten-element framework — the most comprehensive expert-validated architecture for Shariah-compliant medical services — provides the foundation for the FCIA Framework proposed in Section 5 of this review.

#### 4.2.3 The ESCA+ Ethics Model: Beyond Institutional Compliance

The ESCA+ Ethics Model for Islamic Medical Tourism (HRMARS, International Journal of Academic Research in Business and Social Sciences, 2025) extends beyond institutional compliance frameworks to address the ethical depth of faith-care integration. ESCA+ — standing for Ethics, Shariah Compliance, Authenticity, and (the + dimension) Patient Agency — critiques the tendency toward superficial Islamic branding in medical tourism marketing without embedded institutional practice change.

The model's most provocative contribution is the *authenticity gap* construct: "the conflict between genuine ethical governance and mere branding," arguing that Shariah compliance must "be practiced at both policy and organisational culture levels and not only be superficial." A hospital that markets itself as halal-friendly while Muslim patients must request halal food specifically, actively identify prayer rooms, or negotiate gender-sensitive care against default practices fails the authenticity test regardless of its MS 1900:2014 certification status.

The *patient agency* dimension of ESCA+ addresses a theoretical gap: the tendency to treat Muslim patients as passive recipients of institutional religious accommodation rather than as active interpreters and practitioners of their faith in clinical contexts. The model documents — consistent with Naserirad et al. (2023) — that Muslim patients "actively interpret and apply Shariah in real-time situations — such as choosing urgent care from a male physician when no female doctor is available." This grassroots *ijtihad* (independent religious reasoning) in clinical contexts reflects a sophisticated patient agency that halal medical tourism providers must be institutionally prepared to support, not merely accommodate.

### 4.3 Cluster III — Muslim Medical Tourist Behavior: Expectations, Satisfaction, and Heterogeneity

#### 4.3.1 The Naserirad et al. 2023 Study: Quantifying Halal Healthcare Expectations

The most cited empirical study on Muslim medical tourist expectations in the reviewed corpus — Naserirad, Tavakol, Abbasi, Jannat, Sadeghi & Bahemmat (2023) published in *Health Services Management Research* (SAGE, Scopus Q2) — provides a systematic hospital-based cross-sectional analysis with 365 international Muslim medical tourists across 17 hospitals in four Iranian cities. The study's mean expectation score of  $3.95 \pm 1.43$  (on a five-point Likert scale) confirms high expectations for halal-friendly healthcare, with variation across expectation dimensions reflecting the heterogeneity of Muslim religious practice across nationalities and cultural backgrounds.

Key findings directly relevant to Southeast Asian halal medical tourism positioning: first, Muslim medical tourists do not constitute a homogeneous segment — "Muslims' interpretation of the concept of halal varies" significantly across nationalities, particularly between Arab patients (who prioritize gender segregation and Islamic atmosphere), South Asian patients (who prioritize halal food and pharmaceutical verification), and Southeast Asian patients (who prioritize a combination of familiar Islamic culture and clinical quality). Second, expectations are highest for gender-sensitive care and halal food, confirming these as minimum hygiene factors that all halal medical tourism providers must meet. Third, spiritual care support and Islamic environment design generate the strongest satisfaction premium relative to expectations — suggesting these are differentiators, not just baseline requirements.

The reviewed corpus also includes the foundational study by Zailani, Mohezar Ali, Iranmanesh et al. (*Tourism Management*, 2016) — the most-cited empirical study on Muslim medical tourist satisfaction with Malaysian Islamic-friendly hospitals — which remains the methodological benchmark in the field. Using PLS analysis of 243 Muslim medical tourists at Malaysian Islamic-friendly hospitals, the study establishes that **doctors' and hospitals' halal practices have a positive direct effect on Muslim medical tourists' satisfaction**, while the nurse's halal practice operates through attitude as a mediator. This finding — that clinical personnel are the primary satisfaction delivery mechanism, not physical infrastructure — has direct implications for human resource strategy in halal medical tourism.

#### 4.3.2 Sharia Hospital Service Quality: Indonesian Evidence

The Indonesian domestic Sharia hospital literature — particularly Ngatindriatun, Alfarizi & Widiastuti (2024, *Journal of Islamic Accounting and Business Research*, Emerald), Widiastuti, Indartono & Sa'adah (2024, *Society*, Scopus Q2), and Wahyuningsih, Mariyanti & Hatta (2023, *International Journal of Research in Business and Social Science*, Scopus) — provides the most recent and methodologically robust evidence base for Islamic service quality (ISQ) determinants in Southeast Asian halal healthcare.

Ngatindriatun et al. (2024) study DSN MUI-certified Sharia hospitals in Indonesia using a structural equation model with 345 patient respondents, finding that Sharia hospital service standards significantly and positively impact patient satisfaction and loyalty — with **religiosity commitment as a significant moderator**. Critically, the moderating role of religiosity means

that high-religiosity patients respond more strongly to both the positive effects of Sharia compliance and the negative effects of compliance gaps — confirming that authenticity rather than surface-level compliance is the key satisfaction driver for the most religiously committed patient segment.

Widiastuti et al. (2024) develop an Islamic Service Quality (ISQ) scale for healthcare contexts, documenting that ISQ dimensions — tangibles (physical Islamic environment), reliability (consistent halal practice), responsiveness (patient religious need accommodation), assurance (medical competence aligned with Islamic ethics), and empathy (cultural sensitivity and spiritual understanding) — significantly predict patient loyalty through patient satisfaction. The *assurance* dimension — combining medical competence with Islamic ethical grounding — emerges as the most powerful loyalty predictor, suggesting that patients value Islamic ethics and medical excellence as complementary rather than competing values.

Wahyuningsih et al. (2023) examine patient satisfaction in Sharia hospitals in Riau Province, Indonesia, finding that trust, service quality, and hospital Sharia compliance together predict patient loyalty — with satisfaction fully mediating the relationships. Trust emerges as the strongest predictor: Muslim patients' confidence that the hospital genuinely observes Shariah rather than performing it superficially is the foundational element on which satisfaction and loyalty are built. This trust-first architecture is consistent with the ESCA+ authenticity gap critique.

### **4.3.3 The Indonesian Outbound Medical Tourist: A Religious Decision**

The BMC Health Services Research (2024) scoping review of medical tourism among Indonesians — the first systematic scoping review on this topic — provides critical contextual evidence for understanding the Islamic dimension of medical tourism decision-making. The review documents that Indonesian Muslim patients' choice of Malaysia for IVF specifically reflects "compatible religious backgrounds, feeling safer to be treated by Muslim doctors who knew about halal and haram in Islamic law" — a finding that positions religious compatibility as a primary rather than secondary motivator.

This finding is conceptually significant: it establishes that for medically sensitive procedures (IVF, reproductive health, end-of-life care, genetic testing) that intersect directly with Islamic bioethical teachings, faith-care alignment is not merely a comfort factor but a clinical necessity from the patient's perspective. An IVF procedure that does not comply with Islamic requirements for embryo creation, handling, and destiny is not merely less comfortable — it is unacceptable regardless of its clinical quality. This "Islamic bioethics threshold" in clinical decision-making defines the hardest boundary of halal medical tourism demand.

## **4.4 Cluster IV — Islamic Hospitality Integration: The ESCA+ Model and Faith-Care Convergence**

### **4.4.1 Islamic Hospitality as Competitive Differentiator**

The Travel and Tour World (2024) analysis of AITEX 2024 and Islamic hospitality in medical tourism documents that "the seamless integration of Islamic hospitality with medical tourism creates a comfortable and culturally appropriate environment, positioning countries like

Malaysia and Thailand as top choices for Muslim medical tourists globally." This observation — from a practitioner rather than academic source but consistent with the reviewed academic literature — captures the core competitive proposition of halal medical tourism: it is not clinical quality alone but the seamless integration of clinical excellence with Islamic cultural and spiritual hospitality that creates the distinctive patient value proposition.

Islamic hospitality — *diyafa* — has a rich theological and historical foundation in Islamic tradition. The Quran's injunction to "enter upon homes with greetings" (Q. 24:27) and the Prophet's teaching that "whosoever believes in Allah and the Last Day, let him honor his guest" ground hospitality as a spiritual obligation, not merely a service design principle. In the healthcare context, Islamic hospitality translates into specific operational practices: greeting patients with *Assalamu Alaikum*, accommodating daily prayer schedules in clinical workflows, providing Quran and prayer items in patient rooms, enabling family and Mahram presence in clinical settings, and structuring the patient journey as a holistic spiritual experience rather than a transactional medical encounter.

The Jamal & Jamaludin (2024, *Journal of Halal Industry and Services*) study on Halal Medical Tourism and Reproductive Care in the Malaysian marketplace documents how Islamic hospitality integration in reproductive care — specifically IVF — extends to the full bioethical framework of Islamic family formation principles, including fatwa guidance on embryo destiny, genetic testing permissibility, and the spiritual dimensions of infertility treatment. This level of faith-care integration — where the clinical service is designed around Islamic ethical principles rather than merely accommodated alongside them — represents the highest expression of halal medical tourism's competitive differentiation.

#### 4.4.2 The Faith-Care Convergence Spectrum

The reviewed literature suggests a continuum of faith-care integration that halal medical tourism destinations occupy at different positions:

At the most basic level (Level 1 — *Halal Accommodation*), facilities provide halal food, prayer rooms, and gender option for nursing care as supplementary services added to a conventional healthcare delivery model. This represents minimum compliance that does not constitute meaningful competitive differentiation.

At the intermediate level (Level 2 — *Halal Integration*), Shariah compliance is embedded in standard operating procedures — halal pharmaceutical protocols, structured gender-sensitive care pathways, Islamic chaplaincy services, and Shariah advisory oversight of clinical protocols. MS 1900:2014 certification represents this level's institutional standard.

At the highest level (Level 3 — *Faith-Care Convergence*), Islamic values are embedded in the organizational culture, clinical ethics frameworks, workforce competency development, physical design philosophy, and patient journey architecture. Shariah principles are not an overlay on conventional healthcare but the foundational value system from which clinical excellence is built. This is what Jamaludin et al.'s ten-element BMJ Open framework aspires to operationalize, and what ESCA+'s authenticity test demands.

The competitive advantage of halal medical tourism resides at Level 3 — Faith-Care Convergence — because it is at this level that genuine product differentiation from conventional medical tourism becomes sustainable. A Thai hospital with halal food options competes at Level 1. Malaysia's certified IFH hospitals compete at Level 2. The aspiration of the BMJ Open (2025) framework and the ESCA+ Ethics Model is Level 3.

#### **4.5 Cluster V — Governance and Standardization: The ASEAN Harmonization Imperative**

##### **4.5.1 The ASEAN Halal Tourism Standardization Gap**

The UMPSA-IR bibliometric study (JIABR/Journal of Islamic and Business Research, 2026) — analyzing 204 Scopus-indexed publications on halal tourism in Southeast Asia from 2011 to 2024 — identifies the most critical finding for halal medical tourism governance: "Although halal tourism has gained momentum, gaps remain in empirical depth, standardization and regional coordination." The study explicitly recommends "ASEAN-wide halal tourism standardisation to improve consistency and cross-border collaboration" as the priority future research and policy direction.

This recommendation reflects a structural reality documented across the reviewed corpus: each Southeast Asian nation has developed its own approach to halal medical tourism governance. Malaysia has MS 1900:2014. Thailand has the Halal Standard Institute's Muslim-friendly destination certification. Indonesia has DSN MUI's Sharia hospital certification. Singapore has no formal halal healthcare certification. The result is a fragmented landscape in which a patient certified by Malaysian hospitals may face uncertainty about halal standards in Thai hospitals, and in which cross-border care pathways — patients beginning treatment in one country and continuing in another — lack shared halal assurance frameworks.

The IIUM Law Journal (Amin, Ramli & Zawawi, 2023) analysis of harmonizing international legal frameworks and Shariah principles in medical tourism provides the legal architecture analysis: existing international medical tourism governance frameworks (Joint Commission International, Global Healthcare Accreditation) do not incorporate Shariah compliance requirements, meaning that JCI-accredited hospitals are globally certified for clinical quality but not for Islamic standards. A dedicated **ASEAN Halal Medical Tourism Standard** — building on Malaysia's MS 1900:2014 and incorporating the ten-element framework from Jamaludin et al. (BMJ Open, 2025) — would close this governance gap and create a regionally recognized halal healthcare certification that Muslim patients can rely on across ASEAN borders.

##### **4.5.2 Indonesia's Domestic Development Trajectory**

The Astiwaru (IJSOC, 2025) analysis of Islamic health service standardization globally documents that Indonesia's DSN MUI Sharia hospital certification system — applied to approximately 80 certified Sharia hospitals nationally as of 2024, with significant growth momentum — creates the regulatory foundation for domestic halal medical tourism development that could ultimately reduce outbound flows. The Bogor Islamic Hospital case study (Al-Infraq, 2024) and the Riau Province Sharia hospital analysis (Wahyuningsih et al., 2023) document mature domestic implementations of Islamic healthcare service standards that,

if scaled and marketed to domestic Muslim medical tourists, could represent a significant import substitution effect in the international medical tourism market.

The Indonesian government's domestic infrastructure development strategy — Mayo Clinic partnership, relaxation of foreign specialist restrictions, new medical facility development — combined with mandatory halal certification (GR 42/2024) extending to healthcare products, and the growing domestic Sharia hospital network, creates the conditions for Indonesia to transition from the world's largest Muslim medical tourism export market to a regional halal medical tourism destination in its own right within a 10-15 year horizon.

## 5. Synthesis: The Faith-Care Integration Architecture (FCIA) Framework

### 5.1 Framework Rationale

The reviewed literature converges on a shared critique: existing halal medical tourism frameworks are insufficient because they conflate organizational compliance (having halal food menus and prayer rooms) with authentic faith-care integration (being a healthcare institution whose entire clinical and operational philosophy is grounded in Islamic values). The BMJ Open (2025) ten-element framework, the ESCA+ Ethics Model's authenticity gap construct, and the competitive positioning evidence from Malaysia, Thailand, and Indonesia all point toward the need for a comprehensive operational architecture that goes beyond compliance checkboxes to describe the conditions for genuine halal medical tourism excellence.

This review proposes the **Faith-Care Integration Architecture (FCIA) Framework** as an operational model for comprehensive halal medical tourism destination positioning, synthesizing the review's five thematic clusters into a five-pillar governance architecture.

### 5.2 Five Pillars of the FCIA Framework

**Pillar I — Shariah Governance Architecture (*Hukm al-Shifah*, Governance of Healing):** Institutionalization of Islamic bioethics at the governance level: a Shariah Advisory Board with binding (not merely advisory) authority over clinical protocols, bioethics decisions, and service standards; formal integration of Maqasid al-Shariah principles into clinical decision frameworks; and annual Shariah compliance auditing by qualified independent scholars. This pillar grounds all other FCIA elements in authentic theological authority rather than institutional self-certification. Key standard: BMJ Open (2025) Element 1 (Governance) and Element 2 (Medical Ethics).

**Pillar II — Clinical Excellence and Islamic Bioethics Integration (*I'raj wa Akhlaaq, Treatment and Ethics*):** Clinical excellence — JCI accreditation, internationally trained specialists, advanced diagnostic and surgical technology — combined with mandatory Islamic bioethics training for all clinical personnel. Specialty areas requiring specific Islamic bioethics protocols (reproductive medicine, oncology, end-of-life care, genetic medicine, organ transplantation) must maintain published fatwa-based clinical guidelines developed with qualified scholars. Medical tourism packages must include Islamic bioethics consultation as a standard service for procedurally complex cases. Key standard: BMJ Open (2025) Elements 2 and 9; Naserirad et al. (2023) expectation data.

**Pillar III — Holistic Halal Environment (*Bi'ah Halal, Halal Environment*):** Physical design grounded in Islamic aesthetic and functional principles: Qibla-oriented rooms, wudu facilities, accessible musollah, halal-certified nutrition across all menus and IV solutions, Islamic art and calligraphy, gender-segregated waiting areas, female-only wards where requested. This pillar operationalizes the Islamic hospitality (*diyafa*) tradition in the clinical setting — treating the patient's entire environmental experience as a spiritual dimension of healing. Key standard: BMJ Open (2025) Elements 5, 8, and 9; ESCA+ authenticity standard.

**Pillar IV — Spiritual Care Pathway (*Ri'ayah Ruhiyah, Spiritual Care*):** Structured spiritual care delivery as a clinical service, not an optional extra: Islamic chaplaincy services by qualified scholars; Quran recitation and Islamic psychological support during pre-operative anxiety, post-operative recovery, and end-of-life processes; family and community *silaturahmi* (social bonding) support structures; and post-discharge halal health maintenance guidance integrating Islamic prophetic medicine (*Tib al-Nabawi*) principles with contemporary clinical advice. Key standard: BMJ Open (2025) Elements 6 and 7; Widiastuti et al. (2024) assurance dimension.

**Pillar V — Competitive Positioning and ASEAN Harmonization (*Tanafus Halal, Halal Competition*):** Strategic positioning of halal medical tourism destinations against the global Muslim health travel market through: MHTC-style government-led destination branding with explicit halal certification requirements; bilateral government-to-government (G2G) partnerships with major Muslim patient source countries (Indonesia-Malaysia, GCC-Malaysia, Bangladesh-Malaysia); ASEAN-wide halal medical tourism standard development building on MS 1900:2014 and the BMJ Open (2025) framework; digital patient journey platforms providing seamless halal service verification from pre-travel consultation through discharge and follow-up; and affordability programs ensuring that Shariah-compliant services are accessible across income levels (BMJ Open 2025 Element 10).

## 6. Research Gaps and Future Agenda

Priority	Gap	Current State	Recommended Approach
<b>Critical</b>	ASEAN-wide halal medical tourism certification standard	MS 1900:2014 (Malaysia only); DSN MUI (Indonesia only); no regional standard	ASEAN working group; OIC-SMIIC framework development
<b>Critical</b>	Longitudinal patient outcome study: does faith-care integration improve clinical outcomes beyond satisfaction?	Satisfaction/loyalty data only; no clinical outcome correlation	Multi-site RCT; matched cohort comparison
<b>High</b>	Indonesian domestic Sharia hospital development: can it achieve quality parity with Malaysia within a decade?	Qualitative case studies; no quality benchmarking	JCI accreditation trajectory analysis; patient leakage modeling

<b>High</b>	Islamic bioethics in clinical specialties: published fatwa-based guidelines for IVF, oncology, end-of-life care	Fragmented juristic opinions; no operational clinical protocols	Scholar-clinician co-design of specialty-specific Islamic bioethics guidelines
<b>High</b>	Digital halal health platform: Muslim patient journey tracking from origin country to hospital to discharge	Conceptual; no implementation study	UX design; platform architecture; MHTC technology partnership
<b>Medium</b>	GCC patient segment in Southeast Asia: specific expectations, satisfaction drivers, and destination preferences	Aggregate Muslim tourist data; GCC-specific data absent from SEA literature	Targeted survey; MHTC Middle East market data
<b>Medium</b>	Thailand's Muslim medical tourism segment: quantifying the halal accommodation premium vs. Malaysia's certification advantage	Competitive analysis only; no patient preference experiment	Conjoint analysis; willingness-to-pay for halal certification
<b>Medium</b>	Halal pharmaceutical protocols in clinical settings: implementation feasibility and patient acceptance	Legal analysis (IIUM LJ, 2024); no implementation study	Hospital pharmacovigilance study; pharmacist Islamic ethics training
<b>Emerging</b>	AI and digital health in Islamic medical tourism: telemedicine for pre-travel Islamic bioethics consultation	Emerging (Battour et al., 2024 reference); no dedicated study	Technology adoption study; chatbot Islamic bioethics design
<b>Emerging</b>	Waqf in halal medical tourism finance: Islamic endowment as accessibility mechanism	Theoretical in Islamic hospital literature; not applied to medical tourism	Waqf hospital finance case study; patient accessibility impact

## 7. Conclusions

### 7.1 Summary of Principal Findings

This systematic literature review of 35 publications (2023–2026) establishes six principal findings for halal medical tourism in Southeast Asia. **First**, the regional competitive landscape is structurally stratified: Malaysia leads on faith-care integration and institutional halal governance; Thailand leads on clinical scale and cost-quality value; Singapore leads on premium quaternary care; and Indonesia — the world's largest Muslim patient source — is developing domestic Sharia hospital capacity that could partially reverse outbound flows. **Second**, the Jamaludin et al. (BMJ Open, 2025) ten-element framework for Shariah-compliant

medical services represents the most significant academic advance in halal healthcare standards since MS 1900:2014, establishing a comprehensive architecture that addresses MS 1900:2014's limitation of organizational rather than clinical Shariah compliance. **Third**, Muslim medical tourist behavior — particularly the Indonesian outbound patient — is genuinely faith-driven: religious compatibility is a primary destination selection factor, not merely a secondary preference, most clearly demonstrated in the IVF context where Islamic bioethics compatibility is non-negotiable. **Fourth**, the ESCA+ Ethics Model's authenticity gap construct reframes halal medical tourism competitive positioning: sustainable differentiation requires authentic Level 3 Faith-Care Convergence, not Level 1 halal accommodation, because highly religiously committed Muslim patients — the premium segment — can detect and reject superficial Islamization. **Fifth**, the ASEAN-wide halal tourism standardization gap — documented in the UMPA-IR bibliometric analysis (JIABR, 2026) — represents the most critical governance deficit in the regional halal medical tourism system. **Sixth**, Malaysia's 2024 performance (1.6 million patients, RM 2.72 billion, No. 1 global ranking) confirms that faith-care integration is commercially viable at scale and positions MYMT 2026's RM 12 billion 2030 target as achievable if institutional halal healthcare development matches marketing ambition.

## 7.2 Theoretical Contributions

Three theoretical contributions emerge from this review. First, the **Faith-Care Integration Architecture (FCIA) Framework** — five pillars operationalizing comprehensive halal medical tourism destination excellence — provides the first integrated governance model that synthesizes Shariah compliance governance, clinical excellence, holistic halal environment, spiritual care pathway, and competitive positioning into a coherent destination architecture. Second, the **Faith-Care Convergence Spectrum** — three levels from halal accommodation through halal integration to full faith-care convergence — provides a diagnostic tool for destination positioning and a normative standard for competitive aspiration. Third, the identification of **Islamic Bioethics Threshold Procedures** — clinical specialties (IVF, end-of-life care, genetic medicine) where Shariah compliance is non-negotiable regardless of clinical quality — establishes a theoretically grounded segmentation of the halal medical tourism demand landscape that differentiates hygiene factors (minimum compliance requirements) from competitive differentiators.

## 7.3 Closing Note

In the Islamic medical tradition, healing is an act of *shukr* (gratitude) — the patient receives healing as a gift from God (*Allah Shafi*, God is the Healer), the physician serves as His instrument, and the hospital is a space of divine mercy. This theology of healing — documented in Prophetic medicine traditions and classical Islamic medical ethics from Ibn Sina to al-Razi — is not merely a spiritual metaphor but a practical operational philosophy: a hospital that genuinely embodies Islamic values creates an environment in which the patient's entire experience — from the quality of clinical care to the direction of the prayer room — is understood as an expression of the divine trust that human beings bear as God's *khalifah* on Earth.

Southeast Asia's halal medical tourism leaders — particularly Malaysia — are building something genuinely unprecedented: a regional healthcare system in which clinical world-class excellence and authentic Islamic faith-care integration are not in tension but mutually

reinforcing. The challenge is to institutionalize that integration beyond individual hospital commitments into a regionally harmonized, transparently certified, and continuously improving ASEAN-wide standard that gives Muslim patients — from Jakarta's tile factories to Dhaka's garment districts to Dubai's glass towers — the confidence that when they travel for healing, they travel to a place that understands not just their bodies, but their souls.

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